



COLORADO
Department of Health Care
Policy & Financing



Colorado Department of Health Care Policy and Financing Preferred Drug List (PDL) Effective July 1, 2024

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

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

Electronic Prior Authorization (ePA): Electronic Prior Authorization Requests are supported by CoverMyMeds and may be submitted via Electronic Health Record (EHR) systems or through the CoverMyMeds provider portal.

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.

Covid-19 Related Treatment Override: Providers may call the Magellan Help Desk at 1-800-424-5725 to request a prior authorization override if a medication is related to the treatment or prevention of COVID-19 or the treatment of a condition that may seriously complicate the treatment of COVID-19.

Health First Colorado, at section 25.5-5-501, C.R.S., 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.

A provider may request a step therapy exception for the treatment of a serious or complex medical condition pursuant to section 25.5-4-428, C.R.S. Serious or complex medical condition means the following medical conditions: serious mental illness, cancer, epilepsy, multiple sclerosis, or human immunodeficiency virus (HIV)/ acquired immune deficiency syndrome (AIDS), or a condition requiring medical treatment to avoid death, hospitalization, or a worsening or advancing of disease progression resulting in significant harm or disability. The step therapy exception request form is available by visiting <https://hcpf.colorado.gov/pharmacy-resources>

**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.)
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I. Analgesics

Therapeutic Drug Class: **NON-OPIOID ANALGESIA AGENTS - Oral** - *Effective 4/1/2024*

No PA Required	PA Required	
Duloxetine 20 mg, 30 mg, 60 mg capsule Gabapentin capsule, tablet, solution Pregabalin capsule SAVELLA (milnacipran) tablet, titration pack	CYMBALTA (duloxetine) capsule DRIZALMA (duloxetine DR) sprinkle capsules Duloxetine 40 mg capsule GRALISE (gabapentin ER) tablet Gabapentin ER tablet HORIZANT (gabapentin ER) tablet LYRICA (pregabalin) capsule, solution, CR tablet NEURONTIN (gabapentin) capsule, tablet, solution Pregabalin solution, ER tablet	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.

Therapeutic Drug Class: **NON-OPIOID ANALGESIA AGENTS - Topical** - *Effective 4/1/2024*

No PA Required	PA Required	
Lidocaine patch LIDODERM (lidocaine) patch	Lidocaine patch (Puretek) 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 a preferred lidocaine patch. Failure is defined as lack of efficacy with an 8-week trial, allergy, intolerable side effects, or significant drug-drug interaction. Lidocaine patch (Puretek manufacturer only) may be approved if the following criteria are met: <ul style="list-style-type: none"> Member is \geq 18 years of age AND Member has had an adequate 8-week trial and failure of: gabapentin AND pregabalin AND duloxetine AND a preferred lidocaine patch. Failure is defined as lack of efficacy with an 8-week trial, allergy, intolerable side effects, or significant drug-drug interaction AND Prescriber has provided a justification of clinical necessity indicating that an alternative generic lidocaine patch formulation cannot be used.

Therapeutic Drug Class: **NON-STEROIDAL ANTI-INFLAMMATORIES (NSAIDs) - Oral** - Effective 4/1/2024

No PA Required	PA Required	
Celecoxib capsule	ARTHROTEC (diclofenac sodium/ misoprostol) tablet	<p>DUEXIS (ibuprofen/famotidine) or VIMOVO (naproxen/esomeprazole) may be approved if the member meets the following criteria:</p> <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
Diclofenac potassium 50 mg tablet	CELEBREX (celecoxib) capsule	
Diclofenac sodium EC/DR tablet	DAYPRO (oxaprozin) caplet	<p>Diclofenac potassium 25 mg immediate-release tablets may be approved if the following criteria are met:</p> <ul style="list-style-type: none"> • Member is ≥ 18 years of age AND • Member does not have any of the following medical conditions: <ul style="list-style-type: none"> ○ History of recent coronary artery bypass graft (CABG) surgery ○ History of myocardial infarction ○ Severe heart failure ○ Advanced renal disease ○ History of gastrointestinal bleeding <p>AND</p> <ul style="list-style-type: none"> • Member has trial and failure[‡] of four preferred oral NSAIDs at maximally tolerated doses
Ibuprofen suspension, tablet (RX)	Diclofenac potassium capsule, powder pack	
Indomethacin capsule, ER capsule	Diclofenac potassium 25 mg tablet	<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>
Ketorolac tablet*	Diclofenac sodium ER/SR tablet	
Meloxicam tablet	Diclofenac sodium/misoprostol tablet	<p>*Ketorolac tablets quantity limits: 5-day supply per 30 days and 20 tablets per 30 days</p>
Nabumetone tablet	Diflunisal tablet	
Naproxen DR/ER, tablet (RX)	DUEXIS (ibuprofen/famotidine) tablet	
Naproxen suspension	ELYXYB (celecoxib) solution	
Sulindac tablet	Etodolac capsule; IR, ER tablet	
	FELDENE (piroxicam) capsule	
	Fenoprofen capsule, tablet	
	Flurbiprofen tablet	
	Ibuprofen/famotidine tablet	
	Ketoprofen IR, ER capsule	
	LOFENA (diclofenac) tablet	
	Meclofenamate capsule	
	Mefenamic acid capsule	
	Meloxicam submicronized capsule, suspension	

	NALFON (fenoprofen) capsule, tablet NAPRELAN (naproxen CR) tablet Naproxen sodium CR, ER, IR tablet Naproxen/esomeprazole DR tablet Oxaprozin tablet Piroxicam capsule RELAFEN DS (nabumetone) tablet Tolmetin tablet VIMOVO (naproxen/esomeprazole) DR tablet	
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Therapeutic Drug Class: NON-STEROIDAL ANTI-INFLAMMATORIES (NSAIDS) - Non-Oral - Effective 4/1/2024

No PA Required	PA Required	
Diclofenac 1.5% topical solution Diclofenac sodium 1% gel (OTC/Rx)	Diclofenac 1.3% topical patch, 2% pump FLECTOR (diclofenac) 1.3% topical patch Ketorolac nasal spray LICART (diclofenac) 1.3% topical patch PENNSAID (diclofenac solution) 2% pump, 2% solution packet	<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>Diclofenac topical patch 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 link: <https://pharmacymp.az.gov/resources/mme-calculator>

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 04/01/23 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)*. 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 4/1/2024

Preferred No PA Required* (If criteria and quantity limit are met)	Non-Preferred PA Required	
*Acetaminophen/codeine tablets	Acetaminophen / codeine elixir	*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.
Hydrocodone/acetaminophen solution, tablet	ASCOMP WITH CODEINE (codeine/butalbital/aspirin/caffeine)	Preferred codeine or tramadol products prescribed for members < 18 years of age must meet the following criteria:
Hydromorphone tablet	*Butalbital/caffeine/acetaminophen/codeine capsule	<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
Morphine IR solution, tablet	Butalbital/caffeine/aspirin/codeine capsule	<ul style="list-style-type: none"> • 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
**NUCYNTA (tapentadol) tablet	Butalbital compound/codeine	
Oxycodone solution, tablet	Butorphanol tartrate (nasal) spray	
Oxycodone/acetaminophen tablet	Carisoprodol/aspirin/codeine	
*Tramadol 25mg, 50mg	Codeine tablet	
*Tramadol/acetaminophen tablet	Dihydrocodeine/acetaminophen/caffeine tablet	

	<p>DILAUDID (hydromorphone) solution, tablet</p> <p>FIORICET/CODEINE (codeine/butalbital/acetaminophen/caffeine) capsule</p> <p>Hydrocodone/ibuprofen tablet</p> <p>Hydromorphone solution</p> <p>Levorphanol tablet</p> <p>Meperidine solution, tablet</p> <p>Morphine concentrated solution, oral syringe</p> <p>NALOCET (oxycodone/acetaminophen) tablet</p> <p>Oxycodone capsule, syringe, concentrated solution</p> <p>Oxycodone/acetaminophen solution</p> <p>Oxycodone/acetaminophen tablet (generic PROLATE)</p> <p>Oxymorphone tablet</p> <p>Pentazocine/naloxone tablet</p> <p>PERCOCET (oxycodone/acetaminophen) tablet</p> <p>ROXICODONE (oxycodone) tablet</p> <p>ROXYBOND (oxycodone) tablet</p> <p>SEGLENTIS (tramadol/celecoxib) tablet</p> <p>Tramadol 100mg tablet</p> <p>Tramadol solution</p>	<ul style="list-style-type: none"> ○ Member is not receiving strong inhibitors of CYP3A4 (such as erythromycin, clarithromycin, itraconazole, ketoconazole, posaconazole, fluconazole [$\geq 200\text{mg}$ 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.” <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>
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Therapeutic Drug Class: FENTANYL PREPARATIONS (buccal, transmucosal, sublingual) - Effective 4/1/2024

	<p align="center">PA Required</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>
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Therapeutic Drug Class: OPIOIDS, Long Acting - Effective 4/1/2024

<p align="center">Preferred No PA Required (unless indicated by * criteria)</p> <p>BELBUCA^{BNR} (buprenorphine) buccal film</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>XTAMPZA ER (oxycodone) capsule</p>	<p align="center">Non-Preferred PA Required</p> <p>**OXYCONTIN (oxycodone ER) tablet</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>Methadone (all forms)</p> <p>Morphine ER capsule</p> <p>MS CONTIN (morphine ER) tablet</p> <p>Oxycodone ER tablet</p> <p>Oxymorphone ER tablet</p> <p>Tramadol ER capsule</p>	<p>*Belbuca (buprenorphine) buccal film may be approved for members who have trialed and failed‡ treatment with Butrans (buprenorphine) patch at a dose of 20 mcg/hr OR with prescriber confirmation that the maximum dose of Butrans 20 mcg/hr will not provide adequate analgesia. <u>Quantity limit:</u> 60 films/30 days.</p> <p>Oxycontin (oxycodone ER) may be approved for members who have trialed and failed‡ treatment with TWO preferred agents.</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, allergy (hives, maculopapular rash, erythema multiforme, pustular rash, intolerable application site skin reactions, 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>
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		<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 Hydrocodone ER (generic 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 1/1/2024

Preferred	Non-Preferred	
No PA Required	PA Required	
(*Must meet eligibility criteria)		
<p>Tobramycin inhalation solution (generic TOBI)</p> <p>*CAYSTON (aztreonam) inhalation solution</p>	<p>ARIKAYCE (amikacin liposomal) inhalation vial</p> <p>BETHKIS (tobramycin) inhalation ampule</p> <p>KITABIS (tobramycin) nebulizer pak</p> <p>TOBI (tobramycin) inhalation solution</p> <p>TOBI PODHALER (tobramycin) inhalation capsule</p> <p>Tobramycin inhalation ampule (generic Bethkis)</p> <p>Tobramycin nebulizer pak (generic Kitabis)</p>	<p>*CAYSTON (aztreonam) inhalation solution may be approved if the following criteria are met:</p> <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 AND • The member has known colonization of <i>Pseudomonas aeruginosa</i> in the lungs AND • The member has been prescribed an inhaled beta agonist to use prior to nebulization of Cayston (aztreonam). <p>ARIKAYCE (amikacin) may be approved if the following criteria are met:</p> <ul style="list-style-type: none"> • Member has refractory mycobacterium avium complex (MAC) lung disease with limited or no alternative treatment options available AND • Member 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). <p>All other non-preferred inhaled antibiotic agents may be approved if the following criteria are met:</p>

- The member has a diagnosis of cystic fibrosis with known colonization of *Pseudomonas aeruginosa* in the lungs **AND**
- Member 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 1: Minimum Age, Maximum Dose, and Quantity Limitations			
Drug Name	Minimum Age	Maximum Dose	Quantity Limit (Based on day supply limitation for pack size dispensed)
ARIKAYCE (amikacin)	≥ 18 years	590 mg once daily	Not applicable
BETHKIS (tobramycin)	Age ≥ 6 years	300 mg twice daily	28-day supply per 56-day period
CAYSTON (aztreonam)	≥ 7 years	75 mg three time 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

† Limitations apply to brand product formulation only

Members currently stabilized on any inhaled antibiotic agent in this class may receive approval to continue that agent.

Therapeutic Drug Class: ANTI-HERPETIC AGENTS - Oral - Effective 1/1/2024

No PA Required	PA Required	
Acyclovir tablet, capsule	Acyclovir suspension (<i>all other members</i>)	<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>
*Acyclovir suspension (<i>members under 18 years or cannot swallow a solid dosage form</i>)	SITAVIG (acyclovir) buccal tablet	
Famciclovir tablet	VALTREX (valacyclovir) tablet	

Valacyclovir tablet		<p>*Acyclovir suspension does not require prior authorization for members < 18 years of age and may be approved for members ≥ 18 years of age who cannot swallow an oral dosage form.</p> <table border="1" data-bbox="1083 219 1877 425"> <thead> <tr> <th colspan="3">Maximum Dose Table</th> </tr> <tr> <th></th> <th>Adult</th> <th>Pediatric</th> </tr> </thead> <tbody> <tr> <td>Acyclovir</td> <td>4,000 mg/day</td> <td>3,200 mg/day</td> </tr> <tr> <td>Famciclovir</td> <td>2,000 mg/day</td> <td></td> </tr> <tr> <td>Valacyclovir</td> <td>4,000 mg/day</td> <td>Age 2-11 years: 3,000mg/day Age ≥ 12 years: 4,000mg/day</td> </tr> </tbody> </table>	Maximum Dose Table				Adult	Pediatric	Acyclovir	4,000 mg/day	3,200 mg/day	Famciclovir	2,000 mg/day		Valacyclovir	4,000 mg/day	Age 2-11 years: 3,000mg/day Age ≥ 12 years: 4,000mg/day
Maximum Dose Table																	
	Adult	Pediatric															
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Famciclovir	2,000 mg/day																
Valacyclovir	4,000 mg/day	Age 2-11 years: 3,000mg/day Age ≥ 12 years: 4,000mg/day															

Therapeutic Drug Class: ANTI-HERPETIC AGENTS- Topical - Effective 1/1/2024

<p>No PA Required <i>Brand/generic changes effective 02/22/2024*</i></p> <p>Acyclovir cream (<i>Teva only</i>)</p> <p>Acyclovir ointment</p> <p>DENAVIR (penciclovir) cream</p> <p>*Penciclovir cream</p>	<p>PA Required</p> <p>Acyclovir cream (<i>all other manufacturers</i>)</p> <p>XERESE (acyclovir/ hydrocortisone) cream</p> <p>ZOVIRAX (acyclovir) cream, ointment</p>	<p>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)</p> <p>Xerese (acyclovir/hydrocortisone) prior authorization may be approved for members that meet the following criteria:</p> <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)
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Therapeutic Drug Class: FLUOROQUINOLONES – Oral - Effective 1/1/2024

<p>Preferred No PA Required (*if meeting eligibility criteria)</p> <p>*CIPRO (ciprofloxacin) oral suspension^{BNR}</p> <p>Ciprofloxacin tablet</p> <p>Levofloxacin tablet</p> <p>Moxifloxacin tablet</p>	<p>Non-Preferred PA Required</p> <p>BAXDELA (delafloxacin) tablet</p> <p>CIPRO (ciprofloxacin) tablet</p> <p>Ciprofloxacin oral suspension</p> <p>Levofloxacin oral solution</p> <p>Ofloxacin tablet</p>	<p>*CIPRO suspension does not require prior authorization for members < 18 years of age and may be approved for members ≥ 18 years of age</p> <p>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).</p> <p>Levofloxacin solution may be approved for members with prescriber attestation that member:</p> <ul style="list-style-type: none"> • is unable to take Cipro (ciprofloxacin) crushed tablet or suspension OR • is < 5 years of age and being treated for pneumonia OR • has failed† an adequate trial (7 days) of ciprofloxacin suspension <p>†Failure is defined as lack of efficacy, allergy, intolerable side effects, significant drug-drug interaction, or contraindication to therapy.</p>
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Therapeutic Drug Class: **HEPATITIS C VIRUS TREATMENTS** - *Effective 1/1/2024*

Direct Acting Antivirals (DAAs)

<p>Preferred No PA Required for initial treatment</p>	<p>Non-Preferred PA Required</p>	
<p>(*must meet eligibility criteria)</p> <p>EPCLUSA (sofosbuvir/velpatasvir) 200 mg -50 mg, 150 mg-37.5 mg tablet, pellet pack</p> <p>HARVONI (ledipasvir/sofosbuvir) 45mg-200mg tablet, pellet pack</p> <p>Ledipasvir/Sofosbuvir 90 mg-400 mg tablet (<i>Asegua only</i>)</p> <p>MAVYRET (glecaprevir/pibrentasvir) tablet, pellet pack</p> <p>Sofosbuvir/Velpatasvir 400mg-100mg (<i>Asegua only</i>)</p> <p>*VOSEVI tablet (sofosbuvir/velpatasvir/voxilaprevir)</p>	<p>EPCLUSA 400 mg-100 mg (sofosbuvir/velpatasvir) tablet</p> <p>HARVONI 90 mg-400 mg (ledipasvir/sofosbuvir) tablet</p> <p>SOVALDI (sofosbuvir) tablet, pellet packet</p> <p>VIEKIRA PAK (ombitasvir/paritaprevir/ritonavir/dasabuvir) tablet</p> <p>ZEPATIER (elbasvir/grazoprevir) tablet</p>	<p>Pharmacy claims for preferred products prescribed for initial treatment will be eligible for up to a 90-day supply fill allowing for the appropriate days' duration for completing the initial treatment regimen (with no PA required). Subsequent fills will require prior authorization meeting re-treatment criteria below.</p> <p>*Second line preferred agents (Vosevi) may be approved for members 18 years of age or older with chronic HCV infection who are non-cirrhotic or have compensated cirrhosis (Child-Pugh A) AND meet the following criteria:</p> <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) OR • GT 1a or 3 and has previously failed treatment with a regimen containing sofosbuvir without an NS5A inhibitor <p>AND</p> <ul style="list-style-type: none"> • Request meets the applicable criteria below for re-treatment. <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 may be requested for re-treatment requests including:</p> <ul style="list-style-type: none"> • Assessment of member readiness for re-treatment • 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>Non-preferred agents may be approved if 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>Members currently receiving treatment with a non-preferred agent will receive approval to finish their treatment regimen, provided required documentation is sent via normal prior authorization request process.</p>

Ribavirin Products

No PA Required		Preferred products are eligible for up to a 90-day supply fill.
Ribavirin capsule		Non-preferred ribavirin products require prior authorizations which will be evaluated on a case-by-case basis.
Ribavirin tablet		

Therapeutic Drug Class: **HUMAN IMMUNODEFICIENCY VIRUS (HIV) TREATMENTS, ORAL** - *Effective 1/1/2024*
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		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		

Nucleoside/Nucleotide Reverse Transcriptase Inhibitors (NRTIs)

No 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		
Tenofovir disoproxil fumarate (TDF) tablet		

<p>VIREAD (TDF) oral powder, tablet</p> <p>ZIAGEN (abacavir) solution, tablet</p> <p>Zidovudine capsule, syrup, tablet</p> <p><i>*TDF – Tenofovir disoproxil fumarate</i></p>		
Protease Inhibitors (PIs)		
<p style="text-align: center;">No PA Required</p> <p>APTIVUS (tipranavir) capsule</p> <p>Atazanavir capsule</p> <p>Darunavir tablet</p> <p>Fosamprenavir tablet</p> <p>LEXIVA (fosamprenavir) suspension, tablet</p> <p>NORVIR (ritonavir) powder packet, tablet</p> <p>PREZISTA (darunavir) suspension, tablet</p> <p>REYATAZ (atazanavir) capsule, powder pack</p> <p>Ritonavir tablet</p> <p>VIRACEPT (nelfinavir) tablet</p>		<p>All products are preferred and do not require prior authorization.</p>
Other Agents		
<p style="text-align: center;">No PA Required</p> <p>ISENTRESS (raltegravir) chewable, powder pack, tablet</p> <p>ISENTRESS HD (raltegravir) tablet</p> <p>Maraviroc tablet</p> <p>RUKOBIA (fostemsavir tromethamine ER) tablet</p> <p>SELZENTRY (maraviroc) solution, tablet</p>		<p>All products are preferred and do not require prior authorization.</p>

SUNLENCA (lenacapavir) tablet		
TIVICAY (dolutegravir) tablet		
TIVICAY PD (dolutegravir) tablet for suspension		
TYBOST (cobicistat) tablet		
VOCABRIA (cabotegravir) tablet		

Combination Agents

<p align="center">No PA Required*</p> <p align="center">*Dispense as written (DAW) should be indicated on the prescription</p> <p>Abacavir/Lamivudine 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>All products are preferred and do not require prior authorization.</p>
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<p>GENVOYA (elvitegravir/cobicistat/emtricitabine/TAF) tablet</p> <p>JULUCA (dolutegravir/rilpivirine) tablet</p> <p>KALETRA (lopinavir/ritonavir) solution, tablet</p> <p>Lamivudine/Zidovudine tablet</p> <p>Lopinavir/Ritonavir solution, tablet</p> <p>ODEFSEY (emtricitabine/rilpivirine/TAF) tablet</p> <p>PREZCOBIX (darunavir/cobicistat) tablet</p> <p>STRIBILD (elvitegravir/cobicistat/emtricitabine/TDF) tablet</p> <p>SYMFI/SYMFILAM (efavirenz/lamivudine/TDF) tablet</p> <p>SYMTUZA (darunavir/cobicistat/emtricitabine/TAF) tablet</p> <p>TRIUMEQ (abacavir/dolutegravir/lamivudine) tablet</p> <p>TRIUMEQ PD (abacavir/dolutegravir) tablet for suspension</p> <p>TRIZIVIR (abacavir/lamivudine/zidovudine) tablet</p> <p>*TRUVADA (emtricitabine/TDF) tablet</p> <p><i>TAF – Tenofovir alafenamide</i> <i>TDF – Tenofovir disoproxil fumarate</i></p>		
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Therapeutic Drug Class: TETRACYCLINES - Effective 7/1/2024

No PA Required	PA Required	
Doxycycline hyclate capsules	Demeclocycline tablet	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.
Doxycycline hyclate tablets	DORYX (doxycycline DR) tablet	

<p>Doxycycline monohydrate 50mg, 100mg capsule</p> <p>Doxycycline monohydrate tablets</p> <p>Minocycline capsules</p>	<p>Doxycycline hyclate DR tablet</p> <p>Doxycycline monohydrate 75mg, 150mg capsule</p> <p>Doxycycline monohydrate suspension</p> <p>Minocycline IR, ER tablet</p> <p>MINOLIRA (minocycline ER) tablet</p> <p>MORGIDOX (doxycycline/skin cleanser) kit</p> <p>NUZYRA (omadacycline) tablet</p> <p>SOLODYN ER (minocycline ER) tablet</p> <p>Tetracycline capsule</p> <p>XIMINO (minocycline ER) capsule</p>	<p>Prior authorization for liquid oral tetracycline formulations may be approved if member is unable to take a solid oral dosage form.</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 (ABSSI) or clinical rationale and supporting literature describing/supporting intended use AND one of the following: <ul style="list-style-type: none"> ○ If member diagnosis is ABSSI, 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 7/1/2024*

No PA Required	PA Required	
<p>Prazosin capsule</p>	<p>MINIPRESS (prazosin) capsule</p>	<p>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).</p>

Therapeutic Drug Class: **BETA-BLOCKERS** - *Effective 7/1/2024*

Beta-Blockers, Single Agent

No PA Required (*Must meet eligibility criteria)	PA Required	
<p>Acebutolol capsule</p> <p>Atenolol tablet</p> <p>Bisoprolol tablet</p> <p>Carvedilol IR tablet</p>	<p>Betaxolol tablet</p> <p>BYSTOLIC (nebivolol) tablet</p> <p>CORGARD (nadolol) tablet</p> <p>COREG (carvedilol) tablet</p> <p>COREG CR (carvedilol ER) capsule</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. Maximum dose: 1.7 mg/kg twice daily</p> <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>INNOPRAN XL (propranolol ER) capsule brand product formulation may be approved if meeting the following:</p>

<p>*HEMANGEOL (propranolol) solution</p> <p>Labetalol tablet</p> <p>Metoprolol tartrate tablet</p> <p>Metoprolol succinate ER tablet</p> <p>Nadolol tablet</p> <p>Nebivolol tablet</p> <p>Propranolol IR tablet, solution</p> <p>Propranolol ER capsule</p>	<p>Carvedilol ER capsule</p> <p>INDERAL LA/XL (propranolol ER) capsule</p> <p>INNOPRAN XL (propranolol ER) capsule</p> <p>KASPARGO (metoprolol succinate) sprinkle capsule</p> <p>LOPRESSOR (metoprolol tartrate) tablet</p> <p>Pindolol tablet</p> <p>TENORMIN (atenolol) tablet</p> <p>Timolol tablet</p> <p>TOPROL XL (metoprolol succinate) tablet</p>	<ul style="list-style-type: none"> Request meets non-preferred criteria listed above AND Member has trialed and failed therapy with a generic propranolol ER capsule formulation OR prescriber provides clinical rationale supporting why generic propranolol ER capsule product formulations cannot be trialed. Failure is defined as lack of efficacy with 4-week trial, allergy, intolerable side effects or significant drug-drug interactions. <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. 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> <p>Members currently stabilized on the non-preferred Bystolic (nebivolol) tablets may receive approval to continue on that product.</p> <p>Members currently stabilized on the non-preferred carvedilol ER capsules may receive approval to continue on that product.</p> <div data-bbox="1129 743 1990 1466" style="border: 1px solid black; padding: 5px;"> <p>Table 1: Receptor Selectivity and Other Properties of Preferred Beta Blockers</p> <table border="1"> <thead> <tr> <th></th> <th>β_1</th> <th>β_2</th> <th>Alpha-1 receptor antagonist</th> <th>Intrinsic sympathomimetic activity (ISA)</th> </tr> </thead> <tbody> <tr> <td>Acebutolol</td> <td>X</td> <td></td> <td></td> <td>X</td> </tr> <tr> <td>Atenolol</td> <td>X</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Betaxolol</td> <td>X</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Bisoprolol</td> <td>X</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Carvedilol</td> <td>X</td> <td>X</td> <td>X</td> <td></td> </tr> <tr> <td>Labetalol</td> <td>X</td> <td>X</td> <td>X</td> <td></td> </tr> <tr> <td>Metoprolol succinate</td> <td>X</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Metoprolol tartrate</td> <td>X</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Nadolol</td> <td>X</td> <td>X</td> <td></td> <td></td> </tr> <tr> <td>Nebivolol</td> <td>X</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Pindolol</td> <td>X</td> <td>X</td> <td></td> <td>X</td> </tr> <tr> <td>Propranolol</td> <td>X</td> <td>X</td> <td></td> <td></td> </tr> </tbody> </table> </div>		β_1	β_2	Alpha-1 receptor antagonist	Intrinsic sympathomimetic activity (ISA)	Acebutolol	X			X	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		
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Propranolol	X	X																																																																	

Beta-Blockers, Anti-Arrhythmics

No PA Required	PA Required	
Sotalol tablet	BETAPACE/AF (sotalol) tablet SOTYLIZE (sotalol) solution	<p>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 are unable to take a solid oral dosage form OR members that have trialed and failed therapy with one preferred product. (Failure is defined as allergy or intolerable side effects.)</p> <p>Maximum dose: 320 mg/day</p>

Beta-Blockers, Combinations

No PA Required	PA Required	
Atenolol/Chlorthalidone tablet Bisoprolol/HCTZ tablet Metoprolol/HCTZ tablet	TENORETIC (atenolol/chlorthalidone) tablet ZIAC (bisoprolol/HCTZ) tablet	<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>

Therapeutic Drug Class: **CALCIUM CHANNEL-BLOCKERS** - *Effective 7/1/2024*

Dihydropyridines (DHPs)

No PA Required	PA Required	
Amlodipine tablet Felodipine ER tablet Nifedipine ER tablet Nifedipine IR capsule	ADALAT CC (nifedipine ER) tablet NORLIQVA (amlodipine) suspension KATERZIA (amlodipine) suspension Isradipine capsule Levamlodipine tablet Nicardipine capsule Nimodipine capsule Nisoldipine ER tablet NORVASC (amlodipine) tablet NYMALIZE (nimodipine) solution, oral syringe	<p>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.</p> <p>Nimodipine oral capsule oral capsule may be approved for adult members (≥ 18 years of age) with subarachnoid hemorrhage</p> <p>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.</p> <p>Maximum dose: 360 mg/day for 21 days (6 syringes/day or 126 syringes/21 days)</p> <p>KATERZIA (amlodipine) suspension may be approved if meeting the following:</p> <ul style="list-style-type: none"> • The member has a feeding tube or confirmed difficulty swallowing solid oral dosage forms OR cannot obtain the required dose through crushed amlodipine tablets 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

	PROCARDIA XL (nifedipine ER) tablet SULAR (nisoldipine ER) tablet	
Non-Dihydropyridines (Non-DHPs)		
No PA Required	PA Required	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.
Diltiazem IR tablet Diltiazem CD/ER capsule Verapamil IR, ER tablet Verapamil ER 120 mg, 180 mg, 240 mg capsule	CALAN SR (verapamil ER) tablet CARDIZEM (diltiazem) tablet CARDIZEM CD/LA (diltiazem CD/ER) capsule, tablet Diltiazem ER/LA 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	
Therapeutic Drug Class: ANGIOTENSIN MODIFIERS - <i>Effective 7/1/2024</i>		
Angiotensin-converting enzyme inhibitors (ACE Inh)		
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). * Enalapril solution may be approved without trial and failure of three preferred agents for members who are unable to take a solid oral dosage form. * QBRELIS (lisinopril) solution may be approved for members 6 years of age or older who are unable to take a solid oral dosage form 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.
Benazepril tablet Enalapril tablet Fosinopril tablet Lisinopril tablet Quinapril tablet Ramipril tablet	ACCUPRIL (quinapril) tablet ALTACE (ramipril) capsule Captopril tablet Enalapril solution EPANED (enalapril) solution LOTENSIN (benazepril) tablet Moexipril tablet Perindopril tablet PRINIVIL (lisinopril) tablet QBRELIS (lisinopril) solution	

	<p>Trandolapril tablet</p> <p>VASOTEC (enalapril) tablet</p> <p>ZESTRIL (lisinopril) tablet</p>	
ACE Inhibitor Combinations		
No PA Required	PA Required	<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>
Amlodipine/Benazepril capsule	ACCURETIC (quinapril/HCTZ) tablet	
Benazepril/HCTZ tablet	Captopril/HCTZ tablet	
Enalapril/HCTZ tablet	Fosinopril/HCTZ tablet	
Lisinopril/HCTZ tablet	<p>LOTENSIN HCT (benazepril/HCTZ) tablet</p> <p>LOTREL (amlodipine/benazepril) capsule</p> <p>Quinapril/HCTZ tablet</p> <p>VASERETIC (enalapril/HCTZ) tablet</p> <p>ZESTORETIC (lisinopril/HCTZ) tablet</p>	
Angiotensin II receptor blockers (ARBs)		
No PA Required	PA Required	<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>
Irbesartan tablet	ATACAND (candesartan) tablet	
Losartan tablet	AVAPRO (irbesartan) tablet	
Olmesartan tablet	BENICAR (olmesartan) tablet	
Telmisartan tablet	Candesartan tablet	
Valsartan tablet	COZAAR (losartan) tablet	
	DIOVAN (valsartan) tablet	
	EDARBI (azilsartan) tablet	
	Eprosartan tablet	
	MICARDIS (telmisartan) tablet	

	Valsartan solution	
ARB Combinations		
Preferred No PA Required (Unless indicated*)	Non-Preferred PA Required	<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 to 17 years 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) OR • Member is \geq 18 years of age and has a diagnosis of chronic heart failure. • Diagnosis will be verified through automated verification (AutoPA) of the appropriate corresponding ICD-10 diagnosis codes related to the indicated use of the medication.
<p>*ENTRESTO (sacubitril/valsartan) tablet</p> <p>Irbesartan/HCTZ tablet</p> <p>Losartan/HCTZ tablet</p> <p>Olmesartan/Amlodipine tablet</p> <p>Olmesartan/HCTZ tablet</p> <p>Valsartan/Amlodipine tablet</p> <p>Valsartan/HCTZ tablet</p>	<p>ATACAND HCT (candesartan/HCTZ) tablet</p> <p>AVALIDE (irbesartan/HCTZ) tablet</p> <p>AZOR (olmesartan/amlodipine) tablet</p> <p>BENICAR HCT (olmesartan/HCTZ) tablet</p> <p>Candesartan/HCTZ tablet</p> <p>DIOVAN HCT (valsartan/HCTZ) tablet</p> <p>EDARBYCLOR (azilsartan/chlorthalidone) tablet</p> <p>EXFORGE (valsartan/amlodipine) tablet</p> <p>EXFORGE HCT (valsartan/amlodipine/HCTZ) tablet</p> <p>HYZAAR (losartan/HCTZ) tablet</p> <p>MICARDIS HCT (telmisartan/HCTZ) tablet</p> <p>Olmesartan/amlodipine/HCTZ tablet</p> <p>Telmisartan/amlodipine tablet</p> <p>Telmisartan/HCTZ tablet</p> <p>TRIBENZOR (olmesartan/amlodipine/HCTZ) tablet</p> <p>Valsartan/Amlodipine/HCTZ tablet</p>	

Renin Inhibitors & Renin Inhibitor Combinations

	PA Required	<p>Aliskiren tablet</p> <p>TEKTURNA (aliskiren) tablet</p> <p>TEKTURNA HCT (aliskiren/HCTZ) tablet</p>
		<p>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).</p> <p>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.</p>

Therapeutic Drug Class: **PULMONARY ARTERIAL HYPERTENSION THERAPIES** - *Effective 7/1/2024*

Phosphodiesterase Inhibitors

Preferred *Must meet eligibility criteria	Non-Preferred PA Required	*Eligibility criteria for preferred products:
<p>*Sildenafil tablet, oral suspension</p> <p>*Tadalafil 20mg tablet</p>	<p>ADCIRCA (tadalafil) tablet</p> <p>ALYQ (tadalafil) tablet</p> <p>LIQREV (sildenafil) suspension</p> <p>REVATIO (sildenafil) suspension, tablet</p> <p>TADLIQ suspension</p>	<p>Preferred sildenafil and tadalafil tablet formulations may be approved for a diagnosis of pulmonary hypertension or right-sided heart failure.</p> <p>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.</p> <p>Non-preferred oral tablet products may be approved if meeting the following:</p> <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. <p>Members who have been previously stabilized on a non-preferred product may receive approval to continue on the medication.</p> <p>Non-preferred oral liquid products may be approved if meeting the following:</p> <ul style="list-style-type: none"> • Member has a diagnosis of pulmonary hypertension AND • Request meets one of the following: <ul style="list-style-type: none"> ○ Member has trialed and failed treatment with one preferred oral liquid formulation (failure is defined as lack of efficacy with a 4-week trial, allergy, intolerable side effects, or significant drug-drug interaction) OR ○ Prescriber verifies that the member is unable to take a solid oral dosage form that there is clinical necessity for use of a regimen with a less frequent dosing interval.

Endothelin Receptor Antagonists

<p style="text-align: center;">Preferred</p> <p>*Must meet eligibility criteria</p> <p>*Ambrisentan tablet</p> <p>*Bosentan 62.5mg, 125mg tablet</p>	<p style="text-align: center;">Non-Preferred PA Required</p> <p>LETAIRIS (ambrisentan) tablet</p> <p>OPSUMIT (macitentan) tablet</p> <p>TRACLEER (bosentan) 32mg tablet for suspension</p> <p>TRACLEER (bosentan) 62.5mg, 125mg tablet</p>	<p>*Eligibility Criteria for all agents in the class</p> <p>Approval may be granted for a diagnosis of pulmonary hypertension. Member and prescriber should be enrolled in applicable REMS program for prescribed medication.</p> <p>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.</p> <p>Members who have been previously stabilized on a non-preferred product may receive approval to continue the medication.</p>
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Prostacyclin Analogues and Receptor Agonists

<p style="text-align: center;">Preferred</p> <p>(*Must meet eligibility criteria)</p> <p>*FLOLAN (epoprostenol) vial</p> <p>*ORENITRAM (treprostinil ER) tablet, titration kit</p> <p>*VENTAVIS (iloprost) inhalation solution</p>	<p style="text-align: center;">Non-Preferred PA Required</p> <p>Epoprostenol vial</p> <p>REMODULIN (treprostinil) vial</p> <p>Treprostinil vial</p> <p>TYVASO (treprostinil) inhaler, inhalation solution</p> <p>UPTRAVI (selexipag) tablet, dose pack, vial</p> <p>VELETRI (epoprostenol) vial</p>	<p>*Eligibility Criteria for all agents in the class</p> <p>Approval will be granted for a diagnosis of pulmonary hypertension.</p> <p>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).</p> <p>Members who have been previously stabilized on a non-preferred product may receive approval to continue on the medication.</p>
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Guanylate Cyclase (sGC) Stimulator

<p style="text-align: center;">Non-Preferred PA Required</p> <p>ADEMPAS (riociguat) tablet</p>	<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 \geq 15 mL/min and is not on dialysis AND • Member does not have severe liver impairment (Child Pugh C) AND • Member has a diagnosis of persistent/recurrent chronic thromboembolic pulmonary hypertension (CTEPH) (WHO Group 4) after surgical treatment or has inoperable CTEPH OR
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- 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 7/1/2024

Bile Acid Sequestrants

No PA Required	PA Required	
Colesevelam tablet Colestipol tablet Cholestyramine packet, light packet, powder	Colesevelam packet COLESTID (colestipol) tablet, granules Colestipol granules QUESTRAN (cholestyramine/sugar) packet, powder QUESTRAN LIGHT (cholestyramine/ aspartame) packet, powder WELCHOL (colesevelam) packet, tablet	<p>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).</p> <p>Non-preferred lipotropic agents with a preferred product with same strength, dosage form, and active ingredient may 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>

Fibrates

No PA Required	PA Required	
Fenofibric acid DR (generic Trilipix) capsule Fenofibrate capsule, tablet (generic Lofibra/Tricor) Gemfibrozil tablet	ANTARA (fenofibrate) capsule Fenofibric acid tablet Fenofibrate capsule (generic Antara/Fenoglide/Lipofen) FENOGLIDE (fenofibrate) tablet LIPOFEN (fenofibrate) capsule LOPID (gemfibrozil) tablet TRICOR (fenofibrate nano) tablet TRILIPIX (fenofibric acid) capsule	<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 may 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

No PA Required (*Must meet eligibility criteria)	PA Required	
<p>Ezetimibe tablet</p> <p>Niacin ER tablet</p> <p>*Omega-3 ethyl esters capsule (generic Lovaza)</p> <p>VASCEPA (icosapent ethyl) capsule^{BNR}</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>ZETIA (ezetimibe) tablet</p>	<p>Non-preferred lipotropic agents with a preferred product with same strength, dosage form, and active ingredient may 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>Nexletol (bempedoic acid) or Nexlizet (bempedoic acid/ezetimibe) may be approved if meeting the following criteria:</p> <ul style="list-style-type: none"> • Member is ≥ 18 years of age AND • Member is not pregnant AND • Member is not receiving concurrent simvastatin > 20 mg daily or pravastatin > 40 mg daily AND • Member has a diagnosis of either heterozygous familial hypercholesterolemia or established atherosclerotic cardiovascular disease (see definition below), AND <div style="border: 1px solid black; padding: 5px; margin: 5px 0;"> <p style="text-align: center; margin: 0;">Conditions Which Define Clinical Atherosclerotic Cardiovascular Disease</p> <ul style="list-style-type: none"> • Acute Coronary Syndrome • History of Myocardial Infarction • Stable or Unstable Angina • Coronary or other Arterial Revascularization • Stroke • Transient Ischemic Attack • Peripheral Arterial Disease of Atherosclerotic Origin </div> <ul style="list-style-type: none"> • Member is concurrently adherent ($> 80\%$ of the past 180 days) on a maximally tolerated dose of a high intensity statin therapy (atorvastatin ≥ 40 mg daily OR rosuvastatin ≥ 20 mg daily [as a single-entity or as a combination product]) AND ezetimibe (as a single-entity or as a combination product) concomitantly for ≥ 8 continuous weeks), AND • If intolerant to a statin due to side effects, member must have a one month documented trial with at least two other maximally dosed statins in addition to ezetimibe. For members with a past or current incidence of rhabdomyolysis, a one-month trial and failure of a statin is not required, AND • Member has a treated LDL > 70 mg/dL for a clinical history of ASCVD OR LDL > 100 mg/dL if familial hypercholesterolemia <p><u>Initial Approval:</u> 1 year</p>

		<p><u>Reauthorization</u>: Reauthorization may be approved for 1 year with provider attestation of medication safety and efficacy during the initial treatment period</p> <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 \geq 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 \geq 45 years of age and has established atherosclerotic CV disease (e.g., coronary artery disease, cerebrovascular/carotid disease, peripheral arterial disease) OR ○ Member is \geq 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 \geq 55 years of age or female \geq 65 years of age ▪ Cigarette smoker ▪ Hypertension ▪ HDL-C \leq 40 mg/dL for men or \leq 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 <p>Maximum Dose: 4g daily</p>
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Therapeutic Drug Class: STATINS -Effective 7/1/2024

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 will not be approved for members < 10 years of age. Livalo will not be approved for members < 8 years of age.</p>
Lovastatin tablet	ATORVALIQ (atorvastatin) suspension	
Pravastatin tablet	CRESTOR (rosuvastatin) tablet	
Rosuvastatin tablet	EZALLOR (rosuvastatin) sprinkle capsule	
Simvastatin tablet	Fluvastatin capsule, ER tablet LESCOL XL (fluvastatin ER) tablet	

	<p>LIPITOR (atorvastatin) tablet</p> <p>LIVALO (pitavastatin) tablet</p> <p>Pitavastatin tablet</p> <p>ZOCOR (simvastatin) tablet</p> <p>ZYPITAMAG (pitavastatin) tablet</p>	
Therapeutic Drug Class: STATIN COMBINATIONS -Effective 7/1/2024		
No PA Required	PA Required	
Simvastatin/Ezetimibe tablet	<p>Atorvastatin/Amlodipine tablet</p> <p>CADUET (atorvastatin/amlodipine) tablet</p> <p>VYTORIN (simvastatin/ezetimibe) tablet</p>	<p>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).</p> <p><u>Age Limitations:</u> Vytorin and generic ezetimibe/simvastatin will not be approved for members < 18 years of age. Caduet and generic amlodipine/atorvastatin will not be approved for members < 10 years of age.</p>
Therapeutic Drug Class: Movement Disorders -Effective 7/1/2024		
No PA Required (*Must meet eligibility criteria)	PA Required	
<p>*Austedo (deutetrabenazine) tablet</p> <p>*Austedo (deutetrabenazine) XR tablet, titration pack</p> <p>*Ingrezza (valbenazine) capsule, initiation pack</p> <p>* Tetrabenazine tablet</p>	Xenazine (tetrabenazine) tablet	<p>*Eligibility Criteria for all agents in the class</p> <ul style="list-style-type: none"> • Member is ≥18 years of age AND • Member has been diagnosed with tardive dyskinesia or chorea associated with Huntington’s disease AND • If the member has hepatic impairment, FDA labeling for use has been evaluated AND • <u>For chorea associated with Huntington’s disease:</u> <ul style="list-style-type: none"> ○ Member has been evaluated for untreated or inadequately treated depression and member has been counseled regarding the risks of depression and suicidality associated with agents in this therapeutic class. AND • <u>For tardive dyskinesia:</u> <ul style="list-style-type: none"> ○ If applicable, the need for ongoing treatment with 1st and 2nd generation antipsychotics, metoclopramide, or prochlorperazine has been evaluated AND ○ A baseline Abnormal Involuntary Movement Scale (AIMS) has been performed. <p>Xenazine (tetrabenazine) Maximum dose 50 mg/day (PA available for extensive metabolizers of CYP2D6)</p>

		<p>Ingrezza (valbenazine) Quantity limits:</p> <ul style="list-style-type: none"> • 40 mg: 1.767 capsules/day • 60 mg: 1 capsule/day • 80 mg: 1 capsule/day <p>Austedo (deutetrabenazine) Maximum dose: 48 mg/day</p> <p>Non-preferred Movement Disorder Agents may be approved for members ≥18 years of age 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>
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IV. Central Nervous System

Therapeutic Drug Class: ANTICONVULSANTS -Oral-Effective 4/1/2024

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>	
Barbiturates		
Phenobarbital elixir, solution, tablet Primidone tablet	MYSOLINE (primidone) tablet	<p>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.</p> <p>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.</p> <p><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 the following criteria are met:</p> <ul style="list-style-type: none"> • The requested medication is being prescribed by a practitioner who has sufficient education and experience to safely manage treatment AND • The request 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 medication indicated for treatment of seizure disorder/convulsions AND • The request meets additional criteria listed for any of the following: <p>APTIOM (eslicarbazepine):</p> <ul style="list-style-type: none"> • Member has history of trial and failure‡ of any carbamazepine-containing product <p>BRIVIACT (brivaracetam):</p> <ul style="list-style-type: none"> • Member has history of trial and failure‡ of any levetiracetam-containing product <p>DIACOMIT (stiripentol):</p>
Hydantoins		
DILANTIN (phenytoin) 30 mg capsules, Infatab, suspension PHENYTEK (phenytoin ER) capsule Phenytoin suspension, chewable, ER capsule	DILANTIN (phenytoin ER), 100 mg capsules	
Succinamides		
Ethosuximide capsule, solution	CELONTIN (methsuximide) Kapseal	

	Methsuximide capsule ZARONTIN (ethosuximide) capsule, solution	<ul style="list-style-type: none"> Member is concomitantly taking clobazam AND Member has diagnosis of seizures associated with Dravet syndrome
Benzodiazepines		
Clobazam tablet, suspension Clonazepam tablet, ODT	KLONOPIN (clonazepam) tablet ONFI (clobazam) suspension, tablet SYMPAZAN (clobazam) SL film	<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 OR Member 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 or Lennox-Gastaut syndrome <p>OXTELLAR XR (oxcarbazepine ER):</p> <ul style="list-style-type: none"> Member is being treated for partial-onset seizures AND Member 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 OR Provider 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 AND The 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 Consortium Guideline. This may be considered a trial for prior authorization approvals of a non-preferred agent.</p>
Valproic Acid and Derivatives		
DEPAKOTE (divalproex DR) sprinkle capsule Divalproex sprinkle capsule, DR tablet, ER tablet Valproic acid capsule, solution	DEPAKOTE (divalproex DR) tablet DEPAKOTE ER (divalproex ER) tablet	
Carbamazepine Derivatives		
Carbamazepine IR tablet, ER tablet, chewable, ER capsule, suspension CARBATROL ER (carbamazepine) capsule Oxcarbazepine tablet TEGRETOL (carbamazepine) suspension, tablet TEGRETOL XR (carbamazepine ER) tablet TRILEPTAL ^{BNR} (oxcarbazepine) suspension	APTIOM (eslicarbazepine) tablet EQUETRO (carbamazepine) capsule Oxcarbazepine suspension OXTELLAR XR (oxcarbazepine) tablet TRILEPTAL (oxcarbazepine) tablet	

Lamotrigines	
LAMICTAL (lamotrigine) chewable/dispersible dose pack ^{BNR} tablet, tablet	LAMICTAL (lamotrigine) ODT, ODT dose pack
Lamotrigine IR tablet, ER tablet, chewable/dispersible tablet, ODT	LAMICTAL XR (lamotrigine ER) tablet, dose pack Lamotrigine ER/IR/ODT dose packs
Topiramates	
Topiramate tablet, sprinkle capsule	EPRONTIA (topiramate) solution QUDEXY XR (topiramate) capsule TOPAMAX (topiramate) tablet, sprinkle capsule Topiramate ER capsule TROKENDI XR (topiramate ER) capsule
Brivaracetam/Levetiracetam	
Levetiracetam IR tablet, ER tablet, solution	BRIVIACT (brivaracetam) solution, tablet ELEPSIA XR (levetiracetam ER) tablet KEPPRA (levetiracetam) tablet, solution KEPRA XR (levetiracetam ER) tablet SPRITAM (levetiracetam) tablet
Other	
*Felbamate suspension	BANZEL (rufinamide) suspension, tablet
FELBATOL (felbamate) suspension	DIACOMIT (stiripentol) capsule, powder packet
FELBATOL (felbamate) ^{BNR} tablet	EPIDIOLEX (cannabidiol) solution Felbamate tablet

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) suspension, tablet	2 years	40 mg per day
clobazam film (SYMPAZAN)	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		
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)		25 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		
cannabidiol (EPIDIOLEX)	1 year	25 mg/kg/day
cenobamate (XCOPRI)	18 years	400 mg per day
felbamate tablet, suspension	2 years	3,600 mg per day
fenfluramine (FINTEPLA)	2 years	26 mg per day
lacosamide (VIMPAT)	1 month	400 mg per day

Lacosamide solution, tablet	FINTEPLA (fenfluramine) solution	perampanel (FYCOMPA)	4 years	12 mg per day
Zonisamide capsule	FYCOMPA (perampanel) suspension, tablet	rufinamide (BANZEL) tablet and suspension	1 year	3,200 mg per day
	GABITRIL (tiagabine) tablet	stiripentol (DIACOMIT)	6 months (weighing \geq 7 kg)	3,000 mg per day
	Lacosamide UD solution	tiagabine	12 years	56 mg per day
	MOTPOLY XR (lacosamide) capsule	tiagabine (GABITRIL)	12 years	56 mg per day
	Rufinamide suspension, tablet	vigabatrin	1 month	3,000 mg per day
	SABRIL (vigabatrin) powder packet, tablet	vigabatrin (SABRIL)	1 month	3,000 mg per day
	Tiagabine tablet	vigabatrin (VIGADRONE) powder packet	1 month	3,000 mg per day
	Vigabatrin tablet, powder packet	zonisamide (ZONEGRAN)	16 years	600 mg per day
	VIMPAT (lacosamide) solution, kit, tablet	**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.		
	XCOPRI (cenobamate) tablet, pack			
	ZONISADE (zonisamide) suspension			
	ZTALMY (ganaxolone) suspension			

Therapeutic Drug Class: NEWER GENERATION ANTI-DEPRESSANTS -Effective 4/1/2024

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>	<p>Non-preferred products may be approved for members who have failed adequate trial with two preferred newer generation anti-depressant products. If two 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).</p> <p>Zurzuvae (zuranolone) may be approved if meeting the following criteria:</p> <ul style="list-style-type: none"> • Member is \geq 18 years of age AND • Member has a diagnosis of postpartum depression based on Diagnostic and Statistical Manual of Mental Disorders (DSM-5) criteria for a major depressive episode AND • Member is not currently pregnant AND • Prescriber attests that the member has been counseled and has been engaged in shared decision making with regard to:
Citalopram tablet, solution	APLENZIN (bupropion ER) tablet	
Desvenlafaxine succinate ER (generic Pristiq) tablet	AUVELITY ER (dextromethorphan/bupropion) tablet	
Duloxetine (generic Cymbalta) capsule	Bupropion XL (generic Forfivo XL) tablet	
Escitalopram tablet	CELEXA (citalopram) tablet	
Fluoxetine capsule, solution, 60 mg tablet	Citalopram hydrobromide capsule	
Fluvoxamine tablet	CYMBALTA (duloxetine) capsule	

<p>Mirtazapine tablet, ODT</p> <p>Paroxetine IR tablet</p> <p>Sertraline tablet, solution</p> <p>Trazodone tablet</p> <p>Venlafaxine IR tablet</p> <p>Venlafaxine ER capsules</p>	<p>Desvenlafaxine fumarate ER tablet</p> <p>DRIZALMA (duloxetine) sprinkle capsule</p> <p>EFFEXOR XR (venlafaxine ER) capsule</p> <p>Escitalopram solution</p> <p>FETZIMA (levomilnacipran ER) capsule, titration pack</p> <p>Fluoxetine IR tablet, 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 CR/ER tablet, suspension</p> <p>Paroxetine mesylate capsule</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) Soltab (ODT), tablet</p> <p>Sertraline capsule</p> <p>TRINTELLIX (vortioxetine) tablet</p> <p>Venlafaxine ER tablet</p> <p>Venlafaxine besylate ER tablet</p> <p>VIIBRYD (vilazodone) tablet, dose pack</p> <p>Vilazodone tablet</p> <p>WELLBUTRIN SR, XL (bupropion) tablet</p> <p>ZOLOFT (sertraline) tablet, oral concentrate</p> <p>ZURZUVAE (zuranolone) capsule</p>	<ul style="list-style-type: none"> ○ The importance of effective contraception during zuranolone treatment, as zuranolone may cause fetal harm AND ○ The potential risks for the breastfed child and the lack of data supporting safe use of zuranolone during lactation AND ○ Consideration for the favorable long-term safety data associated with use of SSRIs as first-line, recommended therapies for perinatal depressive disorders by the American College of Obstetricians and Gynecologists (ACOG) or SNRIs as reasonable ACOG-recommended alternatives <p>AND</p> <ul style="list-style-type: none"> ● Prescriber attests that the member has been counseled to refrain from engaging in potentially hazardous activities requiring mental alertness, including driving, for ≥ 12 hours after each zuranolone dose AND ● The member has been counseled to take the medication with 400 to 1,000 calories of food containing 25% to 50% fat AND ● If patient is taking another oral antidepressant medication, the dose has been stable for ≥ 30 days AND ● Prescriber verifies that concomitant medications have been assessed for potential drug interactions (CNS depressants, CYP3A4 inhibitors, CYP3A4 inducers) and any needed dosage adjustments for zuranolone have been made in accordance with package labeling AND ● Baseline renal and hepatic function have been assessed and prescriber verifies that dosing is appropriate in accordance with package labeling. <p><u>Quantity Limit:</u></p> <ul style="list-style-type: none"> ● Zurzuvae 20 mg and 25 mg: 28 capsules/14 days ● Zurzuvae 30 mg: 14 capsules/14 days <p><u>Maximum dose:</u> 50 mg once daily</p> <p><u>Duration of Approval:</u> Approval will allow 30 days to fill for one 14-day course of treatment per postpartum period</p> <p>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.</p> <p>Members currently stabilized on a non-preferred newer generation antidepressant may receive approval to continue on that agent for one year if medically necessary.</p> <p>Verification may be provided from the prescriber or the pharmacy.</p>
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Therapeutic Drug Class: MONOAMINE OXIDASE INHIBITORS (MAOIs) -Effective 4/1/2024		
	<p style="text-align: center;">PA Required</p> <p>EMSAM (selegiline) patch</p> <p>MARPLAN (isocarboxazid) tablet</p> <p>NARDIL (phenelzine) tablet</p> <p>Phenelzine tablet</p> <p>Tranlycypromine 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> <p>Members currently stabilized on a Non-preferred MAOi antidepressant may receive approval to continue that agent for one year if medically necessary. Verification may be provided from the prescriber or the pharmacy.</p>
Therapeutic Drug Class: TRICYCLIC ANTI-DEPRESSANTS (TCAs) -Effective 4/1/2024		
<p style="text-align: center;">No PA Required</p> <p>Amitriptyline tablet</p> <p>Clomipramine capsule</p> <p>Desipramine tablet</p> <p>Doxepin 10mg, 25mg, 50mg, 75mg, 100mg, 150mg capsule, oral concentrate</p> <p>Imipramine HCl tablet</p> <p>Nortriptyline capsule</p>	<p style="text-align: center;">PA Required</p> <p><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></p> <p>Amoxapine tablet</p> <p>ANAFRANIL (clomipramine) capsule</p> <p>Imipramine pamoate capsule</p> <p>NORPRAMIN (desipramine) tablet</p> <p>Nortriptyline solution</p> <p>PAMELOR (nortriptyline) capsule</p> <p>Protriptyline tablet</p> <p>Trimipramine capsule</p>	<p>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)</p> <p>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.</p>
Therapeutic Drug Class: ANTI-PARKINSON’S AGENTS -Effective 4/1/2024		
Dopa decarboxylase inhibitors, dopamine precursors and combinations		
<p style="text-align: center;">No PA Required</p> <p>Carbidopa/Levodopa IR, ER tablet</p> <p>Carbidopa/Levodopa/Entacapone tablet</p>	<p style="text-align: center;">PA Required</p> <p>Carbidopa tablet</p> <p>Carbidopa/Levodopa ODT</p> <p>DHIVY (carbidopa/levodopa) tablet</p>	<p>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).</p> <p>Carbidopa or levodopa single agent products may be approved for members with diagnosis of Parkinson’s Disease as add-on therapy to carbidopa-levodopa.</p>

	<p>DUOPA (carbidopa/levodopa) suspension</p> <p>INBRIJA (levodopa) capsule for inhalation</p> <p>LODOSYN (carbidopa) tablet</p> <p>RYTARY ER (carbidopa/levodopa) capsule</p> <p>SINEMET (carbidopa/levodopa) IR tablet</p> <p>STALEVO (carbidopa/levodopa/ entacapone) tablet</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 for other FDA-labeled indications 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>
MAO-B inhibitors		
<p style="text-align: center;">No PA Required</p> <p>Rasagiline tablet</p> <p>Selegiline capsule, tablet</p>	<p style="text-align: center;">PA Required</p> <p>AZILECT (rasagiline) tablet</p> <p>XADAGO (safinamide) tablet</p> <p>ZELAPAR (selegiline) ODT</p>	<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 are not prescribed for Parkinson’s Disease (or an indication related to Parkinson’s Disease) may receive approval for other FDA-labeled indications 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		
<p style="text-align: center;">No PA Required</p> <p>Pramipexole IR tablet</p> <p>Ropinirole IR tablet</p>	<p style="text-align: center;">PA Required</p> <p>APOKYN (apomorphine) SC cartridge</p> <p>Apomorphine SC cartridge</p> <p>Bromocriptine capsule, tablet</p> <p>KYNMOBI (apomorphine) SL film</p> <p>MIRAPEX (pramipexole) ER tablet</p> <p>NEUPRO (rotigotine) patch</p>	<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>PARLODEL (bromocriptine) capsule, tablet</p> <p>Pramipexole ER tablet</p> <p>Ropinirole ER tablet</p>	<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 for other FDA-labeled indications 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 style="text-align: center;">No PA Required</p> <p>Amantadine capsule, solution/syrup</p> <p>Benztropine tablet</p> <p>Trihexyphenidyl tablet, elixir</p>	<p style="text-align: center;">PA Required</p> <p>Amantadine tablet</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 for other FDA-labeled indications 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 4/1/2024*

No PA Required (*may be subject to age limitations)	PA Required	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.																							
Alprazolam IR, ER tablet*	Alprazolam ODT, oral concentrate																								
Chlordiazepoxide capsule*	ATIVAN (lorazepam) tablet	Children: 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.																							
Clonazepam tablet, ODT	Diazepam Intensol																								
Clorazepate tablet*	KLONOPIN (clonazepam) tablet	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.																							
Diazepam tablet*, solution	LOREEV (lorazepam ER) capsule	All benzodiazepine anxiolytics will require prior authorization for members ≥ 65 years of age when exceeding 90 days of therapy.																							
Lorazepam tablet*, oral concentrate	XANAX (alprazolam) tablet	Continuation of Therapy:																							
Oxazepam capsule*	XANAX XR (alprazolam ER) tablet	<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. 																							
		Prior authorization will be required for prescribed doses that exceed the maximum (Table 1).																							
		<table border="1"> <thead> <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> </thead> <tbody> <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</td> <td>Total of 9,000 mg (adults) and 120 mg (children, pre-op)</td> </tr> </tbody> </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	Total of 9,000 mg (adults) and 120 mg (children, pre-op)
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	Total of 9,000 mg (adults) and 120 mg (children, pre-op)																							

			<u>Children 6-17 years:</u> up to 40 mg/day (pre-operative apprehension and anxiety)	therapy) from all tablet strengths per 30 days
		Diazepam Intensol oral concentrate 5 mg/mL	<u>Adults > 18 years:</u> 40 mg/day <u>Members age 6 months to 17 years:</u> up to 10 mg/day	Total of 1200 mg (adults) and 300 mg (pediatrics) from all dosage forms per 30 days
		Diazepam solution 5 mg/5 mL		
		Diazepam tablet		
		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 - Effective 4/1/2024

No PA Required		
Buspirone tablet		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- Effective 4/1/2024

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 (unless indicated by criteria)*	PA Required	
Aripiprazole 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>	* Vraylar (cariprazine) may be approved for members after trial and failure of one preferred agent. Failure is defined as contraindication, 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.
Clozapine tablet		
Lurasidone tablet		
	ABILIFY (aripiprazole) tablet, MyCite	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

Olanzapine tablet, ODT	Aripiprazole oral solution, ODT	<ul style="list-style-type: none"> Member has history of trial and failure of two 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, contraindication, significant drug-drug interactions, or known interacting genetic polymorphism that prevents safe preferred product dosing) <p>**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 approval.</p> <p>Atypical Antipsychotic prescriptions for members under 5 years of age may require a provider-provider telephone consult with a child and adolescent psychiatrist (provided at no cost to provider or member).</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, or clinical rationale is provided supporting why these medications cannot be trialed. Failure will be defined as contraindication, 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
Paliperidone ER tablet	Asenapine SL tablet	
Quetiapine IR tablet***	CAPLYTA (lumateperone) capsule	
Quetiapine ER tablet	Clozapine ODT	
Risperidone ODT, oral solution, tablet	CLOZARIL (clozapine) tablet, ODT	
SAPHRIS ^{BNR} (asenapine) SL tablet	GEODON (ziprasidone) capsule	
VRAYLAR (cariprazine) capsule*	INVEGA ER (paliperidone) tablet	
Ziprasidone capsule	LATUDA (lurasidone) tablet	
	LYBALVI (olanzapine/samidorphan) tablet	
	NUPLAZID (pimavanserin) capsule, tablet	
	Olanzapine/Fluoxetine capsule	
	REXULTI (brexpiprazole) dose pack, tablet	
	RISPERDAL (risperidone) tablet, oral solution	
	SECUADO (asenapine) patch	
	SEROQUEL IR (quetiapine IR) tablet***	
	SEROQUEL XR (quetiapine ER) tablet	
	SYMBYAX (olanzapine/fluoxetine) capsule	
	VERSACLOZ (clozapine) suspension	
	ZYPREXA (olanzapine) tablet	
	ZYPREXA ZYDIS (olanzapine) ODT	

		<p>(failure is defined as lack of efficacy with 8-week trial, contraindication, allergy, intolerable side effects, significant drug-drug interactions) AND</p> <ul style="list-style-type: none"> • 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. <p><u>Quantity Limits:</u> Quantity limits will be applied to all products (Table 1). In order to receive approval for off-label dosing, the member must have an FDA approved indication and must have tried and failed on the FDA approved dosing regimen.</p> <p>Members currently stabilized on a non-preferred atypical antipsychotic may receive approval to continue therapy with that agent for one year.</p>
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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 Adjunctive treatment of MDD	≥ 13 years ≥ 18 years 10-17 years 6-17 years 6-18 years ≥ 18 years	30 mg 30 mg 30 mg 15 mg 20 mg (weight-based) 15 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 Bipolar I Disorder	≥ 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	16 mg 6 mg 6 mg 3 mg	Maximum dosage of 16mg/day (4 tablet/day limitation applied in claims system to allow for dose escalation and tapering)
REXULTI	brexpiprazole	Schizophrenia Adjunctive treatment of MDD Agitation associated with Alzheimer's disease (AD)	≥ 13 years ≥ 18 years	4 mg 3 mg	Maximum of 3mg/day for MDD adjunctive therapy, and agitation due to AD, 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 Adjunctive treatment of MDD	≥ 18 years ≥ 18 years ≥ 18 years ≥ 18 years	6 mg 6 mg 3 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 4/1/2024

PA Required for all agents

Preferred	Non-Preferred
* AIMOVIG (erenumab-aooe) auto-injector	EMGALITY (galcanezumab-gnlm) 100 mg syringe
* AJOVY (fremanezumab-vfrm) auto-injector, syringe	QULIPTA (atogepant) tablet ZAVZPRET (zavegepant) nasal
* EMGALITY (galcanezumab-gnlm) pen, 120 mg syringe	
* NURTEC (rimegepant) ODT	
* UBRELVY (ubrogepant) tablet	

*Preferred agents may be approved if meeting the following criteria:

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 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. Failure is defined as lack of efficacy, contraindication to therapy, allergy, intolerable side effects, or significant drug-drug interaction.

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

- 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
- 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):
 - Oxygen therapy AND
 - Sumatriptan subcutaneous or intranasal OR zolmitriptan intranasal
- 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.

Age Limitations:

All products: ≥ 18 years

Table 1. Calcitonin Gene-Related Peptide Inhibitor Quantity Limits

Drug Name	Maximum Dosing
Aimovig (erenumab)	one 140 mg autoinjector per 30 days
Ajovy (fremanezumab)	one 225 mg autoinjector or syringe per 30 days or three 225 mg autoinjectors or syringes every 90 days
Emgality 100mg (galcanezumab)	three 100 mg prefilled syringes per 30 days
Emgality 120 mg (galcanezumab)	two 120 mg pens or prefilled syringes once as first loading dose then one 120 mg pen or prefilled syringe per 30 days
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
Ubrelvy 100 mg (ubrogepant)	16 tablets/30 days
ZAVZPRET (zavegepant)	6 unit-dose nasal spray devices per 30 days

Members with current prior authorization approval on file for a preferred agent may receive approval for continuation of therapy with the preferred agent.

Therapeutic Drug Class: LITHIUM AGENTS -Effective 4/1/2024

No PA Required	PA Required	
<p>Lithium carbonate capsule, tablet</p> <p>Lithium citrate solution</p> <p>Lithium ER tablet</p>	<p align="center"><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></p> <p>LITHOBID ER (lithium ER) tablet</p>	<p>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).</p> <p>Members currently stabilized on a non-preferred product may receive approval to continue therapy with that product.</p>

Therapeutic Drug Class: NEUROCOGNITIVE DISORDER AGENTS -Effective 4/1/2024

Preferred *Must meet eligibility criteria	Non-Preferred PA Required	
<p>*Donepezil 5mg, 10mg tablet</p> <p>*Donepezil ODT</p> <p>*Galantamine IR tablet</p> <p>*Memantine IR tablet, dose pack</p> <p>*Memantine ER capsule</p> <p>*Rivastigmine capsule, patch</p>	<p>ADLARITY (donepezil) patch</p> <p>ARICEPT (donepezil) tablet</p> <p>Donepezil 23mg tablet</p> <p>EXELON (rivastigmine) patch</p> <p>Galantamine solution, ER capsule</p> <p>Memantine IR solution</p> <p>MESTINON (pyridostigmine) IR/ER tablet, syrup</p> <p>NAMENDA (memantine) tablet, dose pack</p> <p>NAMENDA XR (memantine ER) capsule</p> <p>NAMZARIC (memantine/donepezil ER) capsule, dose pack</p> <p>Pyridostigmine syrup, IR/ER tablet</p>	<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>

Therapeutic Drug Class: **SEDATIVE HYPNOTICS** -Effective 4/1/2024

Non-Benzodiazepines

<p>Preferred No PA Required* (Unless age, dose, or duplication criteria apply)</p>	<p>Non-Preferred PA Required</p>	
<p>Eszopiclone tablet</p> <p>Ramelteon tablet</p> <p>Zaleplon capsule</p> <p>Zolpidem IR, ER tablet</p>	<p>AMBIEN (zolpidem) tablet</p> <p>AMBIEN CR (zolpidem ER) tablet</p> <p>BELSOMRA (suvorexant) tablet</p> <p>DAYVIGO (lemborexant) tablet</p> <p>Doxepin tablet</p> <p>EDLUAR (zolpidem) SL tablet</p> <p>HETLIOZ (tasimelteon) capsule</p> <p>HETLIOZ LQ (tasimelteon) suspension</p> <p>LUNESTA (eszopiclone) tablet</p> <p>QUVIVIQ (daridorexant) tablet</p> <p>ROZEREM (ramelteon) tablet</p> <p>SILENOR (doxepin) tablet</p> <p>Tasimelteon capsule</p> <p>Zolpidem capsule, SL tablet</p>	<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 members < 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"> • 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 receiving strong CYP3A4 inhibitors (such as erythromycin, clarithromycin, telithromycin, itraconazole, ketoconazole, posaconazole, fluconazole, voriconazole, delavirdine, and milk thistle) or strong CYP3A4 inducers (such as carbamazepine, oxcarbazepine, phenobarbital, phenytoin, rifampin, rifabutin, rifapentine, dexamethasone, efavirenz, etravirine, nevirapine, darunavir/ritonavir, ritonavir, and St John’s Wort) AND • 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 Belsomra (surovexant). Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction AND • Member is not receiving strong CYP3A4 inhibitors (such as erythromycin, clarithromycin, telithromycin, itraconazole, ketoconazole, posaconazole, fluconazole, voriconazole, delavirdine, and milk thistle) or strong CYP3A4 inducers (such as carbamazepine, oxcarbazepine, phenobarbital, phenytoin, rifampin, rifabutin, rifapentine, dexamethasone, efavirenz, etravirine, nevirapine, darunavir/ritonavir, ritonavir, and St John’s Wort) AND • Member does not have a diagnosis of narcolepsy <p>Hetlioz (tasimelteon) capsules may be approved for members meeting the following criteria:</p> <ul style="list-style-type: none"> • Member is ≥18 years of age and has a documented diagnosis of Non-24-hour sleep wake disorder (Non-24) OR • Member is ≥16 years of age and has a documented diagnosis of nighttime sleep disturbances in Smith-Magenis syndrome (SMS) AND

		<ul style="list-style-type: none"> The requested medication is being prescribed by a sleep specialist or a practitioner who has sufficient education and experience to safely prescribe tasimelteon <p>Hetlioz LQ (tasimelteon) oral suspension may be approved for members meeting the following criteria:</p> <ul style="list-style-type: none"> Member is 3 to 15 years of age and has a documented diagnosis of nighttime sleep disturbances in Smith-Magenis Syndrome (SMS) AND the requested medication is being prescribed by a sleep specialist or a practitioner who has sufficient education and experience to safely prescribe tasimelteon. <p>Silenor (doxepin) may be approved for adult members that meet ONE of the following criteria:</p> <ul style="list-style-type: none"> Member has tried and failed two preferred oral sedative hypnotics (Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) OR Provider attests to the medical necessity of prescribing individual doxepin doses of less than 10 mg, OR Member's age is ≥ 65 years <p>Prior authorization will be required for prescribed doses exceeding maximum (Table 1) below.</p>
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Benzodiazepines

<p align="center">Preferred No PA Required* (Unless age, dose, or duplication criteria apply)</p> <p>Temazepam 15mg, 30mg capsule</p> <p>Triazolam tablet</p>	<p align="center">Non-Preferred PA Required</p> <p>DORAL (quazepam) tablet</p> <p>Estazolam tablet</p> <p>Flurazepam capsule</p> <p>HALCION (triazolam) tablet</p> <p>Quazepam 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 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>Temazepam 7.5 mg may be approved if provider attests to the medical necessity of prescribing individual temazepam doses of less than 15 mg.</p> <p><u>Children:</u> Prior authorization will be required for all sedative hypnotic agents when prescribed for members < 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>
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Prior authorization will be required for prescribed doses exceeding maximum (Table 1).

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	10 mg/day
Edluar	Zolpidem sublingual	10 mg/day
-	Zolpidem sublingual	Men: 3.5mg/day Women: 1.75 mg/day
Hetlioz	Tasimelteon capsule	20 mg/day
Hetlioz LQ	Tasimelteon liquid	≤ 28 kg: 0.7 mg/kg/day > 28 kg : 20 mg/day
Lunesta	Eszopiclone	3 mg/day
Quviviq	Daridorexant	50 mg/day
-	Zaleplon	20 mg/day
Rozerem	Ramelteon	8 mg/day
Benzodiazepine		
Halcion	Triazolam	0.5 mg/day
Restoril	Temazepam	30 mg/day
Silenor	Doxepin	6mg/day
-	Estazolam	2 mg/day
-	Flurazepam	30 mg/day
Doral	Quazepam	15 mg/day

Therapeutic Drug Class: SKELETAL MUSCLE RELAXANTS -Effective 4/1/2024

No PA Required (*if under 65 years of age)	PA Required	
Baclofen tablet	AMRIX ER (cyclobenzaprine ER) capsule	<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 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 ● Dantrolene will be approved for the period of one year ● If a member is stabilized on dantrolene, they may continue to receive approval
Cyclobenzaprine tablet	Baclofen solution, suspension	
Methocarbamol tablet	Carisoprodol tablet	
Tizanidine tablet	Carisoprodol/Aspirin tablet	
	Chlorzoxazone tablet	
	Cyclobenzaprine ER capsule	

	<p>DANTRIUM (dantrolene) capsule</p> <p>*Dantrolene capsule</p> <p>FEXMID (cyclobenzaprine) tablet</p> <p>FLEQSUVY (baclofen) solution</p> <p>LORZONE (chlorzoxazone) tablet</p> <p>LYVISPAH (baclofen) granules</p> <p>Metaxalone tablet</p> <p>NORGESIC/NORGESIC FORTE (orphenadrine/aspirin/ caffeine) tablet</p> <p>Orphenadrine ER tablet</p> <p>Orphenadrine/Aspirin/Caffeine tablet</p> <p>SOMA (carisoprodol) tablet</p> <p>Tizanidine capsule</p> <p>ZANAFLEX (tizanidine) capsule, tablet</p>	<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>
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Therapeutic Drug Class: STIMULANTS AND RELATED AGENTS -Effective 4/1/2024

<p style="text-align: center;">Preferred *No PA Required (if age, max daily dose, and diagnosis met)</p>	<p style="text-align: center;">Non-Preferred PA Required</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>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>Clonidine ER tablet</p>	<p>ADZENYS XR-ODT (amphetamine)</p> <p>Amphetamine salts, mixed ER (generic Adderall XR) capsule</p> <p>Amphetamine tablet (generic Evekeo)</p> <p>APTENSIO XR (methylphenidate ER) capsule</p> <p>AZSTARYS (serdexmethylphenidate/dexmethylphenidate) capsule</p> <p>COTEMPLA XR-ODT (methylphenidate ER)</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 • <u>If member is ≥ 6 years of age:</u> <ul style="list-style-type: none"> ○ Has documented trial and failure‡ with three preferred products in the last 24 months AND ○ If the member is unable to swallow solid oral dosage forms, two of the trials must be methylphenidate solution, dexmethylphenidate ER, Vyvanse, Adderall XR, or any other preferred product that can be taken without the need to swallow a whole capsule. <p style="text-align: center;">OR</p> <ul style="list-style-type: none"> • <u>If member is 3–5 years of age:</u>

<p>CONCERTA^{BNR} (methylphenidate ER) tablet</p> <p>DAYTRANA^{BNR} (methylphenidate) patch</p> <p>Dexmethylphenidate IR tablet</p> <p>Dexmethylphenidate ER capsule</p> <p>Guanfacine ER tablet</p> <p>Methylphenidate (generic Methylin/Ritalin) solution, tablet</p> <p>Modafinil tablet</p> <p>VYVANSE^{BNR} (lisdexamfetamine) capsule</p>	<p>DESOXYN (methamphetamine) tablet</p> <p>DEXEDRINE (dextroamphetamine) Spansule</p> <p>Dextroamphetamine ER capsule, solution, tablet</p> <p>DYANAVEL XR (amphetamine) suspension, tablet</p> <p>EVEKEO (amphetamine) ODT, tablet</p> <p>FOCALIN (dexmethylphenidate) tablet, XR capsule</p> <p>INTUNIV (guanfacine ER) tablet</p> <p>JORNAY PM (methylphenidate) capsule</p> <p>Lisdexamfetamine capsule, chewable tablet</p> <p>Methamphetamine tablet</p> <p>METHYLIN (methylphenidate) solution</p> <p>Methylphenidate CD/ER/LA capsule, tablet, chewable tablet, ER tablet (generic Relexxi/Ritalin), ER tablet (generic Concerta), patch</p> <p>MYDAYIS ER (dextroamphetamine/ amphetamine) capsule</p> <p>NUVIGIL (armodafinil) tablet</p> <p>PROCENTRA (dextroamphetamine) solution</p> <p>PROVIGIL (modafinil) tablet</p> <p>QELBREE (viloxazine ER) capsule</p> <p>QUILLICHEW ER (methylphenidate) chewable tablet, XR suspension</p> <p>RELEXXII (methylphenidate ER) tablet</p>	<ul style="list-style-type: none"> ○ Has documented trial and failure‡ with one preferred product in the last 24 months AND ○ If the member is unable to swallow solid oral dosage forms, the trial must be methylphenidate solution, dexmethylphenidate ER, Vyvanse, Adderall XR, or any other preferred product that can be taken without the need to swallow a whole capsule. <p>SUNOSI (solriamfetol) prior authorization may be approved if member meets the following criteria:</p> <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. <p>WAKIX (pitolisant) prior authorization may be approved if member meets the following criteria:</p> <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 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. <p>Maximum Dose (all products): See Table 2</p> <p>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:</p> <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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	RITALIN (methylphenidate) IR/ER tablet, ER capsule STRATTERA (atomoxetine) capsule SUNOSI (solriamfetol) tablet VYVANSE (lisdexamfetamine) chewable tablet WAKIX (pitolisant) tablet XELSTRYM (dextroamphetamine) patch ZENZEDI (dextroamphetamine) tablet	‡Failure is defined as: lack of efficacy with 4-week trial, allergy, intolerable side effects, or significant drug-drug interaction.
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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 tablet (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)	ADHD (Age ≥ 6 years [†]), Narcolepsy (Age ≥ 6 years), OSA. [†] Prior Authorization for members 3-6 years of age with a diagnosis of ADHD may be approved with prescriber attestation to the following: <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 • 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)

Mixedamphetamine 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 ER patch (XELSTRYM)	ADHD (Age ≥ 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 (RELEXXI ER)	ADHD (Age 6 to 65 years)
Methylphenidate ER (RITALIN LA)	ADHD (Age ≥ 6 years)
Methylphenidate ER (ADHANSIA XR)	ADHD (Age ≥ 6 years)
Methylphenidate ER (JORNAY PM)	ADHD (Age ≥ 6 years)
Methylphenidate XR (APTENSIO XR)	ADHD (Age ≥ 6 years)
Methylphenidate XR ODT (COTEMPLA XR-ODT)	ADHD (Age 6 to 17 years)
Serdexmethylphenidate/dexmethylphenidate (AZSTARYS)	ADHD (Age ≥ 6 years)
Non-Stimulants	
Atomoxetine (generic STRATTERA)	ADHD (Age ≥ 6 years)
Clonidine ER	ADHD as monotherapy OR adjunctive therapy to stimulants (Age ≥ 6 years)
Guanfacine ER (generic INTUNIV)	ADHD as monotherapy OR adjunctive therapy to stimulants (Age ≥ 6 years)
Viloxazine ER (QELBREE)	ADHD (Age ≥ 6 years)
Wakefulness-promoting Agents	
Armodafinil (generic NUVIGIL)	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)
Modafinil (PROVIGIL)	Excessive sleepiness associated with narcolepsy, OSA, SWD, and adjunct therapy to treat fatigue and sleepiness in patients with major depressive disorder (MDD), antipsychotic medication-related fatigue (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 \geq 13)
AMPHETAMINE SALTS	40 mg
APTENSIO XR	60 mg
CONCERTA	54 mg (age 6-12) or 72 mg (\geq age 13)
AZSTARYS	52.3 mg serdexmethylphenidate and 10.4 mg dexmethylphenidate
CLONIDINE ER	0.4 mg
COTEMPLA XR-ODT	51.8 mg
DEXTROAMPHETAMINE ER	60 mg
DAYTRANA	30 mg/9 hour patch (3.3 mg/hr)
DESOXYN	25 mg
DEXEDRINE	60 mg
DYANAVEL XR	20 mg
EVEKEO	60 mg
FOCALIN	20 mg
FOCALIN XR	40 mg
GUANFACINE ER	4 mg (age 6-12) or 7 mg (age \geq 13)
INTUNIV ER	4 mg (age 6-12) or 7 mg (age \geq 13)
JORNAY PM	100 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 \geq 18)
NUVIGIL	250 mg
PROCENTRA	60 mg
PROVIGIL	400 mg
QELBREE	400 mg (age 6-17) or 600 mg (age \geq 18)
QUILLICHEW ER	60 mg
QUILLIVANT XR	60 mg
RELEXXII	54 mg (ages 6-12) or 72 mg (\geq age 13)
RITALIN IR	60 mg
RITALIN SR	60 mg

RITALIN LA	60 mg
STRATTERA	100mg
SUNOSI	150 mg
VYVANSE CAPSULES AND CHEWABLE TABLETS	70 mg
WAKIX	35.6 mg
XELSTRYM ER PATCH	18 mg/9 hours
ZENZEDI	60 mg

Therapeutic Drug Class: TRIPTANS, DITANS AND OTHER MIGRAINE TREATMENTS - Oral -Effective 4/1/2024

No PA Required (Quantity limits may apply)	PA Required											
Eletriptan tablet (generic Relpax) Naratriptan tablet (generic Amerge) Rizatriptan tablet, ODT (generic Maxalt) Sumatriptan tablet (generic Imitrex) Zolmitriptan tablet (generic Zomig)	Almotriptan tablet FROVA (frovatriptan) tablet Frovatriptan tablet IMITREX (sumatriptan) tablet MAXALT/MAXALT MLT (rizatriptan) tablet, ODT RELPAK (eletriptan) tablet REYVOW (lasmiditan) tablet Sumatriptan/Naproxen tablet Zolmitriptan ODT ZOMIG (zolmitriptan) tablet	<p>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.</p> <p><u>Note:</u> There is limited information available regarding the safety, tolerability, and efficacy of coadministering lasmiditan with a triptan or a gepant.</p> <p>Quantity Limits:</p> <table border="1" data-bbox="1087 711 1942 906"> <tr> <td>Amerge (naratriptan), Frova (frovatriptan), Imitrex (sumatriptan), Zomig (zolmitriptan)</td> <td>9 tabs/30 days</td> </tr> <tr> <td>Treximet (sumatriptan/naproxen)</td> <td>9 tabs/30 days</td> </tr> <tr> <td>Axert (almotriptan) and Relpax (eletriptan)</td> <td>6 tabs/30 days</td> </tr> <tr> <td>Maxalt (rizatriptan)</td> <td>12 tabs/30 days</td> </tr> <tr> <td>Reyvow (lasmiditan)</td> <td>8 tabs/30 days</td> </tr> </table>	Amerge (naratriptan), Frova (frovatriptan), Imitrex (sumatriptan), Zomig (zolmitriptan)	9 tabs/30 days	Treximet (sumatriptan/naproxen)	9 tabs/30 days	Axert (almotriptan) and Relpax (eletriptan)	6 tabs/30 days	Maxalt (rizatriptan)	12 tabs/30 days	Reyvow (lasmiditan)	8 tabs/30 days
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Reyvow (lasmiditan)	8 tabs/30 days											

Therapeutic Drug Class: TRIPTANS, DITANS, AND OTHER MIGRAINE TREATMENTS - Non-Oral -Effective 4/1/2024

No PA Required (Quantity limits may apply)	PA Required	
<i>Brand/generic changes effective 02/22/2024*</i> IMITREX (sumatriptan) nasal spray IMITREX ^{BNR} (sumatriptan) cartridge, pen injector	Dihydroergotamine injection, nasal spray Sumatriptan cartridge, pen injector TOSYMRA (sumatriptan) nasal spray TRUDHESA (dihydroergotamine) nasal spray ZEMBRACE SYMTOUCH (sumatriptan) auto-injector	<p>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.</p> <p>All other non-preferred products may be approved for members who have trialed 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.</p>

MIGRANAL ^{BNR} (dihydroergotamine) nasal spray Sumatriptan nasal spray*, vial	Zolmitriptan nasal spray	Quantity Limits: <table border="1"> <tr> <td>Dihydroergotamine mesylate vial 1mg/mL</td> <td>24 vials/ 28 days</td> </tr> <tr> <td>Imitrex (sumatriptan) injection</td> <td>4 injectors / 30 days</td> </tr> <tr> <td>Imitrex (sumatriptan) nasal spray</td> <td>6 inhalers / 30 days</td> </tr> <tr> <td>Migranal (dihydroergotamine mesylate) nasal spray</td> <td>8 nasal spray devices/ 30 days</td> </tr> <tr> <td>Onzetra Xsail (sumatriptan) nasal powder</td> <td>16 nosepieces / 30 days</td> </tr> <tr> <td>Tosymra (sumatriptan) nasal spray</td> <td>12 nasal spray devices / 30 days</td> </tr> <tr> <td>Zembrace Symtouch (sumatriptan) injection</td> <td>36mg / 30 days</td> </tr> <tr> <td>Zomig (zolmitriptan) nasal spray</td> <td>6 inhalers / 30 days</td> </tr> </table>	Dihydroergotamine mesylate vial 1mg/mL	24 vials/ 28 days	Imitrex (sumatriptan) injection	4 injectors / 30 days	Imitrex (sumatriptan) nasal spray	6 inhalers / 30 days	Migranal (dihydroergotamine mesylate) nasal spray	8 nasal spray devices/ 30 days	Onzetra Xsail (sumatriptan) nasal powder	16 nosepieces / 30 days	Tosymra (sumatriptan) nasal spray	12 nasal spray devices / 30 days	Zembrace Symtouch (sumatriptan) injection	36mg / 30 days	Zomig (zolmitriptan) nasal spray	6 inhalers / 30 days
	Dihydroergotamine mesylate vial 1mg/mL		24 vials/ 28 days															
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Migranal (dihydroergotamine mesylate) nasal spray	8 nasal spray devices/ 30 days																	
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Zembrace Symtouch (sumatriptan) injection	36mg / 30 days																	
Zomig (zolmitriptan) nasal spray	6 inhalers / 30 days																	
ZOMIG (zolmitriptan) nasal spray																		
Members currently utilizing a non-oral dihydroergotamine product formulation (based on recent claims history) may receive one year approval to continue therapy with that medication.																		

V. Dermatological

Therapeutic Drug Class: ACNE AGENTS– Topical -Effective 7/1/2024

Preferred No PA Required (if age and diagnosis criteria are met*)	Non-Preferred PA Required	
*Adapalene gel	ACANYA (clindamycin/benzoyl peroxide) gel, pump	Authorization for all acne agents prescribed solely for cosmetic purposes will not be approved.
*Adapalene/benzoyl peroxide gel (generic Epiduo), gel pump (generic Epiduo Forte)	Adapalene cream, gel pump, solution	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.
*Clindamycin phosphate gel, lotion, solution, medicated swab/pledget	ALTRENO (tretinoin) lotion	All other preferred topical acne agents may be approved if meeting the following criteria:
*Clindamycin/benzoyl peroxide gel jar (generic Benzaclin)	ARAZLO (tazarotene) lotion	<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.
*Clindamycin/benzoyl peroxide gel tube (generic Duac)	ATRALIN (tretinoin) gel	
*Dapsone gel	BENZAMYCIN (erythromycin/benzoyl peroxide) gel	
*Erythromycin solution	BP (sulfacetamide sodium/sulfur/urea) cleansing wash	
*Erythromycin/Benzoyl peroxide gel (generic Benzamycin)	CABTREO (adapalene/benzoyl peroxide/clindamycin) gel	
	CLEOCIN-T (clindamycin) lotion	Non-preferred topical products may be approved for members meeting all of the following criteria:
	CLINDACIN ETZ/PAC (clindamycin phosphate) kit	

<p>*Sulfacetamide sodium suspension</p> <p>*Sulfacetamide sodium/sulfur cleanser,</p> <p>*RETIN-A^{BNR} (tretinoin) cream, gel</p>	<p>CLINDAGEL gel</p> <p>Clindamycin phosphate foam</p> <p>Clindamycin/Benzoyl peroxide gel pump</p> <p>Clindamycin/tretinoin gel</p> <p>Dapsone gel pump</p> <p>ERY/ERYGEL (erythromycin/ethanol) gel, medicated swabs/pads</p> <p>Erythromycin gel</p> <p>EVOCLIN (clindamycin) foam</p> <p>FABIOR (tazarotene) foam</p> <p>KLARON (sulfacetamide) suspension</p> <p>NEUAC (clindamycin/benzoyl peroxide/emollient) kit</p> <p>ONEXTON (clindamycin/benzoyl peroxide) gel, gel pump</p> <p>RETIN-A MICRO (tretinoin) (all products)</p> <p>ROSULA (sulfacetamide sodium/sulfur) cloths, wash</p> <p>SSS 10-5 (sulfacetamide sodium/sulfur) foam</p> <p>Sulfacetamide sodium cleanser, cleansing gel, lotion, shampoo, wash</p> <p>Sulfacetamide sodium/sulfur cream, pad, suspension, wash</p> <p>SUMADAN/XLT (sulfacetamide sodium/sulfur) kit, wash</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.
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	<p>SUMAXIN/ CP/TS (sulfacetamide sodium/sulfur) kit, pads, suspension, wash</p> <p>Tazarotene cream, foam, gel</p> <p>Tretinoin (all products)</p> <p>Tretinoin microspheres (all products)</p> <p>WINLEVI (clascoterone) cream</p> <p>ZIANA (clindamycin/tretinoin) gel</p>	
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Therapeutic Drug Class: ACNE AGENTS– ORAL ISOTRETINOIN -Effective 7/1/2024

PA Required for all agents		<p>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.</p> <p>Non-preferred products may be approved for members meeting the following:</p> <ul style="list-style-type: none"> Member has trialed/failed one preferred agent (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.
Preferred	Non-Preferred	
<p>AMNESTEEM capsule</p> <p>CLARAVIS capsule</p> <p>Isotretinoin 10 mg, 20 mg, 30 mg, 40 mg capsule (<i>Mayne-Pharma, Upsher-Smith, Zydus only</i>)</p> <p>ZENATANE capsule</p>	<p>ABSORICA capsule</p> <p>ABSORICA LD capsule</p> <p>Isotretinoin 10 mg, 20 mg, 30 mg, 40 mg capsule (<i>All manufacturers except Mayne-Pharma, Upsher-Smith, Zydus</i>)</p> <p>Isotretinoin 25 mg, 35 mg capsule</p> <p>MYORISAN capsule</p>	

Therapeutic Drug Class: ANTI-PSORIATICS - Oral -Effective 7/1/2024

No PA Required	PA Required	<p>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.</p>
<p>Acitretin capsule</p>	<p>Methoxsalen capsule</p>	

Therapeutic Drug Class: ANTI-PSORIATICS -Topical -Effective 7/1/2024

No PA Required	PA Required	<p>ZORYVE (roflumilast) may receive approval if meeting the following based on prescribed indication:</p> <p><u>Seborrheic dermatitis</u> (0.3% foam formulation)</p> <ul style="list-style-type: none"> Member is ≥ 9 years of age AND
<p>Calcipotriene cream, solution</p> <p>TACLONEX SCALP ^{BNR} (calcipotriene/betamethasone) suspension</p>	<p>Calcipotriene foam, ointment</p> <p>Calcipotriene/betamethasone dipropionate ointment, suspension</p>	

<p>TACLONEX (calcipotriene/betamethasone) ointment</p>	<p>Calcitriol ointment</p> <p>DUOBRII (halobetasol/tazarotene) lotion</p> <p>ENSTILAR (calcipotriene/betamethasone) foam</p> <p>SORILUX (calcipotriene) foam</p> <p>VTAMA (tapinarof) cream</p> <p>ZORYVE (roflumilast) cream</p>	<ul style="list-style-type: none"> • Member has a diagnosis of seborrheic dermatitis AND • Member does not have moderate or severe hepatic impairment (Child-Pugh B or C) AND • Medication is being prescribed by or in consultation with a dermatologist AND • <u>If the affected area is limited to the scalp:</u> <ul style="list-style-type: none"> ○ Prescriber attests that member has been counseled regarding alternative treatment options, including over-the-counter (OTC) antifungal shampoo (such as selenium sulfide, zinc pyrithione) and OTC coal tar shampoo, when appropriate) <p style="text-align: center;">AND</p> ○ Member has documented trial and failure (with a minimum 2-week treatment period) of at least one prescription product for seborrheic dermatitis, such as ketoconazole 2% antifungal shampoo or a topical corticosteroid. Failure is defined as lack of efficacy, allergy, intolerable side effects or significant drug-drug interaction. • <u>If the affected area includes the face or body:</u> <p>Member has documented trial and failure (with a minimum 2-week treatment period) with at least one product from ALL of the following categories (Failure is defined as lack of efficacy, allergy, intolerable side effects or significant drug-drug interaction):</p> <ul style="list-style-type: none"> ▪ Topical antifungal (such as ketoconazole, ciclopirox) ▪ Topical corticosteroid ▪ Topical calcineurin inhibitor (such as pimecrolimus, tacrolimus) <p style="text-align: center;">AND</p> • Member has been counseled that Zoryve foam is flammable. Fire, flame, or smoking during and immediately following application must be avoided. <p><u>Plaque psoriasis (0.3% cream formulation)</u></p> <ul style="list-style-type: none"> • Member is ≥ 6 years of age AND • Member has a diagnosis of plaque psoriasis AND • Member has body surface area (BSA) involvement of $\leq 20\%$ AND • Member does not have moderate or severe hepatic impairment (Child-Pugh B or C) AND
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- Medication is being prescribed by or in consultation with a dermatologist AND
- If the affected area is limited to the scalp:
 - Prescriber attests that member has been counseled regarding alternative treatment options, including over-the-counter (OTC) emollients, vitamin D analogs, and coal tar shampoo when appropriate

AND

 - Member has documented trial and failure (with a minimum 2-week treatment period) of a topical corticosteroid. Failure is defined as lack of efficacy, allergy, intolerable side effects or significant drug-drug interaction.
- If the affected area includes the face or body:
 - Member has documented trial and failure (with a minimum 2-week treatment period) of at least one product from ALL of the following categories. (Failure is defined as lack of efficacy, allergy, intolerable side effects or significant drug-drug interaction):
 - Topical corticosteroid
 - Topical calcineurin inhibitor (such as pimecrolimus, tacrolimus)

Quantity limit:
Foam or cream - 60 grams/30 days

Initial approval:
Foam or cream: 8 weeks

Reauthorization: Reauthorization for one year may be approved based on provider attestation that member's symptoms improved during the initial 8 weeks of treatment and continuation of therapy is justified.

Prior authorization for all other non-preferred topical agents may be approved with failure of two preferred topical agents. If non-preferred topical agent being requested 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. Members may not apply Zoryve (roflumilast) cream to >20% of affected body surface area, as safety and efficacy have not been established.
Therapeutic Drug Class: IMMUNOMODULATORS, TOPICAL – Effective 7/1/2024		
Atopic Dermatitis		
<p style="text-align: center;">No PA Required</p> <p>ELIDEL (pimecrolimus) cream^{BNR}</p> <p>Tacrolimus ointment</p>	<p style="text-align: center;">PA Required</p> <p>EUCRISA (crisaborole) ointment</p> <p>OPZELURA (ruxolitinib) cream</p> <p>Pimecrolimus cream</p> <p>ZORYVE (tapinarof) foam</p>	<p>EUCRISA (crisaborole) may be approved if the following criteria are met:</p> <ul style="list-style-type: none"> • Member is at least 3 months of age and older AND • Member has a diagnosis of mild to moderate atopic dermatitis AND • Member has a history of failure, contraindication, or intolerance to at least two medium-to high-potency topical corticosteroids for a minimum of 2 weeks OR is not a candidate for topical corticosteroids AND • Member must have tried and failed pimecrolimus and tacrolimus. Failure is defined as a lack of efficacy, allergy, intolerable side effects, contraindication to, or significant drug-drug interactions. AND • Eucrisa (crisaborole) must be prescribed by or in consultation with a dermatologist or allergist/immunologist. <p>OPZELURA (ruxolitinib) cream may be approved if the following criteria are met based on prescribed indication:</p> <p><u>Atopic Dermatitis</u></p> <ul style="list-style-type: none"> • Member is ≥ 12 years of age AND • Member is immunocompetent AND • Member has a diagnosis of mild to moderate atopic dermatitis AND • Member has body surface area (BSA) involvement of $\leq 20\%$ AND • Medication is being prescribed by or in consultation with a dermatologist or allergist/immunologist AND • Member has a history of failure, contraindication, or intolerance to at least two medium-to high potency topical corticosteroids for a minimum of 2 weeks OR is not a candidate for topical corticosteroids AND • Member must have trialed and failed twice-daily pimecrolimus and tacrolimus. Failure is defined as a lack of efficacy, allergy, intolerable side effects, contraindication to, or significant drug-drug interaction AND • Member is not using Opzelura (ruxolitinib) cream along with a strong inhibitor of CYP3A4 (such as fluconazole ≥ 200 mg/day, ketoconazole, itraconazole, voriconazole, ritonavir) due to the potential for increased systemic exposure to ruxolitinib. <p><u>Nonsegmental Vitiligo</u></p>

		<ul style="list-style-type: none"> • Member is ≥ 12 years of age AND • Member is immunocompetent AND • Member has a diagnosis of stable nonsegmental vitiligo, defined as no increase in the size of existing lesions and the absence of new lesions in the previous 3 to 6 months, AND • Medication is being prescribed by or in consultation with a dermatologist AND • Member will be applying Opzelura (ruxolitinib) to $\leq 10\%$ of body surface area (BSA) per application AND • Member has a history of failure, contraindication, or intolerance to at least two medium-to high-potency topical corticosteroids for a minimum of 2 weeks OR is not a candidate for topical corticosteroids AND <ul style="list-style-type: none"> • Member must have trialed and failed twice-daily pimecrolimus OR tacrolimus. Failure is defined as a lack of efficacy, allergy, intolerable side effects, contraindication to, or significant drug-drug interaction AND • Member is not using Opzelura (ruxolitinib) cream along with a strong inhibitor of CYP3A4 (such as fluconazole ≥ 200 mg/day, ketoconazole, itraconazole, voriconazole, ritonavir) due to the potential for increased systemic exposure to ruxolitinib. <p><u>Quantity limit:</u> 60 grams/week</p> <p>All other 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>
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Antineoplastic Agents

Preferred No PA Required (Unless indicated*)	Non-Preferred PA Required	
<p>*Diclofenac 3% gel (generic Solaraze)</p> <p>Fluorouracil 5% cream (generic Efudex)</p> <p>Fluorouracil 2%, 5% solution</p>	<p>Bexarotene gel</p> <p>CARAC (fluorouracil) cream</p> <p>EFUDEX (fluorouracil) cream</p> <p>Fluorouracil 0.5% (generic Carac) cream</p> <p>PANRETIN (alitretinoin) gel</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 AND • Member and partners have been counseled on appropriate use of contraception

	<p>TARGRETIN (bexarotene) gel</p> <p>VALCHLOR (mechlorethamine) gel</p>	<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>
Other Agents		
<p style="text-align: center;">No PA Required</p> <p>Imiquimod (generic Aldara) cream</p> <p>Podofilox gel, solution</p>	<p style="text-align: center;">PA Required</p> <p>CONDYLOX (podofilox) gel</p> <p>HYFTOR (sirolimus) gel</p> <p>Imiquimod (generic Zyclara) cream, cream pump</p> <p>VEREGEN (sinecatechins) ointment</p> <p>ZYCLARA (imiquimod) cream, cream pump</p>	<p>Hyftor (sirolimus) gel</p> <ul style="list-style-type: none"> Member has a diagnosis of facial angiofibroma associated with tuberous sclerosis AND Member is ≥ 6 years of age AND Provider has evaluated, and member has received, all age-appropriate vaccinations as recommended by current immunization guidelines prior to initiating treatment with HYFTOR <p><u>Initial approval:</u> 6 months</p> <p><u>Reauthorization:</u> An additional 6 months may be approved based on provider attestation that symptoms improved during the initial 6 months of treatment and the provider has assessed use of all vaccinations recommended by current immunization guidelines.</p> <p><u>Maximum dose:</u> one 10-gram tube/28 days</p> <p>Veregen (sinecatechins) may be approved if the following criteria are met:</p> <ul style="list-style-type: none"> Member has a diagnosis of external genital and/or perianal warts (Condylomata acuminata) AND Member is ≥ 18 years of age AND Member is immunocompetent AND Member has tried and failed two preferred products. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction. <p>Zyclara (imiquimod) 2.5% cream may be approved if the following criteria are met:</p> <ul style="list-style-type: none"> Member has a diagnosis of clinically typical visible or palpable actinic keratoses (AK) of the full face or balding scalp AND Member is ≥ 18 years of age AND Member is immunocompetent AND Member has tried and failed one preferred product in the Antineoplastic Agents class (such as diclofenac gel or fluorouracil) AND the preferred imiquimod (generic Aldara) product. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction. <p>Zyclara (imiquimod) 3.75% cream may be approved for:</p> <ul style="list-style-type: none"> Treatment of clinically typical visible or palpable, actinic keratoses (AK) of the full face or balding scalp if the following criteria are met: <ul style="list-style-type: none"> Member is ≥ 18 years of age AND

		<ul style="list-style-type: none"> • Member is immunocompetent AND • Member has tried and failed one preferred product from the Antineoplastic Agents class (such as diclofenac gel or fluorouracil) AND the preferred imiquimod (generic Aldara) product. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction. <p>OR</p> <ul style="list-style-type: none"> • Treatment of external genital and/or perianal warts (Condylomata acuminata) if the following criteria are met: <ul style="list-style-type: none"> • Member is ≥ 12 years of age AND • Member has tried and failed two preferred products. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction. <p>All other non-preferred products may be approved for members who have trialed and failed all preferred products that are FDA-approved for use for the prescribed indication. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.</p> <p><u>Quantity Limits:</u> Aldara (imiquimod) cream has a quantity limit of 12 packets/28 days.</p>
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Therapeutic Drug Class: ROSACEA AGENTS -Effective 7/1/2024

No PA Required	PA Required	
<p>Azelaic acid gel (<i>Sandoz only</i>)</p> <p>FINACEA (azelaic acid) gel</p> <p>FINACEA (azelaic acid) foam</p> <p>Metronidazole cream, lotion</p> <p>Metronidazole 0.75% gel</p>	<p>Azelaic acid gel (<i>All other manufacturers</i>)</p> <p>Brimonidine gel pump</p> <p>*Doxycycline monohydrate DR capsule (generic Oracea)</p> <p>Ivermectin cream</p> <p>Metronidazole 1% gel, gel pump</p> <p>NORITATE (metronidazole) cream</p> <p>RHOFADE (oxymetazoline) cream</p> <p>ROSADAN (metronidazole/skin cleanser) cream kit, gel kit</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>*Doxycycline monohydrate DR (generic Oracea) may be approved if the following criteria are met:</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 7/1/2024

Low potency

No PA Required	PA Required	
<p>DERMA-SMOOTHIE-FS (fluocinolone) 0.01% body oil/scalp oil^{BNR}</p> <p>Desonide 0.05% cream, ointment</p> <p>Fluocinolone 0.01% cream</p> <p>Hydrocortisone (Rx) cream, lotion, ointment</p>	<p>Alclometasone 0.05% cream, ointment</p> <p>CAPEX (fluocinolone) 0.01% shampoo</p> <p>Desonide 0.05% lotion</p> <p>Fluocinolone 0.01% body oil, 0.01% scalp oil, 0.01% solution</p> <p>PROCTOCORT (hydrocortisone) (Rx) 1% cream</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

No PA Required	PA Required	
<p>Betamethasone dipropionate 0.05% cream, lotion, ointment</p> <p>Betamethasone valerate 0.1% cream, ointment</p> <p>Fluocinolone 0.025% cream, 0.05% cream, 0.005% ointment</p> <p>Fluticasone cream, ointment</p> <p>Hydrocortisone valerate 0.2% cream</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,</p>	<p>BESER (fluticasone) lotion, emollient kit</p> <p>Betamethasone valerate 0.1% lotion, 0.12% foam</p> <p>Clocortolone 0.1% cream, cream pump</p> <p>CLODERM (clocortolone) 0.1% cream, cream pump</p> <p>CUTIVATE (fluticasone) 0.05% cream, lotion</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>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>0.1% ointment, 0.025% lotion, 0.1% lotion</p> <p>Triamcinolone 0.1% dental paste</p>	<p>Hydrocortisone butyrate 0.1% cream, lotion, solution, ointment, lipid/lipocream</p> <p>Hydrocortisone valerate 0.2% 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>	
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High potency

<p align="center">No PA Required (*unless exceeds duration of therapy)</p> <p>* Betamethasone dipropionate 0.05% ointment</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 align="center">PA Required</p> <p>Amcinonide 0.1% cream, lotion</p> <p>APEXICON-E (diflorasone/emollient) 0.05% cream</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>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>*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> <p>Claims for compounded products containing high-potency topical steroids will be limited to a maximum of 60 grams or 60 mL of a high-potency ingredient per 4-week treatment period. Claims exceeding this quantity limit will require prior authorization with prescriber's justification for use of the product at the prescribed dose.</p>
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Very high potency

No PA Required (Unless exceeds duration of therapy*)	PA Required	
*Betamethasone dipropionate/propylene glycol (augmented) ,0.05% lotion 0.05% ointment	Betamethasone dipropionate/propylene glycol (augmented) 0.05% gel	<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>
*Clobetasol 0.05% cream, 0.05% gel, 0.05% ointment, 0.05% solution	BRYHALI (halobetasol) 0.01% lotion Clobetasol emollient/emulsion 0.05% cream, foam	
*Fluocinonide 0.1% cream	Clobetasol 0.05% lotion, foam, spray, shampoo CLODAN (clobetasol) 0.05% cleanser kit	
	Desoximetasone 0.25% spray	
	DIPROLENE (betamethasone dipropionate/propylene glycol, augmented) 0.05% ointment	
	Halobetasol 0.05% cream, foam, ointment	
	IMPEKLO (clobetasol) 0.05% lotion	
	LEXETTE (halobetasol) 0.05% foam	
	OLUX (clobetasol) 0.05% foam	
	TOPICORT (desoximetasone) 0.25% spray	
	TOVET EMOLLIENT (clobetasol) 0.05% foam	
	ULTRAVATE (halobetasol) 0.05% lotion	
	VANOS (fluocinonide) 0.1% cream	

VI. Endocrine

Therapeutic Drug Class: **ANDROGENIC AGENTS, Topical, Injectable, Oral** -Effective 10/1/2023

PA Required for all agents in this class	
Preferred	Non-Preferred

<p>ANDRODERM (testosterone) patch</p> <p>Testosterone cypionate IM injection</p> <p>Testosterone gel packet</p> <p>Testosterone 1.62% gel pump</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>ANDROGEL (testosterone) gel packet</p> <p>ANDROGEL (testosterone) gel 1.62% pump</p> <p>ANDROID (methyltestosterone) capsule</p> <p>DEPO-TESTOSTERONE (testosterone cypionate) IM injection</p> <p>FORTESTA (testosterone) gel pump</p> <p>METHITEST (methyltestosterone) tablet</p> <p>Methyltestosterone capsule</p> <p>NATESTO (testosterone) nasal spray</p> <p>TESTIM (testosterone) gel</p> <p>Testosterone 1% gel tube, 30 mg/1.5 ml pump</p> <p>Testosterone enanthate IM injection</p> <p>TLANDO (testosterone undecanoate) capsules</p> <p>VOGELXO (testosterone) packet, pump</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 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 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"> 1. Female sex assigned at birth and has reached Tanner stage 2 of puberty AND 2. Is undergoing female to male transition AND 3. Has a negative pregnancy test prior to initiation AND 4. Hematocrit (or hemoglobin) is being monitored. <p>Non-Preferred Products:</p> <p>Non-preferred topical androgenic agents may be approved for patients meeting the above criteria with trial and failed\ddagger 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\ddagger 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\ddagger therapy with a preferred topical agent AND testosterone cypionate injection.</p>
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		<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 hypogonadism secondary to Klinefelter Syndrome).</p>
Therapeutic Drug Class: BONE RESORPTION SUPPRESSION AND RELATED AGENTS -Effective 10/1/2023		
Bisphosphonates		
No PA Required	PA Required	
Alendronate tablet, solution	ACTONEL (risedronate) tablet	<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>
Ibandronate tablet	ATELVIA (risedronate) tablet	
Risedronate tablet	BONIVA (ibandronate) tablet	
	FOSAMAX (alendronate) tablet	
	FOSAMAX plus D (alendronate/vit D) tablet	
Non-Bisphosphonates		
	PA Required	
	Calcitonin salmon nasal spray	<p>CALCITONIN SALMON (nasal) may be approved if the member meets the following criteria:</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"> Male primary or hypogonadal osteoporosis (BMD T-scores of -2.5 or less). Osteoporosis due to corticosteroid use Postmenopausal osteoporosis <p>AND</p>
	FORTEO (teriparatide) SC pen	
	Raloxifene tablet	
	Teriparatide SC pen	
	TYMLOS (abaloparatide) SC pen	

- Member is at 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

Maximum dose: 20mcg daily

TYMLOS (abaloparatide) may be approved if the member meets the following criteria:

- 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.

Maximum dose: 80 mcg daily

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.

*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 - Topical** Effective 10/1/2023

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	PA Required	
ANNOVERA (segesterone acetate/EE) vaginal ring NUVARING ^{BNR} (etonorgestrel/EE) vaginal ring PHEXXI (lactic acid/citric/potassium) vaginal gel* TWIRLA (levonorgestrel/EE) TD patch XULANE (norelgestromin/EE) TD patch *EE – Ethinyl Estradiol	ELURYNG (Etonorgestrel/EE) vaginal ring Etonorgestrel/EE vaginal ring Haloette vaginal ring Norelgestromin/EE TD patch ZAFEMY (norelgestromin/EE) TD patch *EE – Ethinyl Estradiol	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. Effective 7/1/2022: Prescriptions are eligible to be filled for up to a twelve-month supply. <i>Note: IUD and select depot product formulations are billed through the medical benefit</i> * PHEXXI (lactic acid/citric/potassium) vaginal gel <ul style="list-style-type: none"> • <u>Quantity Limit:</u> 120 grams per 30 days

Therapeutic Drug Class: DIABETES MANAGEMENT CLASSES, INSULINS- Effective 10/1/2023

Rapid-Acting

No PA Required	PA Required	
HUMALOG ^{BNR} 100U/mL KwikPen, vial HUMALOG (insulin lispro) cartridge HUMALOG Jr. ^{BNR} (insulin lispro) KwikPen Insulin aspart cartridge, pen, vial NOVOLOG (insulin aspart) cartridge, FlexTouch pen, vial	ADMELOG (insulin lispro) Solostar pen, vial AFREZZA (regular insulin) cartridge, unit APIDRA (insulin glulisine) Solostar pen, vial FIASP (insulin aspart) FlexTouch pen, PenFill, pump cartridge, vial HUMALOG (insulin lispro) 200 U/mL pen, Tempo pen Insulin lispro Kwikpen, Jr. Kwikpen, vial LYUMJEV (insulin lispro-aabc) Kwikpen, vial, Tempo pen	Non-preferred products may be approved following trial and failure of treatment with two preferred products, one of which is the same rapid-acting insulin analog (lispro or aspart) as the non-preferred product being requested. (Failure is defined as allergy [hives, maculopapular rash, erythema multiforme, pustular rash, severe hypotension, bronchospasm, and angioedema] or intolerable side effects). bone Afrezza (human insulin) may be approved if meeting the following criteria: <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 • Prescriber acknowledges that Afrezza is not recommended in patients who smoke or have recently stopped smoking.

Short-Acting

No PA Required	PA Required	
	NOVOLIN R U-100 (insulin regular) vial (OTC)	

HUMULIN R U-100 (insulin regular) vial (OTC) NOVOLIN R U-100 (insulin regular) FlexPen (OTC)		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).
Intermediate-Acting		
No PA Required	PA Required	
HUMULIN N U-100 (insulin NPH) vial (OTC) NOVOLIN N U-100 (insulin NPH) FlexPen (OTC)	HUMULIN N U-100 (insulin NPH) KwikPen (OTC) NOVOLIN N U-100 (insulin NPH) vial (OTC)	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).
Long-Acting		
No PA Required*	PA Required	
LANTUS ^{BNR} (insulin glargine) vial, Solostar LEVEMIR (insulin detemir) vial, FlexTouch	BASAGLAR (insulin glargine) Kwikpen, Tempo pen Insulin degludec FlexTouch, vial Insulin glargine solostar, vial Insulin glargine MAX solostar Insulin glargine-yfgn pen, vial REZVOGLAR (insulin glargine-aglr) Kwikpen SEMGLEE (insulin glargine-yfgn) pen, vial TOUJEO (insulin glargine) Solostar TOUJEO MAX (insulin glargine) Solostar TRESIBA (insulin degludec) FlexTouch, vial	* Tresiba (insulin degludec) may be approved for members who have trialed and failed‡ Lantus. All other non-preferred products may be approved if the member has tried and failed‡ treatment with Lantus AND Tresiba. ‡Failure is defined as lack of efficacy, allergy, or intolerable side effects.
Concentrated		
No PA Required	PA Required	
HUMULIN R U-500 (insulin regular) concentrated vial, Kwikpen		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).
Mixtures		
No PA Required	PA Required	

HUMALOG MIX 50/50 Kwikpen, 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).
HUMALOG MIX 75/25 Kwikpen ^{BNR} , vial	Insulin lispro protamine/insulin lispro 75/25 Kwikpen (generic Humalog Mix)	
HUMULIN 70/30 (OTC) Kwikpen, vial		
Insulin aspart protamine/insulin aspart 70/30 FlexPen, vial (generic Novolog Mix)		
NOVOLOG MIX 70/30 FlexPen, vial		

Therapeutic Drug Class: DIABETES MANAGEMENT CLASSES, NON- INSULINS- 10/1/2023

Amylin

	PA Required	
	SYMLIN (pramlintide) pen	<p>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.</p> <p>Maximum Dose: Prior authorization will be required for doses exceeding FDA-approved dosing listed in product package labeling.</p>

Biguanides

No PA Required	PA Required	
Metformin IR tablets	FORTAMET ER (metformin) tablet	<p>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.</p> <p>Liquid metformin may be approved for members who meet one of the following:</p> <ul style="list-style-type: none"> Member is under the age of 12 with a feeding tube OR Prescriber confirms that member has difficulty swallowing
Metformin ER 500mg, 750mg tablets (generic Glucophage XR)	GLUMETZA ER (metformin) tablet	
	Metformin ER (generic Fortamet, Glumetza)	
	RIOMET (metformin) solution	
	RIOMET ER (metformin) suspension	

Dipeptidyl Peptidase-4 Enzyme inhibitors (DPP-4is)

Preferred	Non-Preferred PA Required	
JANUVIA (sitagliptin) tablet	Alogliptin tablet	<p>Non-preferred DPP-4 inhibitors may be approved after a member has failed 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.</p> <p><u>Maximum Dose:</u></p>
TRADJENTA (linagliptin) tablet	NESINA (alogliptin) tablet	

	ONGLYZA (saxagliptin) tablet Saxagliptin tablet	Prior authorization will be required for doses exceeding the FDA-approved maximum dosing listed in the following table: <table border="1" data-bbox="940 159 1711 521"> <thead> <tr> <th data-bbox="940 159 1272 233">DPP-4 Inhibitor</th> <th data-bbox="1272 159 1711 233">FDA-Approved Maximum Daily Dose</th> </tr> </thead> <tbody> <tr> <td data-bbox="940 233 1272 290">Alogliptin (generic Nesina)</td> <td data-bbox="1272 233 1711 290">25 mg/day</td> </tr> <tr> <td data-bbox="940 290 1272 347">Januvia (sitagliptin)</td> <td data-bbox="1272 290 1711 347">100 mg/day</td> </tr> <tr> <td data-bbox="940 347 1272 404">Nesina (alogliptin)</td> <td data-bbox="1272 347 1711 404">25 mg/day</td> </tr> <tr> <td data-bbox="940 404 1272 461">Onglyza (saxagliptin)</td> <td data-bbox="1272 404 1711 461">5 mg/day</td> </tr> <tr> <td data-bbox="940 461 1272 521">Tradjenta (linagliptin)</td> <td data-bbox="1272 461 1711 521">5 mg/day</td> </tr> </tbody> </table>	DPP-4 Inhibitor	FDA-Approved Maximum Daily 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
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Nesina (alogliptin)	25 mg/day													
Onglyza (saxagliptin)	5 mg/day													
Tradjenta (linagliptin)	5 mg/day													

DPP-4 Inhibitors – Combination with Metformin

Preferred	Non-Preferred PA Required													
JANUMET (sitagliptin/metformin) tablet JANUMET XR (sitagliptin/metformin) tablet JENTADUETO (linagliptin/metformin) tablet JENTADUETO XR (linagliptin/metformin) tablet	Alogliptin/metformin tablet KAZANO (alogliptin/metformin) tablet KOMBIGLYZE XR (saxagliptin/metformin) Saxagliptin/metformin tablet	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. <u>Maximum Dose:</u> Prior authorization will be required for doses exceeding the FDA-approved maximum dosing listed in the following table: <table border="1" data-bbox="1081 920 2039 1417"> <thead> <tr> <th data-bbox="1081 920 1635 1005">DPP-4 Inhibitor Combination</th> <th data-bbox="1635 920 2039 1005">FDA Approved Maximum Daily Dose</th> </tr> </thead> <tbody> <tr> <td data-bbox="1081 1005 1635 1097">Alogliptin/metformin tablet</td> <td data-bbox="1635 1005 2039 1097">25 mg alogliptin/2,000 mg metformin</td> </tr> <tr> <td data-bbox="1081 1097 1635 1179">Janumet and Janumet XR (sitagliptin/metformin)</td> <td data-bbox="1635 1097 2039 1179">100 mg sitagliptin/ 2,000 mg of metformin</td> </tr> <tr> <td data-bbox="1081 1179 1635 1260">Jentadueto and Jentadueto XR(linagliptin/metformin)</td> <td data-bbox="1635 1179 2039 1260">5 mg linagliptin/ 2,000 mg metformin</td> </tr> <tr> <td data-bbox="1081 1260 1635 1341">Kazano (alogliptin/metformin)</td> <td data-bbox="1635 1260 2039 1341">25 mg alogliptin/ 2,000 mg metformin</td> </tr> <tr> <td data-bbox="1081 1341 1635 1417">Kombiglyze XR (saxagliptin ER/metformin ER) tablet</td> <td data-bbox="1635 1341 2039 1417">5 mg saxagliptin/ 2,000 mg metformin</td> </tr> </tbody> </table>	DPP-4 Inhibitor Combination	FDA Approved Maximum Daily Dose	Alogliptin/metformin tablet	25 mg alogliptin/2,000 mg metformin	Janumet and Janumet XR (sitagliptin/metformin)	100 mg sitagliptin/ 2,000 mg of metformin	Jentadueto and Jentadueto XR(linagliptin/metformin)	5 mg linagliptin/ 2,000 mg metformin	Kazano (alogliptin/metformin)	25 mg alogliptin/ 2,000 mg metformin	Kombiglyze XR (saxagliptin ER/metformin ER) tablet	5 mg saxagliptin/ 2,000 mg metformin
DPP-4 Inhibitor Combination	FDA Approved Maximum Daily Dose													
Alogliptin/metformin tablet	25 mg alogliptin/2,000 mg metformin													
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Glucagon-like Peptide-1 Receptor Agonists (GLP-1 Analogues)

<p>Preferred *Must meet eligibility criteria</p> <p>*BYETTA (exenatide) pen</p> <p>*TRULICITY (dulaglutide) pen</p> <p>*VICTOZA (liraglutide) pen</p>	<p>Non-Preferred PA Required</p> <p>ADLYXIN (lixisenatide)</p> <p>BYDUREON BCISE (exenatide ER) autoinjector</p> <p>MOUNJARO (tirzepatide) pen</p> <p>OZEMPIC (semaglutide) pen</p> <p>RYBELSUS (semaglutide) oral tablet</p>	<p>*Preferred products may be approved for members with a diagnosis of type 2 diabetes.</p> <p>Non-preferred products may be approved for members with a diagnosis of type 2 diabetes following 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.</p> <p><u>Maximum Dose:</u> Prior authorization is required for all products exceeding maximum dose listed in product package labeling.</p> <table border="1" data-bbox="1150 423 1808 751"> <thead> <tr> <th colspan="2">Table 1: GLP-1 Analogue Maximum Dose</th> </tr> </thead> <tbody> <tr> <td>Adlyxin (lixisenatide)</td> <td>20 mcg per day</td> </tr> <tr> <td>Bydureon Bcise (exenatide)</td> <td>2 mg weekly</td> </tr> <tr> <td>Byetta (exenatide)</td> <td>20 mcg per day</td> </tr> <tr> <td>Mounjaro (tirzepatide)</td> <td>15 mg weekly</td> </tr> <tr> <td>Ozempic (semaglutide)</td> <td>2 mg weekly</td> </tr> <tr> <td>Rybelsus (semaglutide)</td> <td>14 mg daily</td> </tr> <tr> <td>Trulicity (dulaglutide)</td> <td>4.5 mg weekly</td> </tr> <tr> <td>Victoza (liraglutide)</td> <td>1.8 mg per day</td> </tr> </tbody> </table> <p><i>Note: Prior Authorization for GLP-1 analogues prescribed solely for weight loss will not be approved.</i></p>	Table 1: GLP-1 Analogue Maximum Dose		Adlyxin (lixisenatide)	20 mcg per day	Bydureon Bcise (exenatide)	2 mg weekly	Byetta (exenatide)	20 mcg per day	Mounjaro (tirzepatide)	15 mg weekly	Ozempic (semaglutide)	2 mg weekly	Rybelsus (semaglutide)	14 mg daily	Trulicity (dulaglutide)	4.5 mg weekly	Victoza (liraglutide)	1.8 mg per day
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Other Hypoglycemic Combinations

	<p align="center">PA Required</p> <p>Alogliptin/pioglitazone tablet</p> <p>DUETACT (pioglitazone/glimepiride) tablet</p> <p>Glipizide/metformin tablet</p> <p>Glyburide/metformin tablet</p> <p>GLYXAMBI (empagliflozin/linagliptin) tablet</p> <p>OSENI (alogliptin/pioglitazone) tablet</p> <p>Pioglitazone/glimepiride tablet</p> <p>QTERN (dapagliflozin/saxagliptin) tablet</p> <p>SOLIQUA (insulin glargine/lixisenatide) pen</p> <p>STEGLUJAN (ertugliflozin/sitagliptin) tablet</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>
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	<p>TRIJARDY XR tablet(empagliflozin/linagliptin/metformin)</p> <p>XULTOPHY (insulin degludec/liraglutide) pen</p>															
Meglitinides																
	<p style="text-align: center;">PA Required</p> <p>Nateglinide tablet</p> <p>Repaglinide tablet</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																
	<p style="text-align: center;">PA Required</p> <p>Repaglinide/metformin</p>	<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>														
Sodium-Glucose Cotransporter Inhibitors (SGLT inhibitors)																
<p style="text-align: center;">No PA Required</p> <p>FARXIGA^{BNR} (dapagliflozin) tablet</p> <p>INVOKANA (canagliflozin) tablet</p> <p>JARDIANCE (empagliflozin) tablet</p>	<p style="text-align: center;">PA Required</p> <p>Dapagliflozin tablet</p> <p>INPEFA (sotagliflozin) tablet</p> <p>STEGLATRO (ertugliflozin) tablet</p>	<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> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="3" style="text-align: center;">SGLT Inhibitor Renal Dosing Recommendations</th> </tr> <tr> <th style="text-align: center;">SGLT Inhibitor</th> <th style="text-align: center;">Clinical Setting</th> <th style="text-align: center;">Renal Dosing Recommendations (FDA labeling)</th> </tr> </thead> <tbody> <tr> <td rowspan="2" style="text-align: center;">FARXIGA (dapagliflozin)</td> <td>Glycemic control in patients without established CV disease or CV risk factors</td> <td>Not recommended when eGFR is <45 mL/min/1.73 m²</td> </tr> <tr> <td>Chronic kidney disease (CKD) or heart failure (HF)</td> <td>Initiation of therapy not recommended when eGFR is <25 mL/min/1.73 m² (safety and efficacy in members on dialysis has not been established)</td> </tr> <tr> <td style="text-align: center;">INPEFA (sotagliflozin)</td> <td>Reduce risk of CV death, HF hospitalization and urgent HF visit in adults with HF or Type 2 DM, CKD and other CV risk factors</td> <td>Safety and efficacy in members with eGFR less than 25 mL/min/1.73 m² or on dialysis has not been established</td> </tr> </tbody> </table>	SGLT Inhibitor Renal Dosing Recommendations			SGLT Inhibitor	Clinical Setting	Renal Dosing Recommendations (FDA labeling)	FARXIGA (dapagliflozin)	Glycemic control in patients without established CV disease or CV risk factors	Not recommended when eGFR is <45 mL/min/1.73 m ²	Chronic kidney disease (CKD) or heart failure (HF)	Initiation of therapy not recommended when eGFR is <25 mL/min/1.73 m ² (safety and efficacy in members on dialysis has not been established)	INPEFA (sotagliflozin)	Reduce risk of CV death, HF hospitalization and urgent HF visit in adults with HF or Type 2 DM, CKD and other CV risk factors	Safety and efficacy in members with eGFR less than 25 mL/min/1.73 m ² or on dialysis has not been established
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		INVOKANA (canagliflozin) Glycemic control in patients without established CV disease or CV risk factors Initiation of therapy not recommended when eGFR is <30 mL/min/1.73 m ²
		JARDIANCE (empagliflozin) Glycemic control in patients without established CV disease or CV risk factors Not recommended when eGFR is <30 mL/min/1.73 m ² (contraindicated in members on dialysis)
		JARDIANCE (empagliflozin) Chronic kidney disease (CKD) or heart failure (HF) Not recommended when eGFR is < 20 mL/min/1.73 m ² (Contraindicated in members on dialysis)
		STEGLATRO (ertugliflozin) Adjunct to diet and exercise in members with Type 2 DM Not recommended when eGFR is <45 mL/min/1.73 m ² (contraindicated in members on dialysis)
<u>Maximum Dose:</u> Prior authorization is required for all products exceeding maximum dose listed in product package labeling.		

SGLT Inhibitor Combinations with Metformin

No PA Required	PA Required	
INVOKAMET (canagliflozin/metformin) tablet INVOKAMET XR (canagliflozin/metformin) tablet SYNJARDY (empagliflozin/metformin) tablet SYNJARDY XR (empagliflozin/metformin) tablet XIGDUO XR^{BNR} (dapagliflozin/metformin) tablet	Dapagliflozin/Metformin XR tablet SEGLUROMET (ertugliflozin/metformin) tablet	Non-preferred products may be approved for members who have been stable on the two individual ingredients of the requested combination for 3 months. INVOKAMET, INVOKAMET XR, SEGLUROMET, SYNJARDY, SYNJARDY XR and XIGDUO XR are contraindicated in patients with an eGFR less than 30 mL/min/1.73 m ² or on dialysis.

Thiazolidinediones (TZDs)

No PA Required	PA Required	
Pioglitazone tablet	ACTOS (pioglitazone) tablet	Non-preferred agents may be approved following 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																						
	<p align="center">PA Required</p> <p>ACTOPLUS MET (pioglitazone/metformin) TABLET</p> <p>Pioglitazone/metformin tablet</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.																				
Therapeutic Drug Class: ESTROGEN AGENTS -Effective 10/1/2023																						
No PA Required	PA Required	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.																				
Parenteral																						
<p>DELESTROGEN^{BNR} (estradiol valerate) vial</p> <p>DEPO-ESTRODIOL (estradiol cypionate) vial</p> <p>Estradiol valerate 40mg/mL vial</p>	Estradiol valerate 10mg/mL vial, 20mg/mL vial	<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>																				
Oral/Transdermal																						
<p>Estradiol oral tablet</p> <p>Estradiol (generic Climara) weekly patch</p> <p>MINIVELLE^{BNR} (estradiol) patch</p> <p>VIVELLE-DOT^{BNR} (estradiol) patch</p>	<p>ALORA (estradiol) patch</p> <p>CLIMARA (estradiol) patch</p> <p>DOTTI (estradiol) patch</p> <p>ESTRACE (estradiol) oral tablet</p> <p>Estradiol daily patch</p> <p>Estradiol bi-weekly patch</p> <p>LYLLANA (estradiol) patch</p> <p>MENOSTAR (estradiol) patch</p>	<table border="1"> <thead> <tr> <th colspan="2">Table 1: Transdermal Estrogen FDA-Labeled Dosing</th> </tr> </thead> <tbody> <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> </tbody> </table> <p><i>Note: Estrogen agents are a covered benefit for gender affirming hormone therapy and treating clinicians and mental health providers should be knowledgeable about the diagnostic criteria for gender-affirming hormone treatment and have sufficient training and experience in assessing related mental health conditions.</i></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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VIVELLE-DOT (estradiol) patch	2/week																					
Therapeutic Drug Class: GLUCAGON, SELF-ADMINISTERED -Effective 10/1/2023																						
Preferred	Non-Preferred																					

<p>No PA Required</p> <p>BAQSIMI (glucagon) nasal spray</p> <p>GLUCAGEN HYPOKIT (glucagon)</p> <p>Glucagon Emergency Kit (<i>Eli Lilly</i>)</p> <p>Glucagon Emergency Kit (<i>Amphastar</i>)</p> <p>ZEGALOGUE (dasiglucagon) autoinjector</p>	<p>PA Required</p> <p>Glucagon Emergency Kit (<i>Fresenius</i>)</p> <p>GVOKE (glucagon) Hypopen, Syringe, vial</p> <p>ZEGALOGUE (dasiglucagon) syringe</p>	<p>Non-preferred products may be approved if the member has failed treatment with two preferred products (failure is defined as allergy to ingredients in product, intolerable side effects, contraindication, or inability to administer dosage form).</p> <p>Quantity limit for all products: 2 doses per year unless used/ damaged/ lost</p>
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Therapeutic Drug Class: GROWTH HORMONES -Effective 10/1/2023

<p>Preferred No PA Required (If diagnosis and dose met)</p> <p>GENOTROPIN (somatropin) cartridge, Miniquick pen</p> <p>NORDITROPIN (somatropin) Flexpro pen</p>	<p>Non-Preferred 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>SOGROYA (somapacitan-beco) pen</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) AND • Member has a qualifying diagnosis that includes at least one of the following conditions: <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 (such as 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) <p>AND</p>
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- Prescription does not exceed limitations for FDA-labeled maximum dosing for prescribed indication (Table 1) based on prescriber submission/verification of patient weight from most recent clinical documentation

Table 1: Growth Hormone Product Maximum Dosing*		
Medication	Pediatric Maximum Dosing (age < 18 years)	Adult Maximum Dosing (age ≥ 18 years)
Genotropin	0.48 mg/kg/week	0.08 mg/kg/week
Humatrope	0.47 mg/kg/week	0.0875 mg/kg/week
Norditropin Flexpro	0.47 mg/kg/week	0.112 mg/kg/week
Nutropin AQ Nuspin	0.375 mg/kg/week	0.175 mg/kg/week for ≤35 years of age 0.0875 mg/kg/week for >35 years of age
Omnitrope	0.48 mg/kg/week	0.08 mg/kg/week
Saizen	0.18 mg/kg/week	0.01 mg/kg/day
Serostim	Not Indicated	42 mg/week for cachexia with HIV only (in combination with antiretroviral therapy)
Skytrofa	0.2625 mg/kg/week	N/A
Zomacton	0.47 mg/kg/week	0.0125 mg/kg/day
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 7/1/2024

No PA Required	PA Required	
Ursodiol capsule	BYLVAY (odevixibat) capsule, pellet	Chenodal (chenodiol) and Actigall (ursodiol) may be approved for members who meet the following criteria: <ul style="list-style-type: none"> • Member is ≥ 18 years of age AND
Ursodiol tablet	CHENODAL (chenodiol) tablet	

	<p>CHOLBAM (cholic acid) capsule</p> <p>LIVMARLI (maralixibat) solution</p> <p>OICALIVA (obeticholic acid) tablet</p> <p>RELTONE (ursodiol) capsule</p> <p>URSO (ursodiol) tablet</p> <p>URSO FORTE (ursodiol) tablet</p>	<ul style="list-style-type: none"> 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. <p>Ocaliva (obeticholic acid) 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 without cirrhosis OR a diagnosis of primary biliary cholangitis with compensated cirrhosis with no evidence of portal hypertension AND Member has failed treatment with a preferred ursodiol product for at least 6 months due to an inadequate response, intolerable side effects, drug-drug interaction, or allergy to preferred ursodiol formulations. <p>Reltone (ursodiol) may be approved for members meeting the following criteria:</p> <ul style="list-style-type: none"> Member is ≥ 18 years of age AND The requested medication is prescribed by or in consultation with a gastroenterologist, hepatologist, or liver transplant provider AND The requested medication is being prescribed for one of the following: <ul style="list-style-type: none"> Treatment of radiolucent, noncalcified gallbladder stones < 20 mm in greatest diameter AND elective cholecystectomy would be undertaken except for the presence of increased surgical risk due to systemic disease, advanced age, idiosyncratic reaction to general anesthesia, or for those patients who refuse surgery OR Prevention of gallstone formation in obese patients experiencing rapid weight loss <p>AND</p>
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- No compelling reasons for the member to undergo cholecystectomy exist, including unremitting acute cholecystitis, cholangitis, biliary obstruction, gallstone pancreatitis, or biliary-gastrointestinal fistula, **AND**
- Member has trialed and failed treatment with a preferred ursodiol product for at least 6 months due to an inadequate response, intolerable side effects, drug-drug interaction, or allergy to inactive ingredients contained in the preferred ursodiol formulations.

Initial approval: 1 year

Reauthorization: May be reauthorized for 1 additional year with provider attestation that partial or complete stone dissolution was observed after completion of the initial year of Reltone therapy. Maximum cumulative approval per member is 24 months.

Urso (ursodiol) and **Urso Forte** (ursodiol) may be approved for members meeting the following criteria:

- 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:
 - 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**
- Member has failed treatment with a preferred ursodiol product for at least 6 months due to an inadequate response, intolerable side effects, drug-drug interaction, or allergy to inactive ingredients contained in the preferred ursodiol formulations.

Requests for drug products that are FDA-indicated for the treatment of nonalcoholic steatohepatitis (NASH) may be approved if meeting the following:

- A diagnosis of NASH has been confirmed through liver biopsy **AND**
- Member meets the FDA-labeled minimum age requirement for the prescribed product **AND**
- Member does not have significant liver disease other than NASH, **AND**
- The requested medication is being prescribed for use for the FDA-labeled indication and as outlined in product package labeling **AND**
- Medication is prescribed by or in consultation with a gastroenterologist, hepatologist, or liver transplant provider.

Non-preferred products prescribed for FDA-labeled indications not identified above may receive approval for use as outlined in product package labeling.

Therapeutic Drug Class: ANTI-EMETICS, Oral -Effective 7/1/2024		
<p>No PA Required</p> <p>DICLEGIS DR^{BNR} tablet (doxylamine/pyridoxine)</p> <p>Meclizine (Rx) 12.5 mg, 25 mg tablet</p> <p>Metoclopramide solution, tablet</p> <p>Ondansetron ODT, tablet</p> <p>Ondansetron oral suspension/solution</p> <p>Prochlorperazine tablet</p> <p>Promethazine syrup, tablet</p>	<p>PA Required</p> <p>AKYNZEO (netupitant/palonosetron) capsule</p> <p>ANTIVERT (meclizine) 50 mg tablet</p> <p>ANZEMET (dolasetron) tablet</p> <p>Aprepitant capsule, tripack</p> <p>BONJESTA ER (doxylamine/pyridoxine) 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>REGLAN (metoclopramide) tablet</p> <p>Trimethobenzamide capsule</p> <p>ZOFRAN (ondansetron) tablet</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) <p>OR</p> <ul style="list-style-type: none"> ○ Dopamine antagonist (such as metoclopramide, prochlorperazine, promethazine) OR ○ Serotonin antagonist (ondansetron, granisetron) <p>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.</p> <p>Dronabinol prior authorization may be approved for members meeting above non-preferred criteria OR via AutoPA for members with documented HIV diagnosis.</p> <p>Promethazine product formulations require prior authorization for members < 2 years of age due to risk of fatal respiratory depression.</p>
Therapeutic Drug Class: ANTI-EMETICS, Non-Oral -Effective 7/1/2024		
<p>No PA Required</p> <p>Prochlorperazine 25 mg suppository</p>	<p>PA Required</p> <p>PROMETHEGAN 50 mg (Promethazine) suppository</p> <p>SANCUSO (granisetron) patch</p>	<p>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.</p>

Promethazine 12.5 mg, 25 mg suppository	TRANSDERM-SCOP (scopolamine) patch	
Scopolamine patch		
Therapeutic Drug Class: GI MOTILITY, CHRONIC -Effective 7/1/2024		
PA Required for all agents in this class		<p>All agents will only be approved for FDA labeled indications and up to FDA approved maximum doses listed below.</p> <p>Preferred agents may be approved if the member meets the following criteria:</p> <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 bisacodyl, 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 bisacodyl 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 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>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
Preferred	Non-Preferred	
<p>LINZESS (linaclotide) capsule</p> <p>Lubiprostone capsule</p> <p>MOVANTIK (naloxegol) tablet</p>	<p>Alosetron tablet</p> <p>AMITIZA (lubiprostone) capsule</p> <p>IBSRELA tablet</p> <p>LOTRONEX (alosetron) tablet</p> <p>MOTTEGRITY (prucalopride) tablet</p> <p>RELISTOR (methylnaltrexone) syringe, tablet, vial</p> <p>SYMPROIC (naldemedine) tablet</p> <p>TRULANCE (plecanatide) tablet</p> <p>VIBERZI (eluxadoline) tablet</p>	

- Member does not drink more than 3 alcoholic drinks per day

LOTROXEX (alosetron) and generic alosetron may be approved for members who meet the following additional criteria:

- 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.

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 subcutaneous injection (methylnaltrexone)	OIC	12mg/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 7/1/2024

No PA Required	PA Required	
PYLERA ^{BNR} capsule (bismuth subcitrate/metronidazole tetracycline)	Amoxicillin/lansoprazole/clarithromycin pack Bismuth subcitrate/metronidazole tetracycline capsule OMECLAMOX-PAK (amoxicillin/omeprazole/clarithromycin) TALICIA (omeprazole/amoxicillin/ rifabutin) tablet VOQUEZNA DUAL (vonoprazan/amoxicillin) dose pack	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.

	VOQUEZNA TRIPLE (vonoprazan/amoxicillin/ clarithromycin dose pack)	
Therapeutic Drug Class: HEMORRHOIDAL, ANORECTAL, AND RELATED TOPICAL ANESTHETIC AGENTS - Effective 7/1/2024		
Hydrocortisone single agent		
No PA Required	PA Required	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).
ANUSOL-HC (hydrocortisone) 2.5% cream with applicator	CORTENEMA (hydrocortisone) enema PROCORT cream	
CORTIFOAM (hydrocortisone) 10% aerosol		
Hydrocortisone 1% cream with applicator		
Hydrocortisone 2.5% cream with applicator		
Hydrocortisone enema		
Lidocaine single agent		
No PA Required	PA Required	
Lidocaine 5% ointment	Lidocaine 3% cream	
Other and Combinations		
No PA Required	PA Required	Rectiv (nitroglycerin) ointment may be approved if meeting the following: <ul style="list-style-type: none"> • Member has a diagnosis of anal fissure AND • Prescriber attests that member has trialed and maximized use of appropriate supportive therapies including sitz bath, fiber, topical analgesics (such as lidocaine), and stool softeners/laxatives.
Hydrocortisone-Pramoxine 1%- 1% cream	ANALPRAM HC (Hydrocortisone-Pramoxine) 1%-1% cream, 2.5%-1% cream	
Lidocaine-Hydrocortisone 3- 0.5% cream with applicator	EPIFOAM (Hydrocortisone-Pramoxine) 1%-1% foam	
Lidocaine-Prilocaine Cream (<i>all other manufacturers</i>)	Hydrocortisone-Pramoxine 2.5%-1% cream	
PROCTOFOAM-HC (hydrocortisone-pramoxine) 1%-1% foam	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	

	<p>Lidocaine-Hydrocortisone 3%-2.5% gel kit</p> <p>Lidocaine-Prilocaine Cream (<i>Fougera only</i>)</p> <p>PLIAGIS (lidocaine-tetracaine) 7%-7% cream</p> <p>PROCORT (Hydrocortisone-Pramoxine) 1.85%-1.15% cream</p> <p>RECTIV (nitroglycerin) 0.4% ointment</p>	
Therapeutic Drug Class: PANCREATIC ENZYMES -Effective 7/1/2024		
No PA Required	PA Required	<p>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.)</p>
<p>CREON (pancrelipase) capsule</p> <p>VIOKACE (pancrelipase) tablet</p> <p>ZENPEP (pancrelipase) capsule</p>	<p>PERTZYE (pancrelipase) capsule</p>	
Therapeutic Drug Class: PROTON PUMP INHIBITORS -Effective 7/1/2024		
No PA Required	PA Required	<p>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) be trialed in order to reduce long-term PPI use. 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 trialed 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:</p>
<p>Esomeprazole DR capsule (RX)</p> <p>Lansoprazole DR capsules (RX)</p> <p>Lansoprazole ODT (lansoprazole) (<i>for members under 2 years</i>)</p> <p>NEXIUM^{BNR} (esomeprazole) oral suspension packet</p> <p>Omeprazole DR capsule (RX)</p> <p>Pantoprazole tablet</p> <p>PROTONIX (pantoprazole DR) packet for oral suspension^{BNR}</p>	<p>ACIPHEX (rabeprazole) tablet, sprinkle capsule</p> <p>DEXILANT (dexlansoprazole) capsule</p> <p>Dexlansoprazole capsule</p> <p>Esomeprazole DR 49.3 capsule (RX), (OTC) capsule, packet for oral suspension</p> <p>KONVOMEK (Omeprazole/Na bicarbonate) 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</p> <p>Rabeprazole tablet</p> <p>VOQUEZNA (vonoprazan) tablet</p> <p>ZEGERID (omeprazole/Na bicarbonate) capsule, packet for oral suspension</p>	<p>All agents will be limited to once daily dosing except when used for the following diagnoses: Barrett’s esophagus, GI Bleed, H. pylori infection, 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> <p><u>Continuation of Care:</u> Members currently taking Dexilant (dexlansoprazole) capsules may continue to receive approval for that medication.</p>
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Therapeutic Drug Class: NON-BIOLOGIC ULCERATIVE COLITIS AGENTS- Oral -Effective 7/1/2024

No PA Required	PA Required	
<p>APRISO^{BNR} (mesalamine ER) capsule</p> <p>LIALDA^{BNR} (mesalamine DR) tablet</p> <p>PENTASA^{BNR} (mesalamine) capsule</p> <p>Sulfasalazine IR and DR tablet</p>	<p>AZULFIDINE (sulfasalazine) Entab, tablet</p> <p>Balsalazide capsule</p> <p>Budesonide DR tablet</p> <p>COLAZAL (balsalazide) capsule</p> <p>DELZICOL (mesalamine DR) capsule</p> <p>DIPENTUM (olsalazine) capsule</p> <p>Mesalamine DR tablet (generic Asacol HD, Lialda)</p> <p>Mesalamine DR/ER capsule (generic Apriso, Delzicol, Pentasa)</p> <p>UCERIS (budesonide) tablet</p>	<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 7/1/2024		
No PA Required	PA Required	
Mesalamine suppository	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>
Mesalamine 4gm/60 ml enema (generic SF ROWASA)	CANASA (mesalamine) suppository	
	Mesalamine enema, kit	
	ROWASA/SF ROWASA enema, kit (mesalamine)	
	UCERIS (budesonide) foam	

VIII. Hematological

Therapeutic Drug Class: ANTICOAGULANTS- Oral -Effective 7/1/2024		
No PA Required	PA Required	
ELIQUIS (apixaban) tablet, tablet pack	Dabigatran capsule	<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
PRADAXA ^{BNR} (dabigatran) capsule	PRADAXA (dabigatran) pellet	
Warfarin tablet	SAVAYSA (edoxaban) tablet	
XARELTO (rivaroxaban) 10 mg, 15 mg, 20 mg tablet, dose pack	XARELTO (rivaroxaban) 2.5 mg tablet	
	XARELTO (rivaroxaban) oral suspension	

		<p>XARELTO (rivaroxaban) oral suspension may be approved without prior authorization for members <18 years of age who require a rivaroxaban dose of less than 10 mg OR with prior authorization verifying the member is unable to use the solid oral dosage form.</p> <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>
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Therapeutic Drug Class: ANTICOAGULANTS- Parenteral -Effective 7/1/2024

No PA Required	PA Required	
Enoxaparin syringe Enoxaparin vial	ARIXTRA (fondaparinux) syringe Fondaparinux syringe FRAGMIN (dalteparin) vial, syringe LOVENOX (enoxaparin) syringe, vial	<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 ● 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 7/1/2024

No PA Required	PA Required	
Aspirin/dipyridamole ER capsule BRILINTA (tigacrelor) tablet Cilostazol tablet Clopidogrel tablet Dipyridamole tablet Pentoxifylline ER tablet Prasugrel tablet	EFFIENT (prasugrel) tablet PLAVIX (clopidogrel) tablet	<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 7/1/2024		
PA Required for all agents in this class*		*Prior authorization for preferred agents may be approved if meeting the following criteria: <ul style="list-style-type: none"> • Medication is being used for one of the following indications: <ul style="list-style-type: none"> ○ Patient with cancer 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) <ul style="list-style-type: none"> ▪ <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"> ○ Patient with cancer 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.
Preferred	Non-Preferred	
FULPHILA (pegfilgrastim-jmdb) syringe NEUPOGEN (filgrastim) vial, syringe	FYLNETRA (pegfilgrastim-jmdb) syringe GRANIX (tbo-filgrastim) syringe, vial LEUKINE (sargramostim) vial NEULASTA (pegfilgrastim) kit, syringe NIVESTYM (filgrastim-aafi) syringe, vial NYVEPRIA (pegfilgrastim-apgf) syringe RELEUKO (filgrastim-ayow) syringe, vial STIMUFEND (pegfilgrastim-fpgk) syringe UDENYCA (pegfilgrastim-cbqv) autoinjector, On-Body, syringe ZARXIO (filgrastim-sndz) syringe ZIENTENZO (pegfilgrastim-bmez) syringe	
Therapeutic Drug Class: ERYTHROPOIESIS STIMULATING AGENTS Effective 7/1/2024		
PA Required for all agents in this class*		*Prior Authorization is required for all products and may be approved if meeting the following:
Preferred	Non-Preferred	

<p>EPOGEN (epoetin alfa) vial</p> <p>RETACRIT (epoetin alfa-epbx) (Pfizer only) vial</p>	<p>ARANESP (darbepoetin alfa) syringe, vial</p> <p>MIRCERA (methoxy peg-epoetin beta) syringe</p> <p>PROCRIT (epoetin alfa) vial</p> <p>RETACRIT (epoetin alfa-epbx) (Vifor only) vial</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 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 1/1/2024

PA Required for all agents in this class*		
Preferred	Non-Preferred	
<p>CUVITRU 20% SQ liquid</p> <p>GAMMAGARD 10% IV/SQ liquid</p> <p>GAMUNEX-C 10% IV/SQ liquid</p> <p>HIZENTRA 20% SQ syringe</p> <p>PRIVIGEN 10% IV liquid</p> <p><i>If immune globulin is being administered in a long-term care</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>GAMMAKED 10% IV/SQ liquid</p> <p>GAMMAPLEX 5%, 10% IV liquid</p> <p>HYQVIA 10% SQ 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

facility or in a member's home by a home healthcare provider, it should be billed as a pharmacy claim. All other claims must be submitted through the medical benefit.

OCTAGAM 5%, 10% IV liquid

PANZYGA 10% IV liquid

XEMBIFY 20% IV liquid

- Neurological disorders including:
 - Guillain-Barré Syndrome
 - Relapsing-Remitting Multiple Sclerosis
 - 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:
 - Requiring preoperative therapy for undergoing elective splenectomy with platelet count < 20,000/mcL
 - Members with active bleeding & platelet count <30,000/mcL
 - Pregnant members with platelet counts <10,000/mcL in the third trimester
 - Pregnant members with platelet count 10,000 to 30,000/mcL who are bleeding
- Multisystem Inflammatory Syndrome in Children (MIS-C)

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 –subcutaneous admin	12 grams/site for up to four sites weekly (48grams/week)
Flebogamma DIF – IV admin	600 mg/kg every 3 weeks
Gammaplex 5% – IV admin	800 mg/kg every 3 weeks
Gammagard liquid subcutaneous or IV admin	2.4 grams/kg/month
Gammaked –subcutaneous or IV admin	600 mg/kg every 3 weeks
Gamunex-C –subcutaneous or IV admin	600 mg/kg every 3 weeks
Hizentra –subcutaneous admin	0.4 g/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 over 2 to 5 consecutive days

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).

Therapeutic Drug Class: NEWER GENERATION ANTIHISTAMINES - <i>Effective 1/1/2024</i>		
<p>No PA Required</p> <p>Cetirizine (OTC) syrup/solution (OTC/RX), tablet</p> <p>Desloratadine tablet (RX)</p> <p>Levocetirizine tablet (RX/OTC)</p> <p>Loratadine tablet (OTC), syrup/solution (OTC)</p>	<p>PA Required</p> <p>Cetirizine (OTC) chewable tablet, softgel, UD cups solution</p> <p>CLARINEX (desloratadine) tablet</p> <p>Desloratadine ODT (RX)</p> <p>Fexofenadine tablet (OTC), suspension (OTC)</p> <p>Levocetirizine solution (RX)</p> <p>Loratadine chewable (OTC), ODT (OTC)</p>	<p>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.</p> <p>Failure is defined as lack of efficacy with a 14-day trial, allergy, intolerable side effects, or significant drug-drug interaction.</p>
Therapeutic Drug Class: ANTI-HISTAMINE/DECONGESTANT COMBINATIONS - <i>Effective 1/1/2024</i>		
<p>No PA Required</p> <p>Loratadine-D (OTC) tablet</p>	<p>PA Required</p> <p>Cetirizine-PSE (OTC)</p> <p>CLARINEX-D (desloratadine-D)</p> <p>Fexofenadine/PSE (OTC)</p>	<p>Non-preferred antihistamine/decongestant combinations may be approved for members who have failed treatment with the preferred product 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.</p> <p>Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.</p>
Therapeutic Drug Class: INTRANASAL RHINITIS AGENTS - <i>Effective 1/1/2024</i>		
<p>No PA Required</p> <p>Azelastine 137 mcg</p> <p>Budesonide (OTC)</p> <p>DYMISTA (azelastine/fluticasone)^{BNR}</p> <p>Fluticasone (RX)</p> <p>Ipratropium</p>	<p>PA Required</p> <p>Azelastine (Astepro) 0.15%</p> <p>Azelastine/Fluticasone</p> <p>BECONASE AQ (beclomethasone dipropionate)</p> <p>Flunisolide 0.025%</p> <p>Fluticasone (OTC)</p> <p>Mometasone</p>	<p>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).</p> <p>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).</p>

<p>Olopatadine</p> <p>Triamcinolone acetonide (OTC)</p>	<p>NASONEX (mometasone)</p> <p>OMNARIS (ciclesonide)</p> <p>PATANASE (olopatadine)</p> <p>QNASL (beclomethasone)</p> <p>RYALTRIS (olopatadine/mometasone)</p> <p>XHANCE (fluticasone)</p> <p>ZETONNA (ciclesonide)</p>	
Therapeutic Drug Class: LEUKOTRIENE MODIFIERS -Effective 1/1/2024		
<p>No PA Required</p> <p>Montelukast tablet, chewable</p>	<p>PA Required</p> <p>ACCOLATE (zafirlukast) tablet</p> <p>Montelukast granules</p> <p>SINGULAIR (montelukast) tablet, chewable, granules</p> <p>Zafirlukast tablet</p> <p>Zileuton ER tablet</p> <p>ZYFLO (zileuton) tablet</p>	<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 1/1/2024		
<p>No PA Required</p> <p>Methotrexate oral tablet, vial</p>	<p>PA Required</p> <p>OTREXUP (methotrexate) auto-injector</p> <p>RASUVO (methotrexate) auto-injector</p> <p>REDITREX (methotrexate) syringe</p> <p>TREXALL (methotrexate) oral tablet</p> <p>XATMEP (methotrexate) oral solution</p>	<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, inability to take oral product formulation, or member has a diagnosis of pJIA and provider has determined that the subcutaneous formulation is necessary to optimize methotrexate therapy) AND Member (or parent/caregiver) 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 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 that agent.</p>
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Therapeutic Drug Class: MULTIPLE SCLEROSIS AGENTS -Effective 4/1/2024

Disease Modifying Therapies

<p align="center">Preferred No PA Required (Unless indicated*)</p>	<p align="center">Non-Preferred PA Required</p>	
<p>AVONEX (interferon beta 1a) pen, syringe</p> <p>BETASERON (interferon beta 1b) injection</p> <p>COPAXONE^{BNR} (glatiramer) injection</p> <p>Dimethyl fumarate tablet, starter pack</p> <p>Fingolimod capsule</p> <p>*KESIMPTA (ofatumumab) pen ^{**2nd Line**}</p>	<p>AUBAGIO (teriflunomide) tablet</p> <p>BAFIERTAM (monomethyl fumarate DR) capsule</p> <p>EXTAVIA (interferon beta 1b) kit, vial</p> <p>GILENYA (fingolimod) capsule</p> <p>Glatiramer 20mg, 40mg injection</p> <p>GLATOPA (glatiramer) injection</p> <p>MAVENCLAD (cladribine) tablet</p> <p>MAYZENT (siponimod) tablet, pack</p> <p>PLEGRIDY (peg-interferon beta 1a) pen, syringe</p>	<p>*Kesimpta (ofatumumab) may be approved if member has trialed and failed treatment with one preferred agent (failure is defined as intolerable side effects, contraindication to therapy, drug-drug interaction, or lack of efficacy).</p> <p><u>Non-Preferred Products:</u> Non-preferred products 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 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 Prescribed dose does not exceed the maximum FDA-approved dose for the medication being ordered AND If indicated in the product labeling, a negative pre-treatment pregnancy test has been documented, AND If indicated in the product labeling, an ophthalmologic examination has been performed and documented prior to medication initiation, AND The request meets additional criteria listed for any of the following: <p>Mayzent (siponimod):</p>

Teriflunomide tablet	PONVORY (ponesimod) tablet, pack REBIF (interferon beta 1a) syringe REBIF REDIDOSE (interferon beta 1a) pen TASCENSO ODT (fingolimod) tablet TECFIDERA (dimethyl fumarate) tablet, pack VUMERITY (diroximel DR) capsule ZEPOSIA (ozanimod) capsule, kit, starter pack	<ul style="list-style-type: none"> 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 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 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 (Kesimpta) or non-preferred product (may receive approval to continue therapy with that agent).</p>
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Symptom Management Therapies

No PA Required	PA Required	
Dalfampridine ER tablet	AMPYRA ER (dalfampridine) tablet	Non-preferred products may be approved with prescriber attestation that there is clinical rationale supporting why the preferred brand/generic equivalent product formulation is unable to be used. <u>Maximum Dose:</u> Ampyra (dalfampridine) 10mg twice daily

Therapeutic Drug Class: **TARGETED IMMUNE MODULATORS** -Effective 1/1/2024

Preferred agents: ADBRY (tralokinumab-ldrm); DUPIXENT (dupilumab); ENBREL (etanercept); FASENRA (benralizumab) pen; HADLIMA (adalimumab- bwwd); HUMIRA (adalimumab); OTEZLA (apremilast) tablet; KEVZARA (sarilumab); TALTZ (ixekizumab); TEZSPIRE (tezepelumab-ekko) pen; XELJANZ IR (tofacitinib) tablet; XOLAIR (omalizumab) syringe

Rheumatoid Arthritis, all other Arthritis (except psoriatic arthritis, see below), and Ankylosing Spondylitis

<p>Preferred No PA Required (If diagnosis met) (*Must meet eligibility criteria)</p>	<p>Non-Preferred PA Required</p>	<p>First line preferred agents (HADLIMA, HUMIRA, ENBREL, and XELJANZ IR) may receive approval for use for FDA-labeled indications.</p>
	Adalimumab-adaz pen, syringe	<p>*TALTZ (ixekizumab) may receive approval for use for FDA-labeled indications following trial and failure‡ of HADLIMA/HUMIRA or ENBREL.</p>
ENBREL (etanercept)	ACTEMRA (tocilizumab) syringe, Actpen	<p>*KEVZARA (sarilumab) may receive approval for use for FDA-labeled indications following trial and failure‡ of HADLIMA/HUMIRA or ENBREL AND XELJANZ IR.</p>
HADLIMA (adalimumab-bwwd) Push-touch, syringe	AMJEVITA (adalimumab-atto) auto-injector, syringe	<p><u>Quantity Limit:</u> XELJANZ IR is limited to 2 tablets per day or 60 tablets for a 30-day supply</p>
HUMIRA (adalimumab)	CIMZIA (certolizumab pegol) syringe	<p><u>Non-Preferred Agents:</u></p>
*KEVZARA (sarilumab) pen, syringe	COSENTYX (secukinumab) syringe, pen-injector	<p>COSENTYX (secukinumab) may receive approval for:</p>
*TALTZ (ixekizumab)	CYLTEZO (adalimumab-adbm) pen, syringe	<ul style="list-style-type: none"> • FDA-labeled indications following trial and failure‡ of all indicated preferred agents OR • Treatment of enthesitis-related arthritis if meeting the following: <ul style="list-style-type: none"> ○ Member is ≥ 4 years of age and weighs ≥ 15 kg AND ○ Member has had trialed and failed‡ NSAID therapy AND ENBREL AND HADLIMA/HUMIRA
XELJANZ IR (tofacitinib) tablet	HULIO (adalimumab-fkjp) syringe	<p>KINERET (anakinra) may receive approval for:</p>
	HYRIMOZ (adalimumab-adaz) pen, syringe	<ul style="list-style-type: none"> • FDA-labeled indications following trial and failure‡ of HADLIMA/HUMIRA OR ENBREL AND XELJANZ IR OR • Treatment of systemic juvenile idiopathic arthritis (sJIA) or Adult-Onset Still’s Disease (AOSD)
	IDACIO (adalimumab-aacf) pen, syringe	<p>ILARIS (canakinumab) may receive approval if meeting the following:</p>
	ILARIS (canakinumab) vial	<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‡ ACTEMRA (tocilizumab)
	KINERET (anakinra) syringe	<ul style="list-style-type: none"> • Quantity Limits (effective 2/15/2024): <ul style="list-style-type: none"> ○ Cryopyrin-associated periodic syndrome: 600mg (4mL) every 8 weeks ○ All other indications: 300mg (2mL) every 4 weeks
	OLUMIANT (baricitinib) tablet	
	ORENCIA (abatacept) clickject, syringe	
	RINVOQ (upadacitinib) tablet	
	SIMPONI (golimumab) pen, syringe	
	XELJANZ (tofacitinib) solution	
	XELJANZ XR (tofacitinib ER) tablet	
	YUFLYMA (adalimumab-aaty) auto-injector	
	YUSIMRY (adalimumab-aqvh) pen	

	<p><i>Note: Product formulations in the physician administered drug (PAD) category are located on Appendix P</i></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>XELJANZ (tofacitinib) oral solution may be approved when the following criteria are met:</p> <ul style="list-style-type: none"> • Member has a diagnosis of polyarticular course juvenile idiopathic arthritis (pJIA) who require a weight-based dose for <40 kg following trial and failure‡ of HADLIMA/HUMIRA OR ENBREL OR • Member cannot swallow a tofacitinib tablet <p>All other non-preferred agents may receive approval for FDA-labeled indications following trial and failure‡ of all preferred agents that are FDA-indicated or have strong evidence supporting use for the prescribed indication from clinically recognized guideline compendia (only one preferred adalimumab product trial required).</p> <p>Non-preferred agents that are being prescribed per FDA-label to treat non-radiographic axial spondyloarthritis (nr-axSpA) will require trial and failure‡ of preferred agents that are FDA-labeled for treating an axial spondyloarthritis condition, including ankylosing spondylitis (AS) or nr-axSpA.</p> <p>Members currently taking COSENTYX or XELJANZ oral solution may receive approval to continue on that agent.</p> <p>‡Failure is defined as lack of efficacy, contraindication to therapy, allergy, intolerable side effects, or significant drug-drug interaction. Note that trial and failure of preferred TNF inhibitors will not be required when prescribed to treat polyarticular juvenile idiopathic arthritis (pJIA) in members with documented clinical features of lupus.</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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Psoriatic Arthritis

<p align="center">Preferred No PA Required (If diagnosis met) (*Must meet eligibility criteria)</p>	<p align="center">Non-Preferred PA Required</p>	<p>First line preferred agents (HADLIMA, HUMIRA, ENBREL, XELJANZ IR) may receive approval for psoriatic arthritis indication.</p> <p>*OTEZLA (apremilast) may receive approval for psoriatic arthritis indication following trial and failure‡ of HADLIMA/HUMIRA or ENBREL AND XELJANZ IR or TALTZ.</p>
<p>ENBREL (etanercept)</p> <p>HADLIMA (adalimumab-bwwd) Pushtouch, syringe</p>	<p>Adalimumab-adaz pen, syringe</p> <p>AMJEVITA (adalimumab-atto) auto-injector, syringe</p> <p>CIMZIA (certolizumab pegol) syringe</p>	

<p>HUMIRA (adalimumab)</p> <p>*OTEZLA (apremilast) tablet</p> <p>*TALTZ (ixekizumab)</p> <p>XELJANZ IR (tofacitinib) tablet</p>	<p>COSENTYX (secukinumab) syringe, pen-injector</p> <p>CYLTEZO (adalimumab-adbm) pen, syringe</p> <p>HULIO (adalimumab-fkjp) syringe</p> <p>HYRIMOZ (adalimumab-adaz) pen, syringe</p> <p>IDACIO (adalimumab-aacf) pen, syringe</p> <p>ORENCIA (abatacept) syringe, clickject</p> <p>RINVOQ (upadacitinib) tablet</p> <p>SIMPONI (golimumab) pen, syringe</p> <p>SKYRIZI (risankizumab-rzaa) OnBody, pen, syringe</p> <p>STELARA (ustekinumab) syringe</p> <p>TREMFYA (guselkumab) injector, syringe</p> <p>XELJANZ (tofacitinib) solution</p> <p>XELJANZ XR (tofacitinib ER) tablet</p> <p>YUFLYMA (adalimumab-aaty) auto-injector</p> <p>YUSIMRY (adalimumab-aqvh) pen</p> <p><i>Note: Product formulations in the physician administered drug (PAD) category are located on Appendix P</i></p>	<p>*TALTZ (ixekizumab) may receive approval for psoriatic arthritis indication following trial and failure‡ of HADLIMA/HUMIRA or ENBREL AND XELJANZ IR or OTEZLA.</p> <p>Quantity Limit: XELJANZ IR is limited to 2 tablets per day or 60 tablets for a 30-day supply</p> <p><u>Non-Preferred Agents:</u></p> <p>COSENTYX (secukinumab) may receive approval for psoriatic arthritis indication for members ≥ 2 years of age and weighing ≥ 15 kg following trial and failure‡ of HADLIMA/HUMIRA (adalimumab) OR ENBREL AND XELJANZ IR AND TALTZ 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 HADLIMA/HUMIRA or ENBREL AND XELJANZ IR AND TALTZ or OTEZLA 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 HADLIMA/HUMIRA OR ENBREL AND XELJANZ IR AND TALTZ or OTEZLA.</p> <p>‡Failure is defined as lack of efficacy, 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>
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Plaque Psoriasis

Preferred No PA Required (If diagnosis met) (*Must meet eligibility criteria)	Non-Preferred PA Required	
ENBREL (etanercept)	Adalimumab-adaz pen, syringe	<p>First line preferred agents (HADLIMA/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 HADLIMA/HUMIRA OR ENBREL.</p> <p><u>Non-Preferred Agents:</u></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 (HADLIMA/HUMIRA, ENBREL) AND two indicated second line agents (TALTZ, OTEZLA), AND <ul style="list-style-type: none"> • 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 (HADLIMA/HUMIRA, ENBREL) AND two second line agents (TALTZ, OTEZLA).</p> <p>‡Failure is defined as lack of efficacy, 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>
HADLIMA (adalimumab-bwwd) Pushtouch, syringe	AMJEVITA (adalimumab-atto) auto-injector, syringe	
HUMIRA (adalimumab)	CIMZIA (certolizumab pegol) syringe	
*OTEZLA (apremilast) tablet	COSENTYX (secukinumab) syringe, pen-injector	
*TALTZ (ixekizumab)	CYLTEZO (adalimumab-adbm) pen, syringe	
	HULIO (adalimumab-fkjp) syringe	
	HYRIMOZ (adalimumab-adaz) pen, syringe	
	IDACIO (adalimumab-aacf) pen, syringe	
	SILIQ (brodalumab) syringe	
	SKYRIZI (risankizumab-rzaa) OnBody, pen, syringe	
	SOTYKTU (ducravacitinib) oral tablet	
	STELARA (ustekinumab) syringe	
	TREMFYA (guselkumab) injector, syringe	
	YUFLYMA (adalimumab-aaty) auto-injector	
	YUSIMRY (adalimumab-aqvh) pen	
	<p><i>Note: Product formulations in the physician administered drug (PAD) category are located on Appendix P</i></p>	

Crohn's Disease and Ulcerative Colitis

Preferred No PA Required (If diagnosis met) (*Must meet eligibility criteria)	Non-Preferred PA Required	
HADLIMA (adalimumab-bwwd) Push touch, syringe	Adalimumab-adaz pen, syringe	<p>Preferred agents (HADLIMA, HUMIRA, XELJANZ IR) may receive approval for Crohn's disease and ulcerative colitis indications.</p> <p>Quantity Limit: XELJANZ IR is limited to 2 tablets per day or 60 tablets for a 30-day supply</p> <p><u>Non-Preferred Agents:</u></p> <p>SKYRIZI (risankizumab) syringe for subcutaneous use and on-body injector formulations may receive approval if meeting the following:</p> <ul style="list-style-type: none"> • The requested medication is being prescribed for use for treating moderately-to-severely active Crohn's disease AND • Member is ≥ 18 years of age AND • Member has trial and failure\ddagger of one preferred adalimumab product AND • Prescriber acknowledges that administration of IV induction therapy prior to approval of SKYRIZI prefilled syringe or on-body injector formulation using the above criteria should be avoided and will not result in an automatic approval of requests for these formulations. <p>Dosing Limit: SKYRIZI on-body formulation maintenance dosing is limited to one 360 mg/2.4 mL single-dose prefilled cartridge or one 180 mg/1.2mL prefilled cartridge every 8 weeks.</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\ddagger of one preferred adalimumab product OR for treatment of moderately-to-severely active ulcerative colitis, member has trial and failure\ddagger of one preferred adalimumab product and XELJANZ IR AND • The member is ≥ 18 years of age 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>
HUMIRA (adalimumab)	AMJEVITA (adalimumab-atto) auto-injector, syringe	
*XELJANZ IR (tofacitinib) tablet	CIMZIA (certolizumab pegol) syringe	
	COSENTYX (secukinumab) syringe, pen-injector	
	CYLTEZO (adalimumab-adbm) pen, syringe	
	ENTYVIO (vedolizumab) pen	
	HULIO (adalimumab-fkjp) syringe	
	HYRIMOZ (adalimumab-adaz) pen, syringe	
	IDACIO (adalimumab-aacf) pen, syringe	
	OLUMIANT (baricitinib) tablet	
	OMVOH (mirikizumab-mrkz) pen	
	RINVOQ (upadacitinib) tablet	
	SIMPONI (golimumab) pen, syringe	
	SKYRIZI (risankizumab-rzaa) OnBody, pen, syringe	
	STELARA (ustekinumab) syringe	
	XELJANZ (tofacitinib) solution	
	XELJANZ XR (tofacitinib ER) tablet	
	YUFLYMA (adalimumab-aaty) auto-injector	
	YUSIMRY (adalimumab-aqvh) pen	

	<p><i>Note: Product formulations in the physician administered drug (PAD) category are located on Appendix P</i></p>	<p>All other non-preferred agents may receive approval for FDA-labeled indications if meeting the following:</p> <ul style="list-style-type: none"> • The requested medication is being prescribed for treating moderately-to-severely active Crohn’s disease or moderately-to-severely active Ulcerative Colitis in alignment with indicated use outlined in FDA-approved product labeling AND • The requested medication meets FDA-labeled indicated age for prescribed use AND • For treatment of moderately-to-severely active Crohn’s disease, member has trial and failure‡ of one preferred adalimumab product OR for treatment of moderately-to-severely active ulcerative colitis, member has trial and failure‡ of one preferred adalimumab product and XELJANZ IR. <p>Members currently taking COSENTYX may receive approval to continue on that agent.</p> <p>‡Failure is defined as lack of efficacy, 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>
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Asthma

Preferred PA Required (*Must meet eligibility criteria)	Non-Preferred PA Required	
<p>*DUPIXENT (dupilumab) pen, syringe</p> <p>*FASENRA (benralizumab) pen</p> <p>*TEZSPIRE (tezepelumab-ekko) pen</p>	<p>NUCALA (mepolizumab) auto-injector, syringe</p> <p><i>Note: Product formulations in the physician administered drug (PAD) category are located on Appendix P</i></p>	<p>*Preferred products (Dupixent, Fasentra, Tezspire) may receive approval if meeting the following:</p> <p>DUPIXENT (dupilumab):</p> <ul style="list-style-type: none"> • Member is 6 years of age or older AND • Member has an FDA-labeled indicated use for treating one of the following: <ul style="list-style-type: none"> ○ Moderate to severe asthma (on medium to high dose inhaled corticosteroid and a long-acting beta agonist) with eosinophilic phenotype based on a blood eosinophil level of ≥ 150/mcL OR ○ Oral corticosteroid dependent asthma <p>AND</p> <ul style="list-style-type: none"> • Member’s asthma has been refractory to recommended evidence-based, guideline-supported pharmacologic therapies AND • Medication is being prescribed as add-on therapy to existing asthma regimen. <p>Quantity Limit: 2 syringes every 28 days after initial 14 days of therapy (first dose is twice the regular scheduled dose)</p>

TEZSPIRE (tezepelumab-ekko):

- Member is ≥ 12 years of age **AND**
- Member has a diagnosis of severe asthma **AND**
- Member's asthma has been refractory to recommended evidence-based, guideline-supported pharmacologic therapies **AND**
- The requested medication is being prescribed as add-on therapy to existing asthma regimen.

Quantity Limit: Four 210 mg unit dose packs every 28 days

FASENRA (benralizumab):

- Member is ≥ 6 years of age **AND**
- Member has an FDA-labeled indicated use for treating severe asthma with an eosinophilic phenotype based on a blood eosinophil level of $\geq 150/\text{mcL}$ **AND**
- Member's asthma has been refractory to recommended evidence-based, guideline-supported pharmacologic therapies **AND**
- The requested medication is being prescribed as add-on therapy to existing asthma regimen.

Quantity Limit: One 30 mg unit dose pack every 28 days for the first 3 doses and then every 8 weeks thereafter

Non-Preferred Agents:

Non-preferred FDA-indicated biologic agents for asthma may receive approval if meeting the following:

- The requested medication is being prescribed for treating asthma in alignment with indicated use outlined in FDA-approved product labeling (including asthma type and severity) **AND**
- If prescribed for use for asthma with eosinophilic phenotype, member has a blood eosinophil count ≥ 150 cells/mcL **AND**
- The requested medication meets FDA-labeled indicated age for prescribed use **AND**
- Member's asthma has been refractory to recommended evidence-based, guideline-supported pharmacologic therapies **AND**
- The requested medication is being prescribed as add-on therapy to existing asthma regimen **AND**
- Member has trialed and failed‡ two preferred agents.

Quantity Limits:

Non-preferred medications will be subject to quantity limitations in alignment with FDA-approved dosing per product package labeling.

		<p>Nucala (mepolizumab) is limited to 100mg every 4 weeks (members ≥ 12 years of age) or 40mg every 4 weeks (members 6-11 years of age).</p> <p>‡Failure is defined as a lack of efficacy, allergy, intolerable side effects, contraindication to, or significant drug-drug interactions.</p> <p>Members currently taking a preferred agent may receive approval to continue therapy with that agent.</p> <p>Members with current prior authorization approval on file for a non-preferred agent may receive approval for continuation of therapy with the prescribed agent.</p>
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Atopic Dermatitis

<p align="center">Preferred</p> <p>(*Must meet eligibility criteria)</p> <p>*ADBRY (tralokinumab-ldrm) syringe</p> <p>*DUPIXENT (dupilumab) pen, syringe</p>	<p align="center">Non-Preferred PA Required</p> <p>CIBINQO (abrocitinib) tablet</p> <p>RINVOQ (upadacitinib) tablet</p> <p><i>Note: Product formulations in the physician administered drug (PAD) category are located on Appendix P</i></p>	<p>*Preferred products (Adbry and Dupixent) may receive approval if meeting the following:</p> <p>ADBRY (tralokinumab-ldrm):</p> <ul style="list-style-type: none"> • The requested drug is being prescribed for moderate-to-severe atopic dermatitis AND • Member has trialed and failed‡ the following agents: <ul style="list-style-type: none"> ○ One medium potency to very-high potency topical corticosteroid (such as mometasone furoate, betamethasone dipropionate) AND ○ One topical calcineurin inhibitor (such as pimecrolimus or tacrolimus) <p><u>Maximum Dose:</u> 600 mg/2 weeks</p> <p><u>Quantity Limit:</u> Four 150 mg/mL prefilled syringes/2 weeks</p> <p><u>Approval:</u> One year</p> <p>DUPIXENT (dupilumab):</p> <ul style="list-style-type: none"> • Member has a diagnosis of moderate to severe atopic dermatitis AND • Member has trialed and failed‡ the following agents: <ul style="list-style-type: none"> ○ One medium potency to very-high potency topical corticosteroid [such as mometasone furoate, betamethasone dipropionate, or fluocinonide (see PDL for list of preferred products)] AND ○ One topical calcineurin inhibitor (such as pimecrolimus or tacrolimus) <p><u>Quantity Limit:</u> 2 syringes every 28 days after initial 14 days of therapy (first dose is twice the regular scheduled dose)</p> <p><u>Approval:</u> One year</p>
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		<p><u>Non-Preferred Agents:</u></p> <p>Non-preferred agents indicated for the treatment of atopic dermatitis may receive approval if meeting the following:</p> <ul style="list-style-type: none"> • Member has a diagnosis of moderate to severe chronic atopic dermatitis AND • Member has trialed and failed‡ therapy with two preferred agents for the prescribed indication AND • Member has trialed and failed‡ the following agents: <ul style="list-style-type: none"> ○ One medium potency to very-high potency topical corticosteroid (such as mometasone furoate, betamethasone dipropionate, or fluocinonide) ○ One topical calcineurin inhibitor (such as pimecrolimus and tacrolimus) <p>AND</p> <ul style="list-style-type: none"> • The medication is being prescribed by or in consultation with a dermatologist, allergist, immunologist, or rheumatologist. <p><u>Approval:</u> One year</p> <p>‡Failure is defined as a lack of efficacy, allergy, intolerable side effects, contraindication to, or significant drug-drug interactions.</p> <p>Members currently taking a preferred agent may receive approval to continue therapy with that agent.</p> <p>Members with current prior authorization approval on file for a non-preferred agent may receive approval for continuation of therapy with the prescribed agent.</p>
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Other indications

<p>Preferred (If diagnosis met, No PA required) (Must meet eligibility criteria*)</p>	<p>Non-Preferred PA Required</p>	<p>*DUPIXENT (dupilumab) may receive approval if meeting the following based on prescribed indication:</p>
<p>*DUPIXENT (dupilumab) pen, syringe</p> <p>ENBREL (etanercept)</p> <p>HUMIRA (adalimumab)</p> <p>*KEVZARA (sarilumab)</p> <p>OTEZLA (apremilast) tablet</p>	<p>ACTEMRA (tocilizumab) syringe, Actpen</p> <p>ARCALYST (rilonacept) injection</p> <p>CIMZIA (certolizumab pegol) syringe</p> <p>COSENTYX (secukinumab) syringe, pen-injector</p> <p>CYLTEZO (adalimumab-adbm) pen, syringe</p> <p>ILARIS (canakinumab) vial</p> <p>KINERET (anakinra) syringe</p>	<p><u>Chronic Rhinosinusitis with Nasal Polyposis</u></p> <ul style="list-style-type: none"> • Member is ≥ 18 years of age AND • Medication is being prescribed as an add-on maintenance treatment in adult patients with inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP) AND • Member has trialed and failed‡ therapy with at least two intranasal corticosteroid regimens <p><u>Eosinophilic Esophagitis (EoE):</u></p> <ul style="list-style-type: none"> • Member is ≥ 1 year of age AND • Member weighs at least 15 kg AND

<p>XELJANZ IR (tofacitinib) tablet</p> <p>*XOLAIR (omalizumab) syringe, autoinjector</p>	<p>NUCALA (mepolizumab) auto-injector, syringe</p> <p>OLUMIANT (baricitinib) tablet</p> <p>YUFLYMA (adalimumab-aaty) auto-injector</p> <p><i>Note: Product formulations in the physician administered drug (PAD) category are located on Appendix P</i></p>	<ul style="list-style-type: none"> • Member has a diagnosis of eosinophilic esophagitis (EoE) with ≥ 15 intraepithelial eosinophils per high-power field (eos/hpf), with or without a history of esophageal dilations AND • Member is following appropriate dietary therapy interventions AND • Medication is being prescribed by or in consultation with a gastroenterologist, allergist or immunologist AND • Member has trialed and failed[‡] one of the following treatment options for EoE: <ul style="list-style-type: none"> ○ Proton pump inhibitor trial of at least eight weeks in duration if reflux is a contributing factor OR ○ Minimum four-week trial of local therapy with fluticasone (using a metered dose inhaler) sprayed into the mouth and then swallowed or budesonide slurry. <p><u>Prurigo Nodularis:</u></p> <ul style="list-style-type: none"> • Member is ≥ 18 years of age AND • Medication is being prescribed as treatment for prurigo nodularis AND • Member has trialed and failed[‡] therapy with at least two corticosteroid regimens (topical or intralesional injection). <p>*KEVZARA (sarilumab) may receive approval if meeting the following based on prescribed indication:</p> <p><u>Polymyalgia Rheumatica:</u></p> <ul style="list-style-type: none"> • Member has had an inadequate response to corticosteroids or who cannot tolerate corticosteroid taper. <p>*XOLAIR (omalizumab) may receive approval if meeting the following based on prescribed indication:</p> <p><u>Asthma::</u></p> <ul style="list-style-type: none"> • Member is ≥ 6 years of age AND • Member has an FDA-labeled indicated use for treating asthma AND • Member has a positive skin test or in vitro reactivity to a perennial inhaled allergen or has a pre-treatment IgE serum concentration ≥ 30 IU/mL AND • Member's asthma has been refractory to recommended evidence-based, guideline-supported pharmacologic therapies AND • The requested medication is being prescribed as add-on therapy to existing asthma regimen.
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Chronic Rhinosinusitis with Nasal Polyps:

- Member is 18 years of age or older **AND**
- Medication is being prescribed as add-on maintenance treatment of chronic rhinosinusitis with nasal polyps (CRSwNP) in adult patients 18 years of age and older with inadequate response to nasal corticosteroids **AND**
- Member has tried and failed‡ therapy with at least two intranasal corticosteroid regimens

Chronic Idiopathic Urticaria (CIU):

- Member is 12 years of age or older **AND**
- Member is diagnosed with chronic idiopathic urticaria **AND**
- Member is symptomatic despite H1 antihistamine treatment **AND**
- Member has tried and failed‡ at least three of the following:
 - High-dose second generation H1 antihistamine
 - H2 antihistamine
 - First-generation antihistamine
 - Leukotriene receptor antagonist
 - Hydroxyzine or doxepin (must include)

AND

- Prescriber attests that the need for continued therapy will be periodically reassessed (as the appropriate duration of Xolair therapy for CIU has currently not been evaluated).

IgE-Mediated Food Allergy:

- Medication is being prescribed for reduction of allergic reactions (Type I), including anaphylaxis, that may occur with accidental exposure to one or more foods in adult and pediatric patients aged 1 year and older with IgE-mediated food allergy.

All other preferred agents (HADLIMA, HUMIRA, ENBREL, OTEZLA, KEVZARA) may receive approval for use for FDA-labeled indications.

Non-Preferred Agents:

ARCALYST (rilonacept) may receive approval if meeting the following:

- 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):
 - Cryopyrin-associated Autoinflammatory Syndrome (CAPS), including:
 - 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 \geq 12 years of age

AND

- 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.

ILARIS (canakinumab) may receive approval if meeting the following:

- Medication is being prescribed for one of the following (approval for all other indications is subject to meeting non-preferred criteria listed below):
 - 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)
 - Symptomatic treatment of adult patients with gout flares in whom NSAIDs and colchicine are contraindicated, are not tolerated, or do not provide an adequate response, and in whom repeated courses of corticosteroids are not appropriate (limited to four 150mg doses per one year approval)

AND

- Member has trialed and failed‡ colchicine.
- Quantity Limits (effective 2/15/2024):
 - Cryopyrin-associated periodic syndrome: 600mg (4mL) every 8 weeks
 - All other indications: 300mg (2mL) every 4 weeks

KINERET (anakinra) may receive approval if meeting the following:

- Medication is being prescribed for one of the following indications (approval for all other indications is subject to meeting non-preferred criteria below):
 - Neonatal onset multisystem inflammatory disease (NOMID).
 - Familial Mediterranean Fever (FMF)

AND

- Member has trialed and failed‡ colchicine.

NUCALA (mepolizumab) may receive approval if meeting the following based on prescribed indication (for any FDA-labeled indications in this subclass category that are not listed, approval is subject to meeting non-preferred criteria listed below):

Chronic Rhinosinusitis with Nasal Polyps:

- Member is 18 years of age or older **AND**
- Medication is being prescribed as an add-on maintenance treatment in adult patients with inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP) **AND**
- Member has a baseline bilateral endoscopic nasal polyps score (NPS; scale 0-8) **AND** nasal congestion/obstruction score (NC; scale 0-3) averaged over 28-day period **AND**
- Member has trialed and failed‡ therapy with three intranasal corticosteroids (see PDL Class) **AND**
- Medication is being prescribed by or in consultation with a rheumatologist, allergist, ear/nose/throat specialist or pulmonologist **AND**
- Initial authorization will be for 24 weeks, for additional 12-month approval member must meet the following criteria:
 - NC and NPS scores are provided and show a 20% reduction in symptoms from baseline **AND**
 - Member continues to use primary therapies such as intranasal corticosteroids.

Eosinophilic Granulomatosis with polyangiitis (EGPA):

- Member is 18 years of age or older **AND**
- Member has been diagnosed with relapsing or refractory EGPA at least 6 months prior to request as demonstrated by ALL the following:
 - Member has a diagnosis of asthma **AND**
 - Member has a blood eosinophil count of greater than or equal to 1000 cells/mcL or a blood eosinophil level of 10%

AND

- Member has the presence of two of the following EGPA characteristics:
 - Histopathological evidence of eosinophilic vasculitis, perivascular eosinophilic infiltration, or eosinophil-rich granulomatous inflammation
 - Neuropathy
 - Pulmonary infiltrates
 - Sinonasal abnormality
 - Cardiomyopathy
 - Glomerulonephritis
 - Alveolar hemorrhage
 - Palpable purpura
 - Antineutrophil cytoplasmic antibody (ANCA) positive

AND

- Member is on a stable dose of corticosteroids for at least 4 weeks prior to request **AND**

- Dose of 300 mg once every 4 week is being prescribed.

Hyper eosinophilic Syndrome (HES):

- Member is 12 years of age or older **AND**
- Member has a diagnosis for HES for at least 6 months that is nonhematologic secondary HES **AND**
- Member has a blood eosinophil count of greater than or equal to 1000 cells/mcL **AND**
- Member has a history of two or more HES flares (defined as worsening clinical symptoms or blood eosinophil counts requiring an increase in therapy) **AND**
- Member has been on stable dose of HES therapy for at least 4 weeks, at time of request, including at least one of the following:
 - Oral corticosteroids
 - Immunosuppressive therapy
 - Cytotoxic therapy**AND**
- Dose of 300 mg once every 4 weeks is being prescribed.

All other non-preferred agent indications may receive approval for FDA-labeled use following trial and failure‡ of all preferred agents that are FDA-indicated or have strong evidence supporting use for the prescribed indication from clinically recognized guideline compendia (only one preferred adalimumab product trial required).

‡Failure is defined as lack of efficacy, contraindication to therapy, allergy, intolerable side effects, or significant drug-drug interaction.

Members currently taking a preferred agent may receive approval to continue therapy with that agent.

Members with current prior authorization approval on file for preferred or non-preferred agents will be subject to meeting reauthorization criteria above when listed for the prescribed indication **OR** if reauthorization criteria are not listed for the prescribed indication, may receive approval for continuation of therapy.

Note: Prior authorization requests for OLUMIANT (baricitinib) prescribed solely for treating alopecia areata will not be approved.

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.

X. Miscellaneous

Therapeutic Drug Class: **EPINEPHRINE PRODUCTS** -Effective 1/1/2024

No PA Required <i>Brand/generic changes effective 02/22/2024*</i>	PA Required	
<p>*Epinephrine 0.15mg/0.15ml, 0.3mg/0.3ml auto-injector (<i>Mylan only</i>)</p> <p>EPIPEN 0.3 mg/0.3 ml (epinephrine) auto-injector</p> <p>EPIPEN JR0.15 mg/0.15 ml, (epinephrine) auto-injector</p>	<p>AUVI-Q (epinephrine) auto-injector</p> <p>Epinephrine 0.15mg/0.15ml, 0.3mg/0.3ml auto-injector (All other manufacturers; generic Adrenaclick, Epipen)</p> <p>SYMJEPI 0.15mg/0.3ml, 0.3mg/0.3ml (epinephrine) syringe</p>	<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>

Therapeutic Drug Class: **NEWER HEREDITARY ANGIOEDEMA PRODUCTS** -Effective 1/1/2024

PA Required for all agents in this class		Medications Indicated for Routine Prophylaxis:
Preferred	Non-Preferred	
<p><u>Prophylaxis:</u></p> <p>HAEGARDA (C1 esterase inhibitor) vial</p> <p><u>Treatment:</u></p> <p>BERINERT (C1 esterase inhibitor) kit, vial</p> <p>FIRAZYR (icatibant acetate) syringe</p>	<p><u>Prophylaxis:</u></p> <p>CINRYZE (C1 esterase inhibitor) kit</p> <p>ORLADEYO (berotralstat) oral capsule</p> <p>TAKHZYRO (lanadelumab-flyo) syringe, vial</p> <p><u>Treatment:</u></p> <p>Icatibant syringe (generic FIRAZYR)</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

Maximum Dose: 60 IU/kg

Minimum Age: 6 years

CINRYZE (C1 esterase inhibitor - human) may be approved for members meeting the following criteria:

- 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:
 - Cinryze is being used for short-term prophylaxis to undergo a surgical procedure or major dental work **OR**
 - Cinryze is being used for long-term prophylaxis and member meets one of the following:
 - 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.

Minimum age: 6 years

Maximum dose: 100 Units/kg

ORLADEYO (berotralstat) may be approved for members meeting the following criteria:

- 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 cyclosporine, fentanyl, pimozide, digoxin) **AND**
- Member meets at least one of the following:
 - 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:
 - 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

Minimum age: 12 years

Maximum dose: 150 mg once daily

TAKHZYRO (lanadelumab-flyo) may be approved for members meeting the following criteria:

- 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.

Minimum age: 2 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

Medications Indicated for Treatment of Acute Attacks:

Members are restricted to coverage of one medication for treatment of acute attacks at one time. Prior authorization approval will be for one year.

FIRAZYR (icatibant acetate) may be approved for members meeting the following criteria:

- 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

Minimum age: 18 years

Maximum dose: 30mg

BERINERT (C1 esterase inhibitor - human) may be approved for members meeting the following criteria:

- 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

Minimum age: 6 years

Max dose: 20 IU/kg

RUCONEST (C1 esterase inhibitor - recombinant) may be approved for members meeting the following criteria:

- 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**

		<ul style="list-style-type: none"> ○ 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: 13 years Maximum dose: 4,200 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>
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Therapeutic Drug Class: PHOSPHATE BINDERS -Effective 10/1/2023

No PA Required	PA Required	
<p>Calcium acetate capsule</p> <p>PHOSLYRA (calcium acetate) solution</p> <p>RENAGEL (sevelamer HCl) 800mg tablet</p> <p>RENVELA^{BNR} (sevelamer carbonate) tablet, powder pack</p> <p>Sevelamer HCl 800mg tablet</p>	<p>AURYXIA (ferric citrate) tablet</p> <p>Calcium acetate tablet</p> <p>CALPHRON (calcium acetate) tablet</p> <p>FOSRENOL (lanthanum carbonate) chewable tablet, powder pack</p> <p>Lanthanum carbonate chewable tablet</p> <p>Sevelamer carbonate tablet, powder pack</p> <p>Sevelamer HCl 400mg tablet</p> <p>VELPHORO (sucroferric oxide) chewable tablet</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 10/1/2023

<p style="text-align: center;">Preferred *Must meet eligibility criteria</p>	<p style="text-align: center;">Non-Preferred PA Required</p>	
<p>COMPLETE NATAL DHA tablet</p> <p>M-NATAL PLUS tablet</p> <p>NESTABS tablets</p> <p>PNV 29-1 tablet</p> <p>PRENATAL VITAMIN PLUS LOW IRON tablet <i>(Patrin Pharma only)</i></p> <p>PREPLUS CA-FE 27 mg – FA 1 mg tablet</p> <p>SE-NATAL 19 chewable tablet</p> <p>TARON-C DHA capsule</p> <p>THRIVITE RX tablet</p> <p>TRINATAL RX 1 tablet</p> <p>Virt C DHA softgel</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 4/1/2024

No PA Required	PA Required	
<p>ALREX^{BNR} (loteprednol) 0.2%</p> <p>Azelastine 0.05%</p> <p>Cromolyn 4%</p> <p>Ketotifen 0.025% (OTC)</p> <p>LASTACAFT (alcaftadine) 0.25% (OTC)</p> <p>Olopatadine 0.1%, 0.2% (OTC) (generic Pataday Once/Twice Daily)</p>	<p>ALAWAY (ketotifen) 0.025% (OTC)</p> <p>ALOCRIIL (nedocromil) 2%</p> <p>ALOMIDE (Iodoxamide) 0.1%</p> <p>Bepotastine 1.5%</p> <p>BEPREVE (bepotastine) 1.5%</p> <p>Epinastine 0.05%</p> <p>Loteprednol 0.2%</p> <p>Olopatadine 0.1%, 0.2% (RX)</p> <p>PATADAY ONCE DAILY (olopatadine) 0.2% (OTC)</p> <p>PATADAY TWICE DAILY (olopatadine) 0.1% (OTC)</p> <p>PATADAY XS ONCE DAILY (olopatadine) 0.7% (OTC)</p> <p>ZADITOR (ketotifen) 0.025% (OTC)</p> <p>ZERVIATE (cetirizine) 0.24%</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>

Therapeutic Drug Class: **OPHTHALMIC, IMMUNOMODULATORS** -Effective 4/1/2024

No PA Required	PA Required	
<p>RESTASIS^{BNR} (cyclosporine 0.05%) vials</p>	<p>CEQUA (cyclosporine) 0.09% solution</p> <p>Cyclosporine 0.05% vials</p> <p>MIEBO (Perfluorohexyloctane/PF)</p> <p>RESTASIS MULTIDOSE (cyclosporine) 0.05%</p>	<p>Non-preferred products may be approved for members meeting all of the following criteria:</p> <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

	TYRVAYA (varenicline) nasal spray VERKAZIA (cyclosporin emulsion) VEVYE (cyclosporine) 0.1% XIIDRA (lifitegrast) 5% solution	<ul style="list-style-type: none"> • 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 and Vevye 3mL/30 days for Miebo
Therapeutic Drug Class: OPHTHALMIC, ANTI-INFLAMMATORIES -Effective 4/1/2024		
NSAIDs		Durezol (difluprednate) may be approved if meeting the following criteria: <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). Eysuvis (loteprednol etabonate) may be approved if meeting all of the following: <ul style="list-style-type: none"> • Member is \geq 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: • 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 Lotemax SM (loteprednol etabonate) or Inveltys (loteprednol etabonate) may be approved if meeting all of the following: <ul style="list-style-type: none"> • Member is \geq 18 years of age AND
No PA Required	PA Required	
Diclofenac 0.1% Flurbiprofen 0.03% Ketorolac 0.5%, Ketorolac LS 0.4% NEVANAC (nepafenac) 0.1%	ACULAR (ketorolac) 0.5%, LS 0.4% ACUVAIL (ketorolac/PF) 0.45% Bromfenac 0.07%, 0.075%, 0.09% BROMSITE (bromfenac) 0.075% ILEVRO (nepafenac) 0.03% PROLENSA (bromfenac) 0.07%	
Corticosteroids		
No PA Required	PA Required	
FLAREX (fluorometholone) 0.1% Fluorometholone 0.1% drops FML FORTE (fluorometholone) 0.25% drops LOTEMAX ^{BNR} (loteprednol) 0.5% drops, gel LOTEMAX (loteprednol) 0.5% ointment	Dexamethasone 0.1% Difluprednate 0.05% DUREZOL (difluprednate) 0.05% EYSUVIS (loteprednol) 0.25% FML LIQUIFILM (fluorometholone) 0.1% drop FML S.O.P (fluorometholone) 0.1% ointment INVELTYS (loteprednol) 1%	

<p>MAXIDEX (dexamethasone) 0.1%</p> <p>PRED MILD (prednisolone) 0.12%</p> <p>Prednisolone acetate 1%</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>	<ul style="list-style-type: none"> • 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 <p>Verkazia (cyclosporine ophthalmic emulsion) may be approved if the following criteria are met:</p> <ul style="list-style-type: none"> • Member is ≥ 4 years of age AND • Verkazia is being used for the treatment of vernal keratoconjunctivitis (VKC) AND • Member has trialed and failed therapy with three agents from the following pharmacologic categories: preferred dual-acting mast cell stabilizer/antihistamine from the Ophthalmics-Allergy PDL class, oral antihistamine, preferred topical ophthalmic corticosteroid from the Ophthalmics-Anti-inflammatories PDL class. Failure is defined as lack of efficacy with 2-week trial, allergy, contraindication to therapy, intolerable side effects, or significant drug-drug interaction • <u>Quantity limit</u>: 120 single-dose 0.3 mL vials/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: OPTHALMIC, GLAUCOMA -Effective 4/1/2024		
Beta-blockers		
No PA Required	PA Required	<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</p>
<p>Levobunolol 0.5%</p> <p>Timolol (generic Timoptic) 0.25%, 0.5%</p>	<p>Betaxolol 0.5%</p> <p>BETIMOL (timolol) 0.25%, 0.5%</p> <p>BETOPIC-S (betaxolol) 0.25%</p> <p>Carteolol 1%</p>	

	<p>ISTALOL (timolol) 0.5%</p> <p>Timolol (generic Istalol) 0.5% drops</p> <p>Timolol GFS 0.25%, 0.5%</p> <p>Timolol/PF (generic Timoptic Ocudose) 0.25%, 0.5%</p> <p>TIMOPTIC, TIMOPTIC OCUDOSE (timolol) 0.25%, 0.5%</p> <p>TIMOPTIC-XE (timolol GFS) 0.25%, 0.5%</p>	<p>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>
Carbonic anhydrase inhibitors		
No PA Required	PA Required	
<p>AZOPT^{BNR} (brinzolamide) 1%</p> <p>Dorzolamide 2%</p>	<p>Brinzolamide 1%</p>	
Prostaglandin analogue		
No PA Required	PA Required	
<p>Latanoprost 0.005%</p> <p>LUMIGAN^{BNR} (bimatoprost) 0.01%</p> <p>TRAVATAN Z^{BNR} (travoprost) 0.004%</p>	<p>Bimatoprost 0.03%</p> <p>IYUZEH (latanoprost/PF) 0.005%</p> <p>Tafluprost 0.0015%</p> <p>Tafluprost PF 0.0015%</p> <p>Travoprost 0.004%</p> <p>VYZULTA (latanoprostene) 0.024%</p> <p>XALATAN (latanoprost) 0.005%</p> <p>XELPROS (latanoprost) 0.005%</p> <p>ZIOPTAN (tafluprost PF) 0.0015%</p>	

Alpha-2 adrenergic agonists	
No PA Required	PA Required
ALPHAGAN P ^{BNR} 0.1%, 0.15% (brimonidine) Brimonidine 0.2%	Apraclonidine 0.5% Brimonidine 0.1%, 0.15% IOPIDINE (apraclonidine) 0.5%, 1%
Other ophthalmic, glaucoma and combinations	
No PA Required	PA Required
COMBIGAN ^{BNR} 0.2%-0.5% (brimonidine/timolol) Dorzolamide/Timolol 2%-0.5% RHOPRESSA (netarsudil) 0.02% ROCKLATAN (netarsudil/latanoprost) 0.02%-0.005%	Brimonidine/Timolol 0.2%-0.5% COSOPT/COSOPT PF (dorzolamide/timolol) 2%-0.5% Dorzolamide/Timolol PF 2%-0.5% PHOSPHOLINE IODIDE (echothiophate) 0.125% Pilocarpine 1%, 2%, 4% SIMBRINZA (brinzolamide/brimonidine) 1%-0.2% VUIITY (pilocarpine) 1.25%

XII. Renal/Genitourinary

Therapeutic Drug Class: **BENIGN PROSTATIC HYPERPLASIA (BPH) AGENTS** -Effective 10/1/2023

No PA Required	PA Required	
Alfuzosin ER tablet	AVODART (dutasteride) softgel	Prior authorization for non-preferred products in this class may be approved if member meets all of the following criteria: <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. ‡Failure is defined as lack of efficacy with 8-week trial, allergy, intolerable side effects, contraindication to, or significant drug-drug interaction.
Doxazosin tablet	CARDURA (doxazosin) tablet	
Dutasteride capsule	CARDURA XL (doxazosin ER) tablet	
Finasteride tablet	*CIALIS (tadalafil) 2.5 mg, 5 mg tablet	
Tamsulosin capsule	Dutasteride/tamsulosin capsule	

Terazosin capsule	ENTADFI (finasteride/tadalafil) capsule FLOMAX (tamsulosin) capsule JALYN (dutasteride/tamsulosin) capsule PROSCAR (finasteride) tablet RAPAFLO (silodosin) capsule Silodosin capsule *Tadalafil 2.5 mg, 5 mg tablet	<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).</p> <p>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>
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Therapeutic Drug Class: ANTI-HYPERURICEMICS -Effective 10/1/2023

No PA Required	PA Required	
Allopurinol 100 mg, 300 mg tablets Colchicine tablet Febuxostat tablet Probenecid tablet Probenecid/Colchicine tablet	Allopurinol 200 mg tablets Colchicine capsule COLCRYS (colchicine) tablet GLOPERBA (colchicine) oral solution MITIGARE (colchicine) capsule ULORIC (febuxostat) tablet ZYLOPRIM (allopurinol) tablet	<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

Therapeutic Drug Class: OVERACTIVE BLADDER AGENTS -Effective 10/1/2023

No PA Required	PA Required	
Fesoterodine ER tablet GELNIQUE (oxybutynin) gel MYRBETRIQ (mirabegron) tablet ^{BNR} Oxybutynin IR, ER tablets, syrup	Darifenacin ER tablet DETROL (tolterodine) tablet DETROL LA (tolterodine ER) ER capsule DITROPAN (Oxybutynin) tablet DITROPAN XL (Oxybutynin ER) tablet	<p>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.</p> <p>Members with hepatic failure can receive approval for trospium (Sanctura) or trospium extended release (Sanctura XR) products without a trial on a Preferred product.</p>

Solifenacin tablet	Flavoxate tablet GELNIQUE (oxybutynin) gel pump GEMTESA (vibegron) tablet Mirabegron tablet MYRBETRIQ (mirabegron) suspension OXYTROL (oxybutynin patch) SANCTURA (trospium) SANCTURA XL (trospium ER) Tolterodine tablet, ER capsule TOVIAZ (Fesoterodine ER) tablet Trospium ER capsule, tablet VESICARE (solifenacin) tablet VESICARE LS (solifenacin) suspension	
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XIII. RESPIRATORY

Therapeutic Drug Class: **RESPIRATORY AGENTS** -Effective 1/1/2024

Inhaled Anticholinergics

Preferred No PA Required (Unless indicated*)	Non-Preferred PA Required	
<p><u>Solutions</u> Ipratropium solution</p> <p><u>Short-Acting Inhalation Devices</u> ATROVENT HFA (ipratropium)</p> <p><u>Long-Acting Inhalation Devices</u></p>	<p><u>Solutions</u> LONHALA MAGNAIR (glycopyrrolate) solution</p> <p>YUPELRI (revefenacin) solution</p> <p><u>Short-Acting Inhalation Devices</u></p> <p><u>Long-Acting Inhalation Devices</u> INCRUSE ELLIPTA (umeclidinium)</p>	<p>*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> <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[†] treatment with two preferred anticholinergic agents.</p>

<p>SPIRIVA Handihaler^{BNR} (tiotropium)</p> <p>*SPIRIVA RESPIMAT (tiotropium)</p>	<p>Tiotropium DPI</p> <p>TUDORZA PRESSAIR (aclidinium)</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‡ treatment with two preferred agents, one of which must be SPIRIVA HANDIHALER.</p> <p>‡Failure is defined as lack of efficacy with 6-week trial, allergy, intolerable side effects, or significant drug-drug interaction.</p>
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Inhaled Anticholinergic Combinations

<p align="center">No PA Required</p> <p><u>Solutions</u> Ipratropium/Albuterol solution</p> <p><u>Short-Acting Inhalation Devices</u> COMBIVENT RESPIMAT (albuterol/ipratropium)</p> <p><u>Long-Acting Inhalation Devices</u> ANORO ELLIPTA (umeclidinium/vilanterol)</p>	<p align="center">PA Required</p> <p><u>Solutions</u></p> <p><u>Short-Acting Inhalation Devices</u></p> <p><u>Long-Acting Inhalation Devices</u> 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>BREZTRI AEROSPHERE (budesonide/glycopyrrolate/formoterol) may be approved for members ≥ 18 years of age with a diagnosis of COPD who have trialed and failed‡ 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‡ 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‡ 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>‡Failure is defined as lack of efficacy with 6-week trial, allergy, intolerable side effects, or significant drug-drug interaction.</p>
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Inhaled Beta2 Agonists (short acting)

<p align="center">No PA Required</p> <p><u>Solutions</u> Albuterol solution, for nebulizer</p> <p><u>Inhalers</u> PROAIR^{BNR} HFA (albuterol)</p> <p>PROVENTIL^{BNR} HFA (albuterol)</p> <p>VENTOLIN^{BNR} HFA (albuterol)</p>	<p align="center">PA Required</p> <p><u>Solutions</u> Levalbuterol solution</p> <p><u>Inhalers</u> AIRSUPRA (budesonide/albuterol)</p> <p>Albuterol HFA</p> <p>Levalbuterol HFA</p> <p>PROAIR DIGIHALER, RESPICLICK (albuterol)</p>	<p>Non-preferred short acting beta-2 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> <p>MDI formulation quantity limits: 2 inhalers / 30 days</p> <p>AIRSUPRA (budesonide/albuterol) <u>Airsupra minimum age: 18 years old</u></p>
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	XOPENEX (levalbuterol) Inhaler	
Inhaled Beta2 Agonists (long acting)		
Preferred	Non-Preferred PA Required	
<u>Solutions</u> <u>Inhalers</u> SEREVENT DISKUS (salmeterol) inhaler	<u>Solutions</u> Arformoterol solution BROVANA (arformoterol) solution Formoterol solution PERFOROMIST (formoterol) solution <u>Inhalers</u> STRIVERDI RESPIMAT (olodaterol)	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	PA Required	
<u>Solutions</u> Budesonide nebulas <u>Inhalers</u> ARNUITY ELLIPTA (fluticasone furoate) ASMANEX HFA (mometasone furoate) inhaler ASMANEX Twisthaler (mometasone) FLOVENT DISKUS (fluticasone) FLOVENT HFA (fluticasone) PULMICORT FLEXHALER (budesonide)	<u>Solutions</u> PULMICORT (budesonide) respules <u>Inhalers</u> ALVESCO (ciclesonide) inhaler ARMONAIR DIGIHALER (fluticasone propionate) Fluticasone propionate diskus *Fluticasone propionate HFA 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, or dexterity/coordination limitations (per provider notes) that significantly impact appropriate use of a specific dosage form.) * FLUTICASONE PROPIONATE HFA is available to members 12 years and under without prior authorization <u>Maximum Dose:</u> Pulmicort (budesonide) nebulizer suspension: 2mg/day <u>Quantity Limits:</u> Pulmicort flexhaler: 2 inhalers / 30 days
Inhaled Corticosteroid Combinations		
No PA Required (*Must meet eligibility criteria)	PA Required	
ADVAIR DISKUS ^{BNR} (fluticasone/salmeterol)	AIRDUO DIGIHALER (fluticasone/salmeterol) BREO ELLIPTA (vilanterol/fluticasone furoate)	* TRELEGY ELLIPTA (fluticasone furoate/umeclidinium/vilanterol) may be approved if the member has trialed/failed one preferred agent. 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

<p>ADVAIR HFA^{BNR} (fluticasone/salmeterol)</p> <p>AIRDUO RESPICLICK^{BNR} (fluticasone/salmeterol)</p> <p>DULERA (mometasone/formoterol)</p> <p>SYMBICORT^{BNR} (budesonide/formoterol) inhaler</p> <p>*TRELEGY ELLIPTA (fluticasone furoate/ umeclidinium/vilanterol)</p>	<p>Budesonide/formoterol (generic Symbicort)</p> <p>Fluticasone/salmeterol (generic Airduo/Advair Diskus)</p> <p>Fluticasone/salmeterol HFA (generic Advair HFA)</p> <p>Fluticasone/vilanterol (generic Breo Ellipta)</p> <p>WIXELA INHUB (fluticasone/salmeterol)</p>	<p>appropriate use of a specific dosage form.</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.
Phosphodiesterase Inhibitors (PDEIs)		
<p style="text-align: center;">No PA Required</p> <p>Roflumilast tablet</p>	<p style="text-align: center;">PA Required</p> <p>DALIRESP (roflumilast) tablet</p>	<p>Requests for use of the non-preferred brand product formulation may be approved if meeting criteria outlined in the Appendix P “Generic Mandate” section.</p>