Indiana Medicaid Statewide Uniform Preferred Drug List (SUPDL)

Optum Rx Call Center

For prior authorization requests, claims processing issues or questions about the SUPDL, please contact Optum Rx at 855-577-6317

Or fax the prior authorization requests to 855-577-6384

Indiana Health Coverage Programs (IHCP) Drug Coverage

In accordance with 405 IAC 5-24, the IHCP covers all FDA-approved legend drugs with the exception of the following:

- Drugs designated by Centers for Medicare and Medicaid Services (CMS, formerly HCFA) as "less than effective" (DESI), or identical, related, or similar to a DESI drug
- Anorectics or any agent used to promote weight loss
- Topical minoxidil preparations
- Fertility enhancement drugs
- Drugs used primarily or solely for cosmetic purposes

Note: Inclusion of, or reference to, any given drug does not indicate market availability of the drug. Drugs that will be or have been withdrawn from the market will be removed from the SUPDL as part of routine periodic updating of the SUPDL.

Nomenclature

- **Statewide Uniform Preferred Drug List (SUPDL)** - a list of drugs within select therapeutic drug classes, developed and maintained by the Drug Utilization Review (DUR) Board, designated as *preferred* or *non-preferred* based upon clinical and financial considerations.
    - **Preferred Drug** – Covered drug designated by the DUR Board as a principle agent for use within a therapeutic class.
    - **Non-preferred Drug** – Covered drug designated by the DUR Board as secondary agent for use within a therapeutic class. Non-preferred drugs typically require prior authorization and history of trial and failure of (each of) the preferred agent(s), as confirmed by claims history, chart documentation, or provider attestation including dates of trial for each preferred agent (unless otherwise specified on the SUPDL).
        - Legacy continuation of therapy - The process whereby criteria are established exempting a drug from prior authorization, under specific conditions, when it would otherwise require prior authorization.
        - Brand name drugs, with an available generic, authorized generic, or authorized brand alternative, are *non-preferred* unless otherwise specified on the SUPDL and the Preferred Brand Drug List. All brand products on the SUPDL with a new available generic, authorized generic, or authorized brand alternative will list the newly released agent as the same status as the brand product until reviewed by the Drug Utilization Review Board for inclusion on the Preferred Brand Drug List. Position of the brand product and its corresponding generic, authorized generic, or authorized brand alternative can then be switched based on financial advantage.

- Prior authorization is typically required for a prescriber's specification of "brand medically necessary" or “generic medically necessary”.
- Certain drugs, sometimes referred to as “narrow therapeutic index” drugs, are exempt from the requirement of prior authorization for “brand medically necessary”; see information in the Pharmacy Services Provider Module.

- **Neutral Drug** – Covered drug that is in a therapeutic class not included on the SUPDL. As such, the drug has neither *preferred* nor *non-preferred* status.
- **Line Extension Drug** – A new strength, formulation, or dosage form of a particular chemical entity for a given manufacturer that has been approved by the FDA. The SUPDL status of a line extension drug is the same as the status of the chemical entity to which it pertains unless otherwise determined by the DUR Board.
- **Point of Sale Quick Check (PSQC)** – real-time automated prior authorization system that utilizes clinical prior authorization edits supported by a member’s medical and pharmacy claims data. This process results in quicker PA determination for pharmacy claims processed by the fee-for-service (FFS) pharmacy benefit, with less intervention on the part of the pharmacy and prescribing providers.
- **Status Pending Drug –** Covered drug that is subject to the SUPDL, but for which *preferred* or *non-preferred* status has yet to be assigned.

Prior Authorization (PA)

This term is defined at 405 IAC 5-2-20. Any IHCP covered legend drug (including drugs that are or are not listed on the SUPDL) may require PA. Prior authorization is generally required in order to ensure appropriate drug utilization, conformance to established therapeutic guidelines, and fiscal reasonability.

Prior authorization request forms are located at https://www.in.gov/medicaid/providers/index.html under Pharmacy Services. Select "PA Criteria and Administrative Forms" under the "Quick Links" column on the right-hand margin. Drug specific PA criteria are attached to each associated drug class within the SUPDL document. Non-specific criteria are located at the end of the SUPDL document.

Indiana Medicaid Statewide Uniform Preferred Drug List Table of Contents

Effective for FFS and Managed Care Organization claims submitted on or after August 1, 2026. V1.0

Inclusion or reference to any given drug does not indicate market availability of the drug. Drugs that will be, or have been, withdrawn from the market will be removed from the SUPDL as part of routine periodic updating of the SUPDL.

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ANTI-INFECTIVES			
Antivirals – Anti-Herpetic	• acyclovir • valacyclovir ○ ST – must have diagnosis of HIV or trial and failure of acyclovir or medical justification for use over acyclovir	• famciclovir • Sitavig	

Antivirals – Influenza and COVID-19	***Influenza***
	• oseltamivir
	• Relenza
	
	COVID-19
	• Paxlovid
	  ○ AGE – 12 years of age and older
	  ○ QL – 1 therapy pack every 30 days
		Influenza
		• Rapivab
		• Xofluza
		
		COVID-19
		• N/A	

Cephalosporins – 3rd Generation	• cefdinir • cefpodoxime	• cefixime caps, susp	
Fluoroquinolones ***Note: All fluoroquinolones will be limited to 14 days per claim***	• ciprofloxacin • levofloxacin • moxifloxacin	• Baxdela • ofloxacin PA criteria must be met for the following: • Cipro suspension • ciprofloxacin suspension • levofloxacin soln	PA Criteria for ciprofloxacin and levofloxacin solution
Hepatitis C Agents	• Pegasys • ribavirin PA criteria must be met for the following (**note: treatment naïve patients must only meet age and quantity limits**): • Epclusa 200-50mg • Epclusa 150-37.5mg • Mavyret • sofosbuvir/velpatasvir 400-100mg	PA criteria must be met for the following: • Epclusa 400-100mg • Harvoni 45-200 mg tablet; 45-200 mg packet; 33.75 mg-150 mg packet • ledipasvir/sofosbuvir 90-400 mg tablet • Sovaldi • Vosevi	Hepatitis C Agents PA Criteria Hepatitis C Agents PA Form

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ANTI-INFECTIVES - Continued			

Macrolides	• azithromycin suspension 100 mg/5 mL, 200 mg/5 mL
	• azithromycin 600 mg oral tablets
	  ○ QL – 1 tablet/day
	• azithromycin 500 mg oral tablets
	  ○ QL – 7 tablets/30 days
	• azithromycin 250 mg oral tablets
	  ○ QL – 6 tablets/30 days
	• clarithromycin
	• erythromycin tablets
	• erythromycin ethylsuccinate susp
	  ○ ST – must be under 12 years of age or unable to swallow tablets/capsules
		• E.E.S. Granules
		  ○ ST – must have tried and failed erythromycin ethylsuccinate suspension in the past 90 days OR member must be under 12 years of age or unable to swallow tablets/capsules and prescriber has provided valid medical justification for the use of E.E.S. Granules over preferred agents
		• E.E.S. tablets
		• erythrocin stearate
		• erythromycin tablets EC
		
		PA criteria must be met for the following:
		• Dificid
		
		PA criteria AND Generic Medically Necessary PA criteria must be met for the following:
		• fidaxomicin
			Dificid PA Criteria
			
			Dificid PA Form

Ophthalmic Antibiotics	• Azasite soln • Besivance susp • Ciloxan oint • ciprofloxacin soln • erythromycin oint • gentamicin soln • moxifloxacin soln ○ AGE – 30 years of age or older; ST – patients under 30 years of age must have tried at least one preferred agent other than moxifloxacin within the past 30 days • ofloxacin soln • polymyxin B/bacitracin oint • polymyxin B/trimethoprim soln • sulfacet sod oint • tobramycin soln • Tobrex oint	• bacitracin oint • besifloxacin susp • gatifloxacin soln • neomycin/bacitracin/polymyxin oint • neomycin/polymyxin B/gramicidin soln	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ANTI-INFECTIVES - Continued			
Ophthalmic Antibiotics/ Corticosteroid Combinations	• neomycin/polymyxin B/dexamethasone oint • neomycin/polymyxin B/dexamethasone susp • sulfacetamide sodium/prednisolone soln • Tobradex oint • Tobradex ST susp • tobramycin/dexamethasone susp • Zylet susp	• loteprednol/tobramycin susp • neomycin/polymyxin/bacitracin/hc oint • neomycin/polymyxin/hc susp	
Otic Antibiotics	• ofloxacin otic soln ***Antibiotic/Steroid Combinations*** • ciprofloxacin-dexamethasone otic susp • Cipro HC susp • Cortisporin TC otic susp • neomycin/polymyxin B/hydrocortisone otic soln • neomycin/polymyxin B/hydrocortisone otic susp	• ciprofloxacin soln ***Antibiotic/Steroid Combinations*** Generic Medically Necessary PA criteria must be met for the following: • ciprofloxacin/hydrocortisone otic susp	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ANTI-INFECTIVES - Continued			

Systemic Antifungals	• fluconazole 50 mg tabs
	  ○ QL – 3 tabs/30 days
	• fluconazole 150 mg tabs
	  ○ QL – 4 tabs/30 days
	• fluconazole suspension
	• itraconazole
	• ketoconazole
	• terbinafine
		• Cresemba
		• itraconazole soln
		  ○ ST – must have tried and failed all preferred agents (i.e., each preferred chemical entity) or must provide medical justification as to why each preferred agent is not appropriate for use (e.g., infection being treated is not susceptible to preferred agents); must be 12 years of age and under OR unable to swallow capsules/tablets
		• Noxafil PAK
		  ○ ST – must be 2 years of age or older and less than 13 years of age
		• posaconazole tablet & 200 mg/5 mL suspension
		  ○ ST – must have tried fluconazole for treatment of oropharyngeal candidiasis or must be severely immunocompromised and need prophylaxis against invasive Aspergillus or Candida infections
		• Tolsura
		• Vfend suspension
		  ○ ST – must have tried and failed all preferred agents (i.e., each preferred chemical entity) or must provide medical justification as to why each preferred agent is not appropriate for use (e.g., infection being treated is not susceptible to preferred agents); must be 12 years of age and under or unable to swallow capsules/tablets
		• voriconazole tabs
		
		Generic Medically Necessary PA criteria must be met for the following:
		• voriconazole suspension
		
		PA criteria must be met for the following:
		• Brexafemme
		• Vivjoa
			Antimicrobials for Treatment of Vaginal Infections PA Criteria
			
			Antimicrobials for Treatment of Vaginal Infections PA form

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ANTI-INFECTIVES - Continued			
Topical Antifungals	***All generics unless otherwise specified*** • ciclopirox (cream & topical soln) • clotrimazole • miconazole • terbinafine 1% cream • tolnaftate 1% cream, powder, spray	• ciclopirox gel, kit, topical shampoo, topical suspension • econazole • Ertaczo • ketoconazole topical foam • miconazole/zinc/pet oint • Mycozyl AL 1% soln • Mycozyl HC gel, liquid • naftifine 1% cream • naftifine 2% cream, gel • Naftin 1% gel • Oxistat • tavaborole soln • Vusion	
Topical Antivirals	• acyclovir cream	• acyclovir ointment • penciclovir cream • docosanol OTC cream	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ANTI-INFECTIVES - Continued			

Vaginal Antimicrobials	***Antibacterials – oral***
	• metronidazole
	
	Antibacterials – intravaginal
	• Cleocin 2% cream
	• metronidazole vaginal gel
	• Nuvessa
	• Xaciato
	  ○ ST – previous trial and failure of a preferred intravaginal antibacterial agent
	
	Antifungals
	• clotrimazole OTC
	  ○ QL – 2 treatment courses/month
	• miconazole cream OTC
	  ○ QL – 2 treatment courses/month
	• tioconazole OTC
	  ○ QL – 2 treatment courses/month
	• terconazole cream
		Antibacterials – oral
		• Solosec
		• tinidazole
		  ○ ST – must have tried and failed metronidazole or provide medical justification as to why metronidazole is not appropriate for use (e.g., infection being treated is not susceptible to preferred agent)
		
		Antibacterials – intravaginal
		• Cleocin Ovules
		• Clindesse
		• Vandazole
		
		Generic Medically Necessary PA criteria must be met for the following:
		• clindamycin 2% cream
		
		Antifungals
		• Gynazole-1
		• miconazole combination pack OTC
		  ○ QL – 2 treatment courses/month
		• miconazole suppositories OTC
		  ○ QL – 2 treatment courses/month
		• miconazole suppositories (Rx)
		• terconazole suppositories	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ANTIMIGRAINE			

Antimigraine Preparations	• rizatriptan
	  ○ QL – 1 box – 12 tabs/30 days
	• rizatriptan ODT
	  ○ QL – 1 box – 12 tabs/30 days
	• sumatriptan nasal spray
	  ○ QL – 1 box – 6 inhalers/30 days
	• sumatriptan tablets
	  ○ QL – 1 box – 9 tabs/30 days
	• sumatriptan stat dose or stat dose refill package
	  ○ QL – 1 box – 2 injections/30 days
	• sumatriptan vial
	  ○ QL – 2 vials – 2 injections/30 days
	
	PSQC/PA criteria must be met for the following:
	• Nurtec ODT
	  ○ QL – 8 tabs/30 days for acute treatment;
	  ○ QL – 16 tabs/30 days for preventative treatment
	• Ubrelvy
	  ○ QL – 10 tabs/20 days
	
	Prophylaxis
	PSQC/PA criteria must be met for the following:
	• Aimovig
	  ○ QL – 140 mg/month
	• Ajovy
	  ○ QL – 225 mg/month or 675 mg/3 months
	• Emgality
	  ○ QL migraine – 240 mg loading dose; then 120 mg/month
	  ○ QL cluster headache – 300mg at start of headache and once monthly thereafter until end of headache
	• Qulipta
	  ○ QL – 1 tab/day
		• almotriptan
		  ○ QL – 1 box – 6 tabs/30 days
		• frovatriptan
		  ○ QL – 1 box – 9 tabs/30 days
		• naratriptan
		  ○ QL – 1 box – 9 tabs/30 days
		• Onzetra Xsail
		  ○ QL – 1 box (8 pouches)/30 days
		• Relpax
		  ○ QL – 1 box – 6 tabs/30 days
		• sumatriptan/naproxen
		  ○ QL – 1 box – 9 tabs/30 days
		  ○ ST – member must have tried and failed one preferred rizatriptan and one preferred sumatriptan product (supported by claims history or chart documentation) AND medical justification for use of naproxen/sumatriptan
		• Symbravo
		  ○ QL – 1 bottle – 9 tabs/30 days
		  ○ ST –member must have tried and failed naproxen/sumatriptan (supported by claims history or chart documentation) AND medical justification for use of Symbravo
		• Tosymra soln
		• Zembrace SymTouch
		  ○ QL – 1 box (4 injections)/30 days
		• zolmitriptan
		  ○ QL – 1 box – 6 tabs/30 days
		• zolmitriptan nasal spray
		  ○ QL – 1 box – 6 inhalers/30 days
		• zolmitriptan ODT
		  ○ QL – 1 box – 6 tabs/30 days
		
		PSQC/PA criteria must be met for the following:
		• Elyxyb
		  ○ QL – 6 bottles/30 days
			Antimigraine PA Criteria

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ANTIMIGRAINE - Continued			
Antimigraine Preparations - Continued		PSQC/PA criteria must be met for the following: • Reyvow ○ QL – 50 mg dose – 4 (50 mg) tabs/30 days ○ QL – 100 mg dose – 4 (100 mg) tabs/30 days ○ QL – 200 mg dose – 8 (100 mg) tabs/30 days • Zavzpret ○ QL – 6 devices/22 days Generic Medically Necessary PA criteria must be met for the following: • eletriptan ○ QL – 1 box – 6 tabs/30 days **Prophylaxis** PSQC/PA criteria must be met for the following: • Vyepti ○ QL – 3 mL/90 days	Antimigraine PA Criteria

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
CARDIOVASCULAR			

ACE Inhibitors	• benazepril
	• enalapril
	• fosinopril
	• lisinopril
	• ramipril
		• captopril
		• enalapril 1 mg/mL soln
		  ○ ST – must be under 12 years of age or unable to swallow tablets
		• moexipril
		• perindopril
		• Qbrelis
		  ○ ST – must be 6 years of age or older and less than 12 years of age OR 12 years of age and older AND unable to swallow tablets
		• quinapril
		• trandolapril	

ACE Inhibitor Combinations	***ACE Inhibitors with Calcium Channel Blockers***
	• amlodipine/benazepril
	  ○ QL – 30 caps/30 days
	
	ACE Inhibitors with Diuretics
	• benazepril/HCTZ
	• enalapril/HCTZ
	• lisinopril/HCTZ
		ACE Inhibitors with Calcium Channel Blockers
		• trandolapril/verapamil
		  ○ QL – 30 caps/30 days
		
		ACE Inhibitors with Diuretics
		• captopril/HCTZ
		• fosinopril/HCTZ
		• quinapril/HCTZ	

Angiotensin Receptor Blockers	• Edarbi
	  ○ QL – 1 tab/day
	• irbesartan
	  ○ QL – 1 tab/day
	• losartan 25 mg, 50 mg
	  ○ QL – 2 tabs/day
	• losartan 100 mg
	  ○ QL – 1 tab/day
	• olmesartan 5 mg
	  ○ QL – 3 tabs/day
	• olmesartan 20 mg, 40 mg
	  ○ QL – 1 tab/day
	• telmisartan
	  ○ QL – 1 tab/day
	• valsartan 40 mg, 80 mg, 160 mg
	  ○ QL – 2 tabs/day
	• valsartan 320 mg
	  ○ QL – 1 tab/day
		• Arbli suspension; valsartan soln
		  ○ ST – must be unable to swallow tablets
		• candesartan 4 mg, 8 mg, 16 mg
		  ○ QL – 2 tabs/day
		• candesartan 32 mg
		  ○ QL – 1 tab/day
		
		Generic Medically Necessary PA criteria must be met for the following:
		• azilsartan
		  ○ QL – 1 tab/day	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
CARDIOVASCULAR - Continued			
Angiotensin Receptor Blocker Combinations	***Angiotensin Receptor Blockers with Diuretics*** • Edarbyclor • losartan/HCTZ • valsartan/HCTZ ***Angiotensin Receptor Blockers with Calcium Channel Blockers*** N/A ***Angiotensin Receptor Blockers with Calcium Channel Blockers and Diuretics*** N/A	***Angiotensin Receptor Blockers with Diuretics*** • candesartan/HCTZ • irbesartan/HCTZ • olmesartan/HCTZ • telmisartan/HCTZ ***Angiotensin Receptor Blockers with Calcium Channel Blockers*** • olmesartan/amlodipine o ST – trial and failure of individual components • telmisartan/amlodipine o ST – trial and failure of individual components • valsartan/amlodipine o ST – trial and failure of individual components ***Angiotensin Receptor Blockers with Calcium Channel Blockers and Diuretics*** • amlodipine/olmesartan/HCTZ o ST – trial and failure of individual components • amlodipine/valsartan/HCTZ o ST – trial and failure of individual components	
Beta Adrenergic Blockers	• acebutolol • atenolol • bisoprolol • carvedilol • labetalol • metoprolol • metoprolol succinate ER • nadolol • nebivolol • propranolol • propranolol ER caps • sotalol	• betaxolol • carvedilol ER cap o QL – 1 cap/day • Hemangeol soln o ST – must be 5 weeks of age or older and less than or equal to 1 year of age • Kapspargo • Lopressor oral soln o ST – must be unable to swallow tablet formulation • pindolol • Sotylize oral soln o ST – must be under 12 years of age or unable to swallow capsules/tablets • timolol	
Beta Adrenergic Blockers with Diuretics	• atenolol/chlorthalidone • bisoprolol/HCTZ	• metoprolol/HCTZ	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
CARDIOVASCULAR - Continued			

Calcium Channel Blockers	***Dihydropyridine***
	• amlodipine
	• felodipine ER
	• nifedipine (short-acting)
	• nifedipine ER
	
	Non-Dihydropyridine
	• diltiazem (long-acting formulations)
	• diltiazem (non-time released)
	• nimodipine
	• verapamil (long-acting formulations)
	• verapamil (non-time released)
	
	Liquid Formulation
	• Norliqva
	  ○ ST – must be unable to swallow tablets
	
	Combinations
	N/A
		Dihydropyridine
		• isradipine (non-time released)
		• nicardipine (non-time released)
		• nisoldipine
		
		Non-Dihydropyridine
		• Matzim LA
		• verapamil ER PM
		• Verelan PM
		
		Liquid Formulation
		• Katerzia
		  ○ ST – must be 6 years of age or older and less than 12 years of age OR 12 years of age and older and unable to swallow tablets AND previous trial and failure of Norliqva OR medical rationale for use
		• Nymalize
		  ○ ST – must be 18 years of age or older AND unable to swallow capsule formulation
		
		Combinations
		• amlodipine/atorvastatin
		  ○ ST – prescriber must provide documentation that separate components are not suitable for use	

Miscellaneous Cardiac Agents	PA criteria must be met for the following: • Corlanor soln • ivabradine • sacubitril/valsartan	PA criteria must be met for the following: • Camzyos • Entresto sprinkle capsules • Verquvo	Cardiac Agents PA Criteria Cardiac Agents PA Form

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
CNS AND OTHERS			

Agents for the Treatment of Opioid Use Disorder or Overdose	***Agents for Opioid Use Disorder – oral***
	• buprenorphine sublingual tablets
	  ○ AGE – 16 years of age and older
	  ○ QL – 24mg/day
	• buprenorphine/naloxone sublingual tablets
	  ○ AGE – 16 years of age and older
	  ○ QL – 24mg/day
	• Suboxone Film
	  ○ AGE – 16 years of age and older
	  ○ QL – 24mg/day
	• Zubsolv
	  ○ AGE – 16 years of age and older
	  ○ QL – 17.2mg/day
	
	Agents for Opioid Use Disorder – injectable
	PA criteria must be met for the following:
	• Brixadi
	• Sublocade
	
	Agents for Opioid Overdose
	• Kloxxado
	• nalmefene
	• naloxone injection
	• naloxone nasal spray
	• Narcan Nasal
	• Rextovy
	• Opvee
	• Zimhi
		Agents for Opioid Use Disorder – oral
		Generic Medically Necessary PA criteria must be met for the following:
		• buprenorphine/naloxone sublingual films
		
		Agents for Opioid Use Disorder – injectable
		• N/A
		
		Agents for Opioid Overdose
		• Zurnai
			Opioid Use Disorder Treatments

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
CNS AND OTHERS - continued			

Antiemetic/Antivertigo Agents
 	
^Note: to meet step therapy requiring historical use of another agent, history must be supported by claims history or chart documentation
	Appetite Stimulant
	N/A
	
	H1 Antagonist/Vitamin
	• Diclegis
	  ○ QL – 4 tabs/day; Max 270/365 days
	
	Selective 5-HT3 Receptor Antagonist
	• ondansetron oral tablets
	  ○ QL – 90 tabs/30 days
	• ondansetron oral disintegrating tablets (4 mg and 8 mg)
	  ○ QL – 90 tabs/30 days
	• ondansetron oral soln
	  ○ QL – 1 bottle/Rx
	• ondansetron soln for injection
	
	Substance P-Neurokinin 1 Receptor Antagonist
	• aprepitant 40 mg and 80 mg oral capsules
	  ○ QL – 6 caps/Rx
	• aprepitant 80 mg/125 mg tripack
	  ○ QL – 2 packs (6 caps)/Rx
	• fosaprepitant vials, Navitrux vials
	  ○ QL – 2 vials/Rx
	
	Substance P-NK 1 Antagonist/Selective 5-HT3 Antagonist
	N/A
		Appetite Stimulant
		PSQC criteria must be met for the following:
		• dronabinol
		
		H1 Antagonist/Vitamin
		• Bonjesta
		  ○ QL – 2 tabs/day; Max 270/365 days
		
		Generic Medically Necessary PA criteria must be met for the following:
		• doxylamine/pyridoxine oral tabs
		
		Selective 5-HT3 Receptor Antagonist
		• Anzemet oral tabs
		  ○ QL – 10 units/Rx
		  ○ ST – must have previous trial of ondansetron – any formulation AND provide medical justification for use of the requested agent over ondansetron^
		• granisetron oral tablets; granisetron soln for injection
		  ○ ST – must have previous trial of ondansetron – any formulation AND provide medical justification for use of the requested agent over ondansetron^
		• ondansetron 16 mg ODT
		  ○ QL – 3 tablets/30 days
		• palonosetron injection
		  ○ QL – 1 vial/Rx
		  ○ ST – must have previous trial of ondansetron – any formulation AND provide medical justification for use of the requested agent over ondansetron^
			Dronabinol PA Criteria

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
CNS AND OTHERS - continued			

Antiemetic/Antivertigo Agents - continued		***Selective 5-HT3 Receptor Antagonist continued***
		• Posfrea
		  ○ QL – 1 vial/Rx
		  ○ ST – must have previous trial of generic palonosetron within the past 90 days AND provide medical justification for use of Posfrea over generic palonosetron injection
		• Sancuso transdermal system
		  ○ ST – prescriber has submitted medical justification for use of Sancuso (granisetron) patch over generic granisetron tablet and injectable formulations
		• Sustol
		  ○ ST – prescriber has submitted medical justification for use of Sustol (granisetron) injection (prefilled syringe) over generic granisetron tablet and injectable formulations
		
		Substance P-Neurokinin 1 Receptor Antagonist
		• aprepitant 125 mg oral capsules
		  ○ QL – 6 caps/Rx
		• Cinvanti injection
		  ○ QL – 2 vials/Rx
		• Emend IV soln
		  ○ QL – 2 vials/Rx
		• Emend suspension
		  ○ QL – 3 packets /Rx
		  ○ ST – must have tried Emend oral capsules or have inability to swallow or tolerate the capsule formulation
		• Focinvez
		  ○ QL – 2 vials/Rx
		
		Substance P-NK 1 Antagonist/Selective 5-HT3 Antagonist
		• Akynzeo
		  ○ ST – must have tried and failed combination therapy with preferred agents of the same classes or provide medical justification for use of the combination product
			Dronabinol PA Criteria

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
CNS AND OTHERS – continued			

Antiseizure Agents
 	
For all gabapentin formulations max total daily dose of 3,600 mg /day applies
 	
^Note: to meet step therapy requiring historical use of another agent, history must be supported by claims history or chart documentation
	• carbamazepine IR/ER tab, ER cap, chew, susp
	• Carbatrol
	• Celontin
	• clobazam tab
	  ○ QL for 10 mg tab – 8 tabs/day
	  ○ QL for 20 mg tab – 4 tabs/day
	• clobazam susp
	  ○ QL – 32 mL/day
	• Depakote Sprinkle
	• diazepam rectal gel
	  ○ QL – 10 doses/30 days
	• Dilantin cap, chew, susp
	• divalproex DR, ER, sprinkle cap
	• ethosuximide cap, soln
	• felbamate susp
	• Felbatol tablets
	• fosphenytoin
	• gabapentin cap, tab, soln*
	• lacosamide tab
	• Lamictal IR/XR/ODT Starter Kit
	  ○ QL – 1 kit/90 days
	• lamotrigine IR tab, chew, ODT, ER tab
	• levetiracetam IR, ER, soln, inj
	• Lyrica soln
	  ○ QL – 30 mL/day
	• Lyrica cap
	  ○ QL for 25 mg, 50 mg, 75 mg, 100 mg, 150 mg, 200 mg cap – 3 caps/day
	  ○ QL for 225 mg or 300 mg cap – 2 caps/day
	• midazolam syrup
	• Nayzilam
	  ○ QL – 10 doses/30 days
	• Neurontin cap, tab, soln*
	• oxcarbazepine tab, susp
	• Oxtellar XR
	• phenobarbital tab, soln, inj
	• Phenytek
	• phenytoin cap, chew, susp, inj
	• pregabalin cap
	  ○ QL for 25 mg, 50 mg, 75 mg 100 mg, 150 mg, 200 mg cap – 3 caps/day
	  ○ QL for 225 mg or 300 mg cap – 2 caps/day
	• primidone
	• Relgaabi cap
	• Roweepra
		PA criteria must be met for the following:
		• Aptiom
		• Briviact inj, soln, tab
		• Brivaracetam inj, soln, tab
		• Diacomit
		• Elepsia XR
		• Epidiolex
		• Fintepla
		• Fycompa tab, susp
		• Gabarone*
		  ○ ST – prescriber has submitted medical justification for use of Gabarone (gabapentin) tablet over preferred gabapentin capsules
		• lacosamide inj, soln
		• Libervant
		  ○ QL – 10 doses/30 days
		• Motpoly XR
		• rufinamide tabs/susp
		• Spritam
		• Subvenite IR tab
		• Subvenite oral suspension
		  ○ ST – must be 2 years of age or older and less than 12 years of age OR 12 years of age or older and unable to swallow tablets
		• Sympazan
		  ○ QL for 5 mg and 10 mg films – 8 films/day
		  ○ QL for 20 mg films – 4 films/day
		  ○ ST –must have trial and failure of clobazam tablet or suspension AND prescriber has submitted medical justification for the use of Sympazan (clobazam) film over clobazam tablet and suspension^
		• vigabatrin
		• Vigadrone
		• Vigafyde
		• Vigpoder
			Antiseizure Agents Prior Authorization Criteria

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
CNS AND OTHERS - Continued			

Antiseizure Agents - continued
 	
For all gabapentin formulations max total daily dose of 3, 600 mg /day applies
	• Tegretol IR tab, XR tab, susp
	• tiagabine
	• topiramate tab, sprinkle cap (generic Topamax)
	• topiramate ER sprinkle cap (generic Qudexy)
	  ○ QL– 2 caps/day
	  ○ ST – must be 2 years of age or older and less than 12 years of age OR 12 years of age or older and unable to swallow capsules
	• Trokendi XR
	  ○ QL for any strength – 2 caps/day
	• valproate inj
	• valproic acid cap, soln
	• Valtoco
	  ○ QL – 10 doses/30 days
	• zonisamide cap
	
	PA criteria must be met for the following:
	• Eprontia
	  ○ QL – 16 mL/day
		• Xcopri tab
		• Xcopri Titration Pak
		  ○ QL – 1 Pak/90 days
		• Zonisade
		• Ztalmy
		
		PA criteria AND Generic Medically Necessary PA criteria must be met for the following:
		• felbamate
		• lamotrigine IR/ODT starter kit; Subvenite IR starter kit
		• levetiracetam ODT
		• methsuximide
		• oxcarbazepine ER tab (generic Oxtellar)
		• perampanel tab
		• pregabalin soln
		• rufinamide 200 mg tab
		• topiramate ER capsule (generic Trokendi XR)
		• topiramate soln (generic Eprontia)
			Antiseizure Agents Prior Authorization Criteria

Gastroprotective Agents	• Celebrex	• diclofenac-misoprostol delayed release tablets • ibuprofen-famotidine • naproxen-esomeprazole magnesium • Vyscoxa ○ ST – must be 2 years of age or older and less than 12 years of age OR 12 years of age or older and unable to swallow capsules Generic Medically Necessary PA criteria must be met for the following: • celecoxib	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
CNS AND OTHERS - Continued			
Mental Health Agents: Alzheimer's and Dementia Agents ***Please refer to Mental Health Medications and Utilization Edits list for drug-specific age and quantity limits. If request is not meeting permitted limit(s), a PA submission will be required.*** ***^Note: to meet step therapy requiring historical use of another agent, history must be supported by claims history or chart documentation***	• donepezil ODT, tab • ergoloid mesylates • galantamine ER cap, IR tab • galantamine oral soln ○ ST – must be unable to swallow tablet formulation, as supported by chart documentation • memantine ER cap, IR tab, oral soln, titration pack • rivastigmine cap, patch	• Namzaric ○ ST – prescriber must provide documentation supporting separate components are not suitable for use; OR history of Namzaric (memantine/ donepezil) capsules for 90 of the past 120 days^ • Zunveyl ○ ST – trial and failure of galantamine (any formulation) AND prescriber has submitted medical justification for use; OR history of Zunveyl (benzgalantamine) for 90 of the past 120 days^ Generic Medically Necessary PA criteria must be met for the following: • memantine/donepezil (generic Namzaric)	Mental Health Medications Medical Necessity Prior Authorization Form Utilization Edits for Mental Health Medications

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
CNS AND OTHERS - Continued			
Mental Health Agents: Anti-Anxiety and Related Disorders ***Please refer to Mental Health Medications and Utilization Edits list for drug-specific age and quantity limits. If request is not meeting permitted limit(s), a PA submission will be required.*** ***^Note: to meet step therapy requiring historical use of another agent, history must be supported by claims history or chart documentation***	***Benzodiazepines*** PA criteria must be met for the following: • alprazolam IR/XR tab, ODT, oral conc soln • chlordiazepoxide • chlordiazepoxide/amitriptyline • clonazepam tab, ODT • clorazepate dipotassium • diazepam oral soln, oral conc soln, tab • lorazepam inj soln, oral conc soln, tab • oxazepam ***Non-Benzodiazepines*** • buspirone tab • cyproheptadine syrup, tab • hydroxyzine hcl syrup, tab • hydroxyzine pamoate • prazosin	***Benzodiazepines*** PA criteria must be met for the following: • Loreev XR ***Non-Benzodiazepines*** • Bucapsol ○ ST – must have previous trial and failure of buspirone tablet AND prescriber must provide rationale for Bucapsol over buspirone tablet^ • meprobamate ○ ST – must have previous trial and failure of buspirone IR tablet and hydroxyzine AND prescriber must provide rationale for meprobamate use over buspirone IR tablet and hydroxyzine; OR history of meprobamate for 90 of the past 120 days^ PA criteria must be met for the following: • Igalmi	Benzodiazepine and Opioid Concurrent Therapy PA Form Igalmi Mental Health Medications Medical Necessity Prior Authorization Form Sedative Hypnotics-Benzodiazepine PA with QL Utilization Edits for Mental Health Medications

DRUG CLASS	PREFERRED		NON-PREFERRED	PA CRITERIA (if applicable)
CNS AND OTHERS - Continued				
Mental Health Agents: Antidepressant Agents ***Please refer to Mental Health Medications and Utilization Edits list for drug-specific age and quantity limits. If request is not meeting permitted limit(s), a PA submission will be required.*** ***^Note: to meet step therapy requiring historical use of another agent, history must be supported by claims history or chart documentation***	***MAO-I*** ***N/A*** ***Miscellaneous Agents*** • Auvelity • bupropion IR/ER/SR/XL tab • mirtazapine ODT, tab • nefazodone • trazodone tab PA criteria must be met for the following: • Zurzuvae ***SNRI*** PA criteria must be met for the following*: • desvenlafaxine ER • desvenlafaxine succinate ER • duloxetine • Fetzima cap/titration pack • Savella tab/titration pack • venlafaxine besylate ER tab venlafaxine hcl IR/ER tab, ER cap	***SSRI*** PA criteria must be met for the following*: • citalopram tab • citalopram oral soln; escitalopram oral soln; fluoxetine oral soln ○ ST – must be under 12 years of age OR 12 years of age or older and unable to swallow capsule/tablet formulation, as supported by chart documentation; OR history of respective oral solution for 90 of the past 120 days^ • escitalopram tab • fluoxetine IR/DR cap, tab • fluvoxamine tab • paroxetine IR/ER tab	***MAO-I*** • Emsam; Marplan; phenelzine; tranylcypromine ○ ST – must have previous trial and failure of one SSRI and one SNRI agent for at least 4 weeks each AND prescriber has submitted medical justification for use; OR history of requested agent for 90 of the past 120 days^ ***Miscellaneous Agents*** • bupropion ER (generic Forfivo XL) 450 mg tablet ○ ST – prescriber has submitted medical justification for use of bupropion ER 450 mg tablet over preferred bupropion agents; OR history of bupropion ER 450 mg tablet for 90 of the past 120 days^ • Exxua tab, titration pack ○ ST – must have trial and failure of two preferred antidepressant agents for at least 4 weeks each; OR history of requested agent for 90 of the past 120 days^ • Raldesy ○ ST – must be under 12 years of age OR 12 years of age or older and unable to swallow tablet formulation, as supported by chart documentation; OR history of Raldesy oral solution for 90 of the past 120 days^ PA criteria must be met for the following: • Spravato ***SNRI*** PA criteria must be met for the following*: • Drizalma sprinkle ○ ST – must be under 12 years of age OR 12 years of age or older and unable to swallow capsule formulation, as supported by chart documentation; OR history of Drizalma sprinkle capsules for 90 of the past 120 days^ PA criteria AND Generic Medically Necessary PA criteria must be met for the following: • milnacipran tab/titration pack	Mental Health Medications Medical Necessity Prior Authorization Form Spravato PA *PA is required for duplication of SSRI/SNRI/NRI therapy SSRI/SNRI/NRI Duplicate Therapy PA with QL Utilization Edits for Mental Health Medications Zurzuvae

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
CNS AND OTHERS - Continued			

Mental Health Agents: Antidepressant Agents – continued
 	
Please refer to Mental Health Medications and Utilization Edits list for drug-specific age and quantity limits. If request is not meeting permitted limit(s), a PA submission will be required.
 	
^Note: to meet step therapy requiring historical use of another agent, history must be supported by claims history or chart documentation
	SSRI-continued
	• paroxetine oral soln
	  ○ ST – must be unable to swallow tablet formulation, as supported by chart documentation; OR history of paroxetine oral suspension for 90 of the past 120 days^
	• sertraline tab
	• sertraline conc soln
	  ○ ST – must be under 12 years of age OR 12 years of age or older and unable to swallow tablet formulation, as supported by chart documentation; OR history of sertraline oral concentrate for 90 of the past 120 days^
	• Trintellix
	• vilazodone
	
	TCA
	• amitriptyline
	• amoxapine
	• clomipramine
	• desipramine
	• doxepin cap, oral soln
	• imipramine hcl
	• imipramine pamoate
	• nortriptyline cap
	• nortriptyline oral soln
	  ○ ST – must be under 12 years of age OR 12 years of age or older and unable to swallow capsule formulation, as supported by chart documentation; OR history of nortriptyline oral solution for 90 of the past 120 days^
	• protriptyline
		SSRI
		PA criteria must be met for the following*:
		• citalopram cap
		  ○ ST – must have previous trial and failure of citalopram tablet AND prescriber has submitted medical justification for the use of citalopram capsule over citalopram tablet; OR history of citalopram capsule for 90 of the past 120 days^
		• escitalopram cap
		  ○ ST – must have previous trial and failure of escitalopram tablet AND prescriber has submitted medical justification for the use of escitalopram capsule over escitalopram tablet; OR history of escitalopram capsule for 90 of the past 120 days^
		• fluvoxamine CR cap
		  ○ ST – must have previous trial and failure of fluvoxamine IR tablet formulation AND prescriber has submitted medical justification for the use of fluvoxamine ER capsule over fluvoxamine IR tablet; OR history of fluvoxamine ER capsule for 90 of the past 120 days^
		• sertraline cap
		  ○ ST – must have trial and failure of sertraline tablet AND prescriber has submitted medical justification for the use of sertraline capsule over sertraline tablet; OR history of sertraline capsule for 90 of the past 120 days^
		TCA
		• trimipramine maleate
		  ○ ST – must have trial and failure of all preferred tricyclic antidepressants OR medical justification for the use of trimipramine over all preferred tricyclic antidepressants^
			Mental Health Medications Medical Necessity Prior Authorization Form
			
			Spravato PA
			
			*PA is required for duplication of SSRI/SNRI/NRI therapy
			SSRI/SNRI/NRI Duplicate Therapy PA with QL
			
			Utilization Edits for Mental Health Medications
			
			Zurzuvae

DRUG CLASS	PREFERRED		NON-PREFERRED	PA CRITERIA (if applicable)
CNS AND OTHERS - Continued				
Mental Health Agents: Antipsychotic and Antimanic Agents ***Please refer to Mental Health Medications and Utilization Edits list for drug-specific age and quantity limits. If request is not meeting permitted limit(s), a PA submission will be required.*** ***^Note: to meet step therapy requiring historical use of another agent, history must be supported by claims history or chart documentation***	***Antipsychotics – First Generation*** PA criteria must be met for the following: • chlorpromazine inj soln, oral conc, tab • fluphenazine decanoate • fluphenazine hcl elixir, inj soln, oral conc soln, tab • haloperidol decanoate IM soln • haloperidol lactate oral conc, inj soln • haloperidol tab • loxapine • molindone • perphenazine • perphenazine/amitriptyline • prochlorperazine edisylate inj soln • prochlorperazine maleate tab • thioridazine • thiothixene • trifluoperazine ***Antipsychotics – Miscellaneous*** ***N/A***	***Antipsychotics – Second Generation*** PA criteria must be met for the following: • Abilify Asimtufii • Abilify Maintena (syringe/vial) • aripiprazole tabs • aripiprazole ODT, soln ○ ST – must be under 12 years of age OR 12 years of age or older and unable to swallow tablet formulation (as supported by chart documentation); OR history of requested agent for 90 of the past 120 days^ • Aristada/Aristada Initio • asenapine SL • Caplyta • clozapine tab • clozapine ODT ○ ST – must have trial and failure of clozapine tablet AND prescriber has submitted medical justification for the use of clozapine ODT over clozapine tablet; OR history of clozapine ODT for 90 of the past 120 days^	***Antipsychotics – First Generation*** PA criteria must be met for the following: • pimozide ○ ST – member has tried and failed two of the following for 4 weeks each: aripiprazole, haloperidol, risperidone; OR history of pimozide for 90 of the past 120 days^ ***Antipsychotics – Second Generation*** PA criteria must be met for the following: • Fanapt tab, titration pack ○ ST – must have trial and failure of one preferred antipsychotic agent OR medical justification for the use of Fanapt over all preferred agents; OR history of the requested agent for 90 of the past 120 days^ • Nuplazid cap, tab • Opipza ○ ST – must have trial and failure of aripiprazole tablet AND prescriber has submitted medical justification for the use of Opipza over aripiprazole tablet; OR history of Opipza for 90 of the past 120 days^ • Secuado ○ ST – must have trial and failure of asenapine SL AND prescriber has submitted medical justification for the use of Secuado patch over asenapine SL; OR history of Secuado patch for 90 of the past 120 days^ • Versacloz ○ ST – must be unable to swallow tablet formulation, as supported by chart documentation	Antipsychotic Therapy PA with QL Mental Health Medications Medical Necessity Prior Authorization Form Nuplazid PA Utilization Edits for Mental Health Medications

DRUG CLASS	PREFERRED		NON-PREFERRED	PA CRITERIA (if applicable)
CNS AND OTHERS - Continued				

Mental Health Agents: Antipsychotic and Antimanic Agents – continued
 	
Please refer to Mental Health Medications and Utilization Edits list for drug-specific age and quantity limits. If request is not meeting permitted limit(s), a PA submission will be required.
 	
^Note: to meet step therapy requiring historical use of another agent, history must be supported by claims history or chart documentation
	Antimanic Agents
	• Equetro
	• lithium cap, IR/ER tab
	• lithium oral soln
	  ○ ST – must be under 12 years of age OR 12 years of age or older and unable to swallow capsule/tablet formulation, as supported by chart documentation
		Antipsychotics – Second Generation – continued
		• Erzofri
		• Invega Hafyera
		• Invega Sustenna
		• Invega Trinza
		• lurasidone
		• Lybalvi
		• olanzapine IM soln, ODT, tab
		• olanzapine/fluoxetine
		• paliperidone tab
		• quetiapine IR/ER tab
		• Rexulti
		• Risperdal Consta
		• risperidone tab
		• risperidone ODT, soln
		  ○ ST – must be under 12 years of age OR unable to swallow tablet formulation (as supported by chart documentation); OR history of requested agent for 90 of the past 120 days^
		• Uzedy
		• Vraylar
		• ziprasidone cap, IM soln
		• Zyprexa Relprevv
			Antipsychotics – Second Generation – continued
			PA criteria AND Generic Medically Necessary PA criteria must be met for the following:
			• risperidone microspheres inj soln
			
			Antipsychotics – Miscellaneous
			PA criteria must be met for the following:
			• Cobenfy tab, titration pack
			
			Antimanic Agents
			N/A
				Antipsychotic Therapy PA with QL
				
				Mental Health Medications Medical Necessity Prior Authorization Form
				
				Nuplazid PA
				
				Utilization Edits for Mental Health Medications

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
CNS AND OTHERS - Continued			

Mental Health Agents: Insomnia Agents
 	
Please refer to Mental Health Medications and Utilization Edits list for drug-specific age and quantity limits. If request is not meeting permitted limit(s), a PA submission will be required.
 	
^Note: to meet step therapy requiring historical use of another agent, history must be supported by claims history or chart documentation
	Benzodiazepines
	PA criteria must be met for the following:
	• estazolam
	• temazepam
	• triazolam
	
	Hypnotic/Sedative
	PA criteria must be met for the following:
	• Belsomra
	• eszopiclone
	• ramelteon
	• zaleplon
	• zolpidem IR/CR tab
	
	Miscellaneous
	• doxepin (generic Silenor)
		Benzodiazepines
		PA criteria must be met for the following:
		• flurazepam
		  ○ ST – must have trial and failure of all preferred benzodiazepine agents for insomnia OR medical justification for use over preferred benzodiazepine agents for insomnia^
		• quazepam
		  ○ ST – must have trial and failure of all preferred benzodiazepine agents for insomnia OR medical justification for use over preferred benzodiazepine agents for insomnia^
		
		Hypnotic/Sedative
		PA criteria must be met for the following:
		• Dayvigo; Quviviq
		  ○ ST – must have trial and failure of Belsomra OR prescriber has submitted medical justification for the use of requested agent over Belsomra^
		• Edluar SL 5 mg, 10 mg
		  ○ ST – must have trial and failure of zolpidem tablet AND prescriber has submitted medical justification for the use of Edluar SL over zolpidem tablet^
		• Hetlioz LQ oral susp
		• tasimelteon cap
		• zolpidem 7.5 mg cap
		  ○ ST – must have trial and failure of zolpidem IR 5 mg^
		• zolpidem SL 1.75 mg and 3.5 mg
		  ○ ST – prescriber has submitted medical justification for the use of zolpidem sublingual tablets AND member is not using concomitantly with other zolpidem strengths/formulations
		
		Miscellaneous
		• N/A
			Benzodiazepine and Opioid Concurrent Therapy PA Form
			
			Hetlioz/Hetlioz LQ PA
			
			Hetlioz/Hetlioz LQ PA Form
			
			Mental Health Medications Medical Necessity Prior Authorization Form
			
			Sedative Hypnotics-Benzodiazepine PA with QL
			
			Utilization Edits for Mental Health Medications

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
CNS AND OTHERS - Continued			
Mental Health Agents: Narcolepsy and Cataplexy Agents ***Please refer to Mental Health Medications and Utilization Edits list for drug-specific age and quantity limits. If request is not meeting permitted limit(s), a PA submission will be required.***	PA criteria must be met for the following: • armodafinil • modafinil • Xyrem	PA criteria must be met for the following: • Sunosi • Wakix • Xywav PA criteria AND Generic Medically Necessary PA criteria must be met for the following: • sodium oxybate	Narcolepsy Agents PA Narcolepsy Agents PA Form Mental Health Medications Medical Necessity Prior Authorization Form Utilization Edits for Mental Health Medications
Mental Health Agents: Non-Stimulant ADHD Agents ***Please refer to Mental Health Medications and Utilization Edits list for drug-specific age and quantity limits. If request is not meeting permitted limit(s), a PA submission will be required.*** ***^Note: to meet step therapy requiring historical use of another agent, history must be supported by claims history or chart documentation***	PA criteria must be met for the following: • clonidine IR/ER tab, patch • guanfacine IR/ER tab • Onyda XR oral susp PA criteria must be met for the following *: • atomoxetine • Qelbree ○ ST – previous trial and failure of a preferred ADHD agent (stimulant or non-stimulant); OR history of Qelbree (viloxazine) for 90 of the past 120 days^		Clonidine and Guanfacine PA Mental Health Medications Medical Necessity Prior Authorization Form *PA is required for duplication of SSRI/SNRI/NRI therapy SSRI/SNRI/NRI Duplicate Therapy PA with QL Utilization Edits for Mental Health Medications

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
CNS AND OTHERS - Continued			

Mental Health Agents: Stimulants
 	
Please refer to Mental Health Medications and Utilization Edits list for drug-specific age and quantity limits. If request is not meeting permitted limit(s), a PA submission will be required.
 	
^Note: to meet step therapy requiring historical use of another agent, history must be supported by claims history or chart documentation
	PA criteria must be met for the following:
	• amphetamine
	• amphetamine/dextroamphetamine ER cap, IR tab
	• Azstarys
	• dextroamphetamine IR tab, ER cap
	• dextroamphetamine oral soln
	  ○ ST – must be under 12 years of age OR 12 years of age or older and unable to swallow capsule/tablet formulation, as supported by chart documentation
	• dexmethylphenidate IR tab, XR cap
	• Dyanavel XR oral susp, XR tab
	• Jornay PM
	  ○ ST – must have trial and failure of at least one preferred long-acting methylphenidate product OR medical justification for use of Jornay PM; OR history of the requested agent for 90 of the past 120 days^
	• methamphetamine
	• methylphenidate chew, ER (CD) cap, ER cap, IR/ER tab, oral soln, patch
	• Quillivant XR
	• Quillichew ER
	• Vyvanse cap
	• Vyvanse chew
	  ○ ST – must be under 12 years of age OR 12 years of age or older and unable to swallow capsule formulation, as supported by chart documentation
		PA criteria must be met for the following:
		• Adzenys XR ODT
		  ○ ST – must have trial and failure of Dyanavel XR (amphetamine) chew or suspension OR medical justification for the use of Adzenys XR (amphetamine) over Dyanavel XR (amphetamine); OR history of the requested agent for 90 of the past 120 days^
		• amphetamine/dextroamphetamine ER capsule (generic Mydayis)
		  ○ ST – must have trial and failure of amphetamine/dextroamphetamine ER capsules (generic Adderall XR) or medical justification for use of generic Mydayis over generic Adderall XR; OR history of the requested agent for 90 of the past 120 days^
		• Cotempla XR ODT; methylphenidate ER ODT; Relexxi; Zenzedi
		  ○ ST – must have trial and failure of two preferred stimulants (different chemical entities) OR medical justification for the use of the non-preferred agent over all preferred agents; OR history of the requested agent for 90 of the past 120 days^
		• methylphenidate ER capsule (generic Aptensio XR)
		  ○ ST – must have trial and failure of at least one preferred long-acting methylphenidate product OR medical justification for use of methylphenidate ER capsule (generic Aptensio XR); OR history of the requested agent for 90 of the past 120 days^
		• Procentra
		  ○ ST – must be under 12 years of age OR 12 years of age or older and unable to swallow capsule/tablet formulation, as supported by chart documentation AND prescriber has submitted medical justification for use of Procentra over dextroamphetamine oral solution
		• Xelstrym
		  ○ ST – must provide medical justification for topical formulation
		
		PA criteria AND Generic Medically Necessary PA criteria must be met for the following:
		• amphetamine XR ODT
		• lisdexamfetamine capsule
		• lisdexamfetamine chewable
			Mental Health Medications Medical Necessity Prior Authorization Form
			
			Stimulants Therapy PA with QL
			
			Utilization Edits for Mental Health Medications

Effective for FFS and Managed Care Organization claims submitted on or after August 1, 2026. V1.0
Inclusion or reference to any given drug does not indicate market availability of the drug. Drugs that will be, or have been, withdrawn from the market will be removed from the SUPDL as part of routine periodic updating of the SUPDL.

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
CNS AND OTHERS - Continued			
Movement Disorder Agents	• benztropine tablet, injection • trihexyphenidyl tablet, soln PA criteria must be met for the following: • Austedo • Austedo XR • Austedo XR Titration Kit • Ingrezza • Ingrezza sprinkle capsules • Ingrezza Therapy Pack • tetrabenazine	N/A	Movement Disorder Agents PA Criteria
Narcotic Antitussives and Combinations ***See Opioid Overutilization with Age and Quantity Limits PA Criteria for product-specific age and quantity limits*** ***Note: All narcotic antitussives will require PA for members under 18 years of age ***	PSQC criteria must be met for the following: • guaifenesin/codeine 100-10mg/5mL soln • hydrocodone/ homatropine syrup • hydrocodone/homatropine tab • Hydromet syrup • promethazine VC/codeine syrup • promethazine with codeine	PSQC criteria must be met for the following: • hydrocodone polst/chlorpheniramine polst ER • Tuxarin ER	Opioid Overutilization with Age and Quantity Limits PA Criteria

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
CNS AND OTHERS - Continued			
Narcotics ***See Opioid Overutilization with Age and Quantity Limits PA Criteria for product-specific age and quantity limits*** ***Note: All codeine products will require PA for members under 18 years of age***	***Short Acting*** PSQC/PA criteria must be met for the following: • apap/codeine • buprenorphine inj • butorphanol injection ○ AGE – 18 years of age and older • butorphanol 10 mg/mL nasal spray • codeine sulfate • codeine/butalbital/apap/caffeine • codeine/butalbital/asa/caffeine • hydrocodone/apap (all formulations/strengths except those listed under non-preferred) • hydrocodone/ibu • hydromorphone • levorphanol • meperidine • morphine • nalbuphine • opium tincture • oxycodone • oxycodone/apap • pentazocine/naloxone • tramadol • tramadol/APAP • Xyvona ***Long Acting*** PSQC criteria must be met for the following: • Butrans • fentanyl patches • morphine ER tab (MS Contin)	***Short Acting*** PSQC/PA criteria must be met for the following: • Apadaz • benzhydrocodone/APAP • belladonna and opium suppositories • hydrocodone/apap 10-300 mg/15 mL soln • Nalocet • oxycodone AD • oxymorphone IR • Prolate • Qdolo • RoxyBond • tapentadol IR • tramadol 5 mg/mL soln • Trezix ***Long Acting*** PSQC criteria must be met for the following: • Belbuca • hydrocodone ER cap (Zohydro) • Hysingla ER • hydromorphone ER tab (Exalgo) • methadone • morphine ER cap (Avinza, Kadian) • oxycodone ER tab • Oxycontin • oxymorphone ER tab (Opana) • tapentadol ER • tramadol ER (Conzip, Ryzolt, Ultram ER) PA criteria AND Generic Medically Necessary PA criteria must be met for the following: • buprenorphine patches • hydrocodone ER tab (Hysingla ER)	APAP High Dose PA Criteria Benzodiazepine and Opioid Concurrent Therapy PA Form Opioid Overutilization with Age and Quantity Limits PA Criteria Opioid PA Form – Request to Exceed MME Limit Opioid with Concurrent Buprenorphine/Naloxone PA Form

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
CNS AND OTHERS - Continued			
Skeletal Muscle Relaxants	• baclofen • chlorzoxazone • cyclobenzaprine IR (tabs) • methocarbamol • orphenadrine citrate • tizanidine tablets ***Granules/Liquid Formulation*** • baclofen 5 mg/5 mL soln; baclofen 10 mg/5 mL soln; baclofen 25 mg/5mL susp; Lyvispah granules ○ ST – must be unable to swallow tablets	• Amrix ○ ST – must try cyclobenzaprine tablets within the past 30 days • dantrolene • Fexmid • metaxalone • Norgesic • Norgesic Forte • Orphengesic Forte • orphenadrine/aspirin/caffeine • Tanlor • tizanidine capsules • Tonmya ○ QL – 2 SL tabs/day ○ ST – must trial cyclobenzaprine IR (tabs) within the past 30 days PA criteria must be met for the following: • carisoprodol ○ QL – 4 tabs/day Generic Medically Necessary PA criteria must be met for the following: • cyclobenzaprine ER (caps) Granules/Liquid Formulation • Ontralfy ○ ST – must be unable to swallow tablets	Carisoprodol Agents PA Criteria Carisoprodol Agents PA Form

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
CNS AND OTHERS - Continued			

Smoking Deterrent Agents	***Nicotine Replacement***
	• nicotine gum
	  ○ AGE – 10 years of age or older
	  ○ QL – 24 pieces/day
	• nicotine lozenge
	  ○ AGE – 10 years of age or older
	  ○ QL – 20 pieces/day
	• nicotine patch
	  ○ AGE – 10 years of age or older
	  ○ QL – 1 patch/day
	• nicotine patch kit
	  ○ AGE – 10 years of age or older
	  ○ QL – 1 kit/90 days
	
	Other Smoking Deterrents
	• bupropion SR 150
	• varenicline
	  ○ AGE – 18 years of age or older
	  ○ QL – 1 starter pack/90 days
		Nicotine Replacement
		• Nicotrol NS
		  ○ AGE – 10 years of age or older
		  ○ QL – 12 bottles/30 days
		• Nicotrol Inhaler
		  ○ AGE – 10 years of age or older
		  ○ QL – 3 inhalers/31 days
		
		Other Smoking Deterrents
		N/A	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
DERMATOLOGIC			

Acne Agents
 	
Note: All Rx acne agents for members over the age of 25 years require step therapy with one covered OTC acne product
 	
Note: A 14-day trial each of at least 2 preferred agents is required prior to receiving a non-preferred agent.
	All legend generic products are preferred unless otherwise specified
	
	• adapalene 0.1% gel (OTC)
	  ○ AGE – 12 years and older
	• benzoyl peroxide OTC gel, wash
	• benzoyl peroxide-erythromycin 5-3% gel
	• clindamycin 1% gel, lotion, solution, swabs
	• clindamycin-benzoyl peroxide 1-5% gel
	• clindamycin-benzoyl peroxide 1.2-5% gel
	• clindamycin-tretinoin 1.2-0.025% gel
	• Differin 0.1% cream
	  ○ AGE – 25 years and under – ST – must have tried a preferred topical tretinoin product
	  ○ AGE – >25 years – ST – must have tried one covered OTC acne product AND a preferred topical tretinoin product
	• Differin 0.3% gel
	  ○ AGE – 25 years and under – ST – must have tried a preferred topical tretinoin product
	  ○ AGE – >25 years – ST – must have tried one covered OTC acne product AND a preferred topical tretinoin product
	• Differin gel cleanser
	• erythromycin 2% gel, solution
	• Neuac 1.2-5% gel
	• tretinoin cream
	• tretinoin gel 0.01%, 0.025%
	
	Oral Formulations
	• Amnesteem
	• Claravis
	• Zenatane
		All legend brand products are non-preferred unless otherwise specified
		
		• adapalene/benzoyl peroxide 0.1-2.5% gel
		• adapalene/benzoyl peroxide 0.3-2.5% gel
		• Aklief 0.005% cream
		• BP 10-1 emulsion
		• Clindacin 1% foam, kit, kit ETZ, swab
		• clindamycin 1% foam
		• clindamycin/benzoyl peroxide 1.2-2.5% gel
		• clindamycin/benzoyl peroxide 1.2-3.75% gel
		• dapsone gel
		• Ery-Pad 2%
		• Fabior 0.1% foam
		• Plexion cleanser
		• SSS 10-5% cream, 10-5% foam
		• sulfacetamide sod/sulfur 8-4% susp, 9-4% wash, 9-4.25% susp, 9-4.5% wash, 9.8-4.8% wash, 10-2% cream, 10-5% cream, 10-1% emulsion, 10-2% wash, 10-5% wash
		• sulfacetamide sod 10% topical lotion
		• Sumadan Kit
		• Sumaxin 10-4% pads, CP kit
		• tazarotene 0.1% foam
		• tretinoin gel 0.05%
		• tretinoin 0.08% microsphere
		• Twyneo
		  ○ ST – trial and failure of concomitant use of individual components for at least 30 days AND rationale for use over separate individual components
		• Winlevi 1% cream
		
		Generic Medically Necessary PA criteria must be met for the following:
		• adapalene 0.1% cream
		• adapalene 0.3% gel
		
		Oral Formulations
		• Absorica LD
		• isotretinoin	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
DERMATOLOGIC - Continued			
Antipsoriatics	• calcipotriene cream • calcipotriene topical soln • Enstilar • Pellix topical soln • Taclonex scalp suspension • tazarotene 0.1% cream • Vectical ointment PA criteria must be met for the following: • acitretin	• calcipotriene 0.005% foam • calcipotriene ointment • calcipotriene/betamethasone ointment • methoxsalen • Sorilux foam • tazarotene 0.05% cream, gel • tazarotene 0.1% gel • Trilitas 0.1% gel Generic Medically Necessary PA criteria must be met for the following: • calcipotriene/betamethasone suspension • calcitriol ointment	Soriatane PA Criteria

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ELECTROLYTE DEPLETERS			
Electrolyte Depleters	***Miscellaneous Agents*** N/A ***Phosphate Binders*** • calcium acetate capsules • calcium acetate tabs • calcium carbonate 500 mg • calcium carbonate 500 mg, 750 mg, 1000 mg chew • calcium carbonate 1.25 gm (500 mg elemental calcium) chew • calcium carbonate 1.25 gm (500 mg elemental calcium) tab • calcium carbonate 1250 mg/5 mL susp ○ QL – 30 mL/day • Magnebind 300 mg tab ○ QL – 2 bottles (300 tabs)/30 days • sevelamer carbonate powder • sevelamer carbonate tabs ***Potassium Binders*** • Lokelma • sodium polystyrene sulfonate powder • SPS (sodium polystyrene sulfonate) suspension • Veltassa	***Miscellaneous Agents*** • Xphozah ○ ST – must have tried and failed preferred phosphate binders OR submit medical rationale for use over ALL preferred phosphate binders ***Phosphate Binders*** • Auryxia • Fosrenol powder packet ○ ST – member must be under 18 years of age or unable to swallow tablets • lanthanum carbonate chew • sevelamer HCl tabs • Velphoro Generic Medically Necessary PA criteria must be met for the following: • ferric citrate (authorized generic Auryxia) ***Potassium Binders*** • Kionex suspension	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ENDOCRINE			
Anaphylaxis Agents	• epinephrine auto-injector	• Auvi-Q • Epipen • Neffy	
Bone Formation Stimulating Agents	PA criteria must be met for the following: • Forteo	PA criteria must be met for the following: • Bonsity • Evenity • teriparatide (authorized generic Bonsity) • Tymlos PA criteria AND Generic Medically Necessary PA criteria must be met for the following: • teriparatide (authorized generic and generic Forteo)	Bone Formation Stimulating Agents PA Criteria Bone Formation Stimulating Agents PA Form

Bone Resorption Inhibitors	***Bisphosphonates***
	• alendronate
	• ibandronate
	• risedronate tablets
	  ○ ST – must try alendronate within the past 90 days
	
	Bone Modifying Monoclonal Antibodies
	N/A
	
	Calcitonin
	• calcitonin-salmon nasal
	
	SERMs
	• raloxifene
		Bisphosphonates
		• alendronate oral soln 70mg/75mL
		  ○ ST – must be 5 years of age or older and less than 12 years of age OR unable to swallow tablets
		• Fosamax Plus D
		• ibandronate pre-filled syringe
		  ○ QL – one single-use, pre-filled syringe per 90 days
		• risedronate DR (generic Atelvia)
		
		Calcitonin
		• calcitonin (salmon) injection
		  ○ ST – trial and failure of calcitonin-salmon nasal or medical justification for use over the preferred calcitonin agent
		
		Bone Modifying Monoclonal Antibodies
		PA criteria must be met for the following:
		• Aukelso
		• Bildyos
		• Bilprevda
		• Bomyntra
		• Bosaya
		• Conexxence
		• Enoby
		• Jubbonti
		• Jubereq
		• Osenvelt
		• Osvyrti
		• Prolia
		• Stoboclo
		• Wyost
		• Xgeva
		• Xtrenbo
		
		SERMs
		N/A
			Bone Resorption Inhibitors PA Criteria

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ENDOCRINE - Continued			
DPP4 Inhibitors and Combination Agents ***Note: For all DPP-4 Inhibitor and Combination Agents, the following ST applies – member must not be on concomitant GLP-1 receptor agonist and/or combination therapy (i.e., history of use of GLP-1 RA and/or combination therapy within the past 45 days)***	***DPP4-I*** • Januvia ○ ST – must have tried metformin for 90 of the past 120 days or provide medical justification for use • sitagliptin (generic Januvia) ○ ST – must have tried metformin for 90 of the past 120 days or provide medical justification for use • Tradjenta ○ ST – must have tried metformin for 90 of the past 120 days or provide medical justification for use ***DPP4-I & metformin combination*** • Janumet ○ ST – must have tried metformin for 90 of the past 120 days or provide medical justification for use • Jentadueto ○ ST – must have tried metformin for 90 of the past 120 days or provide medical justification for use • Jentadueto XR ○ ST – must have tried metformin for 90 of the past 120 days or provide medical justification for use • sitagliptin free base/metformin ER (authorized generic Zituvimet XR) ○ ST – must have tried metformin for 90 of the past 120 days or provide medical justification for use • sitagliptin/metformin (generic Janumet) ○ ST – must have tried metformin for 90 of the past 120 days or provide medical justification for use	***DPP4-I*** • alogliptin ○ ST – must have tried a preferred agent for 90 of the past 120 days or provide medical justification for use • Brynovin oral soln ○ ST – must be 18 years of age or older and unable to swallow (supported by chart documentation) • saxagliptin ○ ST – must have tried a preferred agent for 90 of the past 120 days or provide medical justification for use • Zituvio ○ ST – must have tried a preferred agent for 90 of the past 120 days or provide medical justification for use Generic Medically Necessary PA criteria must be met for the following: • sitagliptin (authorized generic Zituvio) ***DPP4-I & metformin combination*** • alogliptin/metformin ○ ST – must have tried a preferred combination agent for 90 of the past 120 days or provide medical justification for use • Janumet XR ○ ST – must have tried a preferred combination agent for 90 of the past 120 days or provide medical justification for use • saxagliptin/metformin ER ○ ST – must have tried a preferred combination agent for 90 of the past 120 days or provide medical justification for use • Zituvimet ○ ST – must have tried a preferred combination agent for 90 of the past 120 days or provide medical justification for use	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ENDOCRINE - Continued			
DPP4 Inhibitors and Combination Agents - continued ***Note: For all DPP-4 Inhibitor and Combination Agents, the following ST applies – member must not be on concomitant GLP-1 receptor agonist and/or combination therapy (i.e., history of use of GLP-1 RA and/or combination therapy within the past 45 days)***	***DPP4-I & thiazolidinedione combination*** N/A	***DPP4-I & metformin combination - continued*** Generic Medically Necessary PA criteria must be met for the following: • sitagliptin free base/metformin (authorized generic Zituvimet) ***DPP4-I & thiazolidinedione combination*** • alogliptin/pioglitazone ○ ST – must have tried and failed combination therapy with preferred agents of the same classes for 90 of the past 120 days or provide medical justification for use	
GLP-1 Receptor Agonists and Combinations	***GLP-1 RA*** PA criteria must be met for the following: • liraglutide (authorized generic and generic Victoza) • Ozempic • Trulicity • Victoza ***GIP/GLP-1 RA*** PA criteria must be met for the following: • Zepbound ***Combination Agents*** PA criteria must be met for the following: • Soliqua	***GLP-1 RA*** PA criteria must be met for the following: • exenatide • Rybelsus • Wegovy ***GIP/GLP-1 RA*** PA criteria must be met for the following: • Mounjaro ***Combination Agents*** PA criteria must be met for the following: • Xultophy	GLP-1 RA/GIP RA/Combinations PA Criteria

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ENDOCRINE - Continued			
Glucagon Agents	• Baqsimi nasal spray • Gvoke injection • Zegalogue injection	• Glucagon Kit	
Growth Hormones	***Somatropin products*** PA criteria must be met for the following: • Genotropin • Norditropin • Serostim ***Long-acting products*** PA criteria must be met for the following: • Skytrofa ***Miscellaneous growth hormone products*** N/A	***Somatropin products*** PA criteria must be met for the following: • Humatrope • Nutropin AQ • Omnitrope • Zomacton ***Long-acting products*** PA criteria must be met for the following: • Ngenla • Sogroya ***Miscellaneous growth hormone products*** PA criteria must be met for the following: • Increlex • Voxzogo • Yuviwel	Growth Hormone PA Criteria Growth Hormone for Adults PA Form Growth Hormone for Children PA Form

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ENDOCRINE - Continued			
Insulins – Intermediate Acting	• Humalog Mix 50/50 • Humulin N (vials) • Humulin N KwikPen • Humulin 50/50 • Humulin 70/30 (all formulations) • insulin aspart 70/30 (Novolog mix ABA – FlexPen and vial) • insulin lispro protamine/insulin lispro KwikPen • Novolog Mix 70/30 (FlexPen and vial) • Novolin N • Novolin N ReliOn (vials only) • Novolin 70/30 • Novolin 70/30 ReliOn (vials only)	• Humalog Mix 75/25 • Novolin N ReliOn (prefilled pen, innolets, syringes and cartridges) • Novolin 70/30 ReliOn (prefilled pen, innolets, syringes and cartridges) • Novolog Mix 70/30 ReliOn (all formulations)	
Insulins – Rapid Acting	• Fiasp (all formulations) • Humalog (cartridge) • Humalog (vial) • insulin aspart (all formulations) • insulin lispro KwikPen and Jr. KwikPen • Novolog (all formulations)	• Admelog • Admelog Solostar • Apidra • Apidra SoloStar • Humalog KwikPen and Jr. KwikPen • Humalog Tempo Pen • insulin lispro (vial) • Kirsty • Lyumjev • Lyumjev Tempo Pen • Merilog (pen and vial) • Novolog ReliOn (all formulations)	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ENDOCRINE - Continued			
Insulins – Short Acting	• Humulin R (all formulations) • Novolin R (all formulations) • Novolin R ReliOn (vials only)	• Afrezza • Novolin R ReliOn (prefilled pen, innolets, syringes and cartridges)	
Insulins – Long Acting	• Lantus (cartridges, pens, & vials) • Tresiba FlexTouch and vials	• Basaglar • Basaglar Tempo Pen • insulin degludec FlexTouch & vials • insulin glargine • insulin glargine-yfgn • Levemir (Flextouch, & vials) • Rezvoglar • Semglee • Toujeo Solostar	
Miscellaneous Oral Antidiabetic Agents	***Alpha glucosidase inhibitors*** • acarbose ***Biguanides*** • metformin • metformin ER • metformin ER modified release ***Meglitinide*** • repaglinide ***Sulfonylureas and Combinations*** • glimepiride • glipizide • glipizide ER • glipizide/metformin • glyburide • glyburide/metformin ***Thiazolidinediones and Combinations*** • pioglitazone ○ QL – 1 tablet/day	***Alpha glucosidase inhibitors*** • miglitol ***Biguanides*** • metformin ER osmotic • metformin HCl soln ○ ST – must be 10 years of age or older and less than 12 years of age OR unable to swallow tablets ***Meglitinide*** • nateglinide ***Sulfonylureas and Combinations*** N/A ***Thiazolidinediones and Combinations*** • pioglitazone/glimepiride ○ ST – prescriber must provide documentation that separate components are unsuitable for use • pioglitazone/metformin ○ ST – prescriber must provide documentation that separate components are unsuitable for use	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ENDOCRINE - Continued			
SGLT Inhibitors and Combinations ***Note*: For all DPP-4 inhibitor containing agents, the following ST applies – member must not be on concomitant GLP-1 receptor agonist and/or combination therapy (i.e., history of use of GLP-1 RA and/or combination therapy within the past 45 days)***	***SGLT1-I/SGLT2-I*** N/A ***SGLT2-I*** • Farxiga • Jardiance ***SGLT2-I & metformin combination*** • Synjardy • Xigduo XR ***SGLT2-I & DPP4-I combination**** • Glyxambi ***SGLT2-I, DPP4-I, & metformin combination**** N/A	***SGLT1-I/SGLT2-I*** • Inpefa ○ ST – must try and fail each of the following active ingredients as monotherapy or combination product: canagliflozin, dapagliflozin, empagliflozin OR medical justification for use ***SGLT2-I*** • Invokana • Steglatro Generic Medically Necessary PA criteria must be met for the following: • dapagliflozin (Farxiga ABA) ***SGLT2-I & metformin combination*** • Invokamet • Invokamet XR • Segluromet • Synjardy XR Generic Medically Necessary PA criteria must be met for the following: • dapagliflozin/metformin (Xigduo XR ABA) ***SGLT2-I & DPP4-I combination**** • Steglujan ○ ST – must have tried and failed Glyxambi or combination therapy with preferred agents of the same classes OR prescriber has submitted medical justification for use over preferred agents ***SGLT2-I, DPP4-I, & metformin combination**** • Trijardy XR ○ ST – must have tried and failed combination therapy with preferred agents of the same classes or provide medical justification for use over preferred agents	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ENDOCRINE - Continued			
Testosterones ***See Testosterone PA Criteria for product-specific age and quantity limits***	***Injectable Agents*** PA criteria must be met for the following: • Depo-Testosterone • testosterone cypionate ***Oral Agents*** N/A ***Topical Agents*** PA criteria must be met for the following: • Testim 1% (50 mg)/5 gm gel tubes • testosterone 1% (25 mg)/2.5 gm gel packets • testosterone 1% (50 mg)/5 gm gel packets • testosterone 1% (12.5 mg)/act gel pump • testosterone 1.62% (20.25 mg)/act metered pump gel	***Injectable Agents*** PA criteria must be met for the following: • Aveed • Azmiro • Testopel pellet • testosterone enanthate • Xyosted ***Oral Agents*** PA criteria must be met for the following: • Danazol • Jatenzo • Methitest • methyltestosterone • Tlando ***Topical Agents*** PA criteria must be met for the following: • Natesto • testosterone 1% (50 mg)/5 gm gel tubes • testosterone 1.62% (40.5 mg)/2.5 gm gel packets • testosterone 1.62% (20.25 mg)/1.25 gm gel packets • testosterone 2% (10 mg)/act metered pump • testosterone 30 mg/act soln • Vogelxo 1% (50 mg)/5 gm gel packets • Vogelxo 1% (12.5 mg)/act gel pump	Testosterones PA Criteria Testosterones PA Form
Urea Cycle Disorders (Hyperammonemia Treatments)	PA criteria must be met for the following: • Carbaglu • Pheburane • sodium phenylbutyrate powder • sodium phenylbutyrate tab	PA criteria must be met for the following: • Olpruva • Ravicti PA criteria AND Generic Medically Necessary PA criteria must be met for the following: • carglumic acid • glycerol phenylbutyrate	Urea Cycle Disorder Agents

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ESTROGEN AND RELATED AGENTS			
Estrogen and Related Agents	***All legend generic products are preferred unless otherwise specified*** • Angeliq • Climara Pro • Combipatch • Depo-estradiol • Evamist mist • Menest • Minivelle • Premarin • Prempro • Provera • Vivelle Dot Generic Medically Necessary PA criteria must be met for the following: • conjugated estrogens ***Vaginal Preparations*** • Estring • Premarin Vaginal Cream • Vagifem ***Uterine disorder agents*** PA criteria must be met for the following: • Myfembree • Oriahnn • Orilissa	***All legend brand products are non-preferred unless otherwise specified*** • estradiol TD gel 0.1% • ethinyl estradiol and norethindrone tabs PA criteria must be met for the following: • Lynkuet • Veozah Generic Medically Necessary PA criteria must be met for the following: • estradiol TD patch (generic formulations of Minivelle and Vivelle Dot) ***Vaginal Preparations*** • estradiol vaginal cream • Femring • Yuvafem Generic Medically Necessary PA criteria must be met for the following: • estradiol vaginal tablets ***Uterine disorder agents*** PA criteria must be met for the following: ***N/A***	Menopausal Symptom Suppressants Uterine Disorder Agents PA Criteria Uterine Disorder Agents PA Form

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ESTROGEN AND RELATED AGENTS - Continued			

Contraceptives
 	
Note: All contraceptive agents participating in the Medicaid Drug Rebate Program are preferred unless otherwise specified; Brand Medically Necessary PA criteria will apply to brands with available generics
	Injectable Contraception
	• Depo-SubQ Provera
	• medroxyprogesterone contraceptive 150mg/mL suspension for injection
	  ○ QL – 1mL/84 days for contraception
	
	Oral/Topical Contraception
	• drospirenone
	• norethindrone
	• Phexxi
	  ○ QL – 1 box/month
	• progestin/estrogen combinations
	• Twirla
	• Xulane
	
	Long-Acting Reversible Contraception
	• Kyleena
	  ○ QL – 1 device/365 days
	• Liletta
	  ○ QL – 1 device/365 days
	• Mirena
	  ○ QL – 1 device/365 days
	• Nexplanon
	  ○ QL – 1 device/365 days
	• Paragard
	  ○ QL – 1 device/365 days
	• Skyla
	  ○ QL – 1 device/365 days
	
	Emergency Contraception
	• levonorgestrel 1.5mg
	• ulipristal
		Injectable Contraception
		N/A
		
		Oral/Topical Contraception
		• norelgestromin/ethinyl estradiol; Zafemy
		  ○ ST – must have previous trial of all preferred patch formulations of contraception OR medical justification for use
		
		Long-Acting Reversible Contraception
		N/A
		
		Emergency Contraception
		N/A	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
GASTROINTESTINAL AGENTS			
Anti-ulcer Agents	• misoprostol tablets • sucralfate suspension ○ ST – must be 1 year of age or older and less than 12 years of age OR unable to swallow tablets • sucralfate tablets		
***H. Pylori* Agents**	• Pylera • Voquezna Triple Pak	• lansoprazole/amoxicillin/clarithromycin caps • Talicia • Voquezna Dual Pak Generic Medically Necessary PA criteria must be met for the following: • bismuth subcitrate/metronidazole/tetracycline	

H2 Receptor Antagonists	• cimetidine tabs
	  ○ QL – 60/30 days
	• famotidine tabs
	  ○ QL – 60/30 days
	• nizatidine caps
	  ○ QL – 60/30 days
		• famotidine oral suspension
		  ○ ST – member must be under 12 years of age or unable to swallow tablets	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
GASTROINTESTINAL AGENTS - Continued			
Laxatives and Cathartics	• Linzess; lubiprostone ○ ST – requires trial of lactulose, sorbitol, or polyethylene glycol	• Ibsrela ○ ST – requires trial of lubiprostone and Linzess OR trial of lactulose, sorbitol or polyethylene glycol AND medical justification for use over preferred agents • Movantik ○ ST – requires trial of lactulose, sorbitol or polyethylene glycol AND diagnosis of opioid-induced constipation AND medical justification for use over preferred agents ○ QL – 1 tab/day • prucalopride ○ ST – requires trial of lubiprostone and Linzess OR trial of lactulose, sorbitol or polyethylene glycol AND medical justification for use over preferred agents • Symproic ○ ST – requires trial of lactulose, sorbitol or polyethylene glycol AND diagnosis of opioid-induced constipation AND medical justification for use over preferred agents ○ QL – 1 tab (0.2mg)/day	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
GASTROINTESTINAL AGENTS - Continued			
Pancreatic Enzymes ***Note: Access will be granted to non-preferred agents after cumulatively utilizing 30 days of preferred agent therapy in the past 180 days***	• Creon • Zenpep	• Pertzye • Viokace	
Proton Pump Inhibitors ***Note: PA is required for members utilizing therapy for greater than 90 days in a 180-day period.***	***See Proton Pump Inhibitors PA Criteria for product-specific quantity limits*** • Dexilant • esomeprazole capsules • lansoprazole capsules • omeprazole capsules • pantoprazole tablets ***IV Solutions*** N/A ***Oral Solutions*** • Nexium packets • Protonix packets	***See Proton Pump Inhibitors PA Criteria for product-specific quantity limits, step therapy, and criteria to access non-preferred agents*** PA criteria must be met for the following: • omeprazole magnesium/sodium bicarbonate caps • rabeprazole Generic Medically Necessary PA criteria must be met for the following: • dexlansoprazole ***IV Solutions*** PA criteria must be met for the following: • esomeprazole IV • pantoprazole IV ***Oral Solutions*** PA criteria must be met for the following: • Konvomep oral suspension • lansoprazole ODT • omeprazole/sodium bicarb powder • Prilosec packets Generic Medically Necessary PA criteria must be met for the following: • esomeprazole packets • pantoprazole packets	Proton Pump Inhibitor PA Criteria

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
GASTROINTESTINAL AGENTS - Continued			
Ulcerative Colitis Agents	***Oral Formulations*** • Azulfidine/Azulfidine EN • balsalazide • budesonide DR caps • Dipentum • mesalamine DR cap • mesalamine DR (Lialda) tab • mesalamine ER (Apriso) cap • mesalamine 250 mg ER (generic Pentasa) cap • Pentasa ***Rectal Formulations*** • mesalamine enema • mesalamine suppositories • sfRowasa	***Oral Formulations*** • budesonide ER tabs • mesalamine DR (Asacol HD) tabs Generic Medically Necessary PA criteria must be met for the following: • mesalamine ER 500 mg (Pentasa) cap • sulfasalazine IR/DR ***Rectal Formulations*** • budesonide rectal foam	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
GENITOURINARY			

BPH Agents	• alfuzosin ER
	• dutasteride
	• finasteride
	• tamsulosin
		• dutasteride/tamsulosin
		  ○ ST – must provide documentation that separate components are not suitable for use
		• silodosin
		  ○ ST – requires trial of alfuzosin ER and tamsulosin OR medical justification for use of silodosin over alfuzosin ER and tamsulosin
		• tadalafil 2.5mg and 5mg
		  ○ ST – prescriber must provide documentation of trial and failure of nonselective alpha-blocker, a selective alpha-blocker, a 5-alpha reductase inhibitor, and a combination product for the treatment of BPH or a medically justifiable reason that the agents are not suitable for use; therapy duration must not exceed 26 weeks if using concurrently with finasteride	

Urinary Tract Antispasmodic/Anti-Incontinence Agents	• bethanechol
	• fesoterodine ER
	• Myrbetriq tablets
	• oxybutynin IR
	• oxybutynin ER
	• Oxytrol
	• Solifenacin
	• tolterodine IR
	• tolterodine ER
		• darifenacin
		• flavoxate
		• Gemtesa
		  ○ ST – member must have trialed and failed Myrbetriq or prescriber has provided medical justification for the use of Gemtesa (vibegron) over Myrbetriq (mirabegron)
		• Myrbetriq granules; mirabegron granules
		  ○ ST – must be 3 years of age or older and less than 12 years of age OR unable to swallow tablets
		• trospium
		• trospium ER
		• Vesicare LS
		  ○ ST – must be 2 years of age or older and less than 12 years of age OR unable to swallow tablets
		
		Generic Medically Necessary PA criteria must be met for the following:
		• mirabegron tablets	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
HEMATOLOGIC			

Direct Oral Anticoagulants	• dabigatran capsules
	• Eliquis
	  ○ QL – 2 tabs/day of 2.5mg; 4 tabs/day for 7 days, then 2 tabs/day for 5mg
	• Eliquis soluble tablet
	  ○ QL – up to 32 tabs/day for 7 days; then up to 16 tabs/day
	  ○ ST – member is less than 18 years of age and weighs 4 kg to less than 35 kg
	• Eliquis sprinkle capsule
	  ○ QL – 4 caps/day for 7 days; then 2 caps/day
	  ○ ST – member is less than 18 years of age and weighs 2.6 kg to less than 4 kg
	• Eliquis Starter Pack
	  ○ QL – 1 pack/90 days
	• rivaroxaban 2.5mg tablets
	  ○ QL – 2 tabs/day
	• Xarelto 10mg tablets
	  ○ QL – 1 tab/day
	• Xarelto 15 mg tablets
	  ○ QL – 2 tabs/day for max 21 consecutive days every 90 days; no duration restriction for once-daily dosing
	• Xarelto 20 mg tablets
	  ○ QL – 1 tab/day
	• Xarelto Starter Kit
	  ○ QL – 1 starter kit/90 days
	• Xarelto suspension
	  ○ ST – must be under 12-years of age or unable to swallow tablets
	  ○ QL – 20 mg/day (20 mL/day)
		• Pradaxa Pak
		  ○ ST – must be under 8 years of age or unable to swallow capsules OR have medical rationale for use of pellet formulation
		• Savaysa
		  ○ QL – 1 tab/day
		  ○ ST – must have trialed Eliquis and Xarelto OR medical justification for use of Savaysa over Eliquis and Xarelto
		
		Generic Medically Necessary PA criteria must be met for the following:
		• rivaroxaban suspension	

Hematinics	***Erythropoiesis-Stimulating Agents*** PA criteria must be met for the following: • Aranesp • Epogen • Retacrit ***Miscellaneous Hematinics*** • N/A	***Erythropoiesis-Stimulating Agents*** PA criteria must be met for the following: • Mircera • Procrit ***Miscellaneous Hematinics*** PA criteria must be met for the following: • Reblozyl	Hematinic Agents PA Criteria

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
HEMATOLOGIC - Continued			
Hemophilia Prophylaxis Agents	• Hemlibra	PA criteria must be met for the following: • Alhemo • Hympavzi • Qfitlia	Hemophilia Prophylaxis Agents PA
Hereditary Angioedema Agents	• Cinryze • Orladeyo • Takhzyro	• Andembry • Dawnzera • Haegarda	
Leukocyte Stimulants	***Short-Acting*** • Neupogen • Releuko ***Long-Acting*** • Fulphila • Fylnetra	***Short-Acting*** • Granix • Leukine • ST – trial and failure of all preferred short-acting agents OR Leukine (sargramostim) is being used in combination with an antineoplastic monoclonal antibody (e.g., dinutuximab, naxitamab) that requires concurrent use • Nivestym • Nypozi • Zarxio ***Long-Acting*** • Neulasta • Neulasta Onpro • Nyvepria • Rolvedon • Ryzneuta • Stimufend • Udenyca • Udenyca Onbody • Ziextenzo	

Platelet Aggregation Inhibitors	• aspirin/dipyridamole
	• ticagrelor
	  ○ QL – 2 tabs/day
	• cilostazol
	• clopidogrel 75 mg
	• clopidogrel 300 mg tablets
	  ○ QL – 1 tab/Rx
	• prasugrel		

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
LIPOTROPICS			
Bile Acid Sequestrants	• cholestyramine multi-dose containers • colesevelam tablets and suspension • Prevalite powder/packets	• cholestyramine packets • Colestid granules/tablet Generic Medically Necessary PA criteria must be met for the following: • colestipol (granules/tablets)	
Fibric Acid Derivatives	• fenofibrate micronized cap (generic Antara) • fenofibrate micronized cap (generic Lofibra) • fenofibrate tab (generic Tricor) • gemfibrozil	• fenofibrate cap • fenofibric acid cap (generic Trilipix) • fenofibric acid tab • fenofibrate tab (generic Fenoglide) • Lipofen	
HMG CoA Reductase Inhibitors	• Atorvaliq ○ ST – must be 10 years of age or older and less than 12 years of age OR unable to swallow tablets • atorvastatin • lovastatin • pravastatin • rosuvastatin • simvastatin	• Altoprev • Ezallor • fluvastatin • fluvastatin ER • pitavastatin • Zypitamag	

Lipotropics	• ezetimibe
	• ezetimibe/simvastatin
	  ○ ST – must have trial history of a single-agent HMG CoA reductase inhibitor for 90 of the past 120 days
	• omega-3-acid ethyl esters
	• icosapent ethyl
	  ○ Age – 18 years of age or older
	  ○ QL – 4 capsules/day
	
	PA criteria must be met for the following:
	• Praluent
	• Repatha
		• Nexletol
		  ○ ST – must have trialed and failed two statin agents OR a statin in combination with ezetimibe OR medical justification for use over preferred statins and ezetimibe
		• Nexlizet
		  ○ ST – must have trialed and failed a statin in combination with ezetimibe OR medical justification for use over preferred statins and ezetimibe
		
		PA criteria must be met for the following:
		• Evkeeza
		• Juxtapid
		• Leqvio
		• niacin ER
		• Tryngolza
			PCSK9 Inhibitors and Select Lipotropics PA Criteria
			
			PCSK9 Inhibitors and Select Lipotropics PA Form

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
MULTIPLE SCLEROSIS AGENTS			
Multiple Sclerosis Agents	PSQC/PA criteria must be met for the following: • Avonex • Betaseron • Briumvi • Copaxone 20 mg/mL • dalfampridine • dimethyl fumarate • fingolimod 0.5 mg • Gilenya 0.25 mg • glatiramer 40 mg/mL • Glatopa 40 mg/mL • Kesimpta • Ocrevus; Ocrevus Zunovo • Rebif • teriflunomide • Tascenso ODT • Tysabri • Zeposia	PSQC/PA criteria must be met for the following: • Bafiertam • Lemtrada • Mavenclad • Mayzent • Plegridy • Ponvory • Tyruko • Vumerity PSQC/PA criteria AND Generic Medically Necessary PA criteria must be met for the following: • cladribine • glatiramer 20 mg/mL • Glatopa 20 mg/mL	Multiple Sclerosis PA with Quantity Limits Criteria

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
RESPIRATORY			

Antihistamine-Decongestant Combinations/2nd Generation Antihistamines	• cetirizine 5 mg OTC tabs
	  ○ AGE – under 18 years
	• cetirizine 10 mg OTC tabs
	• fexofenadine OTC tabs
	• levocetirizine Rx tabs
	• loratadine 10 mg OTC tabs
	• loratadine 10 mg OTC RDT tabs
	
	Combinations
	• loratadine/pseudoephedrine 12-hour OTC tabs
	  ○ QL – 2 tablets/day
	  ○ ST – previous trial and failure of a preferred single-agent 2nd generation antihistamine
	• loratadine/pseudoephedrine 24-hour OTC tabs
	  ○ QL – 1 tablet/day
	  ○ ST – previous trial and failure of a preferred single-agent 2nd generation antihistamine
	
	Liquid Formulation
	• cetirizine 1 mg/ml OTC syrup and Rx syrup; loratadine 1 mg/mL OTC syrup
	  ○ AGE – under 12 years or unable to swallow tablet formulation, max age 18 years
	  ○ QL – 10 mL/day
	• fexofenadine 30 mg/5 mL OTC susp
	  ○ AGE – under 12 years or unable to swallow tablet formulation, max age 18 years
	  ○ QL – 30 mL/day
	  ○ ST – must have trial of both cetirizine solution (Rx or OTC) and loratadine solution (OTIC) within the past 90 days
	• levocetirizine Rx oral soln
	  ○ QL – 10 mL/day
	  ○ ST – must have trial of both cetirizine solution (Rx or OTC) and loratadine soln (OTC) within the past 90 days
		Note: New patients must first try cetirizine and loratadine within 90 days prior to receiving a non-preferred agent. Patients with an existing PA are not subject to the step edit.
		
		• desloratadine Rx tabs
		• desloratadine Rx ODT tabs
		
		Combinations
		• Clarinex-D Rx tabs
		  ○ QL – 2 tablets/day
		  ○ ST – previous trial and failure of loratadine/pseudoephedrine 12-hour OTC tab
		
		Liquid Formulation
		• desloratadine 0.5 mg/mL solution
		  ○ QL – 10 mL/day
		  ○ ST – must have trial on both cetirizine and loratadine within the past 90 days	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
RESPIRATORY - Continued			
Beta Adrenergics and Corticosteroids ***Note: All agents are limited to 1 diskus or inhaler per month unless otherwise specified***	• Advair Diskus 100/50 mcg, 250/50 mcg, 500/50 mcg • Advair HFA 45/21 mcg, 115/21 mcg, 230/21 mcg • Dulera 200-5 mcg QL of 3 units per 30 days for ages 19 and younger/2 units per 30 days for ages 20 and over apply to the following: • Dulera 50-5 mcg, 100-5 mcg • Symbicort 80-4.5 mcg, 160-4.5 mcg	• Airsupra ○ AGE – 18 years of age and older ○ QL – 2 inhalers per 30 days ○ ST – trial and failure of both Dulera and Symbicort as reliever therapy (supported by chart documentation) • Breo Ellipta • Breztri Aerosphere ○ ST – must have tried and failed Anoro Ellipta therapy for at least 90 days of the past 120 days • fluticasone/salmeterol Respiclick (Airduo Respiclick ABA) 55-13 mcg, 113-14 mcg, 232-14 mcg • Trelegy Ellipta ○ Asthma ST – must have tried and failed a beta adrenergic/corticosteroid combination inhaler for at least 90 days of the past 120 days ○ COPD ST – must have tried and failed Anoro Ellipta therapy for at least 90 of the past 120 days • Wixela Brand Medically Necessary PA criteria must be met for the following: • Airduo Respiclick Generic Medically Necessary PA criteria must be met for the following: • fluticasone/salmeterol (generic Advair Diskus) 100/50 mcg, 250/50 mcg, 500/50 mcg • fluticasone/salmeterol HFA (Advair HFA ABA) 45-21 mcg, 115-21 mcg, 230-21 mcg • fluticasone/vilanterol (Breo Ellipta ABA) QL of 3 units per 30 days for ages 19 and younger/2 units per 30 days for ages 20 and over apply AND Generic Medically Necessary PA criteria apply to the following: • budesonide/formoterol 80-4.5 mcg, 160-4.5 mcg • Breyna	
Beta Agonists – Long Acting	• Serevent	• arformoterol • formoterol • Striverdi Respimat	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
RESPIRATORY - Continued			

Beta Agonists – Short Acting	• albuterol nebs/syrup – (all strengths)
	
	QL of 3 canisters per 30 days for ages 18 and younger/2 canisters per 30 days for ages 19 and over apply to the following:
	• Ventolin HFA
	• Xopenex HFA
	  ○ ST – must have tried an albuterol HFA inhaler in the past 90 days
		• albuterol tablets (brand/generic)
		• levalbuterol neb soln
		  ○ QL – 2 prescriptions per 180 days, 1 box of 25 per prescription
		• terbutaline tablets
		
		QL of 3 canisters per 30 days for ages 18 and younger/2 canisters per 30 days for ages 19 and over apply to the following:
		• albuterol HFA
		• levalbuterol HFA (must also meet generic medically necessary PA criteria)
		• Proair Respiclick	

Bronchodilator Agents-Beta Adrenergic and Anticholinergic Combinations
 	
Note: Must not concurrently use >1 inhaled anticholinergic agent (excluding short-acting nebulization solution)
	Short-Acting
	• Atrovent HFA
	  ○ QL – 2 inhalers/30 days
	• Combivent Respimat
	  ○ QL – 2 inhalers/30 days
	• ipratropium soln
	  ○ QL – 2 boxes/30 days
	• ipratropium/albuterol soln
	  ○ QL – 3 boxes/30 days
	
	Long-Acting
	• Spiriva Handihaler
	  ○ QL – 1 inhaler/30 days
	• Anoro Ellipta
	  ○ QL – 1 inhaler/30 days
	• Incruse Ellipta
	  ○ QL – 1 inhaler/30 days
	• Spiriva Respimat 1.25 mcg
	  ○ QL – 1 inhaler/30 days
	• Spiriva Respimat 2.5 mcg
	  ○ ST – must have trial and failure of Spiriva Handihaler for a least 14 days
	  ○ QL – 1 inhaler/30 days
		Short-Acting
		Generic Medically Necessary PA criteria must be met for the following:
		• ipratropium HFA
		
		Long-Acting
		• Bevespi Aerosphere
		  ○ QL – 1 inhaler/30 days
		• Duaklir Pressair
		  ○ QL – 1 inhaler/30 days
		• Stiolto Respimat
		  ○ QL – 1 box (60 inhalations)/30 days
		• Tudorza Pressair
		  ○ QL – 1 inhaler/30 days
		• Yupelri
		  ○ QL – 1 box (90mL)/30 days
		
		Generic Medically Necessary PA criteria must be met for the following:
		• tiotropium inhalation capsules
		  ○ QL – 1 inhaler/30 days
		• umeclidinium
		• umeclidinium/vilanterol (Anoro Ellipta ABA)
		  ○ QL – 1 inhaler/30 days	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
RESPIRATORY - Continued			
Leukotriene Receptor Antagonists	• montelukast	• montelukast granules ○ ST – must have prescriber documentation indicating tablet formulations are unsuitable for use • zafirlukast • zileuton SR 12 HR • Zyflo	
Nasal Antihistamines/Nasal Anti-Inflammatory Steroids	***Antihistamines/Anticholinergics*** • azelastine 0.1% nasal spray • ipratropium NS ***Steroids/Steroid Combinations*** • Dymista • fluticasone • Omnaris	***Antihistamines/Anticholinergics*** • azelastine 0.15% nasal spray • olopatadine ***Steroids/Steroid Combinations*** • budesonide nasal suspension • flunisolide • mometasone nasal susp • Qnasl • Ryaltris Generic Medically Necessary PA criteria must be met for the following: • azelastine/fluticasone nasal spray	

Oral Inhaled Glucocorticoids	• Arnuity Ellipta
	  ○ QL – 1 inhaler/30days
	• Asmanex, Asmanex HFA
	  ○ QL – 1 inhaler/30days
	• budesonide inhalation suspension
	  ○ AGE – 3 years and younger
	  ○ QL – 120 mL/30 days (0.25 mg/2 mL vial, 0.5 mg/2 mL vial); 60 mL/30 days (1 mg/2 mL vial)
	• fluticasone propionate HFA
	• fluticasone Diskus
	• Pulmicort Flexhaler
	• QVAR Redihaler
		• Alvesco
		• budesonide inhalation suspension
		  ○ AGE – 4 years and older
		  ○ QL – 120 mL/30 days (0.25 mg/2 mL vial, 0.5 mg/2 mL vial); 60 mL/30 days (1 mg/2 mL vial)
		
		Generic Medically Necessary PA criteria must be met for the following:
		• fluticasone (Arnuity Ellipta ABA)
		  ○ QL – 1 inhaler/30 days	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
RESPIRATORY - Continued			
Pulmonary Antihypertensives	PSQC/PA criteria must be met for the following: • Alyq • bosentan IR tablet/dispersible tablet • sildenafil inj/susp/tab • tadalafil • Tadliq	PSQC/PA criteria must be met for the following: • Adempas • ambrisentan • macitentan • Opsynvi • Orenitram. Orenitram Titration Pack • Tyvaso, Tyvaso DPI • Uptravi • Winrevair • Yutrepia	Pulmonary Antihypertensives PA Criteria Pulmonary Antihypertensives PA Form
Respiratory and Allergy Biologics	PSQC/PA criteria must be met for the following: • Dupixent • Fasenra • Nucala • Tezspire • Xolair	PSQC/PA criteria must be met for the following: • Cinqair	Respiratory and Allergy Biologics PA Criteria

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
TARGETED IMMUNOMODULATORS			

Targeted Immunomodulators	PSQC/PA criteria must be met for the following:
	• adalimumab products
	  ○ adalimumab-adaz
	  ○ Hadlima
	• Adbry
	• Cimzia
	• Enbrel
	• Entyvio, Entyvio Pen
	• infliximab products
	  ○ Avsola
	  ○ infliximab (unbranded Remicade)
	• Kevzara
	• Kineret
	• Litfulo
	• Olumiant
	• Orencia vials & syringes
	• Otezla; Otezla XR
	• Rinvoq
	• Rinvoq LQ
	• Simponi, Simponi Aria
	• Taltz
	• tocilizumab products
	  ○ Tyenne
	• ustekinumab products
	  ○ Pyzchiva
	  ○ Selarsdi
	• Xeljanz; tofacitinib
	• Xeljanz oral soln; tofacitinib oral soln
	  ○ ST - the member is 2 years of age or older and weighing 10 kg or more AND less than 18 years of age and weighing less than 40 kg, OR provider has submitted documentation supporting inability to swallow tablet formulation
	• tofacitinib ER
		PSQC/PA criteria must be met for the following:
		• adalimumab products
		  ○ Abrilada
		  ○ adalimumab-aacf
		  ○ adalimumab-aaty
		  ○ adalimumab-adbm
		  ○ adalimumab-fkjp
		  ○ adalimumab-ryvk
		  ○ Amjevita
		  ○ Cyltezo
		  ○ Hulio
		  ○ Humira
		  ○ Hyrimoz
		  ○ Idacio
		  ○ Simlandi
		  ○ Yuflyma
		  ○ Yusimry
		• Arcalyst
		• Bimzelx
		• Cibinqo
		• Cosentyx
		• Ebglyss
		• Ilaris
		• Ilumya
		• infliximab products
		  ○ Inflectra
		  ○ Remicade
		  ○ Renflexis
		  ○ Zymfentra
		• Leqselvi
		• Nemluvio
		• Omvoh
		• Rhapsido
		• Skyrizi
		• Sotyktu
		• Spevigo
		• tocilizumab products
		  ○ Actemra
		  ○ Avtozma
		  ○ Tofidence
		• Tremfya
		• ustekinumab products
		  ○ Imuldosa
		  ○ Otulfi
		  ○ Starjemza
		  ○ Stelara
		  ○ Steqeyma
		  ○ ustekinumab
		  ○ ustekinumab-aauz
		  ○ ustekinumab-aekn
		  ○ ustekinumab-ttwe
		  ○ Yesintek
		• Velsipity
			Targeted Immunomodulators PA Criteria

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
TOPICAL AGENTS			
Dry Eye Disease or Keratoconjunctivitis ***See Dry Eye Disease or Keratoconjunctivitis PA Criteria for product-specific quantity limits*** ***Note: No more than a 30-day supply may be dispensed at one time.***	PSQC/PA criteria must be met for the following: • Restasis single dose • Xiidra	PA criteria must be met for the following: • Cequa • Eysuvis • Miebo • Restasis Multidose • Tryptyr • Tyrvaya • Verkazia • Vevye Generic Medically Necessary PA criteria must be met for the following: • cyclosporine single dose emulsion	Dry Eye Disease of Keratoconjunctivitis PA criteria

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
TOPICAL AGENTS - Continued			
Miotics-Intraocular Pressure Reducers	• Alphagan-P 0.1% • Alphagan-P 0.15% • apraclonidine • Azopt • Betoptic-S • brimonidine 0.2% soln • carteolol • Combigan • dorzolamide • dorzolamide/timolol • Iopidine 1% • latanoprost • levobunolol • Lumigan 0.01% drops • pilocarpine 1%, 2%, 4% soln • Rhopressa • Rocklatan • Simbrinza • timolol maleate soln • Travatan Z	• Betaxolol • Betimol • bimatoprost 0.03% • Cosopt PF • Iyuzeh ○ ST – must have tried and failed latanoprost OR prescriber has provided medical justification for use of Iyuzeh over latanoprost • timolol gel • Vyzulta • Xelpros • Zioptan PA criteria must be met for the following: • Vuity Generic Medically Necessary PA criteria must be met for the following: • bimatoprost 0.01% • brimonidine 0.1% soln • brimonidine 0.15% soln • brimonidine/timolol soln • brinzolamide suspension • tafluprost • timolol hemihydrate soln • travoprost 0.004% PA criteria AND Generic Medically Necessary PA criteria must be met for the following: • pilocarpine 1.25% soln	Presbyopia Agents PA criteria

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
TOPICAL AGENTS - Continued			
Ophthalmic Antihistamines	• Alaway • azelastine • Bepreve • ketotifen	• epinastine • Zerviate Generic Medically Necessary PA criteria must be met for the following: • bepotastine besilate	
Ophthalmic Anti-Inflammatory Agents	***NSAIDs*** • diclofenac 0.1% ophth soln • flurbiprofen 0.3% ophth soln • ketorolac 0.4% ophth soln • ketorolac 0.5% ophth soln • Nevanac 0.1% ophth soln • Prolensa 0.07% ophth soln ***Steroids*** • Alrex 0.2% ophth susp • dexamethasone sod phos 0.1% ophth soln • Durezol 0.05% ophth emul • Flarex 0.1% ophth susp • FML Liquifilm 0.1% ophth susp • Lotemax 0.5% ophth gel/ointment • loteprednol 0.5% ophth susp • prednisolone acetate 1% ophth susp • Pred Mild 0.12% ophth susp • prednisolone sod phos 1% ophth soln	***NSAIDs*** • Acuvail 0.45% ophth soln • bromfenac 0.075% ophth soln • bromfenac 0.09% ophth soln • Ilevro 0.3% ophth soln Generic Medically Necessary PA criteria must be met for the following: • bromfenac 0.07% ophth soln ***Steroids*** • FML Forte 0.25% ophth susp • Inveltys 1% ophth susp • Lotemax SM 0.38% ophth gel • Maxidex 0.1% ophth susp Generic Medically Necessary PA criteria must be met for the following: • difluprednate 0.05% ophth emul • fluorometholone 0.1% ophth susp • loteprednol 0.2% ophth susp • loteprednol 0.5% ophth gel	
Otic Preparations	• acetic acid soln • fluocinolone acetonide oil	• acetic acid HC	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
TOPICAL AGENTS - Continued			
Topical Anti-Inflammatory Agents – NSAIDS	• diclofenac 1% gel • diclofenac 2% topical soln	• diclofenac epolamine patch ○ QL – 2 patches per day ○ ST – requires physician documentation indicating oral medications are unsuitable for use AND trial and failure of diclofenac 1% gel and diclofenac 2% topical solution, OR medical justification for use over preferred agents	
Topical Antiparasitics ***Unless otherwise specified, all products are limited to one bottle or one tube per claim***	• Natroba • permethrin 5% cream • permethrin 1% lotion • spinosad	• Crotan • ivermectin lotion • Malathion • Pruradik • VanaLice	
Topical Immunomodulators	PA criteria must be met for the following: • Eucrisa • Opzelura • pimecrolimus cream • tacrolimus ointment • Vtama	PA criteria must be met for the following: • Anzupgo • Zoryve 0.05% cream • Zoryve 0.15% cream • Zoryve 0.3% cream • Zoryve 0.3% foam	Topical Immunomodulators PA criteria
Topical Post-Herpetic Neuralgia Agents	• lidocaine patches ○ QL – 3 boxes/30 days • Lidoderm ○ QL – 3 boxes/30 days	• Lidotral ○ QL – 3 boxes/30 days • Qutenza ○ QL – 4 patches/3 months ○ ST – must have tried lidocaine patches and over-the-counter capsaicin cream • ZTlido ○ QL – 3 boxes/30 days ○ ST – must have previous trial of at least 30 days of therapy with preferred lidocaine 5% patches	

MISCELLANEOUS INFORMATION	
Brand Medically Necessary/Generic Medically Necessary Prior Authorization Form	PBM Call Center LTC ProDUR and Home Health PA Request Form
IHCP Early Refill Prior Authorization Request Form	PBM Call Center Prior Authorization Form
Mental Health Medications Medical Necessity Prior Authorization Form	Preferred Brand Drug List
Non-Drug-Specific PA Criteria	Utilization Edits for Mental Health Medications
OTC Contraceptive Agents Formulary	Vaccine Utilization Edits
OTC Drug Formulary	Vaccine Utilization Edits for VFC-Enrolled Pharmacies
OTC Pharmacy Supplements Formulary	

Effective for FFS and Managed Care Organization claims submitted on or after August 1, 2026. V1.0
Inclusion or reference to any given drug does not indicate market availability of the drug. Drugs that will be, or have been, withdrawn from the market will be removed from the SUPDL as part of routine periodic updating of the SUPDL.

MISCELLANEOUS INFORMATION - Continued	
Allergy Specific Immunotherapy PA Criteria	Muscular Dystrophy Agents PA Criteria
Amyloid Beta-Directed Antibodies	Muscular Dystrophy Agents PA Form
Aromatase Inhibitors PA Criteria	Niemann-Pick Disease Agents PA Criteria
Complement Inhibitor Agents PA	Non-SUPDL Agents PA and ST
Corticotropin	Nuedexta PA Criteria
Cushing Syndrome Agents	Nuedexta PA Form
Cushing Syndrome Agents PA Form	Oxervate PA Criteria
Cystic Fibrosis Inhaled Agents PA Criteria	Phenylketonuria Agents PA
Cystic Fibrosis Agents PA Criteria	Phosphodiesterase Inhibitors for Pulmonary Related Disorders
Cystic Fibrosis Agents PA Form	Phosphodiesterase Inhibitors for Pulmonary Related Disorders PA Form
Daybue PA Criteria	Pompe Disease Agents PA Criteria
Disposable Insulin Delivery Devices PA	Prenatal Vitamins High Dollar Limit PA
Egrifta PA Criteria	Roctavian PA Criteria
Elevidys PA Criteria	Sickle Cell Agents PA Criteria
Elmiron PA Criteria	Sickle Cell Agents PA Form
Epidermolysis Bullosa Agents PA	Skyclarys PA criteria
Gralise, Horizant, and Lyrica CR PA Criteria	Solaraze PA Criteria
Gralise, Horizant, and Lyrica CR PA Form	Somatostatin Analog PA Criteria
HCG PA Criteria	Spinal Muscular Atrophy Agents PA Criteria
Hemophilia B Gene Therapy PA	Spinal Muscular Atrophy Agents PA Form
Hepatitis B Agents PA Criteria	Thrombopoietin and Related Conditions PA
High Dollar Compounded PA Criteria	Topical Doxepin PA
High Dollar Compounded PA Request Form	Topical Lidocaine QL
Immunoglobulin A Nephropathy (IgAN) Agents PA	Topical Steroid PA
Intravesical Immunotherapy PA	Topical Agents PA Form
Lucemyra PA Criteria	Transthyretin Impacting Agents PA Criteria
Lucemyra PA Form	Tzield PA
MASH/MASLD Agents	Tzield PA Form
Mepron PA Criteria	Vykat XR PA
Metabolic Disorders PA	Yorvipath PA criteria
	Zycubo PA