COLORADO
Department of Health Care Policy & Financing

Health First COLORADO
Colorado's Medicaid Program

Colorado Department of Health Care Policy and Financing
Preferred Drug List (PDL)
Effective July 1, 2025

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.

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.)
I. Analgesics		
Therapeutic Drug Class: **NON-OPIOID ANALGESIA AGENTS - Oral** – *Effective 4/1/2025*		
No PA Required Duloxetine 20 mg, 30 mg, 60 mg capsule Gabapentin capsule, tablet, solution Pregabalin capsule SAVELLA (milnacipran) tablet, titration pack	**PA Required** CYMBALTA (duloxetine) capsule DRIZALMA (duloxetine DR) sprinkle capsules Duloxetine 40 mg capsule GRALISE (gabapentin ER) tablet Gabapentin ER tablet HORIZANT (gabapentin ER) tablet JOURNAVX (suzetrigine) tablet LYRICA (pregabalin) capsule, solution, CR tablet NEURONTIN (gabapentin) capsule, tablet, solution Pregabalin solution, ER tablet	JOURNAVX (suzetrigine) may be approved if the following criteria are met: • Member is ≥ 18 years of age AND • Member is being prescribed suzetrigine for up to 14 days of treatment for moderate-to- severe acute pain AND • Prescriber attests that the member's pain is unable to be managed with an NSAID, acetaminophen, or other non-opioid analgesic AND • Journavx (suzetrigine) is not being prescribed to treat chronic pain AND • The medication is not being prescribed to treat pain associated with migraine AND • Member does not have severe hepatic impairment (Child-Pugh Class C) AND • Member has been counseled to avoid food or drink containing grapefruit during treatment with Journavx (suzetrigine) AND • Member is not concurrently taking a strong CYP3A inhibitor (such as ketoconazole, itraconazole, posaconazole, ritonavir, indinavir, saquinavir, clarithromycin, fluvoxamine) AND • Member is not concurrently taking a strong or moderate CYP3A inducer (such as carbamazepine, phenytoin, rifampin, efavirenz, rifabutin, St. John's Wort) · Members using hormonal contraceptives containing progestins other than levonorgestrel and norethindrone have been counseled regarding alternative or additional contraception, if appropriate, per product labeling. Duration of Approval: 3 months Dosing Limit: One 14-day course per approval on file Quantity limit: 29 tablets/14 days All other non-preferred oral non-opioid analgesic agents may be approved if member meets all of the following criteria: • 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 4/1/2025*		
No PA Required Lidocaine patch	**PA Required** Lidocaine patch (Puretek)	Non-preferred topical products require a trial/failure with an adequate 8-week trial of gabapentin AND pregabalin AND duloxetine AND a preferred lidocaine 5% patch.

<table>
<tr><td>LIDODERM (lidocaine) patch</td><td>ZTLIDO (lidocaine) topical system</td><td>Failure is defined as lack of efficacy with an 8-week trial, allergy, intolerable side effects, or significant drug-drug interaction.

Lidocaine 5% patch (Puretek manufacturer only) may be approved if the following criteria are met:
• Member is ≥ 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 5% 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 5% patch formulation cannot be used.</td></tr>
<tr><td colspan="3">Therapeutic Drug Class: NON-STEROIDAL ANTI-INFLAMMATORIES (NSAIDS) - Oral – Effective 4/1/2025</td></tr>
<tr><td>No PA Required

Celecoxib capsule

Diclofenac potassium 50 mg tablet

Diclofenac sodium EC/DR tablet

Ibuprofen suspension, tablet (RX)

Indomethacin capsule, ER capsule

Ketorolac tablet*

Meloxicam tablet

Nabumetone tablet

Naproxen DR/ER, tablet (RX)

Naproxen suspension

Sulindac tablet</td><td>PA Required

ARTHROTEC (diclofenac sodium/ misoprostol) tablet

CELEBREX (celecoxib) capsule

DAYPRO (oxaprozin) caplet

Diclofenac potassium capsule, powder pack

Diclofenac potassium 25 mg tablet

Diclofenac sodium ER/SR tablet

Diclofenac sodium/misoprostol tablet

Diflunisal tablet

DUEXIS (ibuprofen/famotidine) tablet

ELYXYB (celecoxib) solution

Etodolac capsule; IR, ER tablet

FELDENE (piroxicam) capsule

Fenoprofen capsule, tablet

Flurbiprofen tablet</td><td>DUEXIS (ibuprofen/famotidine) or VIMOVO (naproxen/esomeprazole) may be approved if the member meets the following criteria:
• 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 25 mg immediate-release tablets may be approved if the following criteria are met:
• Member is ≥ 18 years of age AND
• Member does not have any of the following medical conditions:
o History of recent coronary artery bypass graft (CABG) surgery
o History of myocardial infarction
o Severe heart failure
o Advanced renal disease
o History of gastrointestinal bleeding
AND
• Member has trial and failure‡ of four preferred oral NSAIDs at maximally tolerated doses

ELYXYB (celecoxib) oral solution may be approved if the following criteria are met:
• Member is ≥ 18 years of age AND
• Requested medication is being prescribed for acute treatment of migraine (with or without aura) AND
• Member does <u>not</u> have any of the following medical conditions:
o History of asthma, urticaria, or other allergic-type reactions after taking aspirin or other NSAIDs
o History of recent coronary artery bypass graft (CABG) surgery</td></tr>
</table>

	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	○ History of allergic-type reactions to sulfonamides ○ Severe heart failure ○ History of myocardial infarction ○ History of gastrointestinal bleeding ○ Advanced renal disease ○ Pregnancy past 30 weeks gestation **AND** • Member is unable to take an alternative NSAID in a solid oral dosage form AND • Member has tried and failed[ǂ] one preferred NSAID oral liquid AND • Member is unable to use celecoxib capsules, opened and sprinkled into applesauce or other soft food [ǂ]Failure is defined as lack of efficacy, contraindication to therapy, allergy, intolerable side effects, or significant drug-drug interactions. <u>Maximum dose</u>: 120 mg/day 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. *Ketorolac tablets quantity limit: 5-day supply per 30 days and 20 tablets per 30 days
Therapeutic Drug Class: **NON-STEROIDAL ANTI-INFLAMMATORIES (NSAIDS) - Non-Oral** – *Effective 4/1/2025*		
No PA Required Diclofenac 1.5% topical solution Diclofenac sodium 1% gel (OTC/Rx)	**PA Required** 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	**SPRIX (ketorolac)** may be approved if meeting the following criteria: ● 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 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. **Diclofenac topical patch** quantity limit: 2 patches per day

		Diclofenac 3% gel (generic Solaraze) prior authorization criteria can be found in the Antineoplastic agents, topical, section of the PDL.

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://pharmacypmp.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 4/1/2025*

Preferred No PA Required* (If criteria and quantity limit are met)	**Non-Preferred PA Required**	*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. Preferred codeine or tramadol products prescribed for members < 18 years of age must meet the following criteria:
*Acetaminophen/codeine tablets	Acetaminophen / codeine elixir	• **Preferred tramadol and tramadol-containing products** may be approved for members < 18 years of age if meeting the following: o Member is 12 years to 17 years of age **AND** o Tramadol is NOT being prescribed for post-surgical pain following tonsil or adenoid procedure AND o Member's BMI-for-age is not > 95th percentile per CDC guidelines AND o Member does not have obstructive sleep apnea or severe lung disease OR
Hydrocodone/acetaminophen solution, tablet	ASCOMP WITH CODEINE (codeine/butalbital/aspirin/caffeine)	
Hydromorphone tablet	*Butalbital/caffeine/acetaminophen/codeine capsule	

Morphine IR solution, tablet Oxycodone solution, tablet Oxycodone/acetaminophen tablet *Tramadol 25mg, 50mg *Tramadol/acetaminophen tablet	Butalbital/caffeine/aspirin/codeine capsule Butalbital compound/codeine Butorphanol tartrate (nasal) spray Carisoprodol/aspirin/codeine Codeine tablet Dihydrocodeine/acetaminophen/caffeine tablet DILAUDID (hydromorphone) solution, tablet FIORICET/CODEINE (codeine/ butalbital/acetaminophen/caffeine) capsule Hydrocodone/ibuprofen tablet Hydromorphone solution Levorphanol tablet Meperidine solution, tablet Morphine concentrated solution, oral syringe NALOCET (oxycodone/acetaminophen) tablet Oxycodone capsule, syringe, concentrated solution Oxycodone/acetaminophen solution Oxycodone/acetaminophen tablet (generic PROLATE) Oxymorphone tablet Pentazocine/naloxone tablet PERCOCET (oxycodone/ acetaminophen) tablet ROXICODONE (oxycodone) tablet ROXYBOND (oxycodone) tablet	○ For members < 12 years of age with complex conditions or life-limiting illness who are receiving care under a pediatric specialist, tramadol and tramadol-containing products may be approved on a case-by-case basis • **Preferred Codeine and codeine-containing products** will receive prior authorization approval for members meeting the following criteria may be approved for members < 18 years of age if meeting the following: ○ Member is 12 years to 17 years of age AND ○ Codeine is NOT being prescribed for post-surgical pain following tonsil or adenoid procedure AND ○ Member's BMI-for-age is not > 95th percentile per CDC guidelines AND ○ Member does not have obstructive sleep apnea or severe lung disease AND ○ Member is not pregnant, or breastfeeding AND ○ Renal function is not impaired (GFR > 50 ml/min) AND ○ Member is not receiving strong inhibitors of CYP3A4 (such as erythromycin, clarithromycin, itraconazole, ketoconazole, posaconazole, fluconazole [≥200mg daily], voriconazole, delavirdine, and milk thistle) AND ○ Member meets <u>one</u> of the following: • 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." Non-preferred tramadol products may be approved following trial and failure of generic tramadol 50mg tablet AND generic tramadol/acetaminophen tablet. 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. ‡Allergy: hives, maculopapular rash, erythema multiforme, pustular rash, severe hypotension, bronchospasm, and angioedema <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. • 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.

	SEGLENTIS (tramadol/celecoxib) tablet Tramadol 100mg tablet Tramadol solution	• 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). <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)
Therapeutic Drug Class: **FENTANYL PREPARATIONS (buccal, transmucosal, sublingual)** – *Effective 4/1/2025*		
	PA Required ACTIQ (fentanyl citrate) lozenge Fentanyl citrate lozenge, buccal tablet FENTORA (fentanyl citrate) buccal tablet	Fentanyl buccal, intranasal, transmucosal, and sublingual products: 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.
Therapeutic Drug Class: **OPIOIDS, Long Acting** – *Effective 4/1/2025*		
Preferred **No PA Required** **(unless indicated by * criteria)** BELBUCA (buprenorphine) buccal film BUTRANS[BNR] (buprenorphine) transdermal patch *Fentanyl 12mcg, 25mcg, 50mcg, 75mcg, 100mcg transdermal patch Morphine ER (generic MS Contin) tablet Tramadol ER (generic Ultram ER) tablet	**Non-Preferred** **PA Required** **OXYCONTIN (oxycodone ER) tablet Buprenorphine transdermal patch CONZIP (tramadol ER) capsule Fentanyl 37mcg, 62mcg, 87mcg transdermal patch Hydrocodone ER capsule, tablet Hydromorphone ER tablet HYSINGLA (hydrocodone ER) tablet Methadone (all forms) Morphine ER capsule MS CONTIN (morphine ER) tablet	***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. **Oxycontin (oxycodone ER)** may be approved for members who have trialed and failed‡ treatment with TWO preferred agents. All other non-preferred products may be approved for members who have trialed and failed‡ three preferred products. ‡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. <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.

	Oxycodone ER tablet Oxymorphone ER tablet Tramadol ER capsule	<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. *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.* <u>Reauthorization:</u> Reauthorization for a non-preferred agent may be approved if the following criteria are met: • 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 <u>Quantity/Dosing Limits:</u> • **Oxycontin** 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).
Therapeutic Drug Class: **BUPRENORPHINE, Injectable** – *Effective 7/1/2025*		
Preferred **No PA Required** **(*Must meet eligibility criteria)** Brixadi Weekly/Monthly (buprenorphine) syringe Sublocade (buprenorphine) syringe	**Non-Preferred** **PA Required**	Preferred agents may be approved if the following criteria are met: • The requested medication is being dispensed directly to the healthcare professional (medication should not be dispensed directly to the member) **AND** • Provider attests to member's enrollment in a complete treatment program, including counseling and psychosocial support **AND** • Member has a documented diagnosis of moderate to severe opioid use disorder **AND** • For members newly started on therapy who are not currently using a transmucosal buprenorphine-containing product, prescriber attests that transmucosal buprenorphine induction therapy will be initiated in accordance with product labeling. <u>Maximum dose:</u>

		• Brixadi (buprenorphine) injection: 128 mg/month • Sublocade (buprenorphine) injection: 600 mg/month during 1st month of induction therapy; 300 mg/month maintenance dose thereafter

II. Anti-Infectives

Therapeutic Drug Class: **ANTIBIOTICS, Inhaled** – *Effective 1/1/2025*

Preferred **No PA Required** **(*Must meet eligibility criteria)**	**Non-Preferred** **PA Required**	
Tobramycin inhalation solution (generic TOBI) *CAYSTON (aztreonam) inhalation solution	ARIKAYCE (amikacin liposomal) inhalation vial BETHKIS (tobramycin) inhalation ampule KITABIS (tobramycin) nebulizer pak TOBI (tobramycin) inhalation solution TOBI PODHALER (tobramycin) inhalation capsule Tobramycin inhalation ampule (generic Bethkis) Tobramycin nebulizer pak (generic Kitabis)	***CAYSTON (aztreonam)** inhalation solution may be approved if the following criteria are met: • 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 *Pseudomonas aeruginosa* in the lungs **AND** • The member has been prescribed an inhaled beta agonist to use prior to nebulization of Cayston (aztreonam). **ARIKAYCE (amikacin)** may be approved if the following criteria are met: • 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). All other non-preferred inhaled antibiotic agents may be approved if the following criteria are met: • 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 times 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 1/1/2025*

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

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.

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.

*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.

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: 3,000 mg/day Age ≥ 12 years: 4,000 mg/day

Therapeutic Drug Class: **ANTI-HERPETIC AGENTS - Topical** – *Effective 1/1/2025*

No PA Required	PA Required	
Acyclovir cream (*Teva only*) Acyclovir ointment DENAVIR[BNR] (penciclovir) cream	Acyclovir cream (*all other manufacturers*) Penciclovir cream XERESE (acyclovir/ hydrocortisone) cream ZOVIRAX (acyclovir) cream, ointment	**Non-Preferred Zovirax and acyclovir ointment/cream** formulations may be approved for members who have failed an adequate trial with the preferred topical acyclovir ointment/cream product (diagnosis, dose and duration) as deemed by approved compendium. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) **Xerese** (acyclovir/hydrocortisone) prior authorization may be approved for members that meet the following criteria: ● 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)

Therapeutic Drug Class: **FLUOROQUINOLONES – Oral** – *Effective 1/1/2025*

Preferred No PA Required (*if meeting eligibility criteria)	Non-Preferred PA Required	
*CIPRO (ciprofloxacin) oral suspension[BNR] Ciprofloxacin tablet Levofloxacin tablet Moxifloxacin tablet	BAXDELA (delafloxacin) tablet CIPRO (ciprofloxacin) tablet Ciprofloxacin oral suspension Levofloxacin oral solution Ofloxacin tablet	***CIPRO suspension** does not require prior authorization for members < 18 years of age and may be approved for members ≥ 18 years of age Non-preferred products may be approved for members who have failed an adequate trial (7 days) with at least one preferred product. (Failure is defined as: lack of efficacy, contraindication to therapy, allergy, intolerable side effects, or significant drug-drug interaction). **Levofloxacin solution** may be approved for members with prescriber attestation that member: • 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 †Failure is defined as lack of efficacy, allergy, intolerable side effects, significant drug-drug interaction, or contraindication to therapy.

Therapeutic Drug Class: **HEPATITIS C VIRUS TREATMENTS** – *Effective 1/1/2025*

Direct Acting Antivirals (DAAs)

Preferred No PA Required for initial treatment (*must meet eligibility criteria)	Non-Preferred PA Required	
EPCLUSA (sofosbuvir/velpatasvir) 200 mg -50 mg, 150 mg-37.5 mg tablet, pellet pack	EPCLUSA 400 mg-100 mg (sofosbuvir/velpatasvir) tablet HARVONI 90 mg-400 mg (ledipasvir/sofosbuvir) tablet SOVALDI (sofosbuvir) tablet, pellet packet	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. ***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:

HARVONI (ledipasvir/sofosbuvir) 45mg-200mg tablet, pellet pack Ledipasvir/Sofosbuvir 90 mg-400 mg tablet (*Asegua only)* MAVYRET (glecaprevir/pibrentasvir) tablet, pellet pack Sofosbuvir/Velpatasvir 400mg-100mg (*Asegua only)* *VOSEVI tablet (sofosbuvir/velpatasvir/voxilaprevir)	ZEPATIER (elbasvir/grazoprevir) tablet	• 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 **AND** • Request meets the applicable criteria below for re-treatment. **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: • 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. **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). 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.
Ribavirin Products		
No PA Required Ribavirin capsule Ribavirin tablet		Preferred products are eligible for up to a 90-day supply fill. Non-preferred ribavirin products require prior authorizations which will be evaluated on a case-by-case basis.
Therapeutic Drug Class: **HUMAN IMMUNODEFICIENCY VIRUS (HIV) TREATMENTS, ORAL** – *Effective 1/1/2025* **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 EDURANT (rilpivirine) tablet Efavirenz capsule, tablet Etravirine tablet INTELENCE (etravirine) tablet Nevirapine suspension, IR tablet, ER tablet PIFELTRO (doravirine) tablet		All products are preferred and do not require prior authorization.
Nucleoside/Nucleotide Reverse Transcriptase Inhibitors (NRTIs)		
No PA Required 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 VIREAD (TDF) oral powder, tablet ZIAGEN (abacavir) solution, tablet Zidovudine capsule, syrup, tablet		All products are preferred and do not require prior authorization.
Protease Inhibitors (PIs)		
No PA Required APTIVUS (tipranavir) capsule		All products are preferred and do not require prior authorization.

Atazanavir capsule Darunavir tablet Fosamprenavir tablet LEXIVA (fosamprenavir) suspension, tablet NORVIR (ritonavir) powder packet, tablet PREZISTA (darunavir) suspension, tablet REYATAZ (atazanavir) capsule, powder pack Ritonavir tablet VIRACEPT (nelfinavir) tablet		
Other Agents		
No PA Required ISENTRESS (raltegravir) chewable, powder pack, tablet ISENTRESS HD (raltegravir) tablet Maraviroc tablet RUKOBIA (fostemsavir tromethamine ER) tablet SELZENTRY (maraviroc) solution, tablet SUNLENCA (lenacapavir) tablet TIVICAY (dolutegravir) tablet TIVICAY PD (dolutegravir) tablet for suspension TYBOST (cobicistat) tablet VOCABRIA (cabotegravir) tablet		All products are preferred and do not require prior authorization.
Combination Agents		
No PA Required		All products are preferred and do not require prior authorization.

Abacavir/Lamivudine tablet ATRIPLA (efavirenz/Emtricitabine/TDF) tablet BIKTARVY (bictegravir/emtricitabine/TAF) tablet CIMDUO (lamivudine/TDF) tablet COMBIVIR (lamivudine/zidovudine) tablet COMPLERA (emtricitabine/rilpivirine/TDF) tablet DELSTRIGO (doravirine/lamivudine/TDF) tablet DESCOVY (emtricitabine/TAF) tablet DOVATO (dolutegravir/lamivudine) tablet Efavirenz/Emtricitabine/TDF tablet Efavirenz/Lamivudine/TDF tablet Emtricitabine/TDF tablet EPZICOM (abacavir/lamivudine) tablet EVOTAZ (atazanavir/cobicistat) tablet GENVOYA (elvitegravir/cobicistat/ emtricitabine/TAF) tablet JULUCA (dolutegravir/rilpivirine) tablet KALETRA (lopinavir/ritonavir) solution, tablet Lamivudine/Zidovudine tablet Lopinavir/Ritonavir solution, tablet ODEFSEY (emtricitabine/rilpivirine/TAF) tablet		

PREZCOBIX (darunavir/cobicistat) tablet STRIBILD (elvitegravir/cobicistat/ emtricitabine/TDF) tablet SYMFI/SYMFI LO (efavirenz/lamivudine/TDF) tablet SYMTUZA (darunavir/cobicistat/ emtricitabine/TAF) tablet TRIUMEQ (abacavir/dolutegravir/ lamivudine) tablet TRIUMEQ PD (abacavir/dolutegravir) tablet for suspension TRIZIVIR (abacavir/lamivudine/zidovudine) tablet *TRUVADA (emtricitabine/TDF) tablet		

Therapeutic Drug Class: **TETRACYCLINES** – *Effective 7/1/2025*

No PA Required	**PA Required**	
Doxycycline hyclate capsules Doxycycline hyclate tablets Doxycycline monohydrate 50mg, 100mg capsule Doxycycline monohydrate tablets Minocycline capsules	Demeclocycline tablet DORYX (doxycycline DR) tablet Doxycycline hyclate DR tablet Doxycycline monohydrate 75mg, 150mg capsule Doxycycline monohydrate suspension Minocycline IR, ER tablet MINOLIRA (minocycline ER) tablet MORGIDOX (doxycycline/skin cleanser) kit NUZYRA (omadacycline) tablet SOLODYN ER (minocycline ER) tablet Tetracycline capsule	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, contraindication, or significant drug-drug interaction. Prior authorization for liquid oral tetracycline formulations may be approved if member is unable to take a solid oral dosage form. **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: • Member has trialed and failed† therapy with a preferred doxycycline product and preferred minocycline OR clinical rationale is provided describing why these medications cannot be trialed (including resistance and sensitivity) AND • Member has diagnosis of either Community Acquired Bacterial Pneumonia (CABP) or Acute Bacterial Skin and Skin Structure Infection (ABSSSI) or clinical rationale and supporting literature describing/supporting intended use AND one of the following: o If member diagnosis is ABSSSI, member must have trial and failure† of sulfamethoxazole/trimethoprim product in addition to preferred tetracyclines OR

	XIMINO (minocycline ER) capsule	○ If member diagnosis is CABP, member must have trial and failure† of either a beta-lactam antibiotic (amoxicillin/clavulanic acid) or a macrolide (azithromycin) AND • Maximum duration of use is 14 days †Failure is defined as lack of efficacy with 7-day trial, allergy, intolerable side effects, contraindication, or significant drug-drug interaction.

III. Cardiovascular

Therapeutic Drug Class: **ALPHA-BLOCKERS** – *Effective 7/1/2025*

No PA Required	**PA Required**	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).
Prazosin capsule	MINIPRESS (prazosin) capsule	

Therapeutic Drug Class: **BETA-BLOCKERS** – *Effective 7/1/2025*

Beta-Blockers, Single Agent

No PA Required (*Must meet eligibility criteria)	**PA Required**	***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 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). **INNOPRAN XL** (propranolol ER) capsule brand product formulation may be approved if meeting the following: • 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. **KAPSPARGO SPRINKLE (metoprolol succinate)** extended-release capsule may be approved for members ≥ 6 years of age who are unable to take a solid oral dosage form. Maximum dose: 200mg/day (adult); 50mg/day (pediatric) Members currently stabilized on timolol oral tablet non-preferred products may receive approval to continue on that product. Members currently stabilized on the non-preferred Bystolic (nebivolol) tablets may receive approval to continue on that product.
Acebutolol capsule	Betaxolol tablet	
Atenolol tablet	BYSTOLIC (nebivolol) tablet	
Bisoprolol tablet	COREG (carvedilol) tablet	
Carvedilol IR tablet	COREG CR (carvedilol ER) capsule	
*HEMANGEOL (propranolol) solution	Carvedilol ER capsule	
Labetalol tablet	INDERAL LA/XL (propranolol ER) capsule	
Metoprolol tartrate tablet	INNOPRAN XL (propranolol ER) capsule	
Metoprolol succinate ER tablet	KASPARGO (metoprolol succinate) sprinkle capsule	
Nadolol tablet	LOPRESSOR (metoprolol tartrate) tablet	
Nebivolol tablet	Pindolol tablet	
Propranolol IR tablet, solution	TENORMIN (atenolol) tablet	
Propranolol ER capsule	Timolol tablet	
	TOPROL XL (metoprolol succinate) tablet	

Members currently stabilized on the non-preferred carvedilol ER capsules may receive approval to continue on that product.

Table 1: Receptor Selectivity and Other Properties of Preferred Beta Blockers

	$ß_1$	$ß_2$	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		

Beta-Blockers, Anti-Arrhythmics

No PA Required	PA Required	
Sotalol tablet	BETAPACE/AF (sotalol) tablet SOTYLIZE (sotalol) solution	**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.) Maximum dose: 320 mg/day

Beta-Blockers, Combinations

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

Metoprolol/HCTZ tablet		
Therapeutic Drug Class: **CALCIUM CHANNEL-BLOCKERS** – *Effective 7/1/2025*		
Dihydropyridines (DHPs)		
No PA Required Amlodipine tablet Felodipine ER tablet Nifedipine ER tablet Nifedipine IR capsule	**PA Required** 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 PROCARDIA XL (nifedipine ER) tablet SULAR (nisoldipine ER) tablet	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. **Nimodipine oral capsule** may be approved for adult members (≥ 18 years of age) with subarachnoid hemorrhage **NYMALIZE (nimodipine)** oral syringe may be approved for adult members (≥ 18 years of age) with subarachnoid hemorrhage who also have a feeding tube or have difficulty swallowing solid dosage forms. Maximum dose: 360 mg/day for 21 days (6 syringes/day or 126 syringes/21 days) **KATERZIA (amlodipine)** suspension may be approved if meeting the following: • 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
Non-Dihydropyridines (Non-DHPs)		
No PA Required Diltiazem IR tablet Diltiazem CD/ER capsule Verapamil IR, ER tablet Verapamil ER 120 mg, 180 mg, 240 mg capsule	**PA Required** 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	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.

	VERELAN/PM (verapamil ER) pellet capsule	
Therapeutic Drug Class: **ANGIOTENSIN MODIFIERS** – *Effective 7/1/2025*		
Angiotensin-converting enzyme inhibitors (ACE Inh)		
No PA Required Benazepril tablet Enalapril tablet Fosinopril tablet Lisinopril tablet Quinapril tablet Ramipril tablet	**PA Required** 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 Trandolapril tablet VASOTEC (enalapril) tablet ZESTRIL (lisinopril) tablet	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.
ACE Inhibitor Combinations		
No PA Required Amlodipine/Benazepril capsule Benazepril/HCTZ tablet Enalapril/HCTZ tablet Lisinopril/HCTZ tablet	**PA Required** ACCURETIC (quinapril/HCTZ) tablet Captopril/HCTZ tablet Fosinopril/HCTZ tablet LOTENSIN HCT (benazepril/HCTZ) tablet	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).

Quinapril/HCTZ tablet	LOTREL (amlodipine/benazepril) capsule VASERETIC (enalapril/HCTZ) tablet ZESTORETIC (lisinopril/HCTZ) tablet	
Angiotensin II receptor blockers (ARBs)		
No PA Required Irbesartan tablet Losartan tablet Olmesartan tablet Telmisartan tablet Valsartan tablet	**PA Required** ATACAND (candesartan) tablet AVAPRO (irbesartan) tablet BENICAR (olmesartan) tablet Candesartan tablet COZAAR (losartan) tablet DIOVAN (valsartan) tablet EDARBI (azilsartan) tablet Eprosartan tablet MICARDIS (telmisartan) tablet Valsartan solution	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).
ARB Combinations		
Preferred **No PA Required** **(Unless indicated*)** *ENTRESTO (sacubitril/valsartan) tablet[BNR] Irbesartan/HCTZ tablet Losartan/HCTZ tablet Olmesartan/Amlodipine tablet Olmesartan/HCTZ tablet Telmisartan/HCTZ tablet	**Non-Preferred** **PA Required** ATACAND HCT (candesartan/HCTZ) tablet AVALIDE (irbesartan/HCTZ) tablet AZOR (olmesartan/amlodipine) tablet BENICAR HCT (olmesartan/HCTZ) tablet Candesartan/HCTZ tablet DIOVAN HCT (valsartan/HCTZ) tablet EDARBYCLOR (azilsartan/chlorthalidone) tablet	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). ***ENTRESTO** (sacubitril/valsartan) may be approved for members if the following criteria are met: • 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 ≥ 18 years of age and has a diagnosis of chronic heart failure.

Valsartan/Amlodipine tablet Valsartan/HCTZ tablet	ENTRESTO (sacubitril/valsartan) sprinkles EXFORGE (valsartan/amlodipine) tablet EXFORGE HCT (valsartan/amlodipine/HCTZ) tablet HYZAAR (losartan/HCTZ) tablet MICARDIS HCT (telmisartan/HCTZ) tablet Olmesartan/amlodipine/HCTZ tablet Sacubitril/valsartan tablet Telmisartan/amlodipine tablet TRIBENZOR (olmesartan/amlodipine/HCTZ) tablet Valsartan/Amlodipine/HCTZ tablet	• Diagnosis will be verified through automated verification (AutoPA) of the appropriate corresponding ICD-10 diagnosis codes related to the indicated use of the medication.
Renin Inhibitors & Renin Inhibitor Combinations		
	PA Required Aliskiren tablet TEKTURNA (aliskiren) tablet TEKTURNA HCT (aliskiren/HCTZ) tablet	Non-preferred renin inhibitors and renin inhibitor combination products may be approved for members who have failed treatment with three preferred products from the angiotensin modifier class (failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction). Renin inhibitors and combinations will not be approved in patients with diabetes. Renin inhibitors are contraindicated when used in combination with an ACE inhibitor, ACE inhibitor combination, ARB, or ARB combination.
Therapeutic Drug Class: **PULMONARY ARTERIAL HYPERTENSION THERAPIES** – *Effective 7/1/2025*		
Phosphodiesterase Inhibitors		
Preferred ***Must meet eligibility criteria**	**Non-Preferred** **PA Required**	***Eligibility criteria for preferred products:**
*Sildenafil tablet, oral suspension	ADCIRCA (tadalafil) tablet	Preferred sildenafil and tadalafil tablet formulations may be approved for a diagnosis of pulmonary hypertension or right-sided heart failure.
*Tadalafil 20mg tablet	ALYQ (tadalafil) tablet	**Sildenafil suspension** may be approved for a diagnosis of pulmonary hypertension for members < 5

	LIQREV (sildenafil) suspension REVATIO (sildenafil) suspension, tablet TADLIQ suspension	years of age who cannot take a solid oral dosage form. Non-preferred oral tablet products may be approved if meeting the following: • Member has a diagnosis of pulmonary hypertension **AND** • Member has trialed and failed treatment with preferred sildenafil tablet **AND** preferred tadalafil tablet. Failure is defined as lack of efficacy with 4-week trial, allergy, intolerable side effects, or significant drug-drug interaction. Members who have been previously stabilized on a non-preferred product may receive approval to continue on the medication. Non-preferred oral liquid products may be approved if meeting the following: • Member has a diagnosis of pulmonary hypertension AND • Request meets one of the following: o 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, contraindication, or significant drug-drug interaction) OR o Prescriber verifies that the member is unable to take a solid oral dosage form and that there is clinical necessity for use of a regimen with a less frequent dosing interval.
Endothelin Receptor Antagonists		
Preferred ***Must meet eligibility criteria** *Ambrisentan tablet *Bosentan 62.5mg, 125mg tablet	**Non-Preferred** **PA Required** ***Must meet eligibility criteria** LETAIRIS (ambrisentan) tablet OPSUMIT (macitentan) tablet OPSYNVI (macitentan/tadalafil) tablet TRACLEER (bosentan) 32mg tablet for suspension TRACLEER (bosentan) 62.5mg, 125mg tablet	***Eligibility Criteria for all agents in the class** Approval may be granted for a diagnosis of pulmonary hypertension. Member and prescriber should be enrolled in applicable REMS program for prescribed medication. Non-preferred agents may be approved for members who have trialed and failed two preferred agents. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction. **TRACLEER (bosentan)** tablet for suspension may be approved if meeting one of the following: • The member cannot swallow a solid oral dosage form OR • The request meets eligibility criteria and non-preferred criteria listed above. Members who have been previously stabilized on a non-preferred product may receive approval to continue the medication.
Prostacyclin Analogues and Receptor Agonists		
Preferred **(*Must meet eligibility criteria)**	**Non-Preferred** **PA Required**	***Eligibility Criteria for all agents in the class**

*FLOLAN (epoprostenol) vial *ORENITRAM (treprostinil ER) tablet, titration kit *REMODULIN (treprostinil) vial *VENTAVIS (iloprost) inhalation solution	Epoprostenol vial Treprostinil vial TYVASO (treprostinil) inhaler, inhalation solution UPTRAVI (selexipag) tablet, dose pack, vial VELETRI (epoprostenol) vial	Approval will be granted for a diagnosis of pulmonary hypertension. 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). Members who have been previously stabilized on a non-preferred product may receive approval to continue on the medication.
Guanylate Cyclase (sGC) Stimulator		
	Non-Preferred **PA Required** ADEMPAS (riociguat) tablet	**ADEMPAS (riociguat)** may be approved for members who meet the following criteria: • For members of childbearing potential: o Member is not pregnant and is able to receive monthly pregnancy tests while taking ADEMPAS and one month after stopping therapy **AND** o 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) **AND** • Member has a CrCl ≥ 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** • 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 7/1/2025*		
Bile Acid Sequestrants		
No PA Required Colesevelam tablet Colestipol tablet Cholestyramine packet, light packet, powder	**PA Required** Colesevelam packet COLESTID (colestipol) tablet, granules Colestipol granules QUESTRAN (cholestyramine/sugar) packet, powder QUESTRAN LIGHT (cholestyramine/ aspartame) packet, powder	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). 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).

	WELCHOL (colesevelam) packet, tablet	
Fibrates		
No PA Required Fenofibric acid DR (generic Trilipix) capsule Fenofibrate capsule, tablet (generic Lofibra/Tricor) Gemfibrozil tablet	**PA Required** 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	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). 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).
Other Lipotropics		
No PA Required **(*Must meet eligibility criteria)** Ezetimibe tablet Niacin ER tablet *Omega-3 ethyl esters capsule (generic Lovaza)	**PA Required** Icosapent ethyl capsule LOVAZA (omega-3 ethyl esters) capsule NEXLETOL (bempedoic acid) tablet NEXLIZET (bempedoic acid/ezetimibe) tablet ZETIA (ezetimibe) tablet	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 and 2 additional agents. (Failure is defined as: lack of efficacy with 4-week trial, contraindication, allergy, intolerable side effects or significant drug-drug interactions). ***Omega-3 ethyl esters** (generic Lovaza) may be approved for members who have a baseline triglyceride level ≥ 500 mg/dL **Lovaza** (brand name) may be approved if meeting the following: • 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) **Nexletol** (bempedoic acid) or **Nexlizet** (bempedoic acid/ezetimibe) may be approved if meeting the following criteria: • Member is ≥ 18 years of age **AND** • Member is not pregnant **AND**

<table>
<tr>
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<td>

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

<table>
<tr><td>Conditions Which Define Clinical Atherosclerotic Cardiovascular Disease</td></tr>
<tr><td>• 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</td></tr>
</table>

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

<u>Initial Approval</u>: 1 year

<u>Reauthorization</u>: Reauthorization may be approved for 1 year with provider attestation of medication safety and efficacy during the initial treatment period
</td>
</tr>
<tr>
<td colspan="3">Therapeutic Drug Class: STATINS – Effective 7/1/2025</td>
</tr>
<tr>
<td>No PA Required

Atorvastatin tablet

Lovastatin tablet

Pravastatin tablet

Rosuvastatin tablet

Simvastatin tablet</td>
<td>PA Required

ALTOPREV (lovastatin ER) tablet

ATORVALIQ (atorvastatin) suspension

CRESTOR (rosuvastatin) tablet

EZALLOR (rosuvastatin) sprinkle capsule

FLOLIPID (simvastatin) suspension
Fluvastatin capsule, ER tablet

LESCOL XL (fluvastatin ER) tablet

LIPITOR (atorvastatin) tablet</td>
<td>Non-preferred products 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). For members who are unable to take a solid oral dosage form, non-preferred liquid product formulations may be approved without requiring trial and failure of preferred products.

Age Limitations: Altoprev (lovastatin ER) will not be approved for members < 10 years of age. Fluvastatin will not be approved for members < 10 years of age. Livalo (pitavastatin) will not be approved for members < 8 years of age.</td>
</tr>
</table>

	LIVALO (pitavastatin) tablet Pitavastatin tablet ZOCOR (simvastatin) tablet ZYPITAMAG (pitavastatin) tablet	
Therapeutic Drug Class: **STATIN COMBINATIONS** – *Effective 7/1/2025*		
No PA Required Simvastatin/Ezetimibe tablet	**PA Required** Atorvastatin/Amlodipine tablet CADUET (atorvastatin/amlodipine) tablet VYTORIN (simvastatin/ezetimibe) tablet	Non-preferred Statin combinations may be approved following trial and failure of treatment with two preferred products (failure is defined as lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions). Age Limitations: Vytorin 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.
Therapeutic Drug Class: **Movement Disorders** – *Effective 7/1/2025*		
No PA Required **(*Must meet eligibility criteria)** *Austedo (deutetrabenazine) tablet *Austedo (deutetrabenazine) XR tablet, titration pack *Ingrezza (valbenazine) capsule, initiation pack * Tetrabenazine tablet	**PA Required** Xenazine (tetrabenazine) tablet	***Eligibility Criteria for all agents in the class** • 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 • For chorea associated with Huntington's disease: o 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 • For tardive dyskinesia: o If applicable, the need for ongoing treatment with 1st and 2nd generation antipsychotics, metoclopramide, or prochlorperazine has been evaluated AND o A baseline Abnormal Involuntary Movement Scale (AIMS) has been performed. Xenazine (tetrabenazine) Maximum dose 50 mg/day (PA available for extensive metabolizers of CYP2D6) Ingrezza (valbenazine)

		Quantity limits: • 40 mg: 1.767 capsules/day • 60 mg: 1 capsule/day • 80 mg: 1 capsule/day Austedo (deutetrabenazine) Maximum dose: 48 mg/day 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, contraindication, allergy, intolerable side effects or significant drug-drug interaction.

IV. Central Nervous System

Therapeutic Drug Class: **ANTICONVULSANTS -Oral** – *Effective 4/1/2025*

No PA Required	**PA Required** ***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.***	Members currently stabilized (in outpatient or acute care settings) on any non-preferred medication in this class may receive prior authorization approval to continue on that medication. Non-preferred brand name medications do not require a prior authorization when the equivalent generic is preferred and "dispense as written" is indicated on the prescription. <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: ● 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: **APTIOM (eslicarbazepine)** ● Member has history of trial and failure‡ of any carbamazepine-containing product **BRIVIACT (brivaracetam)** ● Member has history of trial and failure‡ of any levetiracetam-containing product **DIACOMIT (stiripentol)** ● Member is concomitantly taking clobazam **AND**
Barbiturates		
Phenobarbital elixir, solution, tablet Primidone tablet	MYSOLINE (primidone) tablet	
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
Benzodiazepines	
Clobazam oral syringe, tablet, suspension Clonazepam tablet, ODT	KLONOPIN (clonazepam) tablet ONFI (clobazam) suspension, tablet SYMPAZAN (clobazam) SL film
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 Oxcarbazepine ER (generic Oxtellar XR) tablet OXTELLAR XR (oxcarbazepine) tablet TRILEPTAL (oxcarbazepine) tablet

- Member has diagnosis of seizures associated with Dravet syndrome

ELEPSIA XR (levetiracetam ER) tablet
- Member has history of trial and failure‡ of levetiracetam ER (KEPPRA XR)

EPIDIOLEX (cannabidiol)
- 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).

FINTEPLA (fenfluramine)
- Member has a diagnosis of seizures associated with Dravet syndrome or Lennox-Gastaut syndrome

OXTELLAR XR (oxcarbazepine ER)
- Member is being treated for partial-onset seizures **AND**
- Member has history of trial and failure‡ of any carbamazepine or oxcarbazepine-containing product

SPRITAM (levetiracetam) tablet for suspension
- Member has history of trial and failure‡ of levetiracetam solution

SYMPAZAN (clobazam) film
- Member has history of trial and failure‡ of clobazam tablet or solution **OR**
- Provider attests that member cannot take clobazam tablet or solution

<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:
- 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.

‡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.

Table 1: Non-preferred Product Minimum Age and Maximum Dose

Lamotrigines	
Lamotrigine IR tablet, ER tablet, chewable/dispersible tablet, ODT	LAMICTAL (lamotrigine) chewable/dispersible dose pack, tablet LAMICTAL (lamotrigine) ODT, ODT dose pack 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 Levetiracetam 250mg tablets for suspension SPRITAM (levetiracetam) tablet
Other	
*Felbamate suspension FELBATOL (felbamate) suspension	BANZEL (rufinamide) suspension, tablet DIACOMIT (stiripentol) capsule, powder packet

	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)	3 years	1,500 mg/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
perampanel (FYCOMPA)	4 years	12 mg per day

FELBATOL (felbamate) [BNR] tablet Lacosamide solution, tablet Rufinamide tablet Zonisamide capsule	EPIDIOLEX (cannabidiol) solution Felbamate tablet FINTEPLA (fenfluramine) solution FYCOMPA (perampanel) suspension, tablet GABITRIL (tiagabine) tablet Lacosamide UD solution MOTPOLY XR (lacosamide) capsule Rufinamide suspension SABRIL (vigabatrin) powder packet, tablet Tiagabine tablet Vigabatrin tablet, powder packet VIGAFYDE (vigabatrin) solution VIMPAT (lacosamide) solution, kit, tablet XCOPRI (cenobamate) tablet, pack ZONISADE (zonisamide) suspension ZTALMY (ganaxolone) suspension	

rufinamide (BANZEL) tablet and suspension	1 year	3,200 mg per day
stiripentol (DIACOMIT)	6 months (weighing ≥ 7 kg)	3,000 mg per day
tiagabine	12 years	56 mg per day
tiagabine (GABITRIL)	12 years	56 mg per day
vigabatrin	1 month	3,000 mg per day
vigabatrin (SABRIL)	1 month	3,000 mg per day
vigabatrin (VIGADRONE) powder packet	1 month	3,000 mg per day
zonisamide (ZONEGRAN)	16 years	600 mg per day
**Limits based on data from FDA package insert. Approval for age/dosing that falls outside of the indicated range may be evaluated on a case-by-case basis.		

Therapeutic Drug Class: **NEWER GENERATION ANTI-DEPRESSANTS** – *Effective 4/1/2025*

No PA Required	**PA Required**	
Bupropion IR, SR, XL tablet Citalopram solution, tablet Desvenlafaxine succinate ER (generic Pristiq) tablet Duloxetine (generic Cymbalta) capsule Escitalopram tablet	***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.*** APLENZIN (bupropion ER) tablet AUVELITY ER (dextromethorphan/bupropion) tablet	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). **Zurzuvae** (zuranolone) may be approved if meeting the following criteria: • Member is ≥ 18 years of age **AND**

Fluoxetine capsule, solution, 60 mg tablet Fluvoxamine tablet Mirtazapine tablet, ODT Paroxetine IR tablet Sertraline solution, tablet Trazodone tablet Venlafaxine IR tablet Venlafaxine ER capsules Vilazodone tablet	Bupropion XL (generic Forfivo XL) tablet CELEXA (citalopram) tablet Citalopram hydrobromide capsule CYMBALTA (duloxetine) capsule Desvenlafaxine fumarate ER tablet DRIZALMA (duloxetine) sprinkle capsule EFFEXOR XR (venlafaxine ER) capsule Escitalopram solution FETZIMA (levomilnacipran ER) capsule, titration pack Fluoxetine IR tablet, DR capsule Fluvoxamine ER capsule FORFIVO XL (bupropion ER) tablet LEXAPRO (escitalopram) tablet Nefazodone tablet Paroxetine CR/ER tablet, suspension Paroxetine mesylate capsule PAXIL (paroxetine) tablet, suspension PAXIL CR (paroxetine ER) tablet PEXEVA (paroxetine mesylate) tablet PRISTIQ (desvenlafaxine succinate ER) tablet PROZAC (fluoxetine) Pulvule RALDESY (trazodone) solution REMERON (mirtazapine) Soltab (ODT), tablet Sertraline capsule TRINTELLIX (vortioxetine) tablet Venlafaxine ER tablet Venlafaxine besylate ER tablet VIIBRYD (vilazodone) tablet, dose pack WELLBUTRIN SR, XL (bupropion) tablet ZOLOFT (sertraline) tablet, oral concentrate	• 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: o The importance of effective contraception during zuranolone treatment, as zuranolone may cause fetal harm **AND** o Zuranolone is present in low levels in human breast milk and there are limited data on its effects on a breastfed infant **AND** o 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 **AND** • 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** • 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. Quantity Limit: • Zurzuvae 20 mg and 25 mg: 28 capsules/14 days • Zurzuvae 30 mg: 14 capsules/14 days Maximum dose: 50 mg once daily Duration of Approval: Approval will allow 30 days to fill for one 14-day course of treatment per postpartum period **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.

	ZURZUVAE (zuranolone) capsule	Members currently stabilized on a non-preferred newer generation antidepressant may receive approval to continue on that agent for one year if medically necessary. **Verification may be provided from the prescriber or the pharmacy.**
Therapeutic Drug Class: **MONOAMINE OXIDASE INHIBITORS (MAOIs)** – *Effective 4/1/2025*		
	PA Required EMSAM (selegiline) patch MARPLAN (isocarboxazid) tablet NARDIL (phenelzine) tablet Phenelzine tablet Tranylcypromine tablet	Non-preferred products may be approved for members who have failed adequate trial (8 weeks) with two preferred anti-depressant products. If two 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) 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.**
Therapeutic Drug Class: **TRICYCLIC ANTI-DEPRESSANTS (TCAs)** – *Effective 4/1/2025*		
No PA Required Amitriptyline tablet Clomipramine capsule Desipramine tablet Doxepin 10mg, 25mg, 50mg, 75mg, 100mg, 150mg capsule, oral concentrate Imipramine HCl tablet Nortriptyline capsule	**PA Required** ***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.*** Amoxapine tablet ANAFRANIL (clomipramine) capsule Imipramine pamoate capsule NORPRAMIN (desipramine) tablet Nortriptyline solution PAMELOR (nortriptyline) capsule Protriptyline tablet Trimipramine capsule	Non-preferred products may be approved for members who have failed adequate trial (8 weeks) with three preferred tricyclic products. If three preferred products are not available for indication being treated, approval of prior authorization for non-preferred products will require adequate trial of all tricyclic preferred products FDA approved for that indication. (Failure is defined as: lack of efficacy after 8-week trial, allergy, intolerable side effects, or significant drug-drug interaction) Members currently stabilized on a non-preferred tricyclic antidepressant may receive approval to continue on that agent for one year if medically necessary. **Verification may be provided from the prescriber or the pharmacy.**
Therapeutic Drug Class: **ANTI-PARKINSON'S AGENTS** – *Effective 4/1/2025*		
Dopa decarboxylase inhibitors, dopamine precursors and combinations		
No PA Required Carbidopa/Levodopa IR, ER tablet	**PA Required** Carbidopa tablet	Non-preferred agents may be approved with adequate trial and failure of carbidopa-levodopa IR and ER formulations (failure is defined as lack of efficacy with a 4-week trial, allergy, intolerable side effects or significant drug-drug interactions).

Carbidopa/Levodopa/Entacapone tablet	Carbidopa/Levodopa ODT CREXONT ER (carbidopa/levodopa) capsule DHIVY (carbidopa/levodopa) tablet DUOPA (carbidopa/levodopa) suspension INBRIJA (levodopa) capsule for inhalation LODOSYN (carbidopa) tablet RYTARY ER (carbidopa/levodopa) capsule SINEMET (carbidopa/levodopa) IR tablet STALEVO (carbidopa/levodopa/ entacapone) tablet	Carbidopa or levodopa single agent products may be approved for members with diagnosis of Parkinson's Disease as add-on therapy to carbidopa-levodopa. Non-preferred medications that <u>are not</u> prescribed for Parkinson's Disease (or an indication related to Parkinson's Disease) may receive approval for other FDA-labeled indications without meeting trial and failure step therapy criteria. 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. Members currently stabilized on a non-preferred product may receive approval to continue therapy with that product.
MAO-B inhibitors		
No PA Required Rasagiline tablet Selegiline capsule, tablet	**PA Required** AZILECT (rasagiline) tablet XADAGO (safinamide) tablet ZELAPAR (selegiline) ODT	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). 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. 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. Members currently stabilized on a non-preferred product may receive approval to continue therapy with that product.
Dopamine Agonists		
No PA Required Pramipexole IR tablet Ropinirole IR tablet	**PA Required** APOKYN (apomorphine) SC cartridge Apomorphine SC cartridge Bromocriptine capsule, tablet KYNMOBI (apomorphine) SL film	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). **APOKYN (apomorphine subcutaneous cartridge)** may be approved if meeting the following: • APOKYN (apomorphine) is being used as an adjunct to other medications for acute, intermittent treatment of hypomobility, "off" episodes ("end-of-dose

	MIRAPEX (pramipexole) ER tablet NEUPRO (rotigotine) patch PARLODEL (bromocriptine) capsule, tablet Pramipexole ER tablet Ropinirole ER tablet	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. Maximum dose: 6mg (0.6mL) three times per day **KYNMOBI (apomorphine sublingual film)** may be approved if meeting the following: • 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. Maximum dose: 30mg five times per day 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. 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. Members currently stabilized on a non-preferred product may receive approval to continue therapy with that product.
Other Parkinson's agents		
No PA Required Amantadine capsule, solution/syrup Benztropine tablet Trihexyphenidyl tablet, elixir	**PA Required** Amantadine tablet COMTAN (entacapone) tablet Entacapone tablet GOCOVRI ER (amantadine ER) capsule NOURIANZ (istradefylline) tablet ONGENTYS (opicapone) capsule OSMOLEX ER (amantadine) tablet TASMAR (tolcapone) tablet	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). 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. 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. Members currently stabilized on a non-preferred product may receive approval to continue therapy with that product.

	Tolcapone tablet	

Therapeutic Drug Class: **BENZODIAZEPINES (NON-SEDATIVE HYPNOTIC)** – *Effective 4/1/2025*

No PA Required (*may be subject to age limitations)	**PA Required**	
Alprazolam IR, ER tablet*	Alprazolam ODT, oral concentrate	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.
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	**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.
Clorazepate tablet*	KLONOPIN (clonazepam) tablet	All benzodiazepine anxiolytics will require prior authorization for members ≥ 65 years of age when exceeding 90 days of therapy.
Diazepam tablet*, solution	LOREEV (lorazepam ER) capsule	Continuation of Therapy: • 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.
Lorazepam tablet*, oral concentrate	XANAX (alprazolam) tablet	Prior authorization will be required for prescribed doses that exceed the maximum (Table 1).
Oxazepam capsule*	XANAX XR (alprazolam ER) tablet	

Table 1 Maximum Doses

Product	Maximum Daily Dose	Maximum Monthly Dose
Alprazolam tablet Alprazolam ER tablet Alprazolam ODT XANAX (alprazolam) tablet XANAX XR (alprazolam ER) tablet Alprazolam Intensol oral concentrate 1 mg/mL	Adults ≥ 18 years: 10 mg/day	Total of 300 mg from all dosage forms per 30 days
Clorazepate tablet	>12 years: 90 mg/day	Total of 2,700 mg (adults) and 1,800 mg

		TRANXENE (clorazepate) T-Tab	Children 9-12 years: up to 60 mg/day	(children) from all tablet strengths per 30 days
		Chlordiazepoxide capsule	Adults ≥ 18 years: 300 mg/day Children 6-17 years: up to 40 mg/day (pre-operative apprehension and anxiety)	Total of 9,000 mg (adults) and 120 mg (children, pre-op therapy) from all tablet strengths per 30 days
		Diazepam Intensol oral concentrate 5 mg/mL Diazepam solution 5 mg/5 mL Diazepam tablet	Adults ≥ 18 years: 40 mg/day Members age 6 months to 17 years: up to 10 mg/day	Total of 1200 mg (adults) and 300 mg (pediatrics) from all dosage forms per 30 days
		ATIVAN (lorazepam) Intensol concentrate 2 mg/mL ATIVAN (lorazepam) tablet Lorazepam oral concentrated soln 2 mg/mL Lorazepam tablet	Adults ≥ 18 years: 10 mg/day Children: N/A	Total of 300 mg from all dosage forms per 30 days
		Oxazepam capsule	Adults ≥ 18 years: 120 mg/day Children 6-18 years: absolute dosage not established	Total of 3600 mg from all dosage forms per 30 days
Therapeutic Drug Class: **ANXIOLYTIC, NON- BENZODIAZEPINES** – *Effective 4/1/2025*				
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 4/1/2025*				
No PA Required (unless indicated by * in criteria; all products subject to dose and age limitations) Aripiprazole tablet Asenapine SL tablet	**PA Required** ***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.*** ABILIFY (aripiprazole) tablet, MyCite	***Vraylar (cariprazine) or Rexulti (brexpiprazole)** 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. Non-preferred products may be approved for members meeting all of the following: • Medication is being prescribed for an FDA-Approved indication AND • Prescription meets dose and age limitations (Table 1) AND		

Clozapine tablet Lurasidone tablet Olanzapine tablet, ODT Paliperidone ER tablet Quetiapine IR tablet** Quetiapine ER tablet REXULTI (brexpiprazole) dose pack, tablet* Risperidone ODT, oral solution, tablet VRAYLAR (cariprazine) capsule* Ziprasidone capsule	Aripiprazole oral solution, ODT CAPLYTA (lumateperone) capsule COBENFY (xanomeline/trospium) capsule, starter pack Clozapine ODT CLOZARIL (clozapine) tablet, ODT FANAPT (iloperidone tablet, titration pack) GEODON (ziprasidone) capsule INVEGA ER (paliperidone) tablet LATUDA (lurasidone) tablet LYBALVI (olanzapine/samidorphan) tablet NUPLAZID (pimavanserin) capsule, tablet Olanzapine/Fluoxetine capsule OPIPZA (aripiprazole) film RISPERDAL (risperidone) tablet, oral solution SAPHRIS (asenapine) SL tablet 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	• Request meets one of the following: o 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 (including rapid weight gain), contraindication, significant drug-drug interactions, or known interacting genetic polymorphism that prevents safe preferred product dosing) **OR** o Prescriber attests that within the last year (365 days) the member has trialed and failed (been unsuccessfully treated with) a preferred antipsychotic medication that was used to treat the member's diagnosis (failure defined as lack of efficacy with 6-week trial, allergy, intolerable side effects (including rapid weight gain), significant drug-drug interactions, or known interacting genetic polymorphism that prevents safe preferred product dosing). Treatment must be under an FDA approved indication for a mental health condition or disorder. 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. **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).** ****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. **Aripiprazole solution**: Aripiprazole tablet 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. **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. **Abilify MyCite** may be approved if meeting all of the following:

		• Member has history of adequate trial and failure of 5 preferred agents (one trial must include aripiprazole tablet). Failure is defined as lack of efficacy with 6-week trial on maximally tolerated dose, allergy, intolerable side effects, significant drug-drug interactions AND • Information is provided regarding adherence measures being recommended by provider and followed by member (such as medication organizer or digital medication reminders) AND • Member has history of adequate trial and failure of 3 long-acting injectable formulations of atypical antipsychotics, one of which must contain aripiprazole (failure is defined as lack of efficacy with 8-week trial, contraindication, allergy, intolerable side effects, significant drug-drug interactions) AND • Abilify MyCite is being used with a MyCite patch and member is using a compatible mobile application. AND • Medication adherence information is being shared with their provider via a web portal or dashboard. <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. Members currently stabilized on a non-preferred atypical antipsychotic may receive approval to continue therapy with that agent for one year.
Therapeutic Drug Class: **ATYPICAL ANTI-PSYCHOTICS – Long Acting Injectables** – *Effective 10/1/2024*		

No PA Required

ABILIFY ASIMTUFII (aripiprazole) syringe, vial

ABILIFY MAINTENA (aripiprazole) syringe, vial

ARISTADA ER (aripiprazole lauroxil) syringe

ARISTADA INITIO (aripiprazole lauroxil) syringe

Chlorpromazine ampule, vial

Fluphenazine vial

Fluphenazine decanoate vial

HALDOL (haloperidol decanoate) ampule

Haloperidol decanoate ampule, vial

Haloperidol lactate syringe, vial

INVEGA HAFYERA (paliperidone palmitate) syringe

INVEGA SUSTENNA (paliperidone palmitate) syringe

INVEGA TRINZA (paliperidone palmitate) syringe

Olanzapine vial

PERSERIS ER (risperidone) syringe, syringe kit

PA Required

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.

GEODON (ziprasidone) vial

Risperidone microspheres ER vial

RYKINDO (risperidone microspheres) vial, vial kit

ZYPREXA (olanzapine) vial

Preferred products do not require prior authorization. All products are subject to meeting FDA-labeled dosing quantity limits listed in Table 1.

Non-preferred products may be approved for members meeting the following:

- Medication is being prescribed for an FDA-Approved indication AND
- Prescription meets dose limitations (Table 1) AND
- Member has history of trial and failure of one preferred product with FDA approval for use for the prescribed indication (failure is 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).

Table 1: FDA-Labeled Dosing Quantity Limits

Long-Acting injectable	Route	Quantity Limit
ABILIFY ASIMTUFII (aripiprazole)	IM	1 pack/2 months (56 days)
ABILIFY MAINTENA (aripiprazole)	IM	1 pack/28 days
ARISTADA ER (aripiprazole)	IM	1,064 mg: 1 pack/2 months (56 days) All other strengths: 1 pack/28 days
ARISTADA INITIO (aripiprazole)	IM	1 pack/7 weeks (49 days)
INVEGA HAFYERA (paliperidone)	IM	1 pack/6 months (168 days)
INVEGA SUSTENNA (paliperidone)	IM	156 mg: 2 packs/5 weeks (35 days) All other strengths: 1 pack/28 days
INVEGA TRINZA (paliperidone)	IM	1 pack/3 months (84 days)
PERSERIS ER (risperidone)	Subcutaneous	1 pack/28 days
RISPERDAL CONSTA (risperidone)	IM	2 packs/28 days
UZEDY (risperidone)	Subcutaneous	150 mg, 200 mg and 250 mg: 1 pack/2 month All other strengths: 1 pack/28 days
ZYPREXA RELPREVV (olanzapine)	IM	405 mg: 1 pack/28 days All other strengths: 1 pack/14 days

RISPERDAL CONSTA[BNR] (risperidone microspheres) syringe, vial UZEDY (risperidone) syringe Ziprasidone ZYPREXA RELPREVV (olanzapine pamoate) Vial kit		*Requests for dosing regimens exceeding maximum may be approved for one year with pres attestation that the member is stabilized on the requested dose and schedule. *Note: Effective January 14, 2022, no place of service prior authorization is required for extended-release injectable medications (LAIs) used for the treatment of mental health or substance use disorders (SUD), when administered by a healthcare professional and billed under the pharmacy benefit. In addition, LAIs may be administered in any setting (pharmacy, clinic, medical office or member home) and billed to the pharmacy or medical benefit as most appropriate and in accordance with all Health First Colorado billing policies.*

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)
CAPLYTA	lumateperone	Schizophrenia Bipolar I Disorder Bipolar II Disorder	≥ 18 years	42 mg	Maximum dosage of 42mg per day
CLOZARIL	clozapine	Treatment-resistant schizophrenia Recurrent suicidal behavior in schizophrenia or schizoaffective disorder	≥ 18 years	900 mg	Maximum dosage of 900mg per day
COBENFY	xanomeline and trospium	Schizophrenia	≥ 18 years	250 mg xanomeline and 60 mg trospium	Maximum two capsules 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 ER	paliperidone	Schizophrenia & schizoaffective disorder	≥ 12 years and weight ≥ 51 kg ≥ 12 years and weight < 51 kg	12 mg 6 mg	Maximum two 6mg tablets per day; all other strengths 1 tablet 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)
LYBALVI	olanzapine and samidorphan	Schizophrenia in adults Bipolar I disorder in adults	≥ 18 years ≥ 18 years	20 mg olanzapine and 10 mg samidorphan	Maximum one tablet 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)
VERSACLOZ	clozapine	Treatment-resistant schizophrenia	≥ 18 years ≥ 18 years	900 mg	Maximum dosage of 900 mg per day

		Recurrent suicidal behavior in schizophrenia or schizoaffective disorder			
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 4/1/2025*

PA Required for all agents

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

*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, significant drug-drug interaction, severe needle phobia, or member (or parent/caregiver) is unable to administer preferred CGRP inhibitor injectable formulation due to limited functional ability (such as vision impairment, limited manual dexterity and/or limited hand strength).

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, severe needle phobia, or member (or parent/caregiver) is unable to administer preferred triptan injectable formulation due to limited functional ability (such as vision impairment, limited manual dexterity and/or limited hand strength).

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 three preferred products indicated for preventive therapy (failure is defined as lack of efficacy with 4-week trial, contraindication to therapy, allergy, intolerable side effects, significant drug-drug interaction, severe needle phobia, or member (or parent/caregiver) is unable to administer preferred triptan injectable formulation due to limited functional ability (such as vision impairment, limited manual dexterity and/or limited hand strength). <u>Non-Preferred Medications for Acute Migraine Treatment (must meet all of the following):</u> • 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 <u>all</u> of the following (failure is defined as lack of efficacy with 4-week trial, allergy, contraindication, intolerable side effects, or significant drug-drug interaction): o Two triptans AND o One NSAID agent AND o One preferred agent indicated for acute migraine treatment <u>Non-Preferred Medications for Treatment of Episodic Cluster Headache (must meet all of the following):</u> • 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): o Oxygen therapy AND o 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 4/1/2025*

No PA Required	**PA Required**	
Lithium carbonate capsule, tablet Lithium citrate solution Lithium ER tablet	***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.*** LITHOBID ER (lithium ER) tablet	Non-preferred products may be approved with trial and failure of one preferred agent (failure is defined as lack of efficacy with 6-week trial, allergy, intolerable side effects, significant drug-drug interactions, intolerance to dosage form). Members currently stabilized on a non-preferred product may receive approval to continue therapy with that product.

Therapeutic Drug Class: **NEUROCOGNITIVE DISORDER AGENTS** – *Effective 4/1/2025*

Preferred ***Must meet eligibility criteria**	**Non-Preferred** **PA Required**	
*Donepezil 5mg, 10mg tablet	ADLARITY (donepezil) patch	***Eligibility criteria for Preferred Agents –** Preferred products may be approved for a diagnosis of neurocognitive disorder (eligible for AutoPA automated approval).

*Donepezil ODT *Galantamine IR tablet *Memantine IR tablet, dose pack *Memantine ER capsule *Rivastigmine capsule, patch	ARICEPT (donepezil) tablet Donepezil 23mg tablet EXELON (rivastigmine) patch Galantamine solution, ER capsule Memantine IR solution MESTINON (pyridostigmine) IR/ER tablet, syrup Nemantine/donepezil ER capsule, NAMZARIC (memantine/donepezil ER) capsule, dose pack Pyridostigmine syrup, IR/ER tablet	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) 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.
Therapeutic Drug Class: **SEDATIVE HYPNOTICS** – *Effective 4/1/2025*		
Non-Benzodiazepines		
Preferred No PA Required* (Unless age, dose, or duplication criteria apply) Eszopiclone tablet Ramelteon tablet Zaleplon capsule Zolpidem IR, ER tablet	**Non-Preferred PA Required** AMBIEN (zolpidem) tablet AMBIEN CR (zolpidem ER) tablet BELSOMRA (suvorexant) tablet DAYVIGO (lemoborexant) tablet Doxepin tablet EDLUAR (zolpidem) SL tablet HETLIOZ (tasimelteon) capsule HETLIOZ LQ (tasimelteon) suspension	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). <u>Children:</u> Prior authorization will be required for all agents for members < 18 years of age. <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). All sedative hypnotics will require prior authorization for members ≥ 65 years of age when exceeding 90 days of therapy. **Belsomra** (suvorexant) may be approved for adult members that meet the following: • 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

	LUNESTA (eszopiclone) tablet QUVIVIQ (daridorexant) tablet ROZEREM (ramelteon) tablet SILENOR (doxepin) tablet Tasimelteon capsule Zolpidem capsule, SL tablet	• 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 **Dayvigo** (lemborexant) may be approved for adult member that meet the following: • 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 **Hetlioz (tasimelteon) capsules** may be approved for members meeting the following criteria: • 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 • The requested medication is being prescribed by a sleep specialist or a practitioner who has sufficient education and experience to safely prescribe tasimelteon **Hetlioz LQ (tasimelteon) oral suspension** may be approved for members meeting the following criteria: • 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. **Silenor** (**doxepin)** may be approved for adult members that meet ONE of the following criteria: • 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 Prior authorization will be required for prescribed doses exceeding maximum (Table 1) below.

Benzodiazepines		
Preferred **No PA Required*** **(Unless age, dose, or duplication criteria apply)** Temazepam 15mg, 30mg capsule Triazolam tablet	**Non-Preferred** **PA Required** DORAL (quazepam) tablet Estazolam tablet Flurazepam capsule HALCION (triazolam) tablet Quazepam tablet RESTORIL (temazepam) capsule Temazepam 7.5mg, 22.5mg capsule	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). 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). Temazepam 7.5 mg may be approved if provider attests to the medical necessity of prescribing individual temazepam doses of less than 15 mg. <u>Children:</u> Prior authorization will be required for all sedative hypnotic agents when prescribed for members < 18 years of age. <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). All sedative hypnotics will require prior authorization for member's ≥ 65 years of age when exceeding 90 days of therapy. Members currently stabilized on a non-preferred benzodiazepine medication may receive authorization to continue that medication. 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 4/1/2025*

No PA Required (*if under 65 years of age)	**PA Required**	
Baclofen tablet Cyclobenzaprine tablet Methocarbamol tablet Tizanidine tablet	AMRIX ER (cyclobenzaprine ER) capsule Baclofen solution, suspension Carisoprodol tablet Carisoprodol/Aspirin tablet Chlorzoxazone tablet Cyclobenzaprine ER capsule DANTRIUM (dantrolene) capsule *Dantrolene capsule FEXMID (cyclobenzaprine) tablet FLEQSUVY (baclofen) solution LORZONE (chlorzoxazone) tablet LYVISPAH (baclofen) granules Metaxalone tablet NORGESIC/NORGESIC FORTE (orphenadrine/aspirin/ caffeine) tablet Orphenadrine ER tablet Orphenadrine/Aspirin/Caffeine tablet	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. 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. ***Dantrolene** may be approved for members who have trialed and failed‡ one preferred agent and meet the following criteria: ● 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 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.

	SOMA (carisoprodol) tablet Tizanidine capsule ZANAFLEX (tizanidine) capsule, tablet	
Therapeutic Drug Class: **STIMULANTS AND RELATED AGENTS** – *Effective 4/1/2025*		
Preferred ***No PA Required (if age, max daily dose, and diagnosis met)** *Brand/generic changes effective 08/08/2024* Amphetamine salts, mixed ER (generic Adderall XR) capsule Amphetamine salts, mixed (generic Adderall IR) tablet Armodafinil tablet Atomoxetine capsule Clonidine ER tablet DAYTRANA[BNR] (methylphenidate) patch Dexmethylphenidate IR tablet Dexmethylphenidate ER capsule Guanfacine ER tablet Methylphenidate (generic Methylin/Ritalin) solution, tablet Methylphenidate ER tablet (generic Concerta) Modafinil tablet	**Non-Preferred** **PA Required** ADDERALL IR (amphetamine salts, mixed IR) tablet ADDERALL XR (amphetamine salts, mixed ER) capsule ADZENYS XR-ODT (amphetamine) Amphetamine tablet (generic Evekeo) APTENSIO XR (methylphenidate ER) capsule AZSTARYS (serdexmethylphenidate/ dexmethylphenidate) capsule CONCERTA (methylphenidate ER) tablet COTEMPLA XR-ODT (methylphenidate ER) DESOXYN (methamphetamine) tablet DEXEDRINE (dextroamphetamine) Spansule Dextroamphetamine ER capsule, solution, tablet DYANAVEL XR (amphetamine) suspension, tablet EVEKEO (amphetamine) ODT, tablet FOCALIN (dexmethylphenidate) tablet, XR capsule INTUNIV (guanfacine ER) tablet	*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). Non-preferred medications may be approved for members meeting the following criteria (for Sunosi (solriamfetol) and Wakix (pitolisant), refer to specific criteria listed below): • Prescription meets indication/age limitation criteria (Table 1) **AND** • <u>If member is ≥ 6 years of age:</u> o Has documented trial and failure‡ with three preferred products in the last 24 months **AND** o 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. **OR** • <u>If member is 3–5 years of age</u>: o Has documented trial and failure‡ with one preferred product in the last 24 months **AND** o **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. **SUNOSI** (solriamfetol) prior authorization may be approved if member meets the following criteria: ● Member is 18 years of age or older AND ● Member has diagnosis of either narcolepsy or obstructive sleep apnea (OSA) and is experiencing excessive daytime sleepiness AND ● Member does not have end stage renal disease AND ● If Sunosi is being prescribed for OSA, member has 1 month trial of CPAP AND ● Member has trial and failure‡ of modafinil AND armodafinil AND one other agent in stimulant PDL class. **WAKIX** (pitolisant) prior authorization may be approved if member meets the following criteria:

VYVANSE[BNR] (lisdexamfetamine) capsule	JORNAY PM (methylphenidate) capsule Lisdexamfetamine capsule, chewable tablet Methamphetamine tablet METHYLIN (methylphenidate) solution Methylphenidate CD/ER/LA capsule, chewable tablet, ER tablet (generic Relexxi/Ritalin), patch MYDAYIS ER (dextroamphetamine/ amphetamine) capsule NUVIGIL (armodafinil) tablet ONYDA XR (clonidine) suspension PROCENTRA (dextroamphetamine) solution PROVIGIL (modafinil) tablet QELBREE (viloxazine ER) capsule QUILLICHEW ER (methylphenidate) chewable tablet, XR suspension RELEXXII (methylphenidate ER) tablet 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	• Member is 6 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 counseled regarding use of an alternative non-hormonal method of contraception during Wakix therapy and for at least 21 days after discontinuing treatment. Maximum Dose (all products): See Table 2 **Exceeding Maximum Dose:** Prior authorization may be approved for doses that are higher than the listed maximum dose (Table 2) for members meeting the following criteria: • 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). [‡]Failure is defined as: lack of efficacy with 4-week trial, allergy, intolerable side effects, or significant drug-drug interaction.

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 to16 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: • 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) †Prior Authorization for members 4-6 years of age with a diagnosis of ADHD may be approved with prescriber attestation to the following: • 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.
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 ≥ 6 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 ADZENYS ER SUSPENSION	18.8 mg (age 6-12) 12.5 mg (age ≥ 13)
AMPHETAMINE SALTS	40 mg
APTENSIO XR	60 mg

CONCERTA	54 mg (age 6-12) or 72 mg (≥ 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 ≥ 13)
INTUNIV ER	4 mg (age 6-12) or 7 mg (age ≥ 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 ≥ 18)
NUVIGIL	250 mg
PROCENTRA	60 mg
PROVIGIL	400 mg
QELBREE	400 mg (age 6-17) or 600 mg (age ≥ 18)
QUILLICHEW ER	60 mg
QUILLIVANT XR	60 mg
RELEXXII	54 mg (ages 6-12) or 72 mg (≥ 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

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 RELPAX (eletriptan) tablet REYVOW (lasmiditan) tablet Sumatriptan/Naproxen tablet SYMBRAVO (rizatriptan/meloxicam) tablet Zolmitriptan ODT ZOMIG (zolmitriptan) tablet	**Reyvow (lasmiditan)** may be approved if meeting the following: • Member has trialed and failed three preferred products **OR** member is unable to use triptan therapy due to cardiovascular risk factors **AND** • Member has trialed and failed two preferred agents in the CGRP Inhibitors drug class indicated for the acute treatment of migraine. All other 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. **Quantity Limits:** 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

Therapeutic Drug Class: **TRIPTANS, DITANS, AND OTHER MIGRAINE TREATMENTS - Non-Oral** – *Effective 4/1/2025*

No PA Required (Quantity limits may apply)	PA Required	
IMITREX (sumatriptan) nasal spray Sumatriptan cartridge, pen injector MIGRANAL[BNR] (dihydroergotamine) nasal spray Sumatriptan nasal spray*, vial	Dihydroergotamine injection, nasal spray IMITREX (sumatriptan) cartridge, pen injector TOSYMRA (sumatriptan) nasal spray TRUDHESA (dihydroergotamine) nasal spray ZEMBRACE SYMTOUCH (sumatriptan) auto-injector Zolmitriptan nasal spray ZOMIG (zolmitriptan) nasal spray	**Zembrace Symtouch injection**, **Tosymra nasal spray**, or **Onzetra Xsail nasal powder** may be approved for members who have trialed and failed one preferred non-oral triptan products AND two oral triptan agents with different active ingredients. Failure is defined as lack of efficacy with 4-week trial, allergy, intolerable side effects, significant drug-drug interaction, or documented inability to take alternative dosage form. All other non-preferred products may be approved for members who have 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. **Quantity Limits:** 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 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 7/1/2025*

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

	Dapsone gel pump ERY/ERYGEL (erythromycin/ethanol) gel, medicated swabs/pads Erythromycin gel EVOCLIN (clindamycin) foam FABIOR (tazarotene) foam KLARON (sulfacetamide) suspension NEUAC (clindamycin/benzoyl peroxide/emollient) kit ONEXTON (clindamycin/benzoyl peroxide) gel, gel pump RETIN-A MICRO (tretinoin) (all products) ROSULA (sulfacetamide sodium/sulfur) cloths, wash SSS 10-5 (sulfacetamide sodium/sulfur) foam Sulfacetamide sodium cleanser, cleansing gel, lotion, shampoo, wash Sulfacetamide sodium/sulfur cleanser, cream, pad, suspension, wash SUMADAN/XLT (sulfacetamide sodium/sulfur) kit, wash SUMAXIN/ CP/TS (sulfacetamide sodium/sulfur) kit, pads, suspension, wash Tazarotene cream, foam, gel Tretinoin (all products) Tretinoin microspheres (all products) WINLEVI (clascoterone) cream	

	ZIANA (clindamycin/tretinoin) gel	
Therapeutic Drug Class: **ACNE AGENTS– ORAL ISOTRETINOIN** – *Effective 7/1/2025*		
PA Required for all agents		Preferred products may be approved for adults and children ≥ 12 years of age for treating severe acne vulgaris or for treating moderate acne vulgaris in members unresponsive to conventional therapy. Non-preferred products may be approved for members meeting the following: ● 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 AMNESTEEM capsule CLARAVIS capsule Isotretinoin 10 mg, 20 mg, 30 mg, 40 mg capsule (*Mayne-Pharma, Upsher-Smith, Zydus only)* ZENATANE capsule	**Non-Preferred** ABSORICA capsule ABSORICA LD capsule Isotretinoin 10 mg, 20 mg, 30 mg, 40 mg capsule (*All manufacturers except Mayne-Pharma, Upsher-Smith, Zydus)* Isotretinoin 25 mg, 35 mg capsule MYORISAN capsule	
Therapeutic Drug Class: **ANTI-PSORIATICS - Oral** – *Effective 7/1/2025*		
No PA Required Acitretin capsule	**PA Required** Methoxsalen capsule	Prior authorization for non-preferred oral agents may be approved with failure of two preferred anti-psoriatic agents, one of which must be a preferred oral agent. Failure is defined as lack of efficacy of a 4-week trial, allergy, intolerable side effects or significant drug-drug interaction.
Therapeutic Drug Class: **ANTI-PSORIATICS -Topical** – *Effective 7/1/2025*		
No PA Required Calcipotriene cream, foam, ointment, solution Calcipotriene/betamethasone dipropionate ointment TACLONEX SCALP [BNR] (calcipotriene/betamethasone) suspension	**PA Required** Calcipotriene/betamethasone dipropionate suspension Calcitriol ointment DUOBRII (halobetasol/tazarotene) lotion ENSTILAR (calcipotriene/betamethasone) foam SORILUX (calcipotriene) foam VTAMA (tapinarof) cream	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. 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. 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.

TACLONEX (calcipotriene/betamethasone) ointment	ZORYVE 0.3% (roflumilast) cream	**ZORYVE (roflumilast)** 0.3% cream may receive approval if meeting the following based on prescribed indication: Plaque psoriasis (0.3% cream formulation only): • Member is ≥ 6 years of age AND • Member has a diagnosis of plaque psoriasis AND • Member has body surface area (BSA) involvement of ≤20% 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 • If the affected area is limited to the scalp: o 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 o 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: o 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) Members may not apply Zoryve (roflumilast) cream to >20% of affected body surface area, as safety and efficacy have not been established. Quantity limit: 60 grams/30 days Initial approval: 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.

Therapeutic Drug Class: **IMMUNOMODULATORS, TOPICAL** – *Effective 7/15/2025*

Atopic Dermatitis

No PA Required (Unless indicated*)	**PA Required**	
ELIDEL (pimecrolimus) cream[BNR] *EUCRISA (crisaborole) ointment *OPZELURA (ruxolitinib) cream Pimecrolimus cream Tacrolimus ointment	Pimecrolimus cream VTAMA (tapinarof) 1% cream ZORYVE (roflumilast) 0.15% cream, 0.3% foam	**EUCRISA** (crisaborole) may be approved if the following criteria are met: • Member is ≥ 3 months of age AND • Member has a diagnosis of mild to moderate atopic dermatitis AND • Member tried and failed‡ one preferred agent **OR** one medium-to-very high potency topical corticosteroid AND • Eucrisa (crisaborole) is being prescribed by or in consultation with a dermatologist or allergist/immunologist. **OPZELURA (ruxolitinib)** cream may be approved if the following criteria are met based on prescribed indication: Atopic Dermatitis • Member is ≥ 12 years of age AND • Member has a diagnosis of mild to moderate atopic dermatitis AND • Medication is being prescribed by or in consultation with a dermatologist or allergist/immunologist AND • Member has trialed and failed‡ one preferred agent OR one medium potency to very high potency topical corticosteroid (such as mometasone furoate, betamethasone dipropionate, or fluocinonide) or prescriber verifies that member is not a candidate for topical corticosteroids. Nonsegmental Vitiligo • 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 has trialed and failed‡ one preferred agent AND one medium potency to very high potency topical corticosteroid (such as mometasone furoate, betamethasone dipropionate, or fluocinonide) or prescriber verifies that member is not a candidate for topical corticosteroids Quantity limit: 60 grams/week 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.

		ZORYVE (roflumilast) 0.15% cream and 0.3% foam may receive approval if meeting the following based on prescribed indication: Atopic dermatitis (0.15% cream formulation only): • 6 years of age and older AND • Member has a diagnosis of mild atopic dermatitis in adult and pediatric patients AND • Request meets trial and failure criteria for non-preferred agents listed above Seborrheic dermatitis (0.3% foam formulation only): • Member is ≥ 9 years of age AND • 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 • Member has been counseled that Zoryve foam is flammable. Fire, flame, or smoking during and immediately following application must be avoided. • If the affected area is limited to the scalp: o 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) **AND** o 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. • If the affected area includes the face or body: o 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): ▪ Topical antifungal (such as ketoconazole, ciclopirox) ▪ Topical corticosteroid ▪ Topical calcineurin inhibitor (such as pimecrolimus, tacrolimus)

		Quantity limit: 60 grams/30 days Initial approval: 8 weeks Members may not apply Zoryve (roflumilast) cream to >20% of affected body surface area, as safety and efficacy have not been established. 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. ‡Failure is defined as a lack of efficacy with a 2-week trial, allergy, intolerable side effects, contraindication, or significant drug-drug interaction
Antineoplastic Agents		
Preferred **No PA Required** **(Unless indicated*)** *Diclofenac 3% gel (generic Solaraze) Fluorouracil 5% cream (generic Efudex) Fluorouracil 2%, 5% solution	**Non-Preferred** **PA Required** Bexarotene gel CARAC (fluorouracil) cream EFUDEX (fluorouracil) cream Fluorouracil 0.5% (generic Carac) cream PANRETIN (alitretinoin) gel TARGRETIN (bexarotene) gel VALCHLOR (mechlorethamine) gel	*__Diclofenac 3% gel__ (generic Solaraze) may be approved if the member has a diagnosis of actinic keratosis (AK). **TARGRETIN** (bexarotene) gel or **VALCHLOR** (mechlorethamine) gel may be approved for members who meet the following criteria: • 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 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, contraindication, or significant drug-drug interaction.
Other Agents		
No PA Required Imiquimod (generic Aldara) cream Podofilox gel, solution	**PA Required** CONDYLOX (podofilox) gel HYFTOR (sirolimus) gel Imiquimod (generic Zyclara) cream, cream pump VEREGEN (sinecatechins) ointment ZYCLARA (imiquimod) cream, cream pump	**Hyftor** (sirolimus) gel • 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 Initial approval: 6 months

		Reauthorization: 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.
		
		Maximum dose: one 10-gram tube/28 days
		
		Veregen (sinecatechins) may be approved if the following criteria are met:
		• 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, contraindication, or significant drug-drug interaction.
		
		Zyclara (imiquimod) **2.5% cream** may be approved if the following criteria are met:
		• 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, contraindication, or significant drug-drug interaction.
		
		Zyclara (imiquimod) **3.75% cream** may be approved for:
		• Treatment of clinically typical visible or palpable, actinic keratoses (AK) of the full face or balding scalp if the following criteria are met:
		  • Member is ≥ 18 years of age AND
		  • 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, contraindication, or significant drug-drug interaction.
		OR
		• Treatment of external genital and/or perianal warts (Condylomata acuminata) if the following criteria are met:
		  • 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, contraindication, or significant drug-drug interaction.

		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, contraindication, or significant drug-drug interaction. Quantity Limits: Aldara (imiquimod) cream has a quantity limit of 12 packets/28 days.
Therapeutic Drug Class: **ROSACEA AGENTS** – *Effective 7/1/2025*		
No PA Required Azelaic acid gel FINACEA (azelaic acid) gel FINACEA (azelaic acid) foam Metronidazole cream, lotion Metronidazole 0.75% gel	**PA Required** Brimonidine gel pump *Doxycycline monohydrate DR capsule (generic Oracea) Ivermectin cream Metronidazole 1% gel, gel pump MIRVASO (Brimonidine gel pump) NORITATE (metronidazole) cream RHOFADE (oxymetazoline) cream ROSADAN (metronidazole/skin cleanser) cream kit, gel kit	Prior authorization for non-preferred products in this class may be approved if meeting the following criteria for the prescribed diagnosis: Rosacea: ● 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, contraindication, or intolerable side effects) Demodex Blepharitis: • Requests for non-preferred topical ivermectin cream may be approved for treatment of moderate to severe Demodex blepharitis *Doxycycline monohydrate DR (generic Oracea) may be approved if the following criteria are met: ● 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 7/1/2025*		
Low potency		
No PA Required	**PA Required** Alclometasone 0.05% cream, ointment	Non-preferred Low Potency topical corticosteroids may be approved following adequate trial and failure of two preferred agents in the Low Potency class

DERMA-SMOOTHE-FS (fluocinolone) 0.01% body oil/scalp oil[BNR] Desonide 0.05% cream, ointment Fluocinolone 0.01% cream, 0.01% solution Hydrocortisone (Rx) cream, lotion, ointment	CAPEX (fluocinolone) 0.01% shampoo Desonide 0.05% lotion Fluocinolone 0.01% body oil, 0.01% scalp oil PROCTOCORT (hydrocortisone) (Rx) 1% cream SYNALAR (fluocinolone) 0.01% solution SYNALAR TS (fluocinolone/skin cleanser) Kit TEXACORT (hydrocortisone) 2.5% solution	(failure is defined as lack of efficacy with 4-week trial, allergy, intolerable side effects or significant drug-drug interactions).
Medium potency		
No PA Required Betamethasone dipropionate 0.05% cream, lotion, ointment Betamethasone valerate 0.1% cream, ointment Fluocinolone 0.025% cream, 0.05% cream, 0.005% ointment Fluticasone cream, ointment Hydrocortisone valerate 0.2% cream Mometasone 0.1% cream, 0.1% ointment, 0.1% solution Triamcinolone acetonide 0.025% cream, 0.1% cream, 0.025% ointment, 0.05% ointment, 0.1% ointment, 0.025% lotion, 0.1% lotion Triamcinolone 0.1% dental paste	**PA Required** BESER (fluticasone) lotion, emollient kit Betamethasone valerate 0.1% lotion, 0.12% foam Clocortolone 0.1% cream, cream pump CLODERM (clocortolone) 0.1% cream, cream pump CUTIVATE (fluticasone) 0.05% cream, lotion Diflorasone 0.05% cream Fluocinolone 0.025% ointment Fluocinonide-E 0.05% cream Flurandrenolide 0.05% cream, lotion, ointment Fluticasone 0.05% lotion Hydrocortisone butyrate 0.1% cream, lotion, solution, ointment, lipid/lipocream Hydrocortisone valerate 0.2% ointment KENALOG (triamcinolone) spray	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).

	LOCOID (hydrocortisone butyrate) 0.1% lotion LOCOID LIPOCREAM (hydrocortisone butyrate-emollient) 0.1% cream LUXIQ (betamethasone valerate) 0.12% foam ORALONE (Triamcinolone) 0.1% dental paste PANDEL (hydrocortisone probutate) 0.1% cream Prednicarbate 0.1% cream, ointment PSORCON (diflorasone) 0.05% cream SYNALAR (fluocinolone) 0.025% cream/kit, ointment/kit Triamcinolone 0.147 mg/gm spray	
High potency		
No PA Required (*unless exceeds duration of therapy) * Betamethasone dipropionate 0.05% ointment *Betamethasone dipropionate/propylene glycol (augmented) 0.05% cream *Fluocinonide 0.05% cream, 0.05% gel, 0.05% solution, 0.05% ointment *Triamcinolone acetonide 0.5% cream, 0.5% ointment	**PA Required** Amcinonide 0.1% cream, lotion APEXICON-E (diflorasone/emollient) 0.05% cream Desoximetasone 0.05%, 0.25% cream, 0.05% gel, 0.05%, 0.25% ointment Diflorasone 0.05% ointment Halcinonide 0.1% cream HALOG (halcinonide) 0.1% cream, ointment, solution TOPICORT (desoximetasone) 0.05%, 0.25% cream, 0.05% gel, 0.05%, 0.25% ointment	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). *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. 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.
Very high potency		
No PA Required	**PA Required**	

(Unless exceeds duration of therapy*) *Betamethasone dipropionate/propylene glycol (augmented) ,0.05% lotion 0.05% ointment *Clobetasol 0.05% cream, 0.05% gel, 0.05% ointment, 0.05% solution *Fluocinonide 0.1% cream	Betamethasone dipropionate/propylene glycol (augmented) 0.05% gel BRYHALI (halobetasol) 0.01% lotion Clobetasol emollient/emulsion 0.05% cream, foam 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	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. *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.

VI. Endocrine

Therapeutic Drug Class: **ANDROGENIC AGENTS, Topical, Injectable, Oral** – *Effective 10/1/2024*

PA Required for all agents in this class	

Preferred	Non-Preferred	
Testosterone cypionate IM injection Testosterone gel packet Testosterone 1.62% gel pump ***Injectable testosterone cypionate is a pharmacy benefit when self-administered. Administration in an office setting is a medical benefit.***	ANDROGEL (testosterone) gel packet ANDROGEL (testosterone) gel 1.62% pump DEPO-TESTOSTERONE (testosterone cypionate) IM injection JATENZO (testosterone undecanoate) capsule KYZATREX (testosterone undecanoate) capsule METHITEST (methyltestosterone) tablet Methyltestosterone capsule NATESTO (testosterone) nasal spray TESTIM (testosterone) gel Testosterone 1% gel tube, 30 mg/1.5 ml pump Testosterone enanthate IM injection TLANDO (testosterone undecanoate) capsule UNDECATREX (testosterone undecanoate) capsule XYOSTED (testosterone enanthate) SC injection	<u>Hypogonadotropic or Primary Hypogonadism (may be secondary to Klinefelter Syndrome):</u> Preferred products may be approved for members meeting the following: • 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% Reauthorization Criteria (requests for renewal of a currently expiring prior authorization for a preferred product may be approved for members meeting the following criteria): • 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% <u>Gender Transition/Affirming Hormone Therapy:</u> Preferred androgenic drugs may be approved for members meeting the following: 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. **Non-Preferred Products:** Non-preferred **topical** androgenic agents may be approved for patients meeting the above criteria with trial and failed‡ therapy with two preferred topical androgen formulations. Non-preferred **injectable** androgenic agents may be approved for patients meeting the above criteria with trial and failed‡ therapy with a preferred injectable androgenic drug. Prior authorization for **oral** androgen agents (tablet, capsule, buccal) may be approved if member has trialed and failed‡ therapy with a preferred topical agent AND testosterone cypionate injection.

		‡Failure is defined as lack of efficacy with 8 week trial, allergy, intolerable side effects, contraindication to, or significant drug-drug interaction. 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).
Therapeutic Drug Class: **BONE RESORPTION SUPPRESSION AND RELATED AGENTS** – *Effective 10/1/2024*		
Bisphosphonates		
No PA Required Alendronate tablet, solution Ibandronate tablet Risedronate tablet	**PA Required** ACTONEL (risedronate) tablet ATELVIA (risedronate) tablet BINOSTO (alendronate) effervescent tablet FOSAMAX (alendronate) tablet FOSAMAX plus D (alendronate/vit D) tablet	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. 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.
Non-Bisphosphonates		
No PA Required Raloxifene tablet	**PA Required** Calcitonin salmon nasal spray EVISTA (raloxifene) tablet FORTEO (teriparatide) SC pen Teriparatide SC pen TYMLOS (abaloparatide) SC pen	**CALCITONIN SALMON (nasal)** may be approved if the member meets the following criteria: ● Member has a diagnosis of post-menopausal osteoporosis (BMD T-scores of -2.5 or less) **AND** ● Has trial and failure of one preferred bisphosphonate or non-bisphosphonate product for 12 months (failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) **OR** ● Member is unable to use a solid oral dosage form. Quantity limit: One spray daily **FORTEO** (teriparatide) or generic teriparatide may be approved if the member meets the following criteria: ● Member has one of the following diagnoses: ○ Male primary or hypogonadal osteoporosis (BMD T-scores of -2.5 or less). ○ Osteoporosis due to corticosteroid use ○ Postmenopausal osteoporosis **AND** ● Member is at very high risk for fracture* **OR** member has history of trial and failure of one preferred bisphosphonate or non-bisphosphonate product for 12 months. 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 one preferred bisphosphonate or non-bisphosphonate product for 12 months (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 yearsMaximum dose: 80 mcg daily All other non-preferred non-bisphosphonates may be approved for members who have failed treatment with one preferred bisphosphonate or non-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 <u>one</u> 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) Raloxifene maximum dose: 60mg daily *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 07/10/2025*

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 Etonorgestrel/EE vaginal ring Norelgestromin/EE TD patch *PHEXXI (lactic acid/citric/potassium) vaginal gel TWIRLA (levonorgestrel/EE) TD patch	NUVARING (etonorgestrel/EE) vaginal ring XULANE (norelgestromin/EE) TD patch ZAFEMY (norelgestromin/EE) TD patch	Non-preferred topical contraceptive products may be approved following a trial and failure of one preferred topical contraceptive product. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction. ***PHEXXI** (lactic acid/citric/potassium) vaginal gel quantity limit: 120 grams per 30 days <u>Continuation of therapy</u>: Members who are currently using Annovera (segesterone/ethinyl estradiol) vaginal ring may receive approval to continue use of the product. Effective 7/1/2022: Prescriptions are eligible to be filled for up to a twelve-month supply. *Note: IUD and select depot product formulations are billed through the medical benefit*

Therapeutic Drug Class: **DIABETES MANAGEMENT CLASSES, INSULINS** – *Effective 02/27/2025*

Rapid-Acting

No PA Required	PA Required	
Insulin aspart cartridge, pen, vial Insulin lispro Kwikpen, Jr. Kwikpen, vial (*Eli Lilly*)	ADMELOG (insulin lispro) Solostar pen, vial AFREZZA (regular insulin) cartridge, unit APIDRA (insulin glulisine) Solostar pen, vial FIASP (insulin aspart) FlexPen, PenFill, pump cartridge, vial HUMALOG (insulin lispro) 200 U/mL pen, Tempo pen HUMALOG 100U/mL KwikPen, vial HUMALOG (insulin lispro) cartridge HUMALOG Jr. (insulin lispro) KwikPen NOVOLOG (insulin aspart) cartridge, FlexPen, vial	All 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). **Afrezza** (human insulin) may be approved if meeting the following criteria: • 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.

	LYUMJEV (insulin lispro-aabc) Kwikpen, vial, Tempo pen	
Short-Acting		
No PA Required HUMULIN R U-100 (insulin regular) vial (OTC) NOVOLIN R U-100 (insulin regular) FlexPen (OTC)	**PA Required** NOVOLIN R U-100 (insulin regular) 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).
Intermediate-Acting		
No PA Required HUMULIN N U-100 (insulin NPH) vial (OTC) NOVOLIN N U-100 (insulin NPH) FlexPen (OTC)	**PA Required** 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 LANTUS[BNR] (insulin glargine) Solostar, vial Insulin degludec vial* TRESIBA [BNR] (insulin degludec) FlexTouch*	**PA Required** BASAGLAR (insulin glargine) Kwikpen, Tempo pen Insulin degludec FlexTouch Insulin glargine solostar, vial Insulin glargine MAX solostar Insulin glargine-yfgn pen, vial LEVEMIR (insulin detemir) FlexTouch, vial REZVOGLAR (insulin glargine-aglr) Kwikpen SEMGLEE (insulin glargine-yfgn) pen, vial TOUJEO (insulin glargine) Solostar TOUJEO MAX (insulin glargine) Solostar TRESIBA (insulin degludec) vial	*Preferred Tresiba pen and insulin degludec vial formulations may be approved for members who have trialed and failed‡ Lantus. Non-preferred products may be approved if the member has tried and failed‡ treatment with Lantus **AND** a preferred insulin degludec product. ‡Failure is defined as lack of efficacy, allergy, or intolerable side effects.

Concentrated		
No PA Required HUMULIN R U-500 (insulin regular) concentrated vial, Kwikpen	**PA Required**	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 HUMULIN 70/30 (OTC) Kwikpen, vial Insulin aspart protamine/insulin aspart 70/30 FlexPen, vial (generic Novolog Mix) Insulin lispro protamine/insulin lispro 75/25 Kwikpen (generic Humalog Mix)	**PA Required** HUMALOG MIX 50/50 Kwikpen, vial HUMALOG MIX 75/25 Kwikpen, vial NOVOLIN 70/30 FlexPen, vial (OTC) NOVOLOG MIX 70/30 FlexPen, vial	Non-preferred products may be approved if the member has failed treatment with two of the preferred products (failure is defined as: allergy or intolerable side effects).
Therapeutic Drug Class: **DIABETES MANAGEMENT CLASSES, NON- INSULINS** – *5/9/2025*		
Amylin		
	PA Required SYMLIN (pramlintide) pen	**SYMLIN** (pramlintide) may be approved following trial and failure of metformin AND trial and failure of a DPP4-inhibitor or GLP-1 analogue. Failure is defined as lack of efficacy (such as not meeting hemoglobin A1C goal despite adherence to regimen) following 3-month trial, allergy, intolerable side effects, or a significant drug-drug interaction. Prior authorization may be approved for Symlin (pramlintide) products for members with a diagnosis of Type 1 diabetes without requiring trial and failure of other products. Maximum Dose: Prior authorization will be required for doses exceeding FDA-approved dosing listed in product package labeling.
Biguanides		
No PA Required Metformin IR tablets Metformin ER 500mg, 750mg tablets (generic Glucophage XR)	**PA Required** GLUMETZA ER (metformin) tablet Metformin 625 mg tablets Metformin ER (generic Fortamet, Glumetza, *Bayshore Pharma*)	Non-preferred products may be approved for members who have failed treatment with two preferred products. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction. Liquid metformin may be approved for members that are unable to use a solid oral dosage form.

	Metformin solution (generic Riomet) RIOMET (metformin) solution RIOMET ER (metformin) suspension	

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

Preferred	Non-Preferred PA Required	
JANUVIA (sitagliptin) tablet TRADJENTA (linagliptin) tablet	Alogliptin tablet NESINA (alogliptin) tablet ONGLYZA (saxagliptin) tablet Saxagliptin tablet Sitagliptin (generic Zituvio) ZITUVIO (sitagliptin tablet)	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. Maximum Dose: Prior authorization will be required for doses exceeding the FDA-approved maximum dosing listed in the following 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
Zituvio (sitagliptin)	100 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)	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. Maximum Dose:

	Saxagliptin/metformin tablet Sitagliptin/metformin (generic Zituvimet)	Prior authorization will be required for doses exceeding the FDA-approved maximum dosing listed in the following 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

Glucagon-like Peptide-1 Receptor Agonists (GLP-1 Analogues)

Preferred ***Must meet eligibility criteria**	**Non-Preferred** **PA Required**	
*BYETTA[BNR] (exenatide) pen *Liraglutide pen *TRULICITY (dulaglutide) pen *VICTOZA (liraglutide) pen **BYDUREON BCISE (exenatide ER) autoinjector *(changes effective 08/08/2024)*	Exenatide pen MOUNJARO (tirzepatide) pen OZEMPIC (semaglutide) pen RYBELSUS (semaglutide) oral tablet WEGOVY (Semaglutide) pen	*Preferred products may be approved for members with a diagnosis of type 2 diabetes. ****BYDUREON BCISE (**exenatide ER): may be approved for members with a diagnosis of Type 2 diabetes following a 3-month trial and failure‡ of ONE other preferred product. **WEGOVY (semaglutide)** may be approved if meeting the following criteria: • Member is 18 years of age or older AND • Member has established cardiovascular disease (history of myocardial infarction, stroke, or symptomatic peripheral arterial disease) and either obesity or overweight (defined as a BMI ≥25 kg/m^2) AND • Member does not have a diagnosis of Type 1 or Type 2 diabetes AND • Wegovy (semaglutide) is being prescribed to decrease the risk of adverse cardiovascular events (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke) AND • Member has been counseled regarding implementation of lifestyle interventions (diet modification and exercise) to promote weight loss. **<u>Note</u>: Prior authorization requests for Wegovy (semaglutide) prescribed solely for weight loss will not be approved.** All other non-preferred products may be approved for members with a diagnosis of type 2 diabetes following a 3-month trial and failure‡ of two preferred products .

Maximum Dose:
Prior authorization is required for all products exceeding maximum dose listed in product package labeling.

Table 1: GLP-1 Analogue Maximum Dose	
Bydureon Bcise (exenatide)	2 mg weekly
Byetta (exenatide)	20 mcg daily
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 daily
Wegovy (semaglutide)	2.4 mg weekly

‡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.

Note: Prior Authorization for GLP-1 analogues prescribed solely for weight loss will not be approved.

Other Hypoglycemic Combinations

PA Required

Alogliptin/pioglitazone tablet

Glipizide/metformin tablet

Glyburide/metformin tablet

GLYXAMBI (empagliflozin/linagliptin) tablet

OSENI (alogliptin/pioglitazone) tablet

Pioglitazone/glimepiride tablet

QTERN (dapagliflozin/saxagliptin) tablet

SOLIQUA (insulin glargine/lixisenatide) pen

STEGLUJAN (ertugliflozin/sitagliptin) tablet

TRIJARDY XR tablet(empagliflozin/linagliptin/metformin)

XULTOPHY (insulin degludec/liraglutide) pen

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).

SOLIQUA (insulin glargine/lixisenatide) may be approved if member has had a trial and failure with one preferred GLP-1 AND one preferred insulin glargine product (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.)

<table>
<tr><td></td><td></td><td></td></tr>
<tr><td colspan="3">Meglitinides</td></tr>
<tr><td></td><td>PA Required
Nateglinide tablet

Repaglinide tablet</td><td>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.</td></tr>
<tr><td colspan="3">Meglitinides Combination with Metformin</td></tr>
<tr><td></td><td>PA Required

Repaglinide/metformin</td><td>Non-preferred products may be approved for members who have been stable on the two individual ingredients of the requested combination for 3 months.</td></tr>
<tr><td colspan="3">Sodium-Glucose Cotransporter Inhibitors (SGLT inhibitors)</td></tr>
<tr><td>No PA Required

FARXIGA[BNR] (dapagliflozin) tablet

JARDIANCE (empagliflozin) tablet</td><td>PA Required

Dapagliflozin tablet

INPEFA (sotagliflozin) tablet

INVOKANA (canagliflozin) tablet

STEGLATRO (ertugliflozin) tablet</td><td>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.
<table>
<tr><th>SGLT Inhibitor</th><th>Clinical Setting</th><th>Renal Dosing Recommendations (FDA labeling)</th></tr>
<tr><td rowspan="2">FARXIGA (dapagliflozin)</td><td>Glycemic control in patients without established CV disease or CV risk factors</td><td>Initiation of therapy not recommended when eGFR is less than 45 mL/min/1.73 m^2</td></tr>
<tr><td>Reduce risk of CV death; Chronic kidney disease (CKD); Reduce risk of CV death, hospitalization or urgent visit for heart failure (HF)</td><td>Initiation of therapy not recommended when eGFR is less than 25 mL/min/1.73 m^2</td></tr>
<tr><td>INPEFA (sotagliflozin)</td><td>Reduce risk of CV death, HF hospitalization and urgent HF visit in adults with HF or Type 2 DM, chronic kidney disease and other CV risk factors</td><td>Safety and efficacy of initiating therapy when eGFR is less than 25 mL/min/1.73 m^2 or on dialysis has not been established</td></tr>
<tr><td>INVOKANA (canagliflozin)</td><td>Glycemic control in adults with Type 2 DM</td><td>Safety and efficacy of initiating therapy when eGFR is less than 30 mL/min/1.73 m^2 or on dialysis has not been established</td></tr>
</table></td></tr>
</table>

			Reduce risk of major CV events in adults with Type 2 DM and established CVD; Reduce risk of ESKD, doubling of serum creatinine, CV death, and hospitalization for HF in adults with Type 2 DM and diabetic nephropathy (albuminuria > 300 mg/day)	Initiation of therapy not recommended when eGFR is less than 30 mL/min/1.73 m^2
		JARDIANCE (empagliflozin)	Glycemic control in patients 10 years and older with Type 2 DM without established CV disease or CV risk factors	Not recommended when eGFR is less than 30 mL/min/1.73 m^2
			Reduce risk of CV death and hospitalization for HF; Chronic kidney disease (CKD); Reduce risk of CV death in adults with Type 2 DM and established CVD	Initiation of therapy not recommended when eGFR is less than 20 mL/min/1.73 m^2or on dialysis
		STEGLATRO (ertugliflozin)	Adjunct to diet and exercise in patients with Type 2 DM	Not recommended when eGFR is less than 45 mL/min/1.73 m^2
		Maximum Dose: Prior authorization is required for all products exceeding maximum dose listed in product package labeling.		
SGLT Inhibitor Combinations with Metformin				
No PA Required SYNJARDY (empagliflozin/metformin) tablet SYNJARDY XR (empagliflozin/metformin) tablet XIGDUO XR[BNR] (dapagliflozin/metformin) tablet	**PA Required** Dapagliflozin/Metformin XR tablet INVOKAMET (canagliflozin/metformin) tablet INVOKAMET XR (canagliflozin/metformin) 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**	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.
Pioglitazone tablet	ACTOS (pioglitazone) tablet	
Thiazolidinediones Combination with Metformin		
	PA Required	Non-preferred products may be approved for members who have been stable on the two individual ingredients of the requested combination for 3 months.
	ACTOPLUS MET (pioglitazone/metformin) TABLET Pioglitazone/metformin tablet	
Therapeutic Drug Class: **ESTROGEN AGENTS** -*Effective 10/1/2024*		
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. 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. 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.
Parenteral		
DELESTROGEN[BNR] (estradiol valerate) vial DEPO-ESTRODIOL (estradiol cypionate) vial Estradiol valerate 40mg/mL vial	Estradiol valerate 10mg/mL vial, 20mg/mL vial	
Oral/Transdermal		
Estradiol oral tablet Estradiol (generic Climara) weekly patch MINIVELLE[BNR] (estradiol) patch VIVELLE-DOT[BNR] (estradiol) patch	CLIMARA (estradiol) patch DOTTI (estradiol) patch ESTRACE (estradiol) oral tablet Estradiol bi-weekly patch LYLLANA (estradiol) patch MENOSTAR (estradiol) patch	

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

		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.
Therapeutic Drug Class: **GLUCAGON, SELF-ADMINISTERED** – *Effective 11/8/2024*		
Preferred **No PA Required** BAQSIMI (glucagon) nasal spray Glucagon Emergency Kit (*Eli Lilly, Fresenius, Amphastar)* ZEGALOGUE (dasiglucagon) autoinjector	**Non-Preferred** **PA Required** GVOKE (glucagon) Hypopen, Syringe, vial ZEGALOGUE (dasiglucagon) syringe	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). Quantity limit for all products: 2 doses per year unless used/ damaged/ lost
Therapeutic Drug Class: **GROWTH HORMONES** – *Effective 10/1/2024*		
Preferred **No PA Required** **(If diagnosis and dose met)** GENOTROPIN (somatropin) cartridge, Miniquick pen NORDITROPIN (somatropin) Flexpro pen	**Non-Preferred** **PA Required** HUMATROPE (somatropin) cartridge NGENLA (somatrogon-ghla) pen NUTROPIN AQ (somatropin) Nuspin injector OMNITROPE (somatropin) cartridge, vial SAIZEN (somatropin) cartridge, vial SEROSTIM (somatropin) vial SKYTROFA (lonapegsomatropin-tcgd) cartridge SOGROYA (somapacitan-beco) pen ZOMACTON (somatropin) vial	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). Non-preferred Growth Hormone products may be approved if the following criteria are met: • Member failed treatment with one preferred growth hormone product (failure is defined as lack of efficacy, allergy, intolerable side effects or signific • ant drug-drug interactions) AND • Member has a qualifying diagnosis that includes any of the following conditions: ▪ 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: o Has failed at least one GH stimulation test (peak GH level < 10 ng/mL) o Has at least one documented low IGF-1 level (below normal range for patient's age – refer to range on submitted lab document) o 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) AND

- 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 per week (age < 18 years)	Adult Maximum Dosing per week (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
Ngenla	0.66 mg/kg/week	Not Indicated
Norditropin Flexpro	0.47 mg/kg/week	0.112 mg/kg/week
Nutropin AQ Nuspin	0.7 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	0.07 mg/kg/week
Serostim	Not Indicated	42 mg/week for HIV wasting or cachexia (in combination with antiretroviral therapy)
Skytrofa	1.68 mg/kg/week	Not Indicated
Sogroya	Dose Individualized for each patient, based on growth response	8 mg/week
Zomacton	0.47 mg/kg/week	0.0875 mg/kg/week
Zorbtive	Not Indicated	56 mg/week for up to 4 weeks for short bowel syndrome only

*Based on FDA labeled indications and dosing

VII. Gastrointestinal

Therapeutic Drug Class: **BILE SALTS** – *Effective 7/1/2025*

No PA Required	**PA Required**	
Ursodiol capsule Ursodiol tablet	BYLVAY (odevixibat) capsule, pellet CHENODAL (chenodiol) tablet CHOLBAM (cholic acid) capsule LIVMARLI (maralixibat) solution OCALIVA (obeticholic acid) tablet RELTONE (ursodiol) capsule URSO (ursodiol) tablet URSO FORTE (ursodiol) tablet	**Actigall** (ursodiol) may be approved for members who meet the following criteria: • Member is ≥ 18 years of age AND • Member has tried and failed therapy with a 12-month trial of a preferred ursodiol product (failure is defined as lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions). **Chenodal** (chenodiol) may be approved for members who meet the following criteria: • Member is > 18 years of age AND • Member has tried and failed therapy with a 12-month trial of a preferred ursodiol product (failure is defined as lack of efficacy, contraindication, allergy, intolerable side effects or significant drug-drug interactions). If chenodiol is being prescribed for treatment of cerebrotendinous xanthomatosis, no trial and failure of ursodiol is required. **Cholbam** (cholic acid) may be approved for members who meet the following criteria: • Bile acid synthesis disorders: o Member age must be greater than 3 weeks old AND o 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: o Member age must be greater than 3 weeks old AND o Member has diagnosis of peroxisomal disorders (PDs) including Zellweger spectrum disorders AND o Member has manifestations of liver disease, steatorrhea or complications from decreased fat-soluble vitamin absorption. **Ocaliva** (obeticholic acid) 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 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. **Reltone** (ursodiol) may be approved for members meeting the following criteria: • 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: o 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 o Prevention of gallstone formation in obese patients experiencing rapid weight loss AND • 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. <u>Initial approval:</u> 1 year <u>Reauthorization:</u> 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: o Evidence of cholestasis with an alkaline phosphatase elevation of at least 1.5 times the upper limit of normal o Presence of antimitochondrial antibody with titer of 1:40 or higher o 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 7/1/2025*		
No PA Required DICLEGIS DR[BNR] tablet (doxylamine/pyridoxine) Meclizine (Rx) 12.5 mg, 25 mg tablet Metoclopramide solution, tablet Ondansetron ODT; 4mg, 8mg tablet Ondansetron oral suspension/ solution Prochlorperazine tablet Promethazine syrup, tablet	**PA Required** AKYNZEO (netupitant/palonosetron) capsule ANTIVERT (meclizine) 50 mg tablet ANZEMET (dolasetron) tablet Aprepitant capsule, tripack BONJESTA ER (doxylamine/pyridoxine) tablet Doxylamine/pyridoxine tablet (generic Diclegis) Dronabinol capsule EMEND (aprepitant) capsule, powder for suspension, dose/tri-pack Granisetron tablet MARINOL (dronabinol) capsule Ondansetron 16mg tablet REGLAN (metoclopramide) tablet	**Emend (aprepitant) TriPack** or **Emend (aprepitant) powder kit** may be approved following trial and failure of two preferred products AND Emend (aprepitant) capsule. Failure is defined as lack of efficacy with 14-day trial, allergy, intolerable side effects, or significant drug-drug interaction. **Doxylamine/pyridoxine tablet (generic)** or **Bonjesta (doxylamine/pyridoxine)** may be approved for 9 months if meeting the following criteria: • 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): o Antihistamine (such as diphenhydramine, dimenhydrinate, meclizine) **OR** o Dopamine antagonist (such as metoclopramide, prochlorperazine, promethazine) **OR** o Serotonin antagonist (ondansetron, granisetron) All other non-preferred products may be approved for members who have trialed and failed treatment with two preferred products. Failure is defined as lack of efficacy with 14-day trial, allergy, intolerable side effects, or significant drug-drug interaction. **Dronabinol** prior authorization may be approved for members meeting above non-preferred criteria OR via AutoPA for members with documented HIV diagnosis.

	Trimethobenzamide capsule ZOFRAN (ondansetron) tablet	**Promethazine** product formulations require prior authorization for members < 2 years of age due to risk of fatal respiratory depression.

Therapeutic Drug Class: **ANTI-EMETICS, Non-Oral** – *Effective 7/1/2025*

No PA Required	**PA Required**	
Prochlorperazine 25 mg suppository Promethazine 12.5 mg, 25 mg suppository Scopolamine patch	PROMETHEGAN 50 mg (Promethazine) suppository SANCUSO (granisetron) patch TRANSDERM-SCOP (scopolamine) patch	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, contraindication, or significant drug-drug interaction.

Therapeutic Drug Class: **GI MOTILITY, CHRONIC** – *Effective 7/1/2025*

PA Required for all agents in this class		
Preferred	**Non-Preferred**	All agents will only be approved for FDA labeled indications and up to FDA approved maximum doses listed below. Preferred agents may be approved if the member meets the following criteria: • Has diagnosis of Irritable Bowel Syndrome – Constipation (IBS-C), Chronic Idiopathic Constipation (CIC), Functional Constipation (FC), 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 **AND** • 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.
LINZESS (linaclotide) capsule Lubiprostone capsule MOVANTIK (naloxegol) tablet	Alosetron tablet AMITIZA (lubiprostone) capsule IBSRELA tablet LOTRONEX (alosetron) tablet MOTEGRITY (prucalopride) tablet Prucalopride tablet RELISTOR (methylnaltrexone) syringe, tablet, vial SYMPROIC (naldemedine) tablet TRULANCE (plecanatide) tablet VIBERZI (eluxadoline) tablet	

Non-preferred agents may be approved if the member meets the following criteria:

- 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.

VIBERZI (eluxadoline) may be approved for members who meet the following additional criteria:

- Diagnosis of Irritable Bowel Syndrome – Diarrhea (IBS-D) **AND**
- Member has a gallbladder **AND**
- Member does not have severe hepatic impairment (Child-Pugh C), history of severe constipation, known mechanical gastrointestinal obstruction, biliary duct obstruction, history of pancreatitis or structural disease of the pancreas **AND**
- Member does not drink more than 3 alcoholic drinks per day

LOTRONEX (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 (≥ 18 years)	290mcg/day
Movantik (naloxegol)	OIC, FC (6 to 17 years)	25mg/day (OIC), 72mcg/day (FC)
Viberzi (eluxadoline)	IBS-D	200mg/day
Relistor subcutaneous injection (methylnaltrexone)	OIC	12mg/day
Relistor oral (methylnaltrexone)	OIC	450mg/day
Lotronex (alosetron)	IBS-D (women only)	2mg/day (women only)
Symproic (Naldemedine)	OIC	0.2mg/day
Trulance (plecanatide)	CIC, IBS-C	3mg/day

Motegrity (prucalopride)	CIC	2mg/day

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

Therapeutic Drug Class: **H. PYLORI TREATMENTS** – *Effective 7/1/2025*

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 VOQUEZNA TRIPLE (vonoprazan/amoxicillin/ clarithromycin dose pack	Non-preferred *H. pylori* treatments should be used as individual product ingredients unless one of the individual products is not commercially available, then a PA for the combination product may be given.

Therapeutic Drug Class: **HEMORRHOIDAL, ANORECTAL, AND RELATED TOPICAL ANESTHETIC AGENTS** – *Effective 7/1/2025*

Hydrocortisone single agent

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

Lidocaine single agent

No PA Required	PA Required
Lidocaine 3% cream, 5% ointment	

Other and Combinations		
No PA Required	**PA Required**	
Lidocaine-Hydrocortisone 3-0.5% cream with applicator Lidocaine-Prilocaine Cream *(all other manufacturers)* PROCTOFOAM-HC (hydrocortisone-pramoxine) 1%-1% foam	ANALPRAM HC (Hydrocortisone-Pramoxine) 1%-1% cream, 2.5%-1% cream EPIFOAM (Hydrocortisone-Pramoxine) 1%-1% foam Hydrocortisone-Pramoxine 1%-1%, 2.5%-1% cream Lidocaine-Hydrocortisone in Coleus 2%-2% cream kit Lidocaine-Hydrocortisone 2.8%-0.55% gel Lidocaine-Hydrocortisone 3%-0.5% cream w/o applicator, cream kit Lidocaine-Hydrocortisone 3%-1% cream kit Lidocaine-Hydrocortisone 3%-2.5% gel kit Lidocaine-Prilocaine Cream *(Fougera only)* PLIAGLIS (lidocaine-tetracaine) 7%-7% cream PROCORT (Hydrocortisone-Pramoxine) 1.85%-1.15% cream RECTIV (nitroglycerin) 0.4% ointment	**RECTIV (nitroglycerin)** ointment may be approved if meeting the following: • 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.
Therapeutic Drug Class: **PANCREATIC ENZYMES** – *Effective 7/1/2025*		
No PA Required	**PA Required**	
CREON (pancrelipase) capsule VIOKACE (pancrelipase) tablet ZENPEP (pancrelipase) capsule	PERTZYE (pancrelipase) capsule	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.
Therapeutic Drug Class: **PROTON PUMP INHIBITORS** – *Effective 7/1/2025*		
No PA Required	**PA Required**	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.
	ACIPHEX (rabeprazole) tablet, sprinkle capsule	

Esomeprazole DR packet for oral suspension, capsule (RX) Lansoprazole DR capsules (RX) Lansoprazole ODT (RX) (*for members under 2 years*) Omeprazole DR capsule (RX) Pantoprazole tablet PROTONIX (pantoprazole DR) packet for oral suspension[BNR]	DEXILANT (dexlansoprazole) capsule Dexlansoprazole capsule Esomeprazole DR 49.3 capsule (RX), (OTC) capsule KONVOMEP (Omeprazole/Na bicarbonate) suspension Lansoprazole DR capsule OTC Lansoprazole ODT (OTC) NEXIUM (esomeprazole) capsule (RX), oral suspension packet, 24HR (OTC) Omeprazole/Na bicarbonate capsule, packet for oral suspension Omeprazole DR tablet (OTC), ODT (OTC) Pantoprazole packet for oral suspension PREVACID (lansoprazole) capsule, Solutab, suspension PRILOSEC (omeprazole) suspension PROTONIX (pantoprazole DR) tablet Rabeprazole tablet VOQUEZNA (vonoprazan) tablet ZEGERID (omeprazole/Na bicarbonate) capsule, packet for oral suspension	Prior authorization for non-preferred proton pump inhibitors may be approved if all of the following criteria are met: ● 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: o Diagnosis made by GI specialist o Endoscopy o X-ray o Biopsy o Blood test o Breath Test **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 **Quantity Limits:** All agents will be limited to once daily dosing except when used for the following diagnoses: Barrett's esophagus, GI Bleed, H. pylori infection, hypersecretory conditions (Zollinger-Ellison), or members who have spinal cord injury with associated acid reflux. **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. **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. **Age Limits:** **Nexium 24H** and **Zegerid** will not be approved for members less than 18 years of age. **Prevacid Solutab** may be approved for members < 2 years of age OR for members ≥ 2 years of age with a feeding tube. <u>Continuation of Care</u>: Members currently taking Dexilant (dexlansoprazole) capsules may continue to receive approval for that medication.

Therapeutic Drug Class: **NON-BIOLOGIC ULCERATIVE COLITIS AGENTS- Oral** – *Effective 7/1/2025*		
No PA Required *Brand/generic changes effective 08/08/2024* APRISO (mesalamine ER) capsule Mesalamine DR tablet (generic Lialda) (*Takeda only*) Mesalamine ER capsule (generic Apriso) (*Teva only*) PENTASA[BNR] (mesalamine) capsule Sulfasalazine IR and DR tablet	**PA Required** AZULFIDINE (sulfasalazine) Entab, tablet Balsalazide capsule Budesonide DR tablet COLAZAL (balsalazide) capsule DELZICOL (mesalamine DR) capsule DIPENTUM (olsalazine) capsule LIALDA (mesalamine DR) tablet Mesalamine DR tablet (generic Asacol HD, Lialda) Mesalamine DR/ER capsule (generic Delzicol and Pentasa) UCERIS (budesonide) tablet	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. **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.
Therapeutic Drug Class: **NON-BIOLOGIC ULCERATIVE COLITIS AGENTS- Rectal** – *Effective 7/1/2025*		
No PA Required Mesalamine suppository Mesalamine 4gm/60 ml enema (generic SF ROWASA) SF ROWASA enema, kit (mesalamine)	**PA Required** Budesonide foam CANASA (mesalamine) suppository Mesalamine enema, kit ROWASA enema, kit (mesalamine) UCERIS (budesonide) foam	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). **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.

VIII. Hematological

Therapeutic Drug Class: **ANTICOAGULANTS- Oral** – *Effective 7/1/2025*		
No PA Required	**PA Required**	**SAVAYSA** (edoxaban) may be approved if all the following criteria have been met:

Dabigatran capsule ELIQUIS (apixaban) tablet, tablet pack Warfarin tablet XARELTO (rivaroxaban) 10 mg, 15 mg, 20 mg tablet, dose pack	PRADAXA (dabigatran) capsule, pellet Rivaroxaban 2.5mg tablet SAVAYSA (edoxaban) tablet XARELTO (rivaroxaban) 2.5 mg tablet XARELTO (rivaroxaban) oral suspension	● The member has failed therapy with two preferred agents. (Failure is defined as lack of efficacy, allergy, intolerable side effects, contraindication, 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 **XARELTO 2.5mg** (rivaroxaban) may be approved for members meeting all of the following criteria: ● 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 **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. 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, contraindication, or significant drug-drug interaction. Continuation of Care: Members with current prior authorization approval on file for a non-preferred oral anticoagulant medication may continue to receive approval for that medication
Therapeutic Drug Class: **ANTICOAGULANTS- Parenteral** – *Effective 7/1/2025*		
No PA Required Enoxaparin syringe Enoxaparin vial	**PA Required** ARIXTRA (fondaparinux) syringe Fondaparinux syringe FRAGMIN (dalteparin) vial, syringe LOVENOX (enoxaparin) syringe, vial	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 **ARIXTRA** (fondaparinux) may be approved if the following criteria have been met: ● 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 Members currently stabilized on fondaparinux (Arixtra) or dalteparin (Fragmin) may receive prior authorization approval to continue receiving that medication.
Therapeutic Drug Class: **ANTI-PLATELETS** – *Effective 4/8/2025*		
No PA Required Aspirin/dipyridamole ER capsule BRILINTA (ticagrelor) tablet [BNR] Cilostazol tablet Clopidogrel tablet Dipyridamole tablet Pentoxifylline ER tablet Prasugrel tablet	**PA Required** EFFIENT (prasugrel) tablet PLAVIX (clopidogrel) tablet Ticagrelor tablet	**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. Non-preferred products without criteria will be reviewed on a case-by-case basis.
Therapeutic Drug Class: **COLONY STIMULATING FACTORS** – *Effective 7/1/2025*		
PA Required for all agents in this class*		*Prior authorization for preferred agents may be approved if meeting the following criteria: • Medication is being used for one of the following indications: o 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%) o Acute Myeloid Leukemia (AML) patients receiving chemotherapy o Bone Marrow Transplant (BMT) o Peripheral Blood Progenitor Cell Collection and Therapy o Hematopoietic Syndrome of Acute Radiation Syndrome o Severe Chronic Neutropenia (Evidence of neutropenia infection exists or ANC is below 750 cells/mm3) Prior authorization for non-preferred agents may be approved if meeting the following criteria: • Medication is being used for one of the following indications: o Patient with cancer receiving myelosuppressive chemotherapy –to reduce incidence of infection (febrile neutropenia) (Either the post nadir ANC is
Preferred FULPHILA (pegfilgrastim-jmdb) syringe NEUPOGEN (filgrastim) vial, syringe	**Non-Preferred** 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 ZIEXTENZO (pegfilgrastim-bmez) syringe	less than 10,000 cells/mm3 or the risk of neutropenia for the member is calculated to be greater than 20%) o Acute Myeloid Leukemia (AML) patients receiving chemotherapy o Bone Marrow Transplant (BMT) o Peripheral Blood Progenitor Cell Collection and Therapy o Hematopoietic Syndrome of Acute Radiation Syndrome o Severe Chronic Neutropenia (Evidence of neutropenia infection exists or ANC is below 750 cells/mm3) **AND** • 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: o Member has limited access to caregiver or support system for assistance with medication administration **OR** o Member has inadequate access to healthcare facility or home care interventions.

Therapeutic Drug Class: **ERYTHROPOIESIS STIMULATING AGENTS** – *Effective 7/1/2025*

PA Required for all agents in this class*		
Preferred	**Non-Preferred**	
EPOGEN (epoetin alfa) vial RETACRIT (epoetin alfa-epbx) (*Pfizer only)* vial	ARANESP (darbepoetin alfa) syringe, vial MIRCERA (methoxy peg-epoetin beta) syringe PROCRIT (epoetin alfa) vial RETACRIT (epoetin alfa-epbx) (*Vifor only)* vial	*Prior Authorization is required for all products and may be approved if meeting the following: ● 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: o A diagnosis of cancer, currently receiving chemotherapy, with chemotherapy-induced anemia, and hemoglobin† of 10g/dL or lower **OR** o A diagnosis of chronic renal failure, and hemoglobin† below 10g/dL **OR** o 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** o A diagnosis of HIV, currently taking zidovudine, hemoglobin† less than 10g/dL, and serum erythropoietin level of 500 mU/mL or less **OR** o 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 **AND** ● 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.

		†Hemoglobin results must be from the last 30 days.

IX. Immunological

Therapeutic Drug Class: **IMMUNE GLOBULINS** – *Effective 1/1/2025*

PA Required for all agents in this class*

Preferred	Non-Preferred
CUVITRU 20% SQ liquid	ALYGLO 10% IV liquid
GAMMAGARD 10% IV/SQ liquid	BIVIGAM 10% IV liquid
GAMUNEX-C 10% IV/SQ liquid	CUTAQUIG 16.5% SQ liquid
HIZENTRA 20% SQ syringe, vial	FLEBOGAMMA DIF 5%, 10% IV liquid
PRIVIGEN 10% IV liquid	GAMMAGARD S/D vial
If immune globulin is being administered in a long-term care 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.	GAMMAKED 10% IV/SQ liquid
	GAMMAPLEX 5%, 10% IV liquid
	HYQVIA 10% SQ liquid
	OCTAGAM 5%, 10% IV liquid
	PANZYGA 10% IV liquid
	XEMBIFY 20% IV liquid

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).

Non-preferred agents may be approved for members meeting the following:

- 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)

Approved Conditions for Immune Globulin Use:

- Primary Humoral Immunodeficiency disorders including:
  - Common Variable Immunodeficiency (CVID)
  - Severe Combined Immunodeficiency (SCID)
  - X-Linked Agammaglobulinemia
  - X-Linked with Hyperimmunoglobulin M (IgM) Immunodeficiency
  - Wiskott-Aldrich Syndrome
  - Members < 13 years of age with pediatric Human Immunodeficiency Virus (HIV) and CD-4 count > 200/mm3
- Neurological disorders including:
  - 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 protein/site for up to four sites weekly (48grams/week) Flebogamma DIF – IV admin: 600 mg/kg every 3 weeks Gammaplex 5% – IV admin: 1 gram/kg for 2 consecutive days 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: 2 grams/kg every 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** – *Effective 1/1/2025*		
No PA Required Cetirizine (OTC) syrup/solution (OTC/RX), tablet Desloratadine tablet (RX) Levocetirizine tablet (RX/OTC) Loratadine tablet (OTC), syrup/solution (OTC)	**PA Required** Cetirizine (OTC) chewable tablet, softgel, UD cups solution CLARINEX (desloratadine) tablet Desloratadine ODT (RX) Fexofenadine tablet (OTC), suspension (OTC) Levocetirizine solution (RX) Loratadine chewable (OTC), ODT (OTC)	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. Failure is defined as lack of efficacy with a 14-day trial, allergy, intolerable side effects, or significant drug-drug interaction.
Therapeutic Drug Class: **ANTIHISTAMINE/DECONGESTANT COMBINATIONS** – *Effective 1/1/2025*		
No PA Required	**PA Required**	

Loratadine-D (OTC) tablet	Cetirizine-PSE (OTC) CLARINEX-D (desloratadine-D) Fexofenadine/PSE (OTC)	Non-preferred antihistamine/decongestant combinations may be approved for members who have failed treatment with 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. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.

Therapeutic Drug Class: **INTRANASAL RHINITIS AGENTS** – *Effective 1/1/2025*		
No PA Required	**PA Required**	
Azelastine 137 mcg Budesonide (OTC) DYMISTA (azelastine/ fluticasone) [BNR] Fluticasone (RX) Ipratropium Olopatadine Triamcinolone acetonide (OTC)	Azelastine (Astepro) 0.15% Azelastine/Fluticasone BECONASE AQ (beclomethasone dipropionate) Flunisolide 0.025% Fluticasone (OTC) Mometasone NASONEX (mometasone) OMNARIS (ciclesonide) PATANASE (olopatadine) QNASL (beclomethasone) RYALTRIS (olopatadine/mometasone) XHANCE (fluticasone) ZETONNA (ciclesonide)	Non-preferred products may be approved following trial and failure of treatment with three preferred products (failure is defined as lack of efficacy with a 2-week trial, allergy, intolerable side effects or significant drug-drug interactions). Non-preferred combination agents may be approved following trial of individual products with same active ingredients AND trial and failure of one additional preferred agent (failure is defined as lack of efficacy with 2-week trial, allergy, intolerable side effects or significant drug-drug interactions).

Therapeutic Drug Class: **LEUKOTRIENE MODIFIERS** – *Effective 1/1/2025*		
No PA Required	**PA Required**	
Montelukast tablet, chewable	ACCOLATE (zafirlukast) tablet Montelukast granules SINGULAIR (montelukast) tablet, chewable, granules	Non-preferred products may be approved if meeting the following criteria: • 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.

	Zafirlukast tablet Zileuton ER tablet ZYFLO (zileuton) tablet	**Montelukast granules** may be approved if a member has tried and failed montelukast chewable tablets AND has difficulty swallowing.
Therapeutic Drug Class: **METHOTREXATE PRODUCTS** – *Effective 1/1/2025*		
No PA Required Methotrexate oral tablet, vial	**PA Required** JYLAMVO (methotrexate) oral solution OTREXUP (methotrexate) auto-injector RASUVO (methotrexate) auto-injector REDITREX (methotrexate) syringe TREXALL (methotrexate) oral tablet XATMEP (methotrexate) oral solution	**OTREXUP, REDITREX** or **RASUVO** may be approved if meeting the following criteria: • 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). **TREXALL** may be approved if meeting the following criteria: • Member has trialed and failed preferred methotrexate tablet formulation. Failure is defined as allergy or intolerable side effects. **XATMEP** may be approved for members who meet the following criteria: • 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 *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.* Members currently stabilized on a non-preferred methotrexate product may receive approval to continue that agent.
Therapeutic Drug Class: **MULTIPLE SCLEROSIS AGENTS** – *Effective 6/5/2025*		
Disease Modifying Therapies		

Preferred **No PA Required** **(Unless indicated*)**	**Non-Preferred** **PA Required**	

AVONEX (interferon beta 1a) pen, syringe
 	
BETASERON (interferon beta 1b) injection
 	
COPAXONE (glatiramer) 20mg injection **BNR**
 	
Dimethyl fumarate tablet, starter pack
 	
Fingolimod capsule
 	
Glatiramer 40mg injection
 	
*KESIMPTA (ofatumumab) pen**2nd Line**
 	
Teriflunomide tablet
	AUBAGIO (teriflunomide) tablet
	
	BAFIERTAM (monomethyl fumarate DR) capsule
	
	COPAXONE (glatiramer) 40mg injection
	
	EXTAVIA (interferon beta 1b) kit, vial
	
	GILENYA (fingolimod) capsule
	
	Glatiramer 20mg
	
	GLATOPA (glatiramer) injection
	
	MAVENCLAD (cladribine) tablet
	
	MAYZENT (siponimod) tablet, pack
	
	PLEGRIDY (peg-interferon beta 1a) pen, syringe
	
	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
		*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).
		
		<u>Non-Preferred Products:</u>
		Non-preferred products may be approved if meeting the following:
		• 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:
		
		Mayzent (siponimod):
		• 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.
		
		Mavenclad (cladribine):
		• 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)
		
		Vumerity (diroximel fumarate) or **Bafiertam (monomethyl fumarate DR)**:
		• 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:
		  o Member has trialed a temporary dose reduction of Tecfidera (with maintenance dose being resumed within 4 weeks) AND
		  o Member has trialed taking Tecfidera with food AND
		  o 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 o Initial authorization will be limited to 3 months. Continuation (12-month authorization) will require documentation of clinically significant reduction in GI adverse events. Members currently stabilized on a preferred second line (Kesimpta) or non-preferred product (may receive approval to continue therapy with that agent.
Symptom Management Therapies		
No PA Required Dalfampridine ER tablet	**PA Required** 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 7/15/2025* *Preferred agents:* Adalimumab-aaty and adbm; ADBRY (tralokinumab-ldrm); Cyltezo (adalimumab-adbm); 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		
Preferred No PA Required (If diagnosis met) (*Must meet eligibility criteria) Adalimumab-aaty pen, syringe Adalimumab-adbm pen, syringe CYLTEZO (adalimumab-adbm) pen, syringe ENBREL (etanercept) HADLIMA (adalimumab-bwwd) Pushtouch, syringe HUMIRA (adalimumab) *KEVZARA (sarilumab) pen, syringe	**Non-Preferred** PA Required ABRILADA (adalimumab-afzb) pen, syringe ACTEMRA (tocilizumab) syringe, Actpen Adalimumab-aacf pen, syringe Adalimumab-adaz pen, syringe Adalimumab-fkjp pen, syringe Adalimumab-ryvk auto-injector AMJEVITA (adalimumab-atto) auto-injector, syringe BIMZELX (bimekizumab-bkzx) pen CIMZIA (certolizumab pegol) syringe, vial	First line preferred agents (preferred adalimumab products, ENBREL, and XELJANZ IR) may receive approval for use for FDA-labeled indications. ***TALTZ (ixekizumab)** may receive approval for use for FDA-labeled indications following trial and failure‡ of a preferred adalimumab product or ENBREL. ***KEVZARA (sarilumab)** may receive approval for use for FDA-labeled indications following trial and failure‡ of: • A preferred adalimumab product or ENBREL **AND** • XELJANZ IR. ***TYENNE (tocilizumab-aazg)** may receive approval for use for FDA-labeled indications following trial and failure‡ of: • A preferred adalimumab product or ENBREL **AND** • XELJANZ IR. <u>Quantity Limit:</u> XELJANZ IR is limited to 2 tablets per day or 60 tablets for a 30-day supply **<u>Non-Preferred Agents:</u>**

*TALTZ (ixekizumab) 80 mg syringe, autoinjector *TYENNE (tocilizumab-aazg) pen, syringe XELJANZ IR (tofacitinib) tablet	COSENTYX (secukinumab) syringe, pen-injector HULIO (adalimumab-fkjp) pen, syringe HYRIMOZ (adalimumab-adaz) pen, syringe IDACIO (adalimumab-aacf) pen, syringe ILARIS (canakinumab) vial KINERET (anakinra) syringe OLUMIANT (baricitinib) tablet ORENCIA (abatacept) clickject, syringe RINVOQ (upadacitinib), solution, tablet SIMLANDI (adalimumab-ryvk) auto-injector SIMPONI (golimumab) pen, syringe SKYRIZI (risankizumab-rzaa) OnBody, SC pen, syringe XELJANZ (tofacitinib) solution XELJANZ XR (tofacitinib ER) tablet YUFLYMA (adalimumab-aaty) auto-injector, syringe YUSIMRY (adalimumab-aqvh) pen ***Note: Product formulations in the physician administered drug (PAD) category are located on Appendix P***	**COSENTYX (secukinumab)** may receive approval for: • FDA-labeled indications following trial and failure‡ of all indicated preferred agents OR • Treatment of enthesitis-related arthritis if meeting the following: o Member is ≥ 4 years of age and weighs ≥ 15 kg **AND** o Member has had trialed and failed‡ NSAID therapy and ENBREL and a preferred adalimumab product **KINERET (anakinra)** may receive approval for: • Treatment of systemic juvenile idiopathic arthritis (sJIA) or Adult-Onset Still's Disease (AOSD) **OR** • Treatment of rheumatoid arthritis following trial and failure‡ of o A preferred adalimumab product or ENBREL **AND** o XELJANZ IR **ILARIS (canakinumab)** may receive approval if meeting the following: • Medication is being prescribed for systemic juvenile idiopathic arthritis (sJIA) or Adult-Onset Still's Disease (AOSD), **AND** • Member has trialed and failed‡ a tocilizumab product. Quantity Limit: 300mg (2mL) every 4 weeks **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. **XELJANZ (tofacitinib) oral solution** may be approved when the following criteria are met: • 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 a preferred adalimumab product or ENBREL **OR** • Member cannot swallow a tofacitinib tablet 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). Non-preferred agents that are being prescribed per FDA labeling 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.

		Continuation of therapy: Members currently taking a preferred agent may receive approval to continue therapy with that agent. Members with current prior authorization approval on file for a non-preferred agent may receive approval for continuation of therapy with the prescribed agent. ‡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. *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.*
Psoriatic Arthritis		
Preferred **No PA Required** **(If diagnosis met)** **(*Must meet eligibility criteria)** Adalimumab-aaty pen, syringe Adalimumab-adbm pen, syringe CYLTEZO (adalimumab-adbm) pen, syringe ENBREL (etanercept) HADLIMA (adalimumab-bwwd) Pushtouch, syringe HUMIRA (adalimumab) *OTEZLA (apremilast) tablet *TALTZ (ixekizumab) 80 mg syringe XELJANZ IR (tofacitinib) tablet	**Non-Preferred** **PA Required** ABRILADA (adalimumab-afzb) pen, syringe Adalimumab-aacf pen, syringe Adalimumab-adaz pen, syringe Adalimumab-fkjp pen, syringe Adalimumab-ryvk auto-injector AMJEVITA (adalimumab-atto) auto-injector, syringe BIMZELX (bimekizumab-bkzx) pen CIMZIA (certolizumab pegol) syringe, vial COSENTYX (secukinumab) syringe, pen-injector HULIO (adalimumab-fkjp) pen, syringe HYRIMOZ (adalimumab-adaz) pen, syringe IDACIO (adalimumab-aacf) pen, syringe IMULDOSA (ustekinumab-SRLF) syringe, vial	First line preferred agents (HADLIMA, HUMIRA, ENBREL, XELJANZ IR) may receive approval for psoriatic arthritis indication. ***OTEZLA (apremilast)** may receive approval for psoriatic arthritis indication following trial and failure‡ of: • A preferred adalimumab product or ENBREL **AND** • XELJANZ IR or TALTZ. ***TALTZ (ixekizumab)** may receive approval for psoriatic arthritis indication following trial and failure‡ of: • A preferred adalimumab product or ENBREL **AND** • XELJANZ IR or OTEZLA. Quantity Limit: XELJANZ IR is limited to 2 tablets per day or 60 tablets for a 30-day supply **Non-Preferred Agents:** **COSENTYX (secukinumab)** may receive approval for psoriatic arthritis indication for members ≥ 2 years of age and weighing ≥ 15 kg following trial and failure‡ of: • A preferred adalimumab product or ENBREL **AND** • XELJANZ IR **AND** • TALTZ or OTEZLA. **USTEKINUMAB (Stelara brand/generic and biosimilar agents)** syringe for subcutaneous use may receive approval if meeting the following:

	ORENCIA (abatacept) syringe, clickject OTULFI (ustekinumab-aauz) syringe PYZCHIVA (ustekinumab-ttwe) syringe RINVOQ (upadacitinib) tablet RINVOQ LQ (upadacitinib) solution SELARSDI (ustekinumab-AEKN) syringe SIMLANDI (adalimumab-ryvk) auto-injector SIMPONI (golimumab) pen, syringe SKYRIZI (risankizumab-rzaa) OnBody, pen, syringe STELARA (ustekinumab) syringe STEQEYMA (ustekinumab-stba) syringe TREMFYA (guselkumab) pen, injector, syringe Ustekinumab (generic Stelara, TTWE, AEKN) syringe, vial WEZLANA (ustekinumab-auub) syringe, vial XELJANZ (tofacitinib) solution XELJANZ XR (tofacitinib ER) tablet YESINTEK (ustekinumab-kfce) syringe, vial YUFLYMA (adalimumab-aaty) auto-injector, syringe YUSIMRY (adalimumab-aqvh) pen ***Note: Product formulations in the physician administered drug (PAD) category are located on Appendix P***	• The request meets one of the following: o The prescribed agent is one of the following favored Ustekinumab products: Imuldosa, Otulfi, Pyzchiva, Selarsdi, Steqeyma, Ustekinumab (generic Stelara), Ustekinumab-AEKN, Yesintek **OR** o If the prescribed agent is brand Stelara or a product that is not favored Ustekinumab product, then the member has trialed and failed‡ at least one favored Ustekinumab product **AND** • Member has trial and failure‡ of: o A preferred adalimumab product or ENBREL **AND** o XELJANZ IR **AND** o 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. **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. All other non-preferred agents may receive approval for psoriatic arthritis following trial and failure‡ of: • A preferred adalimumab product or ENBREL **AND** • XELJANZ IR **AND** • TALTZ or OTEZLA. ‡Failure is defined as lack of efficacy, contraindication to therapy, allergy, intolerable side effects, or significant drug-drug interaction. Continuation of therapy: Members currently taking a preferred agent may receive approval to continue therapy with that agent. Members with current prior authorization approval on file for a non-preferred agent may receive approval for continuation of therapy with the prescribed agent. *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.*
Plaque Psoriasis		

Preferred No PA Required (If diagnosis met) (*Must meet eligibility criteria)	Non-Preferred PA Required	
Adalimumab-aaty pen, syringe Adalimumab-adbm pen, syringe CYLTEZO (adalimumab-adbm) pen, syringe ENBREL (etanercept) HADLIMA (adalimumab-bwwd) Pushtouch, syringe HUMIRA (adalimumab) *OTEZLA (apremilast) tablet *TALTZ (ixekizumab) 80 mg syringe TYENNE (tocilizumab-aazg) pen, syringe	ABRILADA (adalimumab-afzb) pen, syringe Adalimumab-aacf pen, syringe Adalimumab-adaz pen, syringe Adalimumab-fkjp pen, syringe Adalimumab-ryvk auto-injector AMJEVITA (adalimumab-atto) auto-injector, syringe BIMZELX (bimekizumab-bkzx) pen CIMZIA (certolizumab pegol) syringe, vial COSENTYX (secukinumab) syringe, pen-injector HULIO (adalimumab-fkjp) pen, syringe HYRIMOZ (adalimumab-adaz) pen, syringe IDACIO (adalimumab-aacf) pen, syringe IMULDOSA (ustekinumab-SRLF) syringe, vial ORENCIA (abatacept) syringe, clickject OTULFI (ustekinumab-aauz) syringe PYZCHIVA (ustekinumab-ttwe) syringe SELARSDI (ustekinumab-AEKN) syringe SILIQ (brodalumab) syringe SIMLANDI (adalimumab-ryvk) auto-injector SKYRIZI (risankizumab-rzaa) OnBody, pen, syringe	First line preferred agents (preferred adalimumab products, ENBREL) may receive approval for plaque psoriasis indication. *Second line preferred agents (TALTZ, OTEZLA) may receive approval for plaque psoriasis indication following trial and failure‡ of a preferred adalimumab product OR ENBREL. **Non-Preferred Agents:** **USTEKINUMAB (Stelara brand/generic and biosimilar agents)** syringe for subcutaneous use may receive approval if meeting the following: • The request meets one of the following: o The prescribed agent is one of the following favored Ustekinumab products: Imuldosa, Otulfi, Pyzchiva, Selarsdi, Steqeyma, Ustekinumab (generic Stelara), Ustekinumab-AEKN, Yesintek **OR** o If the prescribed agent is brand Stelara or a product that is not favored Ustekinumab product, then the member has trialed and failed‡ at least one favored Ustekinumab product **AND** • Member has trial and failure‡ of one indicated first line agent (preferred adalimumab products, ENBREL) **AND** two indicated second line agents (TALTZ, 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. All other non-preferred agents may receive approval for plaque psoriasis indication following trial and failure‡ of one indicated first line agent (a preferred adalimumab product, ENBREL) AND two second line agents (TALTZ, OTEZLA). ‡Failure is defined as lack of efficacy, contraindication to therapy, allergy, intolerable side effects, or significant drug-drug interaction. Continuation of therapy: Members currently taking a preferred agent may receive approval to continue therapy with that agent. Members with current prior authorization approval on file for a non-preferred agent may receive approval for continuation of therapy with the prescribed agent. *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.*

	SOTYKTU (ducravacitinib) oral tablet STELARA (ustekinumab) syringe STEQEYMA (ustekinumab-stba) syringe TALTZ (ixekizumab) 20mg, 40mg syringe TREMFYA (guselkumab) injector, syringe Ustekinumab (generic Stelara, TTWE, AEKN) syringe, vial WEZLANA (ustekinumab-auub) syringe, vial YESINTEK (ustekinumab-kfce) syringe, vial YUFLYMA (adalimumab-aaty) auto-injector, syringe YUSIMRY (adalimumab-aqvh) pen ***Note: Product formulations in the physician administered drug (PAD) category are located on Appendix P***	
Crohn's Disease and Ulcerative Colitis		
Preferred **No PA Required** **(If diagnosis met)** **(*Must meet eligibility criteria)** Adalimumab-aaty pen, syringe Adalimumab-adbm pen, syringe CYLTEZO (adalimumab-adbm) pen, syringe HADLIMA (adalimumab-bwwd) Pushtouch, syringe HUMIRA (adalimumab) *XELJANZ IR (tofacitinib) tablet	**Non-Preferred** **PA Required** ABRILADA (adalimumab-afzb) pen, syringe Adalimumab-aacf pen, syringe Adalimumab-adaz pen, syringe Adalimumab-fkjp pen, syringe Adalimumab-ryvk auto-injector AMJEVITA (adalimumab-atto) auto-injector, syringe CIMZIA (certolizumab pegol) syringe, vial COSENTYX (secukinumab) syringe, pen-injector	Preferred agents (preferred adalimumab products, XELJANZ IR) may receive approval for Crohn's disease and ulcerative colitis indications. Quantity Limit: XELJANZ IR is limited to 2 tablets per day or 60 tablets for a 30-day supply **Non-Preferred Agents:** **ENTYVIO (vedolizumab) pen for subcutaneous injection** may receive approval if the following criteria are met: • 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 **AND** • Member is ≥ 18 years of age **AND** • Prescriber acknowledges that administration of IV induction therapy prior to approval of ENTYVIO (vedolizumab) pen for subcutaneous injection using the

	ENTYVIO (vedolizumab) pen HULIO (adalimumab-fkjp) syringe HYRIMOZ (adalimumab-adaz) pen, syringe IDACIO (adalimumab-aacf) pen, syringe IMULDOSA (ustekinumab-SRLF) syringe, vial OLUMIANT (baricitinib) tablet OMVOH (mirikizumab-mrkz) pen OTULFI (ustekinumab-aauz) syringe PYZCHIVA (ustekinumab-ttwe) syringe RINVOQ (upadacitinib) tablet RINVOQ LQ (upadacitinib) solution SELARSDI (ustekinumab-AEKN) syringe SIMLANDI (adalimumab-ryvk) auto-injector SIMPONI (golimumab) pen, syringe SKYRIZI (risankizumab-rzaa) OnBody, pen, syringe STELARA (ustekinumab) syringe, vial STEQEYMA (ustekinumab-stba) syringe Ustekinumab (generic Stelara, TTWE, AEKN) syringe, vial VELSIPITY (etrasimod) tablet WEZLANA (ustekinumab-auub) syringe, vial XELJANZ (tofacitinib) solution XELJANZ XR (tofacitinib ER) tablet	above criteria should be avoided and will not result in an automatic approval of requests for these formulations. **OMVOH (mirikizumab-mrkz) pen for subcutaneous injection** may receive approval if the following criteria are met: • The requested medication is being prescribed for treatment of moderately-to-severely active ulcerative colitis **AND** • Member is ≥ 18 years of age **AND** • Member has trial and failure‡ of one preferred adalimumab product AND XELJANZ IR AND ENTYVIO (vedolizumab) **AND** • Prescriber acknowledges that administration of IV induction therapy prior to approval of OMVOH (mirikizumab-mrkz) pen for subcutaneous injection using the above criteria should be avoided and will not result in an automatic approval of requests for these formulations. **SKYRIZI (risankizumab) syringe for subcutaneous use** and **on-body injector formulations** may receive approval if meeting the following: • The requested medication is being prescribed for use for treating moderately-to-severely active Crohn's disease or for treating moderate-to-severly ulcerative colitis **AND** • Member is ≥ 18 years of age **AND** • Request meets one of the following based on prescribed indication: o For treatment of moderately-to-severely active Crohn's disease, member has trial and failure‡ of one preferred adalimumab product and ENTYVIO (vedolizumab) **OR** o For treatment of moderately-to-severely active ulcerative colitis, member has trial and failure‡ of one preferred adalimumab product and XELJANZ IR and ENTYVIO (vedolizumab) **AND** • Prescriber acknowledges that administration of IV induction therapy prior to approval of SKYRIZI (risankizumab) 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. **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. **USTEKINUMAB (Stelara brand/generic and biosimilar agents)** syringe for subcutaneous use may receive approval if meeting the following: • The request meets one of the following: o The prescribed agent is one of the following favored Ustekinumab products: Imuldosa, Otulfi, Pyzchiva, Selarsdi, Steqeyma, Ustekinumab (generic Stelara), Ustekinumab-AEKN, Yesintek **OR**

	YESINTEK (ustekinumab-kfce) syringe, vial YUFLYMA (adalimumab-aaty) auto-injector YUSIMRY (adalimumab-aqvh) pen ZYMFENTRA (infliximab-dyyb) pen kit, syringe kit ***Note: Product formulations in the physician administered drug (PAD) category are located on Appendix P***	○ If the prescribed agent is brand Stelara or a product that is not favored Ustekinumab product, then the member has trialed and failed‡ at least one favored Ustekinumab product **AND** • The requested medication is being prescribed for use for treating moderately-to-severely active Crohn's disease or for treating moderately-to-severely active ulcerative colitis **AND** • Request meets one of the following based on prescribed indication: ○ For treatment of moderately-to-severely active Crohn's disease, member has trial and failure‡ of one preferred adalimumab product and ENTYVIO (vedolizumab) **OR** ○ For treatment of moderately-to-severely active ulcerative colitis, member has trial and failure‡ of one preferred adalimumab product and XELJANZ IR and ENTYVIO (vedolizumab) **AND** • The member is ≥ 18 years of age **AND** • Prescriber acknowledges that loading dose administration prior to approval of ustekinumab for maintenance therapy using the above criteria should be avoided and will not result in an automatic approval of ustekinumab 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. **TREMFYA (guselkumab) pen for subcutaneous injection** may receive approval if the following criteria are met: • For treatment of moderately-to-severely active ulcerative colitis, member has trial and failure‡ of one preferred adalimumab product and XELJANZ IR **AND** • Member is ≥ 18 years of age **AND** • Prescriber acknowledges that administration of IV induction therapy prior to approval of TREMFYA (guselkumab) pen for subcutaneous injection using the above criteria should be avoided and will not result in an automatic approval of requests for these formulations. **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. All other non-preferred agents may receive approval for FDA-labeled indications if meeting the following: • 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. Continuation of therapy: Members currently taking a preferred agent may receive approval to continue therapy with that agent. Members with current prior authorization approval on file for a non-preferred agent may receive approval for continuation of therapy with the prescribed agent. ‡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. *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.*
Asthma		
Preferred **PA Required** **(*Must meet eligibility criteria)** *DUPIXENT (dupilumab) pen, syringe *FASENRA (benralizumab) pen *TEZSPIRE (tezepelumab-ekko) pen *XOLAIR (omalizumab) syringe, autoinjector	**Non-Preferred** **PA Required** NUCALA (mepolizumab) auto-injector, syringe ***Note: Product formulations in the physician administered drug (PAD) category are located on Appendix P***	*Preferred products (Dupixent, Fasenra, Tezspire, Xolair) may receive approval if meeting the following: **DUPIXENT (dupilumab):** • Member is 6 years of age or older **AND** • Member has an FDA-labeled indicated use for treating one of the following: o 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** o Oral corticosteroid dependent asthma **AND** • 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. Quantity Limit: 2 syringes every 28 days after initial 14 days of therapy (first dose is twice the regular scheduled dose) **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 ≥ 150/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 **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 **XOLAIR (omalizumab)** may receive approval if meeting the following based on prescribed indication: • 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. **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. **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). ‡Failure is defined as a lack of efficacy, allergy, intolerable side effects, contraindication to, or significant drug-drug interactions. Continuation of therapy: Members currently taking a preferred agent may receive approval to continue therapy with that agent. Members with current prior authorization approval on file for a non-preferred agent may receive approval for continuation of therapy with the prescribed agent.
Atopic Dermatitis		
Preferred **(*Must meet eligibility criteria)** *ADBRY (tralokinumab-ldrm) syringe, autoinjector *DUPIXENT (dupilumab) pen, syringe	**Non-Preferred** **PA Required** CIBINQO (abrocitinib) tablet RINVOQ (upadacitinib) tablet ***Note: Product formulations in the physician administered drug (PAD) category are located on Appendix P***	*Preferred products (Adbry and Dupixent) may receive approval if meeting the following: **ADBRY (tralokinumab-ldrm):** • The requested drug is being prescribed for moderate-to-severe atopic dermatitis **AND** • Member has trialed and failed‡ the following agents: o One medium potency to very-high potency topical corticosteroid (such as mometasone furoate, betamethasone dipropionate) **AND** o One topical calcineurin inhibitor (such as pimecrolimus or tacrolimus) Maximum Dose: 600 mg/2 weeks Quantity Limit: Four 150 mg/mL prefilled syringes/2 weeks **DUPIXENT (dupilumab):** • Member has a diagnosis of moderate to severe atopic dermatitis **AND** • Member has trialed and failed‡ the following agents: o 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** o One topical calcineurin inhibitor (such as pimecrolimus or tacrolimus) Quantity Limit: 2 syringes every 28 days after initial 14 days of therapy (first dose is twice the regular scheduled dose)

		<u>Non-Preferred Agents:</u> Non-preferred agents indicated for the treatment of atopic dermatitis may receive approval if meeting the following: • 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: o One medium potency to very-high potency topical corticosteroid (such as mometasone furoate, betamethasone dipropionate, or fluocinonide) o One topical calcineurin inhibitor (such as pimecrolimus and tacrolimus) **AND** • The medication is being prescribed by or in consultation with a dermatologist, allergist, immunologist, or rheumatologist. <u>Approval</u>: One year ‡Failure is defined as a lack of efficacy, allergy, intolerable side effects, contraindication to, or significant drug-drug interactions. <u>Continuation of therapy</u>: Members currently taking a preferred agent may receive approval to continue therapy with that agent. Members with current prior authorization approval on file for a non-preferred agent may receive approval for continuation of therapy with the prescribed agent.
Other indications		
Preferred **(If diagnosis met, No PA required)** **(Must meet eligibility criteria*)** *DUPIXENT (dupilumab) pen, syringe ENBREL (etanercept) *FASENRA (benralizumab) pen HUMIRA (adalimumab) *KEVZARA (sarilumab) OTEZLA (apremilast) tablet	**Non-Preferred** **PA Required** ACTEMRA (tocilizumab) syringe, Actpen ARCALYST (rilonacept) injection CIMZIA (certolizumab pegol) syringe COSENTYX (secukinumab) syringe, pen-injector CYLTEZO (adalimumab-adbm) pen, syringe ILARIS (canakinumab) vial KINERET (anakinra) syringe	***DUPIXENT (dupilumab)** may receive approval if meeting the following based on prescribed indication: <u>Chronic Idiopathic Urticaria</u> • 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 o High-dose second generation H1 antihistamine o H2 antihistamine o First-generation antihistamine o Leukotriene receptor antagonist o Hydroxyzine or doxepin <u>Chronic Obstructive Pulmonary Disease</u> • Member is ≥ 18 years of age **AND**

XELJANZ IR (tofacitinib) tablet *XOLAIR (omalizumab) syringe, autoinjector	NUCALA (mepolizumab) auto-injector, syringe OLUMIANT (baricitinib) tablet YUFLYMA (adalimumab-aaty) auto-injector ***Note: Product formulations in the physician administered drug (PAD) category are located on Appendix P***	• Medication is being prescribed by or in consultation with a pulmonologist or allergist **AND** • Requested medication is being prescribed as an add-on maintenance treatment for inadequately controlled chronic obstructive pulmonary disease (COPD) **AND** • Member's COPD is an eosinophilic phenotype based on a blood eosinophil level of ≥ 300 cells/mcL **AND** • Member is receiving, and will continue, standard maintenance triple therapy for COPD (inhaled corticosteroid, long-acting muscarinic agent, long-acting beta agonist) as recommended by the current Global Initiative for Chronic Obstructive Lung Disease (GOLD) guidelines **AND** • Member has experienced at least 2 moderate OR 1 severe COPD exacerbation during the past 12 months Chronic Rhinosinusitis with Nasal Polyposis • Member is ≥ 12 years of age **AND** • Medication is being prescribed as an add-on maintenance treatment for inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP) **AND** • Member has trialed and failed‡ therapy with at least two intranasal corticosteroid regimens Eosinophilic Esophagitis (EoE): • Member is ≥ 1 year of age **AND** • Member weighs at least 15 kg **AND** • 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: o Proton pump inhibitor trial of at least eight weeks in duration if reflux is a contributing factor **OR** o Minimum four-week trial of local therapy with a corticosteroid medication Prurigo Nodularis: • 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).

		***FASENRA (benralizumab)** may be approved for the treatment of adult patients with eosinophilic granulomatosis with polyangiitis (EGPA). ***KEVZARA (sarilumab)** treatment of adult patients with polymyalgia rheumatica who have had an inadequate response to corticosteroids or who cannot tolerate corticosteroid taper. **TYENNE (tocilizumab-aazg)** may receive approval for use for FDA-label indications following trial and failure‡ of a preferred adalimumab product or ENBREL ***XOLAIR (omalizumab)** may receive approval if meeting the following based on prescribed indication: <u>Chronic Rhinosinusitis with Nasal Polyps</u>: • 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 <u>Chronic Idiopathic Urticaria (CIU)</u>: • 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: o High-dose second generation H1 antihistamine o H2 antihistamine o First-generation antihistamine o Leukotriene receptor antagonist o 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). <u>IgE-Mediated Food Allergy</u>: • 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 (preferred adalimumab products, ENBREL, OTEZLA) may receive approval for use for FDA-labeled indications. **<u>Non-Preferred Agents:</u>** **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): o Cryopyrin-associated Autoinflammatory Syndrome (CAPS), including: ▪ Familial Cold Autoinflammatory Syndrome (FCAS) ▪ Muckle-Wells Syndrome (MWS) o Maintenance of remission of Deficiency of Interleukin-1 Receptor Antagonist (DIRA) in adults and pediatric patients weighing at least 10 kg o Treatment of recurrent pericarditis and reduction in risk of recurrence in adults and children ≥ 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): o Familial Mediterranean Fever (FMF) o Hyperimmunoglobulinemia D syndrome (HIDS) o Mevalonate Kinase Deficiency (MKD) o Neonatal onset multisystem inflammatory disease (NOMID) o TNF Receptor Associated Periodic Syndrome (TRAPS) o Cryopyrin-associated Autoinflammatory Syndrome (including Familial Cold Autoinflammatory Syndrome and Muckle-Wells Syndrome) o 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: o Cryopyrin-associated periodic syndrome: 600mg (4mL) every 8 weeks o 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): o Neonatal onset multisystem inflammatory disease (NOMID). o 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): <u>Chronic Rhinosinusitis with Nasal Polyps</u>: • 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: o NC and NPS scores are provided and show a 20% reduction in symptoms from baseline **AND** o Member continues to use primary therapies such as intranasal corticosteroids. <u>Eosinophilic Granulomatosis with polyangiitis (EGPA):</u> • 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: o Member has a diagnosis of asthma **AND** o 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 has trialed and failed‡ Fasenra (benralizumab) **AND** • Dose of NUCALA (mepolizumab) 300 mg once every 4 weeks is being prescribed. <u>Hypereosinophilic Syndrome (HES):</u> • 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. <u>Continuation of therapy</u>: Members currently taking a preferred agent may receive approval to continue therapy with that agent. Members with current prior authorization approval on file for a non-preferred agent 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. *<u>Note</u>: 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 1/1/2025*		
No PA Required *Brand/generic changes effective 02/22/2024** *Epinephrine 0.15mg/0.15ml, 0.3mg/0.3ml auto-injector *(Mylan only)* EPIPEN 0.3 mg/0.3 ml (epinephrine) auto-injector EPIPEN JR 0.15 mg/0.15 ml, (epinephrine) auto-injector	**PA Required** AUVI-Q (epinephrine) auto-injector Epinephrine 0.15mg/0.15ml, 0.3mg/0.3ml auto-injector (All other manufacturers; generic Adrenaclick, Epipen) SYMJEPI 0.15mg/0.3ml, 0.3mg/0.3ml (epinephrine) syringe	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. Quantity limit: 4 auto-injectors per year unless used / damaged / lost

Therapeutic Drug Class: **NEWER HEREDITARY ANGIOEDEMA PRODUCTS** – *Effective 1/1/2025*		
PA Required for all agents in this class		<u>Medications Indicated for Routine Prophylaxis:</u> Members are restricted to coverage of one medication for <u>routine prophylaxis</u> at one time. Prior authorization approval will be for one year. **HAEGARDA** (C1 esterase inhibitor - human) may be approved for members meeting the following criteria: o Member has a diagnosis of HAE Type I or Type II confirmed by laboratory tests obtained on two separate instances at least one month apart (C4 level, C1-INH level) OR has a diagnosis of HAE Type III based on clinical presentation **AND** o 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 o Member meets at least one of the following:
Preferred	**Non-Preferred**	
<u>*Prophylaxis:*</u> CINRYZE (C1 esterase inhibitor) kit HAEGARDA (C1 esterase inhibitor) vial <u>*Treatment:*</u> BERINERT (C1 esterase inhibitor) kit, vial	<u>*Prophylaxis:*</u> ORLADEYO (berotralstat) oral capsule TAKHZYRO (lanadelumab-flyo) syringe, vial <u>*Treatment:*</u> Icatibant syringe (generic FIRAZYR) RUCONEST (C1 estera se inhibitor, recomb) vial	

FIRAZYR (icatibant acetate) syringe [BNR]		▪ 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: o History of ≥1 attack per month resulting in documented ED admission or hospitalization **OR** o History of laryngeal attacks **OR** o History of ≥2 attacks per month involving the face, throat, or abdomen **AND** o Member is not taking medications that may exacerbate HAE including ACE inhibitors and estrogen-containing medications **AND** o Prescriber acknowledges that the member will receive information and/or counseling regarding the information from the FDA-labeled package insert outlining transmission of infectious agents with a medication made from human blood. Maximum Dose: 60 IU/kg Minimum Age: 6 years **CINRYZE** (C1 esterase inhibitor - human) may be approved for members meeting the following criteria: o 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** o Member has a diagnosis of HAE Type I or Type II confirmed by laboratory tests obtained on two separate instances at least one month apart (C4 level, C1-INH level) OR has a diagnosis of HAE Type III based on clinical presentation **AND** o 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 o Member meets at least one of the following: ▪ Cinryze is being used for <u>short-term prophylaxis</u> to undergo a surgical procedure or major dental work **OR** ▪ Cinryze is being used for <u>long-term prophylaxis</u> and member meets one of the following: o History of ≥1 attack per month resulting in documented ED admission or hospitalization **OR** o History of laryngeal attacks **OR** o History of ≥2 attacks per month involving the face, throat, or abdomen **AND** o Member is not taking medications that may exacerbate HAE including ACE inhibitors and estrogen-containing medications **AND** o Prescriber acknowledges that the member will receive information and/or counseling regarding the information from the FDA-labeled package insert

		outlining transmission of infectious agents with a medication made from human blood. Minimum age: 6 years Maximum dose: 100 Units/kg **ORLADEYO** (berotralstat) may be approved for members meeting the following criteria: o 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** o Member has a diagnosis of HAE Type I or Type II confirmed by laboratory tests obtained on two separate instances at least one month apart (C4 level, C1-INH level) OR has a diagnosis of HAE Type III based on clinical presentation **AND** o 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** o ORLADEYO is prescribed by or in consultation with an allergist or immunologist **AND** o Appropriate drug interaction interventions will be made for members using concomitant medications that may require dose adjustments (such as cyclosporine, fentanyl, pimozide, digoxin) **AND** o 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: o 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 Type I or Type II confirmed by laboratory tests obtained on two separate instances at least one month apart (C4 level, C1-INH level) OR has a diagnosis of HAE Type III based on clinical presentation **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: 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 **<u>Medications Indicated for Treatment of Acute Attacks:</u>** Members are restricted to coverage of one medication for <u>treatment of acute attacks</u> at one time. Prior authorization approval will be for one year. **FIRAZYR** (icatibant acetate) may be approved for members meeting the following criteria: ○ Member has a diagnosis of HAE Type I or Type II confirmed by laboratory tests obtained on two separate instances at least one month apart (C4 level, C1-INH level) OR has a diagnosis of HAE Type III based on clinical presentation **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 Type I or Type II confirmed by laboratory tests obtained on two separate instances at least one month apart (C4 level, C1-INH level) OR has a diagnosis of HAE Type III based on clinical presentation **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** ○ Prescriber acknowledges that the member will receive information and/or counseling regarding the information from the FDA-labeled package insert outlining transmission of infectious agents with a medication made from human blood. 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 Type I or Type II confirmed by laboratory tests obtained on two separate instances at least one month apart (C4 level, C1-INH level) OR has a diagnosis of HAE Type III based on clinical presentation **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: 13 years Maximum dose: 4,200 Units/dose 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.
Therapeutic Drug Class: **PHOSPHATE BINDERS** – *Effective 10/1/2024*		
No PA Required Calcium acetate capsule PHOSLYRA (calcium acetate) solution Sevelamer carbonate tablet, powder pack	**PA Required** AURYXIA (ferric citrate) tablet Calcium acetate tablet CALPHRON (calcium acetate) tablet Ferric citrate tablet	Prior authorization for non-preferred products in this class may be approved if member meets all the following criteria: ● 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). **Auryxia** (ferric citrate) may be approved if the member meets all the following criteria:

	FOSRENOL (lanthanum carbonate) chewable tablet, powder pack Lanthanum carbonate chewable tablet RENVELA (sevelamer carbonate) powder pack, tablet Sevelamer HCl tablet VELPHORO (sucroferric oxide) chewable tablet XPHOZAH (tenapanor) tablet	• 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 **OR** • 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) **Velphoro** (sucroferric oxyhydroxide tablet, chewable) may be approved if the member meets all of the following criteria: • 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 Maximum Dose: Velphoro 3000mg daily Members currently stabilized on a non-preferred lanthanum product may receive approval to continue therapy with that product. ‡Failure is defined as lack of efficacy with 6-week trial, allergy, intolerable side effects, or significant drug-drug interaction. *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.*
Therapeutic Drug Class: **PRENATAL VITAMINS / MINERALS** – *Effective 10/1/2024*		
Preferred ***Must meet eligibility criteria** COMPLETE NATAL DHA pack M-NATAL PLUS tablet NESTABS tablets	**Non-Preferred** **PA Required** All other rebateable prescription products are non-preferred	*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. 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.

PRENATAL VITAMIN PLUS LOW IRON tablet (*Patrin Pharma only)* SE-NATAL 19 chewable tablet[BNR] TARON-C DHA capsule THRIVITE RX tablet TRINATAL RX 1 tablet VITAFOL gummies WESNATAL DHA COMPLETE tablet WESTAB PLUS tablet		

XI. Ophthalmic

Therapeutic Drug Class: **OPHTHALMIC, ALLERGY** – *Effective 4/1/2025*

No PA Required	**PA Required**	
ALREX[BNR] (loteprednol) 0.2% Azelastine 0.05% Cromolyn 4% Ketotifen 0.025% (OTC) LASTACAFT (alcaftadine) 0.25% (OTC) Olopatadine 0.1%, 0.2% (OTC) (generic Pataday Once/Twice Daily)	ALAWAY (ketotifen) 0.025% (OTC) ALOCRIL (nedocromil) 2% ALOMIDE (lodoxamide) 0.1% Bepotastine 1.5% BEPREVE (bepotastine) 1.5% Epinastine 0.05% Loteprednol 0.2% Olopatadine 0.1%, 0.2% (RX)	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).

	PATADAY ONCE DAILY (olopatadine) 0.2% (OTC) PATADAY TWICE DAILY (olopatadine) 0.1% (OTC) PATADAY XS ONCE DAILY (olopatadine) 0.7% (OTC) ZADITOR (ketotifen) 0.025% (OTC) ZERVIATE (cetirizine) 0.24%	
Therapeutic Drug Class: **OPHTHALMIC, IMMUNOMODULATORS** – *Effective 4/1/2025*		
No PA Required RESTASIS[BNR] (cyclosporine 0.05%) vials	**PA Required** CEQUA (cyclosporine) 0.09% solution Cyclosporine 0.05% vials MIEBO (Perfluorohexyloctane/PF) RESTASIS MULTIDOSE (cyclosporine) 0.05% TYRVAYA (varenicline) nasal spray VERKAZIA (cyclosporin emulsion) VEVYE (cyclosporine) 0.1% XIIDRA (lifitegrast) 5% solution	Non-preferred products may be approved for members meeting all of the following criteria: • Member is 18 years and older **AND** • Member has a diagnosis of chronic dry eye **AND** • Member has failed a 3-month trial of one preferred product. Failure is defined as a lack of efficacy, allergy, intolerable side effects, contraindication to, or significant drug-drug interactions **AND** • Prescriber is an ophthalmologist, optometrist or rheumatologist Maximum Dose/Quantity: 60 single use containers for 30 days 5.5 mL/20 days for Restasis Multi-Dose and Vevye 3mL/30 days for Miebo **Verkazia (cyclosporine ophthalmic emulsion)** may be approved if the following criteria are met: • 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 • Quantity limit: 120 single-dose 0.3 mL vials/15 days
Therapeutic Drug Class: **OPHTHALMIC, ANTI-INFLAMMATORIES** – *Effective 4/1/2025*		

NSAIDs	
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 MAXIDEX (dexamethasone) 0.1% PRED MILD (prednisolone) 0.12% Prednisolone acetate 1%	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% LOTEMAX SM (loteprednol) 0.38% gel Loteprednol 0.5% drops, 0.5% gel PRED FORTE (prednisolone) 1% Prednisolone sodium phosphate 1%

Durezol (difluprednate) may be approved if meeting the following criteria:

- 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:

- Member is ≥ 18 years of age AND
- Eysuvis (loteprednol etabonate) is being used for short-term treatment (up to two weeks) of the signs and symptoms of dry eye disease AND
- Member has failed treatment with one preferred product in the Ophthalmic Immunomodulator therapeutic class. Failure is defined as lack of efficacy with a 3-month trial, contraindication to therapy, allergy, intolerable side effects, or significant drug-drug interaction) AND
- Member does not have any of the following conditions:
- 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
- Quantity limit: one bottle/15 days

Lotemax SM (loteprednol etabonate) or **Inveltys (loteprednol etabonate)** may be approved if meeting all of the following:

- Member is ≥ 18 years of age AND
- Lotemax SM or Inveltys (loteprednol etabonate) is being used for the treatment of post-operative inflammation and pain following ocular surgery AND
- Member has trialed and failed therapy with two preferred loteprednol formulations (failure is defined as lack of efficacy with 2-week trial, allergy, contraindication to therapy, intolerable side effects, or significant drug-drug interaction) AND
- Member has trialed and failed therapy with two preferred agents that do not contain loteprednol (failure is defined as lack of efficacy with 2-week trial, contraindication to therapy, allergy, intolerable side effects, or significant drug-drug interaction) AND
- Member does not have any of the following conditions:

<table>
<tr><td colspan="2"></td><td>

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

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).
</td></tr>
<tr><td colspan="3">Therapeutic Drug Class: OPHTHALMIC, GLAUCOMA – Effective 4/1/2025</td></tr>
<tr><td colspan="2">Beta-blockers</td><td rowspan="5">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.

Non-preferred combination products may be approved following trial and failure of therapy with one preferred combination product AND trial and failure of individual products with the same active ingredients as the combination product being requested (if available) to establish tolerance. Failure is defined as lack of efficacy with 4-week trial, allergy, intolerable side effects or significant drug-drug interactions.

Preservative free products may be approved with provider documentation of adverse effect to preservative-containing product.</td></tr>
<tr><td>No PA Required</td><td>PA Required</td></tr>
<tr><td>Carteolol 1%

Levobunolol 0.5%

Timolol (generic Timoptic) 0.25%, 0.5%</td><td>Betaxolol 0.5%

BETIMOL (timolol) 0.25%, 0.5%

BETOPIC-S (betaxolol) 0.25%

ISTALOL (timolol) 0.5%

Timolol (generic Istalol) 0.5% drops

Timolol GFS 0.25%, 0.5%

Timolol/PF (generic Timoptic Ocudose) 0.25%, 0.5%

TIMOPTIC, TIMOPTIC OCUDOSE (timolol) 0.25%, 0.5%

TIMOPTIC-XE (timolol GFS) 0.25%, 0.5%</td></tr>
<tr><td colspan="2">Carbonic anhydrase inhibitors</td></tr>
<tr><td>No PA Required</td><td>PA Required</td></tr>
<tr><td>Brinzolamide 1%

Dorzolamide 2%</td><td>AZOPT (brinzolamide) 1%</td></tr>
<tr><td colspan="2">Prostaglandin analogue</td></tr>
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No PA Required	PA Required
Latanoprost 0.005%	Bimatoprost 0.03%
LUMIGAN[BNR] (bimatoprost) 0.01%	IYUZEH (latanoprost/PF) 0.005%
TRAVATAN Z[BNR] (travoprost) 0.004%	Tafluprost 0.0015%
	Tafluprost PF 0.0015%
	Travoprost 0.004%
	VYZULTA (latanoprostene) 0.024%
	XALATAN (latanoprost) 0.005%
	XELPROS (latanoprost) 0.005%
	ZIOPTAN (tafluprost PF) 0.0015%

Alpha-2 adrenergic agonists

No PA Required	PA Required
ALPHAGAN P[BNR] 0.1%, 0.15% (brimonidine)	Apraclonidine 0.5%
Brimonidine 0.2%	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)	Brimonidine/Timolol 0.2%-0.5%
Dorzolamide/Timolol 2%-0.5%	COSOPT/COSOPT PF (dorzolamide/timolol) 2%-0.5%
RHOPRESSA (netarsudil) 0.02%	Dorzolamide/Timolol PF 2%-0.5%
ROCKLATAN (netarsudil/latanoprost) 0.02%-0.005%	PHOSPHOLINE IODIDE (echothiophate) 0.125%
	Pilocarpine 1%, 2%, 4%

	SIMBRINZA (brinzolamide/brimonidine) 1%-0.2% VUITY (pilocarpine) 1.25%	

XII. Renal/Genitourinary

Therapeutic Drug Class: **BENIGN PROSTATIC HYPERPLASIA (BPH) AGENTS** – *Effective 10/1/2024*

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: ● 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. ***CIALIS** (tadalafil) may be approved for members with a documented diagnosis of BPH who have failed a trial of finasteride (at least 3 months in duration) AND either a trial of a nonselective alpha blocker (therapeutic dose for at least two months) OR a trial of tamsulosin (therapeutic dose for at least one month). Documentation of BPH diagnosis will require BOTH of the following: ● AUA Prostate Symptom Score ≥ 8 AND ● Results of a digital rectal exam. Cialis (tadalafil) will not be approved for any patient continuing alpha-blocker therapy as this combination is contraindicated in this population. Doses exceeding 5mg per day of Cialis (tadalafil) will not be approved.
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	FLOMAX (tamsulosin) capsule	
	PROSCAR (finasteride) tablet	
	RAPAFLO (silodosin) capsule	
	Silodosin capsule	
	*Tadalafil 2.5 mg, 5 mg tablet	

Therapeutic Drug Class: **ANTI-HYPERURICEMICS** – *Effective 10/1/2024*

No PA Required	PA Required	
Allopurinol 100 mg, 300 mg tablets	Allopurinol 200 mg tablets	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. 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.
Colchicine tablet	Colchicine capsule	
Febuxostat tablet	COLCRYS (colchicine) tablet	
Probenecid tablet	GLOPERBA (colchicine) oral solution	

Probenecid/Colchicine tablet	MITIGARE (colchicine) capsule ULORIC (febuxostat) tablet	**GLOPERBA (colchicine)** oral solution may be approved for members who require individual doses <0.6 mg **OR** for members who are unable to use a solid oral dosage form. Colchicine tablet quantity limits: • Chronic hyperuricemia/gout prophylaxis: 60 tablets per 30 days • Familial Mediterranean Fever: 120 tablets per 30 days

Therapeutic Drug Class: **OVERACTIVE BLADDER AGENTS** – *Effective 10/1/2024*		
No PA Required	**PA Required**	
Fesoterodine ER tablet MYRBETRIQ (mirabegron) tablet [BNR] Oxybutynin IR, ER tablets, syrup Solifenacin tablet Tolterodine tablet, ER capsule	Darifenacin ER tablet DETROL (tolterodine) tablet DETROL LA (tolterodine) ER capsule Flavoxate tablet GEMTESA (vibegron) tablet Mirabegron tablet MYRBETRIQ (mirabegron) suspension Oxybutynin 2.5 mg tablet OXYTROL (oxybutynin patch) TOVIAZ (Fesoterodine ER) tablet Trospium ER capsule, tablet VESICARE (solifenacin) tablet VESICARE LS (solifenacin) suspension	Non-preferred products may be approved for members who have failed treatment with two preferred products. Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction. Members with hepatic failure can receive approval for trospium (Sanctura) or trospium extended release (Sanctura XR) products without a trial on a Preferred product.

XIII. RESPIRATORY

Therapeutic Drug Class: **RESPIRATORY AGENTS** – *Effective 4/14/2025*		
Inhaled Anticholinergics		
Preferred **No PA Required** **(Unless indicated*)**	**Non-Preferred** **PA Required**	***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

Solutions Ipratropium solution **Short-Acting Inhalation Devices** ATROVENT HFA (ipratropium) **Long-Acting Inhalation Devices** SPIRIVA Handihaler[BNR] (tiotropium) *SPIRIVA RESPIMAT (tiotropium)	**Solutions** YUPELRI (revefenacin) solution **Short-Acting Inhalation Devices** **Long-Acting Inhalation Devices** INCRUSE ELLIPTA (umeclidinium) Tiotropium DPI TUDORZA PRESSAIR (aclidinium)	with regular use of a combination medium-dose inhaled corticosteroid and long-acting beta agonist (LABA). ***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. **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. 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. ‡Failure is defined as lack of efficacy with 6-week trial, allergy, intolerable side effects, or significant drug-drug interaction.
Inhaled Anticholinergic Combinations		
No PA Required **Solutions** Ipratropium/Albuterol solution **Short-Acting Inhalation Devices** COMBIVENT RESPIMAT (albuterol/ipratropium) **Long-Acting Inhalation Devices** ANORO ELLIPTA (umeclidinium/vilanterol) [BNR]	**PA Required** **Solutions** **Short-Acting Inhalation Devices** **Long-Acting Inhalation Devices** BEVESPI AEROSPHERE (glycopyrrolate /formoterol fumarate) BREZTRI AEROSPHERE (budesonide/glycopyrrolate/ formoterol) DUAKLIR PRESSAIR (aclidinium/formoterol) STIOLTO RESPIMAT (tiotropium/olodaterol) Umeclidinium/Vilanterol	**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. **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. 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). Members who are currently stabilized on Bevespi Aerosphere may receive approval to continue therapy with that product. ‡Failure is defined as lack of efficacy with 6-week trial, allergy, intolerable side effects, or significant drug-drug interaction.
Inhaled Beta2 Agonists (short acting)		

No PA Required	PA Required	
Solutions Albuterol solution, for nebulizer **Inhalers** VENTOLIN HFA (albuterol)	**Solutions** Levalbuterol solution **Inhalers** AIRSUPRA (budesonide/albuterol) Albuterol HFA Levalbuterol HFA PROAIR RESPICLICK (albuterol) XOPENEX (levalbuterol) Inhaler	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. MDI formulation quantity limits: 2 inhalers / 30 days **AIRSUPRA** (budesonide/albuterol) Airsupra minimum age: 18 years old
Inhaled Beta2 Agonists (long acting)		
Preferred	**Non-Preferred** **PA Required**	
Solutions **Inhalers** SEREVENT DISKUS (salmeterol) inhaler	**Solutions** Arformoterol solution BROVANA (arformoterol) solution Formoterol solution PERFOROMIST (formoterol) solution **Inhalers** 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**	
Solutions Budesonide nebules **Inhalers** ARNUITY ELLIPTA (fluticasone furoate) ASMANEX HFA (mometasone furoate) inhaler ASMANEX Twisthaler (mometasone)	**Solutions** PULMICORT (budesonide) respules **Inhalers** ALVESCO (ciclesonide) inhaler Fluticasone propionate diskus *Fluticasone propionate HFA	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 without prior authorization for: • Members with a diagnosis of eosinophilic esophagitis (EoE) **OR** • Members ≤ 12 years of age. Maximum Dose:

PULMICORT FLEXHALER (budesonide) QVAR REDIHALER (beclomethasone)		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)** ADVAIR DISKUS[BNR] (fluticasone/salmeterol) ADVAIR HFA[BNR] (fluticasone/salmeterol) AIRDUO RESPICLICK [BNR] (fluticasone/salmeterol) DULERA (mometasone/formoterol) SYMBICORT[BNR] (budesonide/formoterol) inhaler *TRELEGY ELLIPTA (fluticasone furoate/ umeclidinium/vilanterol)	**PA Required** BREO ELLIPTA (vilanterol/fluticasone furoate) Budesonide/formoterol (generic Symbicort) Fluticasone/salmeterol (generic Airduo/Advair Diskus) Fluticasone/salmeterol HFA (generic Advair HFA) Fluticasone/vilanterol (generic Breo Ellipta) WIXELA INHUB (fluticasone/salmeterol)	***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 appropriate use of a specific dosage form. Non-preferred inhaled corticosteroid combinations may be approved for members meeting both of the following criteria: • 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)		
No PA Required Roflumilast tablet	**PA Required** DALIRESP (roflumilast) tablet OHTUVAYRE (ensifentrine) suspension	Requests for use of the non-preferred brand product formulation may be approved if meeting criteria outlined in the Appendix P "Generic Mandate" section.