EFFECTIVE
Version
Updated: 05/01/2015

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

The Commissioner for Office of Vermont Health Access shall establish a pharmacy best practices and cost control progrom designed to reduce the cost of providing prescription drugs, while maintaining high quality in prescription drug therapies. The program shall include:
"A preferred list of covered prescription drugs that identifies preferred choices within therapeutic classes for particular diseases and conditions, including generic alternatives"

From Act 127 passed in 2002

The following pages contain:

- The therapeutic classes of drugs subject to the Preffered Drug List, the drugs within those categories and the criteria required for Prior Authorization (P.A.) of non-preferred drugs in those categories.
- The therapeutic classes of drugs which have clinical criteria for Prior Authorization may or may not be subject to a preferred agent.
- Within both of these categories there may be drugs or even drug classes that are subject to Quantity Limit Parameters.

Therapeutic class criteria are listed alphabetically. Within each category the Prefrred Drugs are noted in the left-hand columns. Representative non-preferred agents have been included and are listed in the right-hand column. Any drug not listed as preferred in any of the included categories requries Prior Authorization.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

Drugs highlighted in yellow denote a change in PDL status.

To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

GHS/Emdeon **PRESCRIBER Call Center:** PA Requests Tel: 1-844-679-5363; Fax: 1-844-679-5366 Note: Fax requests are responded to within 24 hrs. For Urgent requests, please call GHS/Emdeon Directly	**GHS/Emdeon** **PHARMACY Call Center:** PA Requests Tel: 1-844-679-5362 Available for assistance with claims processing	**GHS/Emdeon Sr. Account Manager:** Michael Ouellette Tel: 802-922-9614 Fax: E-Mail: mouellette@ghsinc.com
DVHA Medical Staff: *Medical Director* J. Scott Strenio, M.D. Tel: 802-871-3194	**DVHA Pharmacy Unit Staff:** Stacey Baker Tel: 802-879-5912 Fax: 802-879-5651 E-Mail: stacey.baker@state.vt.us	**DVHA Pharmacy Administration:** *Director of Pharmacy Services* Nancy Hogue, Pharm. D. Tel: 802-879-5611 Fax: 802-879-5651 E-mail: nancy.hogue@state.vt.us

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

EFFECTIVE
Version
Updated: 05/01/2015

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

Contents

ACNE AGENTS 7
ADHD AND NARCOLEPSY CATAPLEXY MEDICATIONS 11
ALLERGEN IMMUNOTHERAPY 15
ALPHA1-PROEINASE INHIBITORS 16
ALZHEIMER'S MEDICATIONS 16
COX-2 INHIBITORS 18
ANALGESICS 18
ANEMIA: HEMATOPOIETIC/ERYTHROPOIETIC AGENTS 27
ANKYLOSING SPONDYLITIS: INJECTABLES 28
ANTI-ANXIETY: ANXIOLYTICS 29
ANTICOAGULANTS 31
ANTICONVULSANTS 33
ANTIDEPRESSANTS 36
ANTI-DIABETICS 42
ANTIDIARRHEALS: HIV/AIDS 48
ANTI-EMETICS 48
ANTI-HYPERTENSIVES 52
ANTI-INFECTIVES ANTIBIOTICS 64
ANTI-INFECTIVES ANTIFUNGAL 72
ANTI-INFECTIVES ANTIMALARIALS: QUININE 75
ANTI-INFECTIVES ANTI-VIRALS 75
ANTI-MIGRAINE TRIPTANS 77
ANTI-OBESITY 79

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

Drugs highlighted in yellow denote a change in PDL status.

To search the PDL, press CTRL + F

EFFECTIVE
Version
Updated: 05/01/2015

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

ANTI-PSYCHOTIC ATYPICAL & COMBINATIONS (CHILDREN < 18 YEARS OLD) 79
ANTI-PSYCHOTIC ATYPICAL & COMBINATIONS (CHILDREN > 18 YEARS OLD) 84
ANTI-PSYCHOTIC: TYPICALS 91
BONE RESORPTION INHIBITORS 92
BOTULINUM TOXINS 95
BPH AGENTS 97
CARDIAC GLYCOSIDES 98
CHEMICAL DEPENDENCY 98
CONSTIPATION: CHRONIC, IBS-C OR OPIOID INDUCED 100
CONTRACEPTIVES: VAGINAL RING 101
CORONARY VASODILATORS/ANTIANGINALS 101
CORTICOSTEROIDS: ORAL 102
COUGH AND COLD PREPARATIONS 103
CYSTIC FIBROSIS MEDICATIONS 104
DERMATOLOGICAL AGENTS 105
FLUOCINOLONE 0.01% C, S, oil† (compare to Derma-Smoothe, Synalar®) 109
DESMOPRESSIN: INTRANASAL/ORAL 113
DIABETIC TESTING SUPPLIES 114
EPINEPHRINE: AUTO-INJECTOR 115
ESTROGENS: VAGINAL 115
FIBROMYALGIA AGENTS 116
GASTROINTESTINAL 117
GAUCHER'S DISEASE MEDICATIONS 124
GOUT AGENTS 124
GROWTH STIMULATING AGENTS 125
HEMOPHILIA FACTORS 127
HEPATITIS C AGENTS 128

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

Drugs highlighted in yellow denote a change in PDL status.

To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

HEREDITARY ANGIOEDEMA MEDICATIONS 129
INTERLEUKIN (IL)-1 RECEPTOR BLOCKERS 130
LIPOTROPICS: 130
MISCELLANEOUS 136
MOOD STABILIZERS 141
MUCOSAL COATING AGENTS 142
MULTIPLE SCLEROSIS MEDICATIONS 142
NEUROGENIC ORTHOSTATIC HYPOTENSION 143
NUTRITIONALS, LIQUID ORAL SUPPLEMENTS 144
ONCOLOGY: ORAL (select) 145
OPHTHALMICS 146
OTIC ANTI-INFECTIVES 153
OVER THE COUNTER (OTC) MEDICATIONS 154
PANCREATIC ENZYME PRODUCTS 154
PARKINSON'S: NON ERGOT DOPAMINE RECEPTOR AGONIST 154
PHOSPHODIESTERASE-4 (PDE-4) INHIBITORS 156
PHOSPHODIESTERASE-5 (PDE-5) INHIBITORS 157
PLATELET INHIBITORS 157
POST-HERPETIC NEURALGIA AGENTS 158
PSORIASIS 158
PULMONARY AGENTS 162
PULMONARY ARTERIAL HYPERTENSION MEDICATIONS 174
RENAL DISEASE: PHOSPHATE BINDERS 175
RESTLESS LEG SYNDROME MEDICATIONS 175
RHEUMATOID, JUVENILE & PSORATIC ARTHRITIS: IMMUNOMODULATORS 176
SILIVA STIMULANTS 181
SEDATIVE/HYPNOTICS 181

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

Drugs highlighted in yellow denote a change in PDL status.

To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

SKELETAL MUSCLE RELAXANTS 183
SMOKING CESSATION THERAPIES 184
TESTOSTERONE: TOPICAL 185
THROMBOPOIETIN RECEPTOR AGONISTS 187
URINARY ANTISPASMODICS 187
VAGINAL ANTI-INFECTIVES 189
VITAMINS: PRENATAL MULTIVITAMINS 189

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ACNE AGENTS		
ORAL AGENTS		
DOXYCYCLINE† 20 mg, 50 mg, 75 mg, 100 mg tab, cap E.E.S.® † (erythromycin ethylsuccinate) ERY-TAB® (erythromycin base, delayed release) ERYTHROMYCIN BASE† ERYTHROMYCIN ETHYLSUCCINATE† (compare to E.E.S.®, Eryped®) MINOCYCLINE† 50 mg, 75 mg, 100 mg TETRACYCLINE† 250 mg, 500 mg cap ISOTRETINOIN† 10 mg, 20 mg, 40 mg cap (AMNESTEEM, CLARAVIS, MYORISAN, SOTRET)	Adoxa®* (doxycycline monohydrate) 50 mg, 75 mg tab, 100 mg tab Monodox®* (doxycycline monohydrate) 50 mg, 100 mg cap Oracea® (doxycycline monohydrate) 40 mg cap Periostat®* (doxycycline hyclate) 20 mg, 100 mg tab Vibramycin®* (doxycycline hyclate) 50 mg, 100 mg cap Vibramycin®* (doxycycline hyclate) suspension Vibramycin® (doxycycline calcium) syrup Vibratab®* (doxycycline hyclate) 100 mg tab All other brands Eryped® (erythromycin ethylsuccinate) Erythrocin (erythromycin stearate) PCE Dispertab® (erythromycin base) All other brands Minocin®* (minocycline) 50 mg, 75 mg, 100 mg cap Dynacin®* (minocycline) 50 mg, 75 mg, 100 mg cap/tab Absorica® (isotretinoin) capsules All other brands	**Brand name minocycline products:** patient has had a documented side effect, allergy, or treatment failure with generic minocycline. If a product has an AB rated generic, the trial must be the generic formulation. **Brand name doxycycline products** (see below for Oracea & Vibramycin Suspension): patient has had a documented side effect, allergy, or treatment failure with generic doxycycline. If a product has an AB rated generic, the trial must be the generic formulation. **Oracea:** patient has a diagnosis of Rosacea AND patient has had a documented side effect, allergy, or treatment failure with doxycycline, minocycline, and tetracycline. **Vibramycin Suspension, Syrup:** patient has a medical necessity for a liquid dosage form. **Brand name erythromycin products:** patient has had a documented side effect or treatment failure with one preferred erythromycin product. **Brand name tetracycline products:** patient has had a documented side effect, allergy, or treatment failure with generic tetracycline. If a product has an AB rated generic the trial must be the generic formulation. **Limitations:** Minocycline SR products and doxycycline SR and DR products (grand and genreic) not covered. Adoxa Pak and doxycycline monohydrate Pak specialty packaging dosage form not covered. Adoxa 150mg cap and doxycycline monohydrate 150mg cap (brand and generic) not covered.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
TOPICAL ANTI-INFECTIVES		
BENZOYL PEROXIDE PRODUCTS BENZOYL PEROXIDE † 4%, 5%, 8%, 10% *G*, *2.5%, 4%, 5%, 7%, 8%, 10% W*; 3.5%, 5.5%, 8.5% *C*; 3%, 4%, 5%, 6%, 8%, 9% *L*; 3%, 6%, 9% *P* BENZOYL PEROXIDE 2.5 % Gel	Benzac AC® 2.5%, 5%, 10% G, W Benzashave® 5%, 10% C Benzoyl peroxide® 10% L Brevoxyl® 4%, 8% W; 4%, 8% G; 4%, 8% L Clinac BPO® 7% G Desquam-E/X® 2.5%, 5%, 10% G; 5%, 10% W Inova 4% P Panoxyl/AQ 2.5%, 5%, 10% G; 5%, 10% B Pacnex HP/LP 4.25%, 7% *P* Triaz® 3%, 6%, 9% G; 3%, 6%, 9% P Zaclir®* 8% L All other brands	**Brand name single ingredient products:** patient has had a documented side effect, allergy, or treatment failure with a preferred generic benzoyl peroxide, clindamycin, erythroymycin, and sodium sulfacetamide (from within the same sub-category). (If a product has an AB rated generic, there must have been a trial of the generic.) **Brand name combination products:** patient has had a documented side effect, allergy, or treatment failure with generic erythroymycin/benzoyl peroxide and sodium sulfacetamide/sulfur. (If a product has an AB rated generic, there must have been a trial of the generic.) AND patient has had a documented side effect or treatment failure on combination therapy with the separate generic ingredients of the requested combination product, if applicable. **Azelex:** the diagnosis or indicaqtion is acne AND patient has had a documented side effect, allergy, or treatment failure with two generic topical anti-infective agents (benzoyl peroxide, clindamycin, erythromycin, erythroymcin/benzoyl peroxide, sodium sulfacetamide, sodium sulfacetamide/sulfur etc.) **Limitations:** Kits with non-drug products are not covered **Benzoyl Peroxide Aerosol (foam)** Benzefoam and Riax Foam not covered. Other topical generic benzoyl peroxide preparations preferred. **Clindamycin Aerosol (Foam) and Evoclin** not covered. Other topical generic clindamycin preparations preferred. **Sodium sulfacetamide/Sulfur Aerosol** (foam), Rosula and Clarifoam not covered. Other topical generic sodium sulfacetamide/sufur preparations preferred. **Epiduo** (adapalene/benzoyl peroxide) combination not covered. Agents may be prescribed separately. **SE BPO** (benzoyl peroxide) foaming cloths dosage form not covered. Other topical generic benzoyl peroxide preparations preferred.
CLINDAMYCIN PRODUCTS CLINDAMYCIN 1% *S, G, L, P* †	Cleocin-T®* (clindamycin 2% G) Clindagel® (clindamycin 1% G) All other brands	
ERYTHROMYCIN PRODUCTS ERYTHROMYCIN 2% *S, G, P* †	Akne-Mycin® (erythromycin 2% O) Erygel®* (erythromycin 2% G) All other brands	
SODIUM SULFACETAMIDE PRODUCTS SODIUM SULFACETAMIDE 10% *L*†	Klaron®* (sodium sulfacetamide 10% L) All other brands	
COMBINATION PRODUCTS	Benzaclin® (clindamycin/benyoyl peroxide) DUAC® (clindamycin/benzoyl peroxide) gel, kit	**Parscion FC and Plexion** (sodium sulfacetamide/sulfur) pads/cloths dosage form

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ERYTHROMYCIN / BENZOYL PEROXIDE† SODIUM SULFACETAMIDE / SULFUR *L*† SODIUM SULFACETAMIDE / SULFUR *W* † <u>OTHER</u> Azelex® (azelaic acid 20%C) *C=cream, E=emulsion, G=gel, L=lotion,O=ointment, P=pads, S=solution, W=wash, B=bar*	Benzamycin®* (erythromycin/benzoyl peroxide) Sulfoxyl (erythromycin/benzoyl peroxide) Z-Clinz® (clindamycin/benzoyl peroxide kit) All other brands Avar® (sodium sulfacetamide/sulfur G) Avar-E *LS*® (sulfacetamide/sulfur *C)* Avar LS® (sulfacetamide/sulfur *W)* Plexion®/ Sumaxin TS® (sulfacetamide/sulfur *S,C,L*) Rosac®* (sulfacetamide/sulfur W) Rosula®* (sulfacetamide/sulfur W) Sulfacet-R®* (sodium sulfacetamide/sulfur L) All other brands Zoderm® (urea/benzoyl peroxide) cream, gel Aczone® (dapsone 5% G) All other brands any topical acne anti-infective medication	not covered. Other topical generi sodium sulfacetamide/sulfur preparations preferred.
TOPICAL - RETINOIDS		
TRETINOIN† *(specific criteria required for ages <10 or >34)* 0.025%, 0.05%, 0.1% *C*; 0.01%, 0.025% *G* AVITA® (tretinoin)	All brand tretinoin products (Atralin® 0.05% G, Retin-A®*, Retin-A Micro® 0.1%, 0.04%, Tretin-X® etc.)	**Brand name tretinoin products and generic tretinoin microsphere:** diagnosis or indication is acne vulgaris, actinic keratosis, or rosacea AND patient has had a documented side effect, allergy, or treatment failure with a preferred generic topical tretinoin product. If a product has an AB rated generic, the trial must be

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
TAZORAC® (tazarotene) 0.05%, 0.1% *C, G* C= *cream*, G=*gel*	Tretinoin microsphere† (compare to Retin-A Micro®) 0.1%, 0.04% adapalene† (compare to Differin®) 0.1% C, G, 0.3% G Differin® (adapalene) 0.1% C, G; L 0.3% G Avage® (tazarotene) ♣ Renova® (tretinoin) ♣ Solage® (tretinoin/mequinol) ♣ Tri-Luma® (tretinoin/hydroquinone/fluocinolone) ♣ ♣ Not indicated for acne. Coverage of topical retinoid products will not be approved for cosmetic use (wrinkles, age spots, etc.).	the generic formulation. **Differin** (brand) and adapalene (generic): diagnosis or indication is acne vulgaris, actinic keratosis, or rosacea AND patient has had a documented side effect, allergy, or treatment failure with a preferred generic topical tretinoin product AND the request is for the brand product, the patient has had a documented intolerance to a generic adapalene product. **Tretinoin** (age < 10 or > 34): diagnosis or indication is acne vulgaris, actinic keratosis, or rosacea. **Limitations:** Coverage of topical retinoid products will not be approved for cosmetic use (wrinkles age spots, etc.) (i.e. Avage, Renova, Solage, Tri-Luma). **Epiduo Gel, Ziana** - these combinations not covered, individual components may be prescribed separately. **Fabior** (tazarotene) Foam not covered. Tazorac cream and gel preferred.
TOPICAL - ROSACEA		
METRONIDAZOLE† 0.75% *C, G, L* *C=cream, G=gel, L=lotion*	All brand metronidazole products (MetroCream®* 0.75% *C*, Metrogel®* 0.75% *G*, Metrogel® 1% *G*, MetroLotion®* 0.75% *L*, Noritate® 1% *C*, Rozex® 0.75% *G* etc.) Metronidazole† 1% *G* Finacea® (azelaic acid) 15% *G*	**Brand name metronidazole products,** metronidazole 1% gel (generic) and Finacea: diagnosis or indication is roacea AND patient has had a documented side effect, allergy or treatment failure with a preferred generic topical metronidazole product. If a product has an AB rated generic, there must have also been a trial of the generic formulation. **Limitations**: The use of Mirvaso (brimonidine topical gel) for treating skin redness is considered cosmetic. Medications used for cosmetic purposes are excluded from coverage. Mirvaso topical gel has not been shown to improve any other symptom of roacea (e.g. pustules, papules, flushing, etc) or to alter the course of the disease.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ADHD AND NARCOLEPSY CATAPLEXY MEDICATIONS		
SHORT/INTERMEDIATE ACTING		
METADATE ER® (compare to Ritalin® SR) METHYLIN® (compare to Ritalin®) METHYLIN® ER (compare to Ritalin® SR) METHYLPHENIDATE † (compare to Ritalin®) METHYLPHENIDATE SR † (compare to Ritalin ® SR) AMPHETAMINE/DETROAMPHETAMINE † (compare to Adderall®) DEXTROAMPHETAMINE IR† (Zenzedi 5 or 10 mg, formerly Dexedrine®)	Dexmethylphenidate † (compare to Focalin®) Focalin® (dexmethylphenidate) Ritalin®* (methylphenidate) Ritalin SR®* (methylphenidate SR) Adderall®* (amphetamine/dextroamphetamine) Desoxyn® (methamphetamine) dextroamphetamine sulfate† 1 mg/ml oral solution Methamphetamine † (compare to Desoxyn®) Procentra® (dextroamphetamine sulfate) 1 mg/ml oral solution Zenzedi® (dextroamphetamine IR) 2.5 mg, 7.5 mg, 15 mg, 20 mg, 30 mg tablets	**Dexmethylphenidate and Focalin:** patient has a diagnosis of ADD, ADHD or narcolepsy AND patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR patient is also on Focalin XR and the prescriber is adding a shorter acting dosage form. OR patient has had a documented side-effect, allergy, or treatment failure on Methylin or methylphenidate. AND In addition, for approval of brand name Focalin, the patient must have had a documented intolerance to generic dexmethylphenidate. **Ritalin and Ritalin SR**: patient has a diagnosis of ADD, ADHD, or narcolepsy. AND patient has had a documented intolerance to the preferred equivalent. For Ritalin SR these are Methlyin ER, Metadate ER, or methylphenidate SR. For Ritalin these are Methylin or methylphenidate. **Adderall:** patient has a diagonsis of ADD, ADHD, or narcolepsy. AND patient has had a documented intolerance to the preferred generic equivalent. **Methamphetamine and Desoxyn:** Given the high abuse potential of methamphetamine and Desoxyn, the patient must have a diagnosis of ADD, ADHD or narcolepsy and have failed all preferred treatment alternatives. In addition, for approval of brand name Desoxyn, the patient must have had a documented intolerance to generic methamphetamine. **Procentra, dextroamphetamine oral solution:** patient has a medical necessity for an oral liquid dosage form. (eg. Swallowing disorder). AND if the request is for Procentra, the patient has a documented intolerance to the generic equivalent. **Zenzedi:** the prescriber provides clinical rationale explaining why other generic dextroamphetamine oral tablet products are not suitable alternatives.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
LONG ACTING		
Oral FOCALIN® XR (dexmethylphenidate SR 24 HR IR/ER, 50:50%) METHYLPHENIDATE SA OSM IR/ER, 22:78%† (compare to Concerta®) **Oral Suspension** QUILLIVANT XR® (methylphenidate IR/ER, 20:80%) (*QL = 12 ml/day)* **Transdermal** DAYTRANA® (methylphenidate patch) (*QL = 1 patch/day)* ADDERALL XR® (amphetamine/dextroamphetamine SR 24 HR, IR/ER, 50:50%) DEXTROAMPHETAMINE 24 hr SR† (compare to Dexedrine CR®) VYVANSE® (lisdexamfetamine) *(QL = 1 cap/day)*	Concerta®* (methylphenidate SA OSM IR/ER, 22:78%) Dexmethylphenidate SR 24 HR IR/ER, 50:50% † (compare to Focalin XR®) Metadate CD® (methylphenidate CR, IR/ER, 30:70%) methylphenidate CR, IR/ER, 30:70% (compare to Metadate CD®) Methylphenidate SR 24 HR, IR/ER, 50:50%† (compare to Ritalin LA®) Ritalin LA® (methylphenidateSR 24 HR, IR/ER, 50:50%) Amphetamine/dextroamphetamine SR 24 HR, IR/ER, 50:50% † (compare to Adderall XR®) Dexedrine CR®* (dextroamphetamine 24 hr SR)	**Metadate CD, Ritalin LA, and Methylphenidate CR, Methylphenidate SR 24 HR:** patient has a diagnosis of ADD, ADHD or narcolepsy. AND patient has been started and stabilized on the requested medication (Note: samples are not considered adequate justification for stabilization) OR patient has had a documented side-effect, allergy, or treatment failure on Focaline XR or Methylphenidate SR OSM. AND for approval of generic methylphenidate CR or methylphenidate SR 24 HR, the patient must have had a documented intolerance to the brand equivalent. **Concerta:** patient has a diagnosis of ADD, ADHD, or narcolepsy. AND patient has had a documented intolerance to generic Methylphenidate SA OSM. **Dexedrine CR**: patient has a diagonsis of ADD, ADHD, or narcolepsy. AND patient has had a documented intolerance to the preferred generic equivalent. **Amphetamine/dextroamphetamine** SR 24 HR (generic) dexmethylphenidate SR 25 HR IR/ER (generic): patient has a diagnosis of ADD, ADHD, or narcolepsy. AND patient must have a documented intolerance to the brand name equivalent.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
MISCELLANEOUS		
	Modafinil (compare to Provigil®) **(not approvable for ADHD in children age ≤12)** ***(Max days supply = 30 days)*** *Qty limit: 100 mg = 1.5 tablets/day;200 mg = 2 tablets/day* *Maximum Daily Dose = 400 mg* Nuvigil® (armodafinil) *Qty limit: 50 mg = 2 tablets/day; 150 mg/200 mg/250 mg = 1 tablet/day* Provigil® (modafinil) ***(not approvable for ADHD in children age ≤12).*** *Qty limit: 100 mg = 1.5 tablets/day;200 mg = 2 tablets/day* *Maximum Daily Dose = 400 mg* ***(Max days supply = 30 days)*** Clonidine extended release †(compare to apvay®) *Qty limit = 4 tabs/day* Intuniv® (guanfacine extended release) Tablet *Qty limit = 1 tablet/day* Kapvay® (clonidine extended release) Tablet *Qty limit = 4 tablets/day* Strattera® (atomoxetine) *Qty limit:10, 18, 25 and 40 mg = 2 capsules/day* *60, 80 and 100 mg = 1 capsule/day* *FDA maximum recommended dose = 100 mg/day*	**Nuvigil®:** Narcolepsy, excessive sleepiness associated with obstructive sleep apnea/hypopnea syndrome (adjunct to standard treatment): The patient is > 17 years old AND The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR The patient has had a documented side-effect, allergy or treatment failure to a CNS stimulant or has a contraindication for use of these agents (e.g. substance abuse history). Nuvigil® will not be approved for sleepiness associated with shift work sleep disorder, idiopathic ypersomnolence, excessive daytime sleepiness, fatigue associated with use of narcotic analgesics, or for ADHD (for any age patient). **Provigil®, Modafinil**: Narcolepsy, Excessive sleepiness associated with obstructive sleep apnea/hypopnea syndrome (adjunct to standard treatment), fatigue associated with multiple sclerosis, fatigue associated with the treatment of depression or schizophrenia: The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.)OR The patient has had a documented side-effect, allergy or treatment failure to a CNS stimulant or has a contraindication for use of these agents (e.g. substance abuse history) AND if the request is for modafinil, the patient has a documented intolerance to brand Provigil ADHD age >12: The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR The patient has a documented treatment failure, due to lack of efficacy, to two long-acting CNS stimulants or the patient has had a documented side effect, allergy, or direct contraindication (e.g. comorbid tics, moderate -to-severe anxiety, substance abuse) to one Long -acting CNS stimulant. AND The patient has had a documented side-effect, allergy, or treatment failure to Strattera® AND And if the request is for modafinil, the patient has a documented intolerance to brand Provigil.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Xyrem® (sodium oxybate) oral solution *Qty limit = 540 ml/30 days*	**Provigil®/Modafinil** will not be approved for sleepiness associated with shift work sleep disorder, idiopathic hypersomnolence, excessive daytime sleepiness, fatigue associated with use of narcotic analgesics, or for ADHD in children age ≤12. **Intuniv:** patient has a diagnosis of ADD or ADHD AND patient has been started and stabilized on the requested medication (Note: samples are not considered adequate justification for stabilization) OR patient has a documented treatment failure, due to lack of efficacy, to 2 long-acting CNS stimulants (Metadate CD, Ritalin LA, Focalin XR, Adderall XR, Methylphenidate SA OSM, Vyvanse, and Daytrana) OR patient has had a documented side-effect, allergy, or direct contraindication (e.g. comorbid tics, moderate-to-severe anxiety) to 1 long-acting CNS stimulant (Metadate CD, Ritalin LA, Focalin XR, Adderal XR, Methylphenidate SA OSM, Vyvanse or Daytrana) OR there is a question of substance abuse with the patient or family of the patient. OR family will choose to decline therapy if a stimulant must be trialed. OR patient has been trialed on immediate release guanfacine with good response but needs a dosage form with exteneded duration of therapy. **Kapvay, Clonidine ER:** patient has a diagnosis of ADD or ADHD. AND patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization). OR patient has a documented treatment failure, due to lack of efficacy, to 2 long-acting CNS stimulants (Metadate CD, Ritalin LA, Focalin XR, Adderall XR, Methylphenidate SA OSM, Vyvanse and Daytrana) OR patient has had a documented side-effect, allergy, or direct contraindication (e.g. comorbid tics, moderate-to-severe anxiety) to 1 long-acting CNS stimulante (Metadate CD, Ritalin LA, Focalin XR, Adderal XR, Methylphenidate SA OSM, Vyvanse or Daytrana) OR there is a question of substance abuse with the patient or family of the patient. AND the patient has been trialed on clonidine IR with at least a partial response but needs and extended duration formulation to maximize the clinical benefit. AND for approval of generic clonidine ER, patient must have

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		had a documented intolerance to the brand equivalent. **Strattera:** patient has a diagnosis of ADD or ADHD. AND patients has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR patient has a documented treatment failure, due to lack of efficacy, to 2 long-acing CNS stimulants (Metadate CD, Ritalin LA, Focalin XR, Adderall XR, Methylphenidate SA OSM, Vyvanse and Daytrana) OR patient has had a documented side ffect, allergy, or direct contraindication (e.g. comorbid tics, moderate-to-severe anxiety) to 1 long-acting CNS stimulant (Metadate CD, Ritalin LA, Focalin XR, Adderall XR, Methylphenidate SA OSM, Vyvanse and Daytrana). OR there is a question of substance abuse with the patient or family of the patient OR family will choose to decline therapy if a stimulant must be trialed. OR patient's need for drug therapy is primarily in early AM and evenings in the home environment. **Limitations:** Kapvay dose pak not covered - prescribe multiple strengths individually.
ALLERGEN IMMUNOTHERAPY		
	Grastek® *(QL = 1 tablet/day)* Oralair® *(QL = 1 tablet/day)* Ragwitek® *(QL = 1 tablet/day)*	**Clinical Criteria** **All agents in class** • Prescriber must provide the testing to show that the patient is allergic to the components in the prescribed therapy and must provide a clinically valid rationale why single agent sublingual therapy is being chosen over subcutaneous therapy • Treatment must start 12 weeks before expected onset of pollen season and only after confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for short ragweed pollen (Ragwitek), timothy grass or cross-reactive

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		grass pollens (Grastek), or any of the 5 grass species contained in Oralair • Have an auto-injectable epinephrine on-hand **Grastek additional criteria:** • Patient age ≥5 years and ≤65 years **Oralair additional criteria:** • Patient age ≥10 years and ≤65 years **Ragwitek additional criteria:** • Patient age ≥18 years and ≤65 years
ALPHA1-PROEINASE INHIBITORS		
	Aralast NP® Glassia® Prolastin® Prolastin-C® Zemaira® **Maximum days supply per fill for all drugs is 14 days**	**Criteria for Approval:** The indication for use is treatment of alpha1 -proteinase inhibitor deficiency-associated lung disease when all of the following criteria are met: Patient's alpha1 -antitrypsin (ATT) concentration < 80 mg per dl [or < 11 micromolar] AND patient has obstructive lung disease as defined by a forced expiratory volume in one second (FEV1) OF 30 - 65% of predicted or a rapid decline in lung function defined as a change in FEV1 of > 120 mL/year. AND medication is being administered intravenously (inhalation administration will not be approved) AND patient is a non-smoker OR patient meets above criteria except lung function has deteriorated beneath above limits while on therapy.
ALZHEIMER'S MEDICATIONS		
CHOLINESTERASE INHIBITORS		

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
DONEPEZIL† (compare to Aricept®) tablet *(QL = 1 tablet/day)* EXELON® (rivastigmine) Capsule *(QL = 2 capsules/day)* **SOLUTION** EXELON® (rivastigmine) Oral Solution **TRANSDERMAL** EXELON® (rivastigmine transdermal) Patch *(QL = 1 patch/day)*	Aricept® (donepezil) Tablet *(QL = 1 tablet/day)* galantamine† tablet § (compare to Razadyne®) Tablet galantamine ER† capsule § (compare to Razadyne ER®) Razadyne® (galantamine) Tablet Razadyne ER® (galantamine) Capsule rivastigmine† (compare to Exelon®) capsule *(QL = 2 capsules/day)* Aricept® ODT (donepezil) *(QL = 1 tablet/day)* Donepezil ODT † (compare to Aricept® ODT) *(QL = 1 tablet/day)* galantamine† (compare to Razadyne®) Oral Solution Razadyne® (galantamine) Oral Solution	**Galantamine Tablet, Galantamine ER Capsule, Razadyne Tablet, Razadyne ER Capsule:** diagnosis or indication for the reqeusted medication is Alzheimer's disease. AND patient has been started and stabilized on the requested medication (Note: samples are not considered adequate justification for stabilization) OR patient had a documented side effect, allergy or treatment failure to donepezil and Exelon. AND if the product has an AB rated generic, the patient has a documented intolerance to the generic. **Aricept:** diagnosis or indication for the requested medication is Alzheimer's disease. AND the patient has a documented intolerance to the generic product. **Galantamine Oral Solution, Razadyne Oral Solution:** diagnosis or indication for the requested medication is Alzheimer's disease. AND patient has been started and stabilized on the requested medication (Note: samples are not considered adequate justification for stabilization) OR the patient had a documented side effect, allergy or treatment failure to Exelon Oral Solution. AND if the product has an AB rated generic, the patient has a documented intolerance to the generic. **Aricept ODT, Donepezil ODT:** diagnosis or indication for the requested medication is Alzheimer's disease. AND medical necessity for a specialty dosage form has been provided. AND if the request is for donepezil ODT, the patient has a documented intolerance to the brand product. **Rivastigmine Oral Capsule:** diagnosis or indication for the requestedc medication is Alzheimer's disease. AND patient has a documented intolerance to the brand Exelon product.
NMDA RECEPTOR ANTAGONIST		
NAMENDA® (memantine) Tablet NAMENDA® XR (memantine ER) Oral Capsule *(QL = 1 capsule/day)* NAMENDA® (memantine) Oral Solution		

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
COX-2 INHIBITORS		
	Celebrex® (celecoxib) *(QL = 2 capsules/day)*	**Celebrex:** patient does not have a history of a sulfonamide allergy. AND patient has had a documented side effect, allergy, or treatment failure to two or more preferred generic NSAIDS. OR patient is not a candidate for therapy with a preferred generic NSAID due to one of the following: patient is 60 years of age or older, patietns has a history of GI bleed, patient is currently taking an antigoagulant (warfarin or heparin), Patient is currently taking an oral corticosteroid, and Patient is currently taking methotrexate.
ANALGESICS		
MISCELLANEOUS: TRANSDERMAL PATCH		
Note: Please refer to "Analgesics: Long Acting Narcotics" for Duragesic® and fentanyl patch Please refer to "Analgesics: NSAIDs" for Flector® patch	Lidocaine 5% patch† (compare to Lidoderm®) *(QL = 3 patches/day)* Lidoderm® Patch (lidocaine 5 %) *(QL = 3 patches/day)* Qutenza® Patch (capsaicin 8 %) *(QL =4 patches/90 days)*	**Lidoderm, Lidocaine Patch:** diagnosis or indication is neuropathis pain/post-herpetic neuralgia AND patient has had a documented side effect, allergy, treatment failure or contraindication to 2 drugs in the tricyclic antidepressant (TCA) class and/or anticonvulsant class AND patient has had a documented side effect, allergy, treatment failure or contraindication to Lyrica, OR patient has a medical necesssity for a transdermal formulation (ex. dysphagia, inability to take oral medications), AND if the request is for generic lidocaine patch, the patient has had a documented intolerance to the brand product. **Qutenza:** diagnosis or indication is post-herpetic neuralgia AND patient has had a documented side effect, allergy, treatment failure or contraindication to 2 drugs in the tricyclic antidepressant (TCA) class and/or anticonvulsant class AND patient has had a documented side effect, allergy, treatment failure or contraindication to Lyrica AND patient has had a documented side effect, allergy treatment failure or contraindication to Lidoderm OR patient has a medical

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		necessity for transdermal formulation (ex. dysphagia, inability to take oral medications) AND patient has had a documented side effect, allergy, treatment failure or contraindication to Lidoderm.
OPIOIDS: SHORT ACTING		
ACETAMINOPHEN W/CODEINE† (compare to Tylenol® w/codeine) ACETAMINOPHEN W/HYDROCODONE† (compare to Vicodin®, Lorcet®, Maxidone®, Norco®, Zydone®) *(QL 5/500 = 8 tablets/day, 10/500 = 8 tablets/day, 7.5/750 = 5 tablets/day)* ACETAMINOPHEN W/OXYCODONE† (compare to Percocet®) *(QL 10/650 = 6 tablets/day)* ASPIRIN W/CODEINE† ASPIRIN W/OXYCODONE† (compare to Percodan®) BUTALBITAL COMP. W/CODEINE† (compare to Fiorinal® w/codeine) CODEINE SULFATE† DIHYDROCODEINE COMPOUND† (compare to Synalgos-DC®)	Abstral® (fentanyl) Sublingual Tablets Acetaminophen w/codeine: *all branded products* Acetaminophen w/hydrocodone: *all branded products* *(QL 5/500 = 8 tablets/day, 10/500 = 8 tablets/day, 7.5/750 = 5 tablets/day)* Acetaminophen w/hydrocodone (compare to Xodol®) *(QL=13 tablets/day)* Acetaminophen w/oxycodone: *all branded products* *(QL 10/650 = 6 tablets/day)* Actiq® (fentanyl lozenge on a stick: 200 mcg, 400 mcg, 600 mcg, 800 mcg, 1200 mcg, 1600 mcg) Anexsia®* (acetaminophen w/hydrocodone) Butorphanol Nasal Spray† (Qty Limit = 2 bottles/month) Capital® w/codeine* (acetaminophen w/codeine) Cocet® /Cocet Plus® (acetaminophen w/codeine) *(QL 30/650 or 60/650 = 6 tablets/day)* Combunox®* (oxycodone w/ ibuprofen) Demerol* (meperidine)	**Butorphanol Nasal Spray:** documented site effect, allergy, treatment failure, or contraindation to codeine, hydrocodone, morphine, & oxycodone (all 4 generic entities) as single or combination products. OR is unable to use tablet or liquid formulations. **Abstral, Actiq, fentanyl transmucosal, Fentora, Lazanda, Subsys:** indication of cancer breakthrough pain AND patient is opioid tolerant AND is on a long acting opioid formulation AND is 18 years of age or older (Actiq 16 years of age or older) AND prescriber is registered in the Transmucosal Immediate Release Fentanyl (TIRF) Risk Evaluation and Mitigation Strategy (REMS) Access program AND member has had a documented treatment failure with or intolerance to 2 of the following 3 immmediate release tratment options: morphine, hydromorphone or oxycodone. OR is unable to use tablet or liquid formulations AND if the request is for brand name Actiq, member has a documented intolerance to generic fentanyl transmucosal. **Dilaudid - 5 Oral Solution, Hydromorphone Oral Solution:** member has had a documented side effect, allergy or treatment failure with oxycodone oral soluction and morphoine oral solution OR has been started and stabilized on another dosage form of hydromophone AND if the request is for the branded product, patient has a documented intolerance to the generic product.Nucynta, Opana, Oxymorphone: member has had a documented side effect, allergy, or treatment failuire to at least two of the following 3 immediate release generic short acting narcotic analgesics - morphine, hydromorphone, or oxycode AND if the request if for brand Opana, member has a documented intolerance to generic oxymorphone.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ENDOCET® (oxycodone w/ acetaminophen) ENDODAN® (oxycodone w/ aspirin) HYDROCODONE† (plain, w/acetaminophen, or w/ibuprofen) (some excpetions apply) HYDROMORPHONE† tablets (compare to Dilaudid®) *First fill limited to 14 days' supply* *(Qty limit = 16 tablets/day)* MEPERIDINE† (compare to Demerol®) (30 tabs or 5 day supply) MORPHINE SULFATE† MORPHINE SULFATE† (compare to Roxanol®) OXYCODONE† (plain) *First fill limited to 14 days' supply* *(For tablets, Qty limit = 12 tablets/day)* OXYCODONE† (w/acetaminophen or w/ibuprofen) ROXICET® (oxycodone w/ acetaminophen) TRAMADOL† (compare to Ultram®) *(Qty Limit = 8 tablets/day)* TRAMADOL/APAP† (compare to Ultracet®) *(Qty Limit = 8 tablets/day)* ZAMICET† (Hydrocodone-Acetaminophen Soln 10-325 Mg/15ml)	Dilaudid®*(hydromorphone) tablets *First fill limited to 14 days' supply* *(Qty limit = 16 tablets/day)* Dilaudid-5®(hydromorphone) oral solution *First fill limited to 14 days' supply* fentanyl citrate transmucosal† (compare to Actiq®) Fentora® (fentanyl citrate buccal tablets) Fioricet® w/codeine*(butalbital/acetaminophen/caffeine/codeine) Hydrocodone-Acetaminophen Soln 10-325 Mg/15ml Hydromorphone† oral soln (compare to Dilaudid-5®) *First fill limited to 14 days' supply* Ibudone®* (hydrocodone w/ ibuprofen) Lazanda® (fentanyl) Nasal Spray Liquicet® (hydrocodone w/ acetaminophen) Lorcet®* (also HD, PLUS) (hydrocodone w/ acetaminophen) Lortab®*(hydrocodone w/ acetaminophen) Magnacet® (oxycodone w/ acetaminophen) Maxidone®*(hydrocodone w/ acetaminophen) Meperidine† (Qty > 30 tabs or 5 day supply) Norco®*(hydrocodone w/ acetaminophen) Nucynta® (tapentadol)	**Oxycodone (generic) Capsules:** member has a documented intolerance to generic oxycodone tablets. **Oxecta:** prescriber provides a clinically valid rationale why the generic immediate release oxycodone cannot be used AND member has a documented side effect, allergy, or treatment failure to at least 2 other preferred short acting narcotic analgesics. NOTE: a history of substance abuse does not warrant approval of Oxeta (oxycodone IR) since a clear advantage of this product over preferred short acting opioids in this population has not been established. **Ultram, Ultracet:** member has a documented intolerance to the generic formulation **Rybix ODT:** member has a medical necessity for a disintegrating tablet formulation (i.e. swallowing disorder) **Xartemis XR:** diagnosis is acute pain AND member has a documented side effect, allergy, or treatment failure to at least 2 short acting opioids not requiring prior approval, one of which is oxycodone w/ apap AND prescriber must provide a compelling clinical reason why an extended release product is required for treatment of acute pain. **Other Short acting Opioids:** member has had a documented side effect, allergy, or treatment failure to at least 2 medications not requiring prior approval. (If a product has an AB rated generic, one trial must be the generic) **PA Requests to Exceed QL for Oxycodone IR or Hydromophone IR:** if dose consolidation is not possible (i.e. use of higher strength dosage form), all requests will be referred to the DVHA Medical Director for review unless the medication is being prescribed for pain related to an oncology diagnosis which will be approved by the Clinical Call Center. **Limitations:** APAP containing products: daily doses that result in > 4 grams of apap/day will reject for PA; Meperidine 75mg/ml injuction no longer available - 25mg/ml, 50mg/ml and 100mg/ml available. Brand name Demerol 75mg/ml and 100mg/2ml not covered - no generic equivalents. Roxicodone (oxycodone) tablets not covered - product does not offer Federal rebate.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Opana® (oxymorphone) Oxycodone† (plain) capsules First fill limited to 14 days' supply (Qty limit = 12 capsules/day) Oxymorphone† (compare to Opana®) Panlor DC® (acetaminophen/caffeine/dihydrocodeine) Pentazocine w/acetaminophen† Pentazocine w/naloxone† Percocet®*(oxycodone w/ acetaminophen) Percodan®* (oxycodone w/aspirin) Reprexain®* (hydrocodone w/ ibuprofen) Roxanol®*(morphine sulfate) Rybix® ODT (tramadol ODT) (Qty Limit = 8 tablets/day) Subsys® (fentanyl) Sublingual Spray Synalgos DC®*(dihydrocodeine compound) Talwin®* (pentazocine) and branded combinations Trezix® (acetaminophen/caffeine/dihydrocodeine) Tylenol® #3*,#4*(acetaminophen w/codeine) Tylox®*(oxycodone w/ acetaminophen) Ultracet® (tramadol w/ acetaminophen) (Qty Limit = 8 tablets/day) Ultram®* (tramadol) (Qty Limit = 8 tablets/day) Vicodin®*(hydrocodone w/acetaminophen) Vicoprofen®*(hydrocodone w/ ibuprofen) Xartemis XR® (oxycodone w/acetamimophen) (Qty Limit = 4 tablets/day) Xodol® (hydrocodone w/acetaminophen) Xolox® (oxycodone w/ acetaminophen)	

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Zydone®*(hydrocodone w/acetaminophen)	
OPIOIDS: LONG ACTING		
TRANSDERMAL **Buprenorphine** **All products require PA.** **Fentanyl** FENTANYL PATCH† (compare to Duragesic®) 12 mcg/hr, 25 mcg/hr, 50 mcg/hr (*QL=15 patches/30 days)* FENTANYL PATCH† (compare to Duragesic®) 75 mcg/hr, 100 mcg/hr (*QL=30 patches/30 days)* **ORAL** **Hydromorphone** **All products require PA.** **Methadone** **All products require PA** **Morphine** MORPHINE SULFATE CR 12 hr† tablet (compare to MS Contin®, formerly Oramorph SR®) (*QL=90 tablets/strength/30*	Butrans (buphrenorphine) Transdermal System *(QL = 2 patches/14 days) (Maximum 14 day fill)* Duragesic®* (fentanyl patch) 12 mcg/hr, 25 mcg/hr, 50 mcg/hr (QL=15 patches/30 days) Duragesic®* (fentanyl patch) 75 mcg/hr, 100 mcg/hr (QL= 30 patches/30 days) Exalgo® (hydromorphone XR) tablet *(QL= 30 tablets/30 days (8 mg, 12 mg, 16 mg tabs), 60 tablets/30 days (32 mg tabs)* hydromorphone XR† (compare to Exalgo®) tablet *(QL= 30 tablets/30 days (8 mg, 12 mg, 16 mg tabs))* Dolophine® (methadone) tablets Methadone† (compare to Dolophine®) 5 mg, 10 mg tablets Methadone† oral solution 1 mg/ml (no PA required for patient less than 1 year old) Methadone† oral concentrate 10 mg/ml ****Maximum initial daily dose all products = 30 mg/day****	**CLINICAL CONSIDERATIONS:** Long acting opioid dosage forms are intended for use in opioid tolerant patients only. These tablet/capsule/topical medication strengths may cause fatal respiratory depression when administered to patients not previously exposed to opioids. LA opioids should be prescribed for patients with a diagnosis or condition that requires a continuous, around-the-clock analgesic. LA opiods should be reserved for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain. LA opiods are NOT intended for use as 'prn' analgesic. LA opioids are NOT indicated for pain in the immedate post-operative period (the first 12-24 hours following surgery) or if the pain is mild, or not expected to persist for an extended perioid of time. LA opioids are not intended to be used in a dosage frequency other than FDA approved regimens. Patients should not be using other etended release opioids prescribed by another physician. Prescribers should consult the VPMS (Vermont Prescription Monitoring System) to review a patient's Schedule II - IV medication use before prescribing long acting opioids. **Brand Duragesic Fentanyl Patches:** patient has a diagnosis of severe pain that requires daily, around-the-clock, long-term treatment and for which alternative treatment options are inadequate AND the patient has had a documented intolerance to generic fentanyl patches. **Butrans Transdermal System:** patient has a diagnosis of severe pain that requires daily, around-the-clock, long term opiod treatment and for which alternative treatment options are inadequate AND patient has had a documented side effect, allergy, or treatment failure to morphine sulfate CR 12hr tablet (generic) AND generic fentanyl patch OR prescriber provides compelling clinical information for case specific discussion with DVHA Mecial Director who will determine PA

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
days) **<u>Tramadol</u>** **All products require PA.**	Avinza® (morphine sulfate beads SR 24hr) Capsules *(QL= 30 capsules/strength/30 days)* Embeda® (morphine sulfate/naltrexone hydrochloride) Capsules *(QL=2 capsules/day)* Kadian® (morphine sulfate XR*) (QL= 60 capsules/strength/30 days)* MS Contin®* (morphine sulfate CR 12 hr) Tablets *(QL=90 tablets/strength/30 days)* Morphine sulfate SR 24hr† capsule (compare to Kadian®) *(QL= 60 capsules/strength/30 days)* Morphine sulfate SR beads 24hr† capsule (compare to Avinza®) *(QL= 30 capsules/strength/30 days)* Oxycodone ER† (compare to OxyContin®) *(QL= 90 tablets/strength/30 days)* OxyContin® (Oxycodone ER) *(QL= 90 tablets/strength/30 days)* Opana ER® (oxymorphone ER) (crush resistant) *(QL=60 tablets/strength/30 days)* Oxymorphone ER *(QL=60 tablets/strength/30 days)* Nucynta ER® (tapentadol ER) *(QL=2 tablets/day)* Conzip® (tramadol ER biphasic release) Capsule *(QL = 1 capsule/day)*	decision. **Methadone Tablet:** patient has a diagnosis of severe pain that requires daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate. (Note: Methadone products, when used for treatment of opioid addiction in detoxification or maintenance programs, shall be dispensed ONLY by certified opioid treatment programs as stripulated in 42 CFR 8.12, NOT retail pharmacy) AND patient has been started and stabilized on the requested medication OR patient has a diagnosis of severe pain that requires daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate. (Note: Methadone products, when used for treatment of opioid addiction in detoxification or maintenance programs, shall be dispensed ONLY by certified opioid treatment programs as stripulated in 42 CFR 8.12, NOT retail pharmacy) AND patient has had a documented side effect, allergy, or treatment failure to morphine sulfate CR 12 hr tablets AND the initial methadone daily dose does not exceed 30mg AND for approval of brand Dolophine tablets, the patient must have a documented intolerance to the equivalent generic tablet. **Methadone Liquid:** patient has a diagnosis of severe pain that requires daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate. (Note: Methadone products, when used for treatment of opioid addiction in detoxification or maintenance programs, shall be dispensed ONLY by certified opioid treatment programs as stripulated in 42 CFR 8.12, NOT retail pharmacy) AND the patient has been started and stabilized on the requested oral liquid medication OR patient has a diagnosis of severe pain that requires daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate. (Note: Methadone products, when used for treatment of opioid addiction in detoxification or maintenance programs, shall be dispensed ONLY by certified opioid treatment programs as stripulated in 42 CFR 8.12, NOT retail pharmacy) AND the initial methadone daily dose does not exceed 30mg AND the patient must have a medical necessity for an oral liquid (i.e. swallowing disorder, inability to take oral medications).

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Tramadol SR† (compare to Ultram ER®) *(Qty Limit = 1 tablet/day)* Tramadol ER biphasic-release® Capsule *(Qty Limit = 1 capsule/day)(150 mg strength)* Tramadol ER biphasic-release† tablet (formerly Ryzolt®) *(Qty Limit = 1 tablet/day)* Ultram ER® (tramadol SR 24 hr) *(Qty Limit = 1 tablet/day)* Zohydro ER®	**Conzip, Tramadol ER biphasic-release Capsule, Tramadol ER biphasic-release Tablet, Tramadol ER/SR, Ultram ER:** member has had a documented treatment failure to a preferred short-acting tramadol product. In addition, for approval of tramadol ER biphasic-release capsule or tablet or Ultram ER, the patient must have a documented intolerance to generic tramadol ER/SR. **Oral Non-Preferred (except methadone & tramadol containing products):** patient has a diagnosis of severe pain that requires daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate AND the patient has had a documentd side effect, allergy, or treatment failure to morphine sulfate CR 12hr tablet (generic) AND generaic fentanyl patch. (If a product has an AB rated generic, there must have been a trial of the generic). NOTE: A history of substance abuse does not warrant approval of Opana ER (crush resistant) since a clear advantage of this product over preferred long-acting opioids in this population has not been established. **Zohydro ER:** Available with PA for those unable to tolerate any preferred medications. All requests will go to the DVHA Medical Director for approval. **Limitations:** Methadone 40mg dispersible tablet not approved for retail dispensing. Methadone 2mg/ml oral solution not covered - use 1mg/ml generic oral solution. Opana ER (crush resistant): a history of substance abuse does not warrant approval of Opana ER (crush resistant) since a clear advantage of this product over preferred long-acting opioids in this population has not been established.
NSAIDS		
ORAL **SINGLE AGENT** DICLOFENAC POTASSIUM† (compare to	Anaprox®* (naproxen sodium) Anaprox DS®* (naproxen sodium) Ansaid®* (flurbriprofen)	**Arthrotec, diclofenac/misoprostol, Duexis:** patient has a documented side effect or treatment failure to 2 or more preferred genreic NSAIDs OR patient is nto a candidate for therapy with a preferred generic NSAID mono-therapy due to one of the following: patiens is 60 years of age or older, Patient has a history of GI bleed, Patient is currently taking an oral corticosteroid, Patient is currently taking

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
Cataflam®) DICLOFENAC SODIUM† (compare to Voltaren®) DIFLUNISAL† (formerly Dolobid®) ETODOLAC† (formerly Lodine®) FLURBIPROFEN† (compare to Ansaid®) IBUPROFEN† (compare to Motrin®) INDOMETHACIN†(formerly Indocin®, Indocin SR®) KETOPROFEN† KETOPROFEN ER† KETOROLAC† (formerly Toradol®) *(QL = 20 doses/5 day supply every 90 days)* MECLOFENAMATE SODIUM† (formerly Meclomen®) MELOXICAM† tabs (compare to Mobic®) NABUMETONE† (formerly Relafen®) NAPROXEN† (compare to Naprosyn®) NAPROXEN ENTERIC COATED† (compare to EC-Naprosyn®) NAPROXEN SODIUM† (compare to Anaprox®, Anaprox DS®, Naprelan®)	Cambia® (diclofenac potassium) packet for oral solution *(QL = 9 packets/month))* Cataflam®* (diclofenac potassium) Clinoril®* (sulindac) Daypro®* (oxaprozin) EC-Naprosyn® * (naproxen sodium enteric coated) Feldene®* (piroxicam) Fenoprofen† 600 mg tab (formerly Nalfon®) Indocin®* (indomethacin) suspension Indocin SR®* (indomethacin) capsules mefenamic acid† capsules (compare to Ponstel®) meloxicam suspension Mobic® (meloxicam) suspension Mobic®* (meloxicam) tablets Motrin®* (ibuprofen) Nalfon® (fenoprofen) 400 mg capsules Naprelan®* (naproxen sodium) Naprosyn®* (naproxen sodium) Ponstel® (mefenamic acid) Voltaren®* (diclofenac sodium) Voltaren XR®* (diclofenac sodium SR) Zipsor® (diclofenac potassium) Zorvolex® (diclofenac) Capsules	methotrexate AND patient is unable to take the individual components separately AND if the request is for brand Arthrotec, the patien has a documented intolerance to the generic equivilant. **Cambia:** drug is being prescribed for treatment of acute migraine attacks AND patietn has had a documented side effect or treatment failure to 2 or more preferred generic NSAIDs, one of which must be generic diclofenac OR drug is being prescribed for treatment of acute migraine attacks AND patient has a requirement for an oral liquid dosage form (i.e. swallowing disorder, inability to take oral medications) AND patient has had a documented side effect or treatmetn failure with the generic ibuprofen suspension and the generic naproxen suspension. **Flector Patch, Pennsaid, Diclofenac 1.5% Topical Solution:** diagnosis or indication is osteoarthritis or acute pain caused by minor strains, sprains, and contusions AND patient has had a documented side effect or inadequate response to Voltaren gel OR patient is not a candidate for therapy with a preferred generic NSAID due to one of the following: Patient is 60 years of age or older, Patient has a history of GI bleed, Patient is currently taking an oral corticosteroid, Patient is currently taking methotrexate OR patient has a documented medical necessity for a topical/transdermal formulation (ex. dysphagia, inability to take oral medicaions), AND for approval of Pennsaid 1.5%, the patient has had a documented intolerance to the generic equivalent. **Sprix:** indication or diagnosis is moderate to moderately severe pain. AND patient has had a documented inadequate response or intolerance to generic ketorolac tablets. OR patient has a documented medical necessity for the specialty dosage form (i.e. inability to take medication orally (NPO)). **Voltaren Gel:** diagnosis or indication is osteoarthritis or acute pain caused by minor strains, sprains, and contusions. AND patient has had a documetned side effect or treatmetn failure with at least 2 preferred generic NSAIDs. OR patient is not a candidate for therapy with a preferred generis NSAID due to one of the following: Patient is 60 years of age or older, Patient has a history of GI bleed,

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
OXAPROZIN† (compare to Daypro®) PIROXICAM† (compare to Feldene®) SULINDAC† (compare to Clinoril®) TOLMETIN SODIUM† (formerly Tolectin®) **INJECTABLE** KETOROLAC † Injection (formerly Toradol®) *(QL = 1 dose per fill)* **NASAL SPRAY** **All products require PA.** **TRANSDERMAL** **All products require PA.** **NSAID/ANTI-ULCER** **All products require PA.** Note: Please refer to "Dermatologicals: Actinic Keratosis Therapy" for Solaraze®	*(QL = 3 capsules/day)* Sprix® (ketorolac) Nasal Spray *(QL = 5 bottles/5 days – once every 90 days)* diclofenac† (compare to Pennsaid®) 1.5 % Topical Solution Flector® (diclofenac) 1.3 % Patch *(QL = 2 patches/day)* Pennsaid® (diclofenac) 1.5 % or 2% Topical Solution Voltaren® (diclofenac) 1 % Gel Arthrotec® (diclofenac sodium w/misoprostol) diclofenac sodium w/misoprostol† (compare to Arthrotec®) Duexis® (ibuprofen/famotidine) *(QL = 3 tablets/day)* Vimovo® (naproxen/esomeprazole) *(QL = 2 tablets/day)*	Patient is currently taking an oral corticosteroid, Patient is currently taking methotrexate OR patient has a documented medical necessity for a topical/transdermal formulation (ex. dysphagia, inability to take oral medication) **Vimovo:** patient has had a documented side effect or treatment failure to 2 or moer preferred generic NSAIDs OR patient is not a candidate for therapy with a preferred generis NSAID due to one of the following: Patient is 60 years of age or older, Patient has a history of GI bleed, Patient is currently taking an oral corticosteroid, Patient is currently taking methotrexate AND patient is unable to take naproxen and a preferred proton pump inhibitor, separately. **Zipsor, Zorvolex:** patient has had a documented intolerance to diclofenac tablets. AND patient has had a documented side effect, allergy, or treatment failure to 4 or more preferred generic NSAIDs. **All other PA requiring NSAIDs:** patient has had a documented side effect or treatmetn failu or 2 or more preferred generic NSAIDS. (If a product has an AB rated generic, one trial must be the generic.)

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ANEMIA: HEMATOPOIETIC/ERYTHROPOIETIC AGENTS		
PREFRRED AFTER CLINICAL CRITERIA ARE MET ARANESP® (darbepoetin alfa) PROCRIT® (epoetin alpha)	Epogen® (epoetin alpha)	**Aranesp, Procrit:** diagnosis or indication for the requested medication is anemia due to one of the following: Chronic kidney disease/renal failure, Post-renal transplant, Use of zidovudine for the treatment of human immunodeficiency virus (HIV) (other causes of anemia, such as iron/folate/vitamin B12 deficiency have been eliminated), Surgery patients at high risk for perioperative blood loss, Cancer chemotherapy, Use of ribavirin or interferon therapy for Hepatitis C, Myelodysplastic syndrome. Hemoglobin level at initiation of therapy is <10 g/dL OR for patients currently maintained on therapy, hemoglobin leven is < 11 g/dL in dialysis patients with chronic kidney disease, < 10 g/dL in non-dialysis patients with chronic kidney disease, or < 12 g/dL in patietns treated for other indications **Epogen:** diagnosis or indication for the requested medication is anemia due to one of the following: Chronic kidney disease/renal failure, Post-renal transplant, Use of zidovudine for the treatment of human immunodeficiency virus (HIV) (other causes of anemia, such as iron/folate/vitamin B12 deficiency have been eliminated), Surgery patients at high risk for perioperative blood loss, Cancer chemotherapy, Use of ribavirin or interferon therapy for Hepatitis C, Myelodysplastic syndrome. Hemoglobin level at initiation of therapy is <10 g/dL OR for patients currently maintained on therapy, hemoglobin leven is < 11 g/dL in dialysis patients with chronic kidney disease, < 10 g/dL in non-dialysis patients with chronic kidney disease, or < 12 g/dL in patients treated for other indications. AND patient has had a documented side effect, allergy, or treatment failure to both Aranesp and Procrit. **Limitations:** Omontys (peginesatide) is available only to dialysis units at this time and so will not be available through the pharmacy benefit. As of 2/23/2013 Omontys is not being marketed due to new post marketing reports of serious hypersensitivity reactions.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ANKYLOSING SPONDYLITIS: INJECTABLES		
****Self-injectables (Enbrel®, Cimzia®, Humira® and Simponi®) must be obtained through Specialty Pharmacy Provider,** Briova** **Length of Authorization: Initial PA 3 months; 12 months thereafter**		
PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET ENBREL® (etanercept) *Qty Limit = 4 syringes/28 days(50 mg), 8 syringes/28 days (25 mg)* HUMIRA® (adalimumab) *Qty Limit = 2 syringes/28 days*	Cimzia® (certolizumab pegol) *(Quantity limit = 1 kit/28 days (starter X 1, then regular))* Remicade® (infliximab) Simponi® (golimumab) Subcutaneous *Qty Limit = 1 of 50 mg prefilled syringe or autoinjector/28 days)*	**Humira:** patient has a diagnosis of ankylosing spondylitis (AS) and has already been stabilized on Humira. OR patient has a confirmed diagnosis of AS, and conventional NSAID treatment and DMARD therapy (e.g. methotrexate therapay) resulted in an adverse effect, allergic reaction, inadequate response, or treatment failure. If methotrexate is contraindicated, another DMARD should be tried. Notes: Approval should be granted in cases where patiens have been treated with infliximab but have lost response to therapy. **Enbrel:** patient has a diagnosis of ankylosing spondylitis (AS) and has already been stabilized on Enbrel. OR diagnosis is AS, and conventional NSAID treatment and DMARD therapy (e.g. methotrexate therapy) resulted in an adverse effect, allergic reaction, inadequate response, or treatment failure. If methotrexate is contraindicated, another DMARD should be tried. **Cimzia:** patient has a diagnosis of ankylosing spondylitis (AS) and has already been stabilized on Cimzial OR diagnosis is AS, and conventional NSAID treatment and DMARD therapy (e.g. methotrexate therapy) resulted in an adverse effect, allergic reaction, inadequate response, or treatment failure. If methotrexate is contraindicated, another DMARD should be tried. AND the prescriber must provide a clinically valid reason why either Humira or Enbrel cannot be used. **Remicade:** patient has a diagnosis of ankylosing spondylitis (AS) and has already been stabilized on Remicade. OR diagnosis is AS, and conventional NSAID treatment and DMARD therapy (e.g. methotrexate therapy) resulted in an adverse effect, allergic reaction, inadequate response, or treatment failure. If methotrexate is contraindicated, another DMARD should be tried. AND the prescriber must provide a clinically valid reason why either Humira or Enbrel

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		cannot be used. **Simponi:** patient has a diagnosis of ankylosing spondylitis (AS) and has already been stabilized on Simponi. OR patient age > 18 years. AND diagnosis is AS, and patient has documentation of an inadequate response, adverse reaction or allergice response to methotrexate, or if ethotreate is contraindicated, at least 1 DMARD (other DMARDs include leflunomide, sulfasalazine, gold, antimalarials, minocycline, D-penicillamine, azathioprine, cyclophosphamide and cyclosporine) AND the prescriber must provide a clinically valid reason why either Humira or Enbrel cannot be used. * Patients with documented diagnosis of active axial involvement should have a trial with two NSAIDs, but a trial with DMARD is not required. If no active axial skelatal involvement, then NSAID trial and a DMARD trial are required (unless otherwise contraindicated) prior to receiving Humira, Cimzia, Enbrel, Remicade, or Simponi.
ANTI-ANXIETY: ANXIOLYTICS		
BENZODIAZEPINE		
CHLORDIAZEPOXIDE† (formerly Librium®) CLONAZEPAM† (compare to Klonopin®) *(QL = 4 tabs/day except 2 mg (QL = 3 tabs/day))* CLONAZEPAM ODT† (formerly Klonopin Wafers®)	alprazolam† (compare to Xanax®) *(QL = 4 tablets/day)* alprazolam ER†, alprazolam XR® (compare to Xanax	**Non-preferred Benzodiazepines (except for alprazolam ODT, Klonopin Wafers, Niravam & Intensol Products):** patient has a documented side effect, allergy, or treatment failure to at least 2 preferred benzodiazepine medications. (If a product has an AB rated generic, there must also be a trial of the generic formulation) **Alprazolam ODT and Niravam:** patient has a documented side effect, allergy, or treatment failure to at least 2 preferred benzodiazepine medications. (If a

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
(QL = 4 tabs/day except 2 mg (QL = 3 tabs/day)) CLORAZEPATE† tabs (compare to Tranxene T®) DIAZEPAM† (compare to Valium®) LORAZEPAM† (compare to Ativan®) *(QL = 4 tablets/day)* OXAZEPAM† (formerly Serax®)	XR®) *(QL = 2 tablets/day)* alprazolam ODT† (compare to Niravam®) *(QL = 3 tablets/day)* Alprazolam Intensol® (alprazolam concentrate) Ativan®* (lorazepam) *(QL = 4 tablets/day)* Diazepam Intensol® (diazepam concentrate) Klonopin®* (clonazepam) *(QL = 4 tabs/day except 2 mg (QL = 3 tabs/day))* Lorazepam Intensol® (lorazepam concentrate) Niravam® (alprazolam ODT) *(QL = 3 tablets/day)* Tranxene T®* (clorazepate tablets) Valium®* (diazepam) Xanax® (alprazolam) *(QL = 4 tablets/day)* Xanax XR® (alprazolam XR) *(QL = 2 tablets/day)*	product has an AB rated generic, there must also be a trial of the generic formulation). OR patient has a medical necessity for disintegrating tablet administration (i.e. inabiloity to swallow tablets) AND patient has a documented side effect, allergy or treatment failure to clonazepam ODT. **Alprazolam Intensol, Diazepam Intensol, Lorazepam Intensol:** patient has a medical necessity for the specialty dosage form (i.e. swallowing disorder). AND the medication cannot be administered by crushing oral tablets.
NON-BENZODIAZEPINE		

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
BUSPIRONE† (formerly Buspar®) HYDROXYZINE HYDROCHLORIDE† (formerly Atarax®) HYDROXYZINE PAMOATE† (compare to Vistaril®) (all strengths except 100 mg) MEPROBAMATE† (formerly Miltown®)	Hydroxyzine Pamoate† (100 mg strength ONLY) (compare to Vistaril®) Vistaril®* (hydroxyzine pamoate)	**Hydroxyzine Pamote 100mg strength ONLY:** patient isunable to use generic 50mg capsules **Vistaril:** patient has a documented intolerance to the generic formulation. **PA Requests to Exceed QL:** all requests will be referred to the DVHA Medical Director for review unless (a) the medication is being prescribed fro acute alcohol withdrawal for a maximum 10 day supply or (b) the patient has been started and stabilized on the requested quantity for treatment of a seizure disorder.
ANTICOAGULANTS		
ORAL		
Vitamin K Antagonist WARFARIN † (compare to Coumadin®) **Preferred Agents after Clinical Criteria are Met** Pradaxa® (dabigatran etexilate) (PA only requires FDA approved indication) *(Quantity Limit = 2 capsules/day)* **Direct Thrombin Inhibitor**	Coumadin®* (warfarin) Eliquis® (apixaban) (PA only requires FDA approved indication) *(Quantity Limit = 2 tablets/day)* *(Quantity limit 5mg = 4 tablets/day for 7 days if indication is treatment of DVT or PE)(followed by 5 mg twice daily)* Xarelto® (rivaroxaban) 15 mg and 20 mg *(Quantity Limit = 1 tablet/day)*	**Coumadin:** patient has been started and stabilized on the requested medication OR patient has had a documented intolerance to generic warfarin. **Pradaxa:** Diagnosis or indication is nonvalvular atrial fibrillation or the indication is treatment of DVT or PE following 5-10 days of parenteral anticoagulation or the indication is reduction of risk of recurrent DVT or PE following initial therapy **Xarelto 15mg & 20mg:** diagnosis or indication is nonvalvular atrial fibrillation AND patient has been started and stabilized on the requested medication OR patient has had documented side effect, allergy, or contraindication (i.e. drug interactions) to warfarin therapy OR patient has not been able to be adherent to

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
Factor Xa Inhibitor XARELTO® (rivaroxaban) 10 mg *(Quantity Limit = 1 tablet/day, maximum 30 day supply to complete total 35 days/every 180 days)*	*(Quantity limit 15 mg = 2 tablets/day for 21 days if indication is treatment of* *DVT or PE)(followed by 20 mg once daily)* Xarelto® (rivaroxaban) starter pack (15 mg/20 mg) *(Quantity Limit = 51 tablets/30 days)*	coagulation monitoring or has not been able to achieve optimal INR control (INR 2-3) with warfarin therapy, despite dose titration attempts OR prescriber has provided another clinically valid reason why generic warfarin cannot be used OR indication is treatment of DVT or PE or reduction of resk of recurrent DVT or PE AND patient has been started and stabilized on the requested medication OR the prescriber has provided a clincally valid reason why low molecular weight heparins, fondaparinux, or generic warfarin cannot be used. **Note:** Xarelto 10mg for the diagnosis of the need for thromboprophylasix followign knee and hip replacemetn surgery is available without PA in the limited durations require for these indications.
INJECTABLE		
UNFRACTIONATED HEPARIN INJECTABLE HEPARIN† **LOW MOLECULAR WEIGHT HEPARINS INJECTABLE** FRAGMIN® (dalteparin) LOVENOX® (enoxaparin) *(QL = 2 syringes/day calculated in ml volume)* **SELECTIVE FACTOR XA INHIBITOR INJECTABLE**	n/a Enoxaparin † (compare to Lovenox®) *(QL = 2 syringes/day calculated in ml volume)* Innohep® (tinzaparin) Arixtra®* (fondaparinux)	**Arixtra:** patient has a documented intolerance to generic fondaparinux. **Enoxaparin:** patient has a documented intolerance to brand Lovenox **Innohep:** diagnosis is treatment of acute, symptomatic deep vein thrombosis (DVT) with or without pulmonary embolism, administered in conjunction with warfarin sodium AND patient does not have a bleeding disorder or documetned heparin-induced thrombocytopenia (HIT) AND prescriber must provide a clinically valid reason why one of Lovenox, Fragmin, or fondaparinux cannot be used OR patient has been started and stabilized on the requested medication in conjunction with warfarin

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
FONDAPARINUX† (compare to Arixtra®)		
ANTICONVULSANTS		
ORAL		
CARBAMAZEPINE† (compare to Tegretol®) CARBAMAZEPINE extended release † (compare to Tegretol XR®) CARBATROL® (carbamazepine) CELONTIN® (methsuxamide) CLONAZEPAM† (compare to Klonopin®) *QL = 4 tablets/day* CLONAZEPAM ODT† (formerly Klonopin Wafers®) *QL = 4 tablets/day* CHLORAZEPATE† (compare to Tranxene-T® Tablets DEPAKOTE SPRINKLES® (divalproex sodium caps) DIAZEPAM† (compare to Valium®) DILANTIN® (phenytoin) DIVALPROEX SODIUM † (compare to Depakote®) DIVALPROEX SODIUM ER† (compare to Depakote ER®) EPITOL† (carbamazepine)	Aptiom® (eslicarbazepine acetate) *QL = 1 tab/day (200, 400 and 800 mg) and 2 tabs/day (600 mg)* Banzel® (rufinamide) *QL = 8 tabs/day (400 mg) and 16 tabs/day (200 mg)* Banzel® (rufinamide) oral suspension *QL = 80 ml/day (3,200 mg/day)* Depakene®* (valproic acid) Depakote®* (divalproex sodium) Depakote ER®* (divalproex sodium) divalproex sodium capsules † (compare to Depakote Sprinkles®) felbamate† (compare to Felbatol®) Felbatol® (felbamate) Fycompa® (perampanel) tablets *QL = 1 tablet/day* Keppra®* (levetiracetam) tablets, oral solution Keppra XR® (levetiracetam extended release)	**Depakene, Depakote, Depakote ER, Keppra tabs or oral solution, Klonopin, Klonopin Wafers, Lamictal tabs or chew tabs, Mysline, Neurontin caps, tabs, sol, Tegretol XR (200mg & 400mg), Topamax tabs, Topamax sprinkles, Trileptal tabs, Zarontin, Zonegran:** patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization) OR patient has had a documented intolerance to the generic equivalent of the requested medication. **Benzel:** diagnosis or indication is treatment of Lennox-Gastaut Syndrome. AND patient has had a documented side effect, allergy, treatment failure/inadequate response or a contraindication to at least TWO preferred anticonvulsants used for the treatment of Lennox-Gastaut syndrome (topiramate, lamotrigine, valproic acid) AND for approval of the oral suspension, patient must be unable to use Benzel tabs (i.e. swallowing disorder) **Felbamate, Felbatol:** patient informaiton/consent describing aplastic anemia and liver injury has been completed AND patient has been started and stabilized on the requeste medicaion. (Note: samples are not considered adequate justification for stabilization). Additionally, if brand is requested, the patient has a documented intolerance to the generic product. OR diagnosis is adjunctive therapy of partial-onset seizures or Lennox-Gastaut seizures and the patient has had a documented side effect, allergy, treatment failure/inadequate response or a contraindication to at least THREE preferred anticonvulsants. Additionally, if brand is requested, the patient has a documented intolerance to the generic product.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ETHOSUXAMIDE† (compare to Zarontin®) GABAPENTIN† 100 mg, 300 mg, 400 mg capsules, 600 mg, 800 mg tablets, 250 mg/5 ml oral solution (compare to Neurontin®) GABITRIL® (tiagabine) LAMOTRIGINE† chew tabs (compare to Lamictal® chew tabs) LAMOTRIGINE† tabs (compare to Lamictal® tabs) LEVETIRACETAM† tabs (compare to Keppra® tabs) LEVETIRACETAM† oral soln (compare to Keppra® oral soln) OXCARBAZEPINE† tablets (compare to Trileptal®) PEGANONE® (ethotoin) PHENYTEK® (phenytoin) PHENYTOIN† (compare to Dilantin®) PHENYTOIN EX† cap (compare to Phenytek®) PRIMIDONE† (compare to Mysoline®) TEGRETOL XR® (carbamazepine) 100 mg ONLY TOPIRAMATE† tabs (compare to Topamax® tabs) TOPIRAMATE† sprinkle caps (compare to Topamax® Sprinkles) TRILEPTAL® oral suspension (oxcarbazepine)	Klonopin®* (clonazepam) *QL = 4 tablets/day* Lamictal®* tabs (lamotrigine tabs) Lamictal®* chew tabs (lamotrigine chew tabs) Lamictal ODT® (lamorigine orally disintegrating tablets) Lamictal XR® tablets (lamotrigine extended release) lamotrigine ER† (compare to Lamictal XR®) levetiracetam ER† (compare to Keppra XR®) Lyrica® (pregabalin) § cap *(Quantity Limit = 3 capsules/day)* Lyrica® (pregabalin) oral solution Mysoline®* (primidone) Neurontin®* (gabapentin) capsules, tablets and solution Onfi® (clobazam) Oral Suspension 2.5 mg/ml *(Quantity limit = 16 ml/day)* Onfi® (clobazam) Tablets *(Quantity Limit = 3 tabs/day (10 mg), 2 tabs/day (20 mg))* Oxcarbazepine † oral suspension (compare to Trileptal®) Oxtellar® XR (oxcarbazapine ER) tablet Potiga® (ezogabine) tablets *(Quantity limit = 9 tablets/day (50mg), 3 tablets/day*	**Divalproex sodium capsules (sprinkles), tiagabine, Oxcarbazepine oral suspension (generics):** patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization). OR patient has had a documented intolerance to the brand name product. **Keppra XR, Lamictal XR, lamotrigine ER, levetiracetam ER, Oxtellar XR, Trokendi XR:** patient has been unable to be compliant with or tolerate twice daily dosing of the immediate release product. Additionally, if brand Keppra XR or Lamictal XR is requested, the patient has a documented intolerance to the generic product. **Lamictal ODT:** medical necessity for a specialty dosage form has been provided AND lamotrigine chewable tabs cannot be used. **Lyrica caps, Lyrica oral solution:** patient has a diagnosis of epilepsy OR patient has had a documented side effect, allergy, or treatment failure to TWO drugs from the following: gabapentin, tricyclic antidepressant, SSRI andidepressant, SNRI antidepressant, miscellaneous antidepressant, cyclobenzaprine or Savella, if medication is being used for fibromyalgia. (This indication not processed via automated step therapy). AND if the request is for the oral solution, the patient is unable to use Lyrica capsules (i.e. swallowing disorder) **Onfi:** patient has been started and stabilized on the requested medication (Note: samples are not considered adequate justification for stabilization) OR diagnosis or indication is adjunctive treatment of Lennox-Gastaut Syndrome. AND patient has had a documented side effect, allergy, treatment failure/inadequate response or a contraindication to at least TWO preferred anticonvulsants used for the treatment of Lennox-Gastaut syndrome (topiramate, lamotrigine, valproic acid) OR diagnosis or indication is adjunctive treatment of refractory epilepsy (may include different types of epilepsy) AND patient has had a documented side effect, allergy, treatment failure/inadequate response or a contraindication to at least THREE preferred anticonvulsants. **Fycompa, Potiga:** patient has been started and stabilized on the requested medication (Note: sampleas are not considered adequate justification for

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
VALPROIC ACID† (compare to Depakene®) ZONISIMIDE† (compare to Zonegran®)	*(all others)* Sabril® (vigabatrin) Stavzor® (valproic acid delayed release) Tegretol®* (carbamazepine) Tegretol XR® (carbamazepine) (200 and 400 mg strengths) tiagabine† (compare to Gabitril®) Topamax®* (topiramate) tablets Topamax®* (topiramate) Sprinkle Capsules Tranxene-T®* (clorazepate) tablets Trileptal®* tablets (oxcarbazepine) Trokendi XR® (topiramate SR 24hr) Capsules *(Quantity limit = 2 caps/day (200mg), 1 cap/day all others)* Valium®* (diazepam) Vimpat® (lacosamide) tablets, oral solution Zarontin®* (ethosuxamide) Zonegran®* (zonisamide)	stabilization) OR diagnosis is adjunctive therapy or partial-onset seizures and the patient has had a documented side effect, allergy, treatment failure,inadequate response or a contraindication to at least TWO preferred anticonvulsants. Sabril: prescriber and patient are registered with the SHARE program AND diagnosis is infantile spasms OR patient is > 16 years old and the indication is adjunctive therapy in refractory complex partial seizures and failure of THREE other preferred anticonvulsants. **Stavzor:** patient has been started and stabilized on the requested medication (Note: samples are not considered adequate justification for stabilization) OR patient has had a documented intolerance to divalproex sodium. **Vimpat:** patient has been started and stablized on the requested medication (Note: samples are not considered adequate justification for stabilization) OR diagnosis is monotherapy adjunctive therapy of partial-onset seizures and the patient has had a documented side effect, allergy, treatment failure/inadequate response or a contraindication to at least TWO preferred anticonvulsants AND if the reqeust is for the oral solution, the patient is unable to use Vimpat tables (eg. swallowing disorder). **PA Requests to Exceed QL for clonazepam/clonazepam ODT or Klonopin**: all requests will be referred to the DVHA Medical Director for review unless the patient has been started and stabilized on the requested quantity for treatment of a seizure disorder.
RECTAL		
DIASTAT® (diazepam rectal gel)	Diazepam rectal gel	**Diazepam Rectal Gel:** patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization) OR patient has had a documented intolerance to Diastat rectal gel.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ANTIDEPRESSANTS		
MAO INHIBITORS – Length of Authorization: Duration of Need for Mental Health Indications		
PHENELZINE SULFATE (compare to Nardil®) *FDA maximum recommended dose = 90 mg/day* TRANYLCYPROMINE (compare to Parnate®) *FDA maximum recommended dose = 60 mg/day*	EMSAM® (selegiline) *(QL = 1 patch/day)* Marplan® (isocarboxazid) Nardil®* (phenylzine) *FDA maximum recommended dose = 90 mg/day* Parnate®* (tranylcypromine) *FDA maximum recommended dose = 60 mg/day*	**Marplan:** patient has been started and stabilized on the requested medication (Note: samples are not considered adequate justification for stabilization). OR patient has had a documented side effect, allergy, or treatment failure to phenelzine and tranylcypromine. **Nardil, Parnate:** patient has had a documented intolerance to generic equivalent product. **EMSAM:** patient has had a documented side effect, allergy, or treatment failure with at least 3 antideprssants from 2 of the major antidepressants classes (Miscellaneous, SNRIs, SSRIs, Tricyclic Antidepressants). OR patient is unable to tolerate oral medication. **Limitations:** Chlordiazepoxide/amitriptyline and amitriptyline/perphenazine combinations are not covered. Generic agents may be prescribed separately.
MISCELLANEOUS - Length of Authorization: Duration of Need for Mental Health Indications, 1 Year for Other Indications		
BUDEPRION® SR/BUPROPION SR† (compare to Wellbutrin SR®) *FDA maximum recommended dose = 400mg/day* BUDEPRION XL/BUPROPION XL† (compare to	Aplenzin® (bupropion hydrobromide) ER tablets *Quantity Limit = 1 tablet/day* Brintellix® (vortioxetine) Tablet *Quantity Limit = 1 tablet/day* Forfivo XL® (bupropion SR 24hr) 450 mg tablet	**Aplenzin:** The patient has had a documented inadequate response to Budeprion XL/bupropion XL AND The patient has had a documented side effect, allergy, or in adequate response to at least 2 different antidepressants from the SSRI, SNRI and/or Miscellaneous Antidepressant categories (may be preferred or non-preferred) **Forfivo XL**: The patient is unable to take the equivalent dose as generic bupropion

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
Wellbutrin XL®) *FDA maximum recommended dose = 450 mg/day* BUPROPION† (compare to Wellbutrin®) *FDA maximum recommended dose = 450 mg/day* MAPROTILINE† (formerly Ludiomil®) *FDA maximum recommended dose = 225 mg/day* MIRTAZAPINE† (compare to Remeron®) *FDA maximum recommended dose = 45 mg/day* MIRTAZAPINE RDT† (compare to Remeron Sol-Tab®) *FDA maximum recommended dose = 45 mg/day* NEFAZADONE† (formerly Serzone®) *FDA maximum recommended dose = 600 mg/day* TRAZODONE HCL† (formerly Desyrel®) *FDA maximum recommended dose = 600 mg/day*	*FDA maximum recommended dose = 450 mg/day* *Quantity Limit = 1 tablet/day* Oleptro® (trazodone) ER tablets *Quantity Limit = 2 tablets/day (150 mg) or 1 tablet/day (300 mg)* Remeron®* (mirtazapine) *FDA maximum recommended dose = 45 mg/day* Remeron Sol Tab®* (mirtazapine RDT) *FDA maximum recommended dose = 45 mg/day* Viibryd® (vilazodone) Tablet *Quantity Limit = 1 tablet/day* Wellbutrin®* (bupropion) *FDA maximum recommended dose = 450 mg/day* Wellbutrin SR®* (bupropion SR) *FDA maximum recommended dose = 400mg/day* Wellbutrin XL®* (bupropion XL) *FDA maximum recommended dose = 450 mg/day*	XL **Oleptro:** The diagnosis for use is MDD (major depressive disorder). AND The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate jusitification for stabilization.) OR The patient has a documentaed treatment failure/inadequate response to immediate release trazodone. **Remeron, Remeron SolTab, Wellbutrin, Wellbutrin SR, and Wellbutrin XL:** The patient has had a documented intolerance to the generic formulation of the requested medication. **Brintellix, Viibryd:** The diagnosis or indication is MDD AND The patient has had a documented side effect, allergy, or inadequate response (defined by at least 4 weeks of therapy) to at least 3 different antidepressants from the SSRI, SNRI, and/or Miscellaneous Antidepressant categories (may be preferred or non-preferred)Document clinically compelling information supporting the choice of a non-preferred agent on a General Prior Authorization Form.After a 4-month lapse in use of a non-preferred agent for a mental health indication, or if there is a change in therapy, a lookback through claims information will identify the need to re-initiate therapy following the PDL and clinical criteria.
SNRI - Length of Authorization: Duration of Need for Mental Health Indications, 1 Year for Other Indications		
VENLAFAXINE ER† capsule (compare to Effexor XR®) *FDA maximum recommended dose = 225 mg/day,Quantity limit = 1 capsule/day (37.5 mg & 75 mg)*	Cymbalta® (duloxetine) Capsule *FDA maximum recommended dose = 120 mg/day(MDD and GAD), 60 mg/day all others* *Quantity limit = 2 capsules/day* Desvenlafax ER (desvenlafaxine fumarate SR 24hr)	**Venlafaxine IR:** The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR The patient has had a documented side effect, allergy, or inadequate response to at least 2 different antidepressants from the SSRI, SNRI and/or Miscellaneous Antidepressant categories (may be preferred or non-preferred). **Venlafaxine ER tablet (generic), Venlafaxine ER tablet (brand), Effexor XR**

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Tablet *FDA maximum recommended dose = 400 mg/day, Quantity limit = 1 tablet/day (50 mg tablet only)* Desvenlafaxine ER® (desvenlafaxine base SR) *FDA maximum recommended dose = 400 mg/day, Quantity limit = 1 tablet/day (50 mg tablet only)* Duloxetine† (compare to Cymbalta®) Capsule *FDA maximum recommended dose = 120 g/day(MDD and GAD), 60 mg/day all others Quantity limit = 2 capsules/day* Effexor XR® (venlafaxine XR) capsule *FDA maximum recommended dose = 225 mg/day, Quantity limit = 1 capsule/day (37.5 mg & 75 mg)* Fetzima® (levomilnacipran ER) capsule *FDA maximum recommended dose = 120 mg/day Quantity limit = 1 capsule/day* Fetzima® (levomilnacipran ER) capsule titration pack *(QL = 1 pack per lifetime)* *FDA maximum recommended dose = 120 mg/day* Khedezla® (desvenlafaxine base SR) *FDA maximum recommended dose = 400 mg/day, Quantity limit = 1 tablet/day (50 mg tablet only)* Pristiq® § (desvenlafaxine succinate SR) *FDA maximum recommended dose = 400 mg/day, Quantity limit = 1 tablet/day (50 mg tablet only)* Venlafaxine ER®† tablet *FDA maximum recommended dose = 225 mg/day,*	**Capsule (brand):** The patient has had a documented intolerance to generic venlafaxiner ER caps. **Fetzima, Pristiq:** The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequatejustification for stabilization.) OR The diagnosis or indication is Major Depressive Disorder (MDD) AND The patient has had a documented side effect, allergy, or inadequate response to at least 3(three) differentantidepressants from the SSRI, SNRI, TCA and/or Miscellaneous Antidepressant categories, one of which must bevenlafaxine ER capsule (may be preferred or non-preferred). **Desvenlafaxine ER, Khedezla:** The patient has had a documented side effect, allergy, or inadequate response to at least 2 different antidepressants from the SSRI, SNRI and/or Miscellaneous Antidepressant categories, one of which must be venlafaxine ER capsule (may be preferred or non-preferred) AND The patient has had a documented intolerance with Pristiq. **Cymbalta, Duloxetine:** Depression: The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR The patient has had a documented side effect, allergy, or inadequate response to at least 2 different antidepressants from the SSRI, SNRI and/or Miscellaneous Antidepressant categories, one of which must be venlafaxine ER capsule (may be preferred or non-preferred). AND If the request is for duloxetine, the patient has had a documented intolerance with brand Cymbalta Generalized Anxiety Disorder: The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR The patient has had a documented side effect, allergy, or inadequate response to at least TWO different antidepressants from the SSRI, SNRI and/or TCA categories (may be preferred or non-preferred) or ONE antidepressant from the SSRI, SNRI and/or TCA categories (may be preferred or non-preferred) and buspirone. AND If the request is for duloxetine, thepatient

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Quantity limit = 1 tablet/day (37.5 mg & 75 mg) Venlafaxine ER† tablet *FDA maximum recommended dose = 225 mg/day,* *Quantity limit = 1 tablet/day (37.5 mg & 75 mg)* venlafaxine IR †§ (previously Effexor®) *FDA maximum recommended dose = 225 mg/day*	has had a documented intolerance with brand Cymbalta Neuropathic pain: The patient has had a documented side effect, allergy, or treatment failure to TWO drugs in the tricyclic anrtidepressant (TCA) class and/or anticonvulsant class. (this indication not processed via automated step therapy).AND If the request is for duloxetine, the patient has had a documented intolerance with brand Cymbalta. Non-neuropathic musculoskeletal pain (osteooarthritis, chronic low back pain): The patient has had a documented side effect, allergy, inadequate response or contraindication to acetaminophen (Tylenol®) AND at least TWO nonsteroidal anti-inflammatory drugs (NSAIDs) (oral and/or topical). (this indication not processed via automated step therapy) AND If the request is for duloxetine, the patient has had a documented intolerance with brand Cymbalta. Fibromyalgia: The patient has had a documented side effect, allergy, or treatment failure to TWO drugs from the following: gabapentin, tricyclic anrtidepressant, SSRI antidepressant, SNRI antidepressant, miscellaneous antidepressant, cyclobenzaprine, Lyrica® or Savella®.(this indication not processed via automated step therapy) AND If the request is for duloxetine, the patient has had a documented intolerance with brand Cymbalta Document clinically compelling information supporting the choice of a non-preferred agent on a General Prior Authorization Form. After a 4-month lapse in use of a non-preferred agent for a mental health indication, or if there is a change in therapy, a lookback through claims information will identify the need to re-initiate therapy following the PDL and clinical criteria.
SSRIs – Length of Authorization: Duration of Need for Mental Health Indications, 1 Year for Other Indications		
CITALOPRAM† (compare to Celexa®) *FDA maximum recommended dose = 40 mg/day* FLUOXETINE† (compare to Prozac®) *FDA maximum recommended dose = 80 mg/day*	Brisdelle® (paroxetine) *Quantity Limit = 1 capsule/day* Celexa®* (citalopram) *FDA maximum recommended dose = 40 mg/day*	**Celexa, Paxil tablet, Prozac, Zoloft:** The patient had a documented side effect, allergy, or treatment failure with 2 preferred SSRIs. (One trial must be the generic formulation of the requested medication.) **Brisdelle:** The indication for use is moderate to sever vasomotor symptions (VMS) associated with menopause. AND The patient has tried and failed generic

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
FLUVOXAMINE† (formerly Luvox®) *FDA maximum recommended dose = 300 mg/day* PAROXETINE tablet† (compare to Paxil®) *FDA maximum recommended dose = 60 mg/day* SERTRALINE† (compare to Zoloft®) *FDA maximum recommended dose = 200 mg/day,* *Quantity limit = 1.5 tabs/day (25 mg & 50 mg tabs)*	escitalopram† (compare to Lexapro®) *FDA maximum recommended dose = 20 mg/day,* *Quantity limit = 1.5 tabs/day (5 mg & 10 mg tabs)* Fluoxetine† (pmdd) *FDA maximum recommended dose = 80 mg/day* Fluoxetine® 60 mg Tablet *FDA maximum recommended dose = 80 mg/day* fluoxetine† 90 mg (compare to Prozac Weekly®) *FDA maximum recommended dose = 90 mg/week* Lexapro® (escitalopram) *FDA maximum recommended dose = 20 mg/day,* *Quantity limit = 1.5 tabs/day (5 mg & 10 mg tabs)* fluvoxamine CR† (compare to Luvox CR®) *FDA maximum recommended dose = 300 mg/day,* *Quantity limit = 2 capsules/day* Luvox CR® (fluvoxamine CR) *FDA maximum recommended dose = 300 mg/day,* *Quantity limit = 2 capsules/day* paroxetine suspension† (compare to Paxil® susp) *FDA maximum recommended dose = 60 mg/day* Paroxetine CR† (compare to Paxil CR®) *FDA maximum recommended dose = 75 mg/day* Paxil®* (paroxetine) *FDA maximum recommended dose = 60 mg/day* Paxil® suspension (paroxetine) *FDA maximum recommended dose = 60 mg/day* Paxil CR® (paroxetine CR)	paroxetine. **Luvox CR, fluovoxamine CR:** The patient had a documented side effect, allergy, or treatment failure with 2 preferred SSRIs. (One trial must be generic fluvoxamine IR.) If the request is for the brand product, the patient also has a documented intolerance to the generic equivalent. **Pexva, Paroxetine CR, and Paxil CR:** The patient had a documented side effect, allergy, or treatment failure with 2 preferred SSRIs. (One trial must be generic paroxetine.) AND If the request is for Paxil CR, the patient has a documented intolerance to paroxetine CR. **Paroxetine suspension, Paxil suspension:** The patient has a requirement for an oral liquid dosage form. AND The patient had a documented side effect, allergy, or treatment failure with 2 preferred SSRIs. **Sarafem, Selfemra, Fluoxetine 60mg tablet, Fluoxetine (pmdd)**: The patient had a documented side effect, allergy, or treatment failure with 2 preferred SSRIs. (One trial must be generic fluoxetine (regular, not pmdd).) In addition, for approval of Sarafem, either Selfemra or fluoxetine pmdd must have been tried. **Lexapro, escitalopram:** The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR The patient had a documented side effect, allergy, or treatment failure with 2 preferred SSRIs. (One trial must be generic citalopram). AND If the request is for Lexapro, the patient has a documented intolerance with generic escitalopram **Fluoxetine 90mg, Prozac Weekly:** The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR The patient failed and is not a candidate for daily fluoxetine. AND The prescriber provides clinically compelling rationale for once-weekly dosing. AND If the request is for Prozac Weekly, the patient has a documented intolerance of fluoxetine 90 mg capsules. Document clinically compelling information supporting the choice of a non-preferred agent on a General Prior Authorization Form. After a 4-month lapse in use of a non-preferred agent for a mental health

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	FDA maximum recommended dose = 75 mg/day Pexeva® (paroxetine) *FDA maximum recommended dose = 60 mg/day* Prozac®* (fluoxetine) *FDA maximum recommended dose = 80 mg/day* Prozac Weekly® (fluoxetine) *FDA maximum recommended dose = 90 mg/week* Sarafem® (fluoxetine pmdd) *FDA maximum recommended dose = 80 mg/day* Selfemra® † (fluoxetine pmdd) *FDA maximum recommended dose = 80 mg/day* Zoloft®* (sertraline) *FDA maximum recommended dose = 200 mg/day,* *Quantity limit = 1.5 tabs/day (25 mg & 50 mg tabs)*	indication, or if there is a change in therapy, a lookback through claims information will identify the need to re-initiate therapy following the PDL and clinical criteria.
TRICYCLICS – Length of Authorization: Duration of Need for Mental Health Information, 1 Year for Other Indications		
AMITRIPTYLINE† (formerly Elavil®) *FDA maximum recommended dose = 300 mg/day* AMOXAPINE† (formerly Asendin®) CLOMIPRAMINE† (compare to Anafranil®) DESIPRAMINE† (compare to Norpramin®) DOXEPIN† (formerly Sinequan®)	Anafranil®* (clomipramine) Norpramin®* (desipramine) Pamelor®* (nortriptyline) Surmontil® (trimipramine) Tofranil®* (imipramine) *FDA maximum recommended dose = 300 mg/day* Tofranil PM®* (imipramine pamoate) Vivactil®* (protriptyline)	**Tricyclics (TCAs) (Brands with generic equivalents):** The patient has had a documented side effect, allergy, or treatment failure to 2 or more TCAs not requiring prior authorization.One trial must be the AB ratedgeneric formulation. OR The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) AND The patient has had a documented intolerance to the generic formulation.**Surmontil:** The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization). OR The patient has had a documented side effect, allergy, or treatment failure to one or more preferred TCAs. **Limitation:** Chlordiazepoxine/amitrityline and amitriptyline/perphenazine combinations not covered. Generic agents may be prescribed separately.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
IMIPRAMINE† (compare to Tofranil®) *FDA maximum recommended dose = 300 mg/day* IMIPRAMINE PAMOATE† (compare to Tofranil PM®) NORTRIPTYLINE† (formerly Aventyl®, compare to Pamelor®) NORTRIPTYLINE Oral Solution PROTRIPTYLINE† (compare to Vivactil®)		Document clinically compelling information supporting the choice of a non-preferred agent on a General Prior Authorization Form. After a 4-month lapse in use of a non-preferred agent for a mental health indication, or if there is a change in therapy, a lookback through claims information will identify the need to re-initiate therapy following the PDL and clinical criteria.
ANTI-DIABETICS		
ALPHA-GLUCOSIDASE INHIBITORS		
ACARBOSE† (compare to Precose®) GLYSET® (miglitol)	Precose®* (acarbose)	**Precose:** patient must have a documented intolerance to generic acarbose
BIGUANIDES & COMBINATIONS		
SINGLE AGENT METFORMIN† (compare to Glucophage®) METFORMIN XR† (compare to Glucophage	Fortamet® (metformin ER Osmotic) Glucophage®* (metformin)	**Fortamet, Glucophage XR, Glumetza, Metformin ER osmotic:** patent has had a documented intolerance to generic metformin XR (if product has an AB rated generic, there must have been a trial of the generic) **Glucophage, Glucovance, Metaglip:** patient has had a documented side effect, allergy OR treatment failure with at least one preferred biguanide OR biguanide

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
XR®) RIOMET® (metformin oral solution) **COMBINATION** GLIPIZIDE/METFORMIN† (compare to Metaglip®) GLYBURIDE/METFORMIN† (compare to Glucovance®)	Glucophage XR®* (metformin XR) Glumetza® (metformin ER) Metformin ER Osmotic† (compare to Fortamet®) Glucovance®* (glyburide/metformin) Metaglip ®* (glipizide/metformin)	combination product (if a product has an AB raged generic, the trial must be the generic)
DIPEPTIDYL PEPTIDASE (DPP-4) INHIBITORS		
PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET **SINGLE AGENT** JANUVIA® (sitagliptin) § *(Quantity Limit = 1 tablet/day)* ONGLYZA® (saxagliptin)§ *(Quantity limit=1 tablet/day)* **COMBINATION**	**NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET** Nesina® (alogliptin) *(Quantity limit=1 tablet/day)* Tradjenta® *(linagliptin) (Quantity limit=1 tab/day)* Janumet XR® (sitagliptin/metformin ER) *(Qty limit=1 tab/day of 50/500 mg or 100/1000 mg or 2 tabs/day of 50/1000 mg)* Jentadueto® (linagliptin/metformin) *(Quantity limit=2*	**Januvia, Onglyza:** patient has had a documented side effect, allergy, contraindication OR treatment failure with metformin **Nesina, Tradjenta:** patient has had a documented side effect, allergy, contraindication OR treatment failure with metformin AND patient has had a documented side effect, allergy OR treatment failure with at least one preferred DDP-4 agent. **Janumet:** patient has had an inadequate response with Januvia OR Metformin monotherapy OR patient has been started and stabilized on Januvia and Metoformin combination therapy.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
JANUMET® (sitagliptin/metformin) § *(Quantity Limit = 2 tablets/day)* KOMBIGLYZE XR® (saxagliptin/metformin ER) § *(Quantity limit=1 tab/day)*	*tabs/day)* Juvisync® (sitagliptin/simvastatin) *(Quantity limit=1 tab/day)* Kazano® (alogliptin/metformin) *(Quantity limit=2 tabs/day)* Oseni® (alogliptin/pioglitazone) *(Quantity limit=1 tab/day)*	**Kazano:** patient has had a documented side effect, allergy OR treatment failure with at least one preferred DDP-4 combination agent. **Janumet XR:** patient has had an inadequate response with Januvia OR Metformin/Metformin XR monotherapy OR patient has been started and stabilized on Januvia and Metformin/Metformin XR combination therapy AND patient is unable to take Januva and Metformin/Metformin XR as the individual separate agents. **Jentadueto:** patient has had an inadequate response with Tradjenta OR Metformin monotherapy OR patient has been started and stabilized on Tradjenta and Metformin combination therapy AND the patent is unable to take Tradjenta and Metformin as the individual separate agents. **Juvisync:** patient has had a documented side effect, allergy, contraindication OR treatment failure with metformin AND patient has been started and stabilized on Januvia AND Simvastatin combination therapy as individual agents. **Kombiglyze XR:** patient has had an inadequate response with Onglyza OR Metformin/Metformin XR monotherapy OR Patient has been started and stabilized on Onglyza/Metformin XR combination therapy. **Oseni:** patient is unable to take Nesina and Actos (pioglitazone) as the individual separate agents (after meeting clinical criteria for each individual agent)
INSULINS		
RAPID-ACTING INJECTABLE HUMALOG® (insulin lispro) NOVOLOG® (Aspart) **SHORT-ACTING INJECTABLE** HUMULIN R® (Regular)	Apidra® (insulin glulisine) ReliOn R® (Regular)	**Apidra:** patient has had a documented side effect, allergy OR treatment failure to Novolog or Humalog **Relion R, Relion N OR Relion 70/30:** patient has had a documented side effect, allergy OR treatment failure to the corresponding Novolin or Humulin product.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
NOVOLIN R® (Regular) **INTERMEDIATE-ACTING INJECTABLE** HUMULIN N® (NPH) NOVOLIN N® (NPH) **LONG-ACTING ANALOGS INJECTABLE** LANTUS® (insulin glargine) LEVEMIR® (insulin detemir)	ReliOn N® (NPH)	
MIXED INSULINS INJECTABLE HUMULIN 70/30® (NPH/Regular) NOVOLIN 70/30® (NPH/Regular) NOVOLOG MIX 70/30® (Protamine/Aspart) HUMALOG MIX 50/50® (Protamine/Lispro) HUMALOG MIX 75/25® (Protamine/Lispro)	ReliOn 70/30® (NPH/Regular)	
MEGLITINIDES		
Single Agent	Prandin® (replaglinide)	**Starlix:** patient has had a documented intolerance to generic nateglinide. **Prandin, Repaglinide:** patient has been started and stabilized on the requested

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
NATEGLINIDE† (compare to Starlix®) COMBINATION	repaglinide† (compare to Prandin®) Starlix®* (nateglinide) Prandimet® (repaglinide/metformin)	medication OR patient has had a documented side effect, allergy OR treatment failure with Starlix AND if the request is for Prandin, the patient has a documented intolerance with generic repaglinide. **Prandimet:** patient has been started and stablizied on Prandimet or on stable doses of the separate agents OR patient has had an inadequate response with repaglinide monotherapy.
PEPTIDE HORMONES		
Preferred Agents after Clinical Criteria are Met **Incretin Mimetics** VICTOZA® (liraglutide) *(Quantity Limit=3 pens/30 days)* **Amylinomimetics**	Bydureon® (exenatide extended-release) *(Quantity Limit=4 vials/28 days)* Byetta® (exenatide) *(Quantity Limit =1 pen/30 days)* Symlin® (pramlintide) *No Quantity Limit applies* Tanzeum ® (albiglutide)	**Bydureon/Byetta:** patient has a diagnosis of type 2 diabetes.AND patient is at least 18 years of age. AND patient has had a documented side effect, allergy, contraindication or treatment failure with metformin. AND patient has a documented side effect, allergy, contraindication, or treatment failure with Victoza (current users as of 05/29/2015 would be grandfathered) **Tanzeum:** patient has a diagnosis of type 2 diabetes AND patient is at least 18 years of age AND patient has a documented side effect, allergy, contraindication, or treatment failure with metformin **Symlin:** patient has a diagnosis of diabetes mellitus. AND patient is at least 18 years of age. AND patient is on insulin. **Victoza:** patient has a diagnosis of type 2 diabetes. AND patient is at least 18 years of age. AND patient has had a documented side effect, allergy, contraindication or treatment failure with metformin.
SODIUM-GLUCOSE CO-TRANSPORTER 2 (SGLT2) INHIBITORS AND COMBINATIONS		
Preferred Agents after Clinical Criteria are Met INVOKANA® (canagliflozin) § *(Quantity limit = 1 tablet/day)*	FARXIGA® (dapagliflozin) *(Quantity limit = 1 tablet/day)* Jardiance *(Quantity limit = 1 tablet/day)*	Patient is 18 years of age or older AND patient has a diagnosis of type 2 diabetes mellitus and has had an inadequate response to diet and exercise alone AND patient has had a documented side effect, allergy, contraindication OR treatment failure with metformin .

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Invokamet (canagliflozin/metformin) *(Quantity limit = 1 tablet/day)*	**Farxiga/Jardiance additional criteria:** • The patient has had a documented side effect, allergy, contraindication, or treatment failure with Invokana **Invokamet additional criteria:** • The patient has documentation of a failure of therapy with the combination of the single agent drugs Invokana plus metformin
SULFONYLUREAS 2ND GENERATION		
GLIMEPIRIDE† (compare to Amaryl®) GLIPIZIDE† (compare to Glucotrol®) GLIPIZIDE ER† (compare to Glucotrol XL®) GLYBURIDE† (compare to Diabeta®, Micronase®) GLYBURIDE MICRONIZED† (compare to Glynase® PresTab®)	Amaryl®* (glimepiride) Diabeta®* (glyburide) Glucotrol®* (glipizide) Glucotrol XL®* (glipizide ER) Glynase® PresTab®* (glyburide micronized) Micronase®* (glyburide)	Patient has had a documented side effect, allergy OR treatment failure with glimperiride, AND glimepiride, AND glipizide/glipizide ER, and glyburide/glyburide micronized.
THIAZOLIDINEDIONES & COMBINATIONS		
Preferred Agents after Clinical Criteria are Met **SINGLE AGENT** PIOGLITAZONE† (compare to Actos®)§ **COMBINATION**	Actos® (pioglitazone) Avandia® (rosiglitazone) Actoplus Met® (pioglitazone/metformin)	**Actos (pioglitazone), Actoplus Met, Duetact, Pioglitazone/Metformin:** Patient has been started and stabilized on the requested medication OR patient has had a documented side effect, allergy, contraindication OR treatment failure with metformin AND if the request is for brand Actos Met or Duetact, patient has a documented intolerance to the generic product. **Actoplus Met XR:** patient has been started AND stabilized on the requested

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
PIOGLITAZONE/GLIMEPIRIDE† (compare to Duetact®) § *(Quantity Limit = 1 tablet/day)* PIOGLITAZONE/METFORMIN† (Compare to Actoplus Met®)§	Actoplus Met XR (pioglitazone/metformin ER) Avandamet® (metformin/rosiglitazone maleate) Avandaryl® (glimepiride/rosiglitazone maleate) Duetact® (pioglitazone/glimepiride) *(Quantity Limit = 1 tablet/day)*	medication OR patient has had a documented treatment failure with generic metformin XR OR patient has had a documented treatment failure OR has been unable to be adherent to a twice daily dosing schedule of Actoplus Met resulting in a significant clinical impact. **Avandia:** patient has been started and stabilized on the requested medication and appears to be benefiting from it and the patient acknowledges that they understand the risks OR patient is unable to achieve glycemic control using other medications (including a documented side effect, allergy, contraindication or treatment failure with metformin)and, in consultation with their health care professional , decide not to take pioglitazone for medical reasons and the patient acknowledges that they understand the risks.
ANTIDIARRHEALS: HIV/AIDS		
Length of Authorization: initial approval 3 months, subsequent approval 1 year		
DIPHENOXYLATE/ATROPINE† LOPERAMIDE†	Fulyzaq® (crofelemer) 125 mg DR Tablets *QL = 2 tablets/day*	Patient has HIV/AIDS and is receiving anti-retroviral therapy AND Patient is at least 18 years of age AND Patient requires symptomatic relief of noninfectious diarrhea AND Infectious diarrhea (e.g. cryptosporidiosis, c. difficile, etc.) has been ruled out AND Patient has tried and failed at least one anti-diarrheal medication (i.e. loperamide or atropine/diphenoxylate)
ANTI-EMETICS		
5HT3 ANTAGONISTS: Length of Authorization: 6 months for chemotherapy or radiotherapy; 3 months for hyperemesis gravadarum,1 time for prevention of post-op		

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
nausea/vomiting: see clinical criteria. Monthly quantity limits apply, PA required to exceed.		
ONDANSETRON† Injection (vial and premix) ONDANSETRON†tablet 4 mg (12 tabs/28 days), 8 mg (6 tabs/28 days) ONDANSETRON† ODT 4 mg (12 tabs/28 days), 8 mg (6 tabs/28 days	Anzemet® (dolansetron) 50 mg (4 tabs/28 days) Anzemet® (dolansetron) 100 mg (2 tabs/28 days) Granisetron† (formerly Kytril®) 1 mg (6 tabs/28 days) Granisetron† (formerly Kytril®) Injectable Granisol® (granisetron) Oral Solution Ondansetron† (generic) 24 mg (1 tab/28 days or per course of chemotherapy) Ondansetron† (generic) Oral Solution 4 mg/5 ml Sancuso® 3.1 mg/24 hrs Transdermal Patch (granisetron) (Qty Limit = 1 patch/28 days) Zofran®* (ondansetron) Injection Zofran®* (ondansetron) Oral Tablets and ODT 4 mg (12 tabs/28 days), 8 mg (6 tabs/28 days) Zofran® (ondansetron) Oral Solution 4 mg/5 ml Zuplenz® (ondansetron) Oral Soluble Film *(Quantity Limit =12 films/28 days (4 mg), 6 films/28 days (8 mg))*	**Anzemet:** has a diagnosis of nausea and vomiting associated with cancer chemotherapy. AND patient has had a documented side effect, allergy, or treatment failure to generic ondansetron. **Granisetron, Granisol:** patient has a diagnosis of nausea and vomiting associated with cancer chemotherapy or radiotherapy. AND patient has had a documented side effect, allergy, or treatment failure to generic ondansetron. **Zofran:** The patient has a diagnosis of nausea and vomiting associated with cancer chemotherapy, radiotherapy, post-operative nausea and vomiting (1 time only) or hyperemesis gravadarum. AND patient must have a documented intolerance to the corresponding generic ondansetron product (tablets, orally disintegrating tablets (ODT), oral solution or injection). If the request is for oral solution, the patient must be unable to use ondansetron ODT or ondansetron tablets. **Ondansetron Oral Sol:** patient has a diagnosis of nausea and vomiting associated with cancer chemotherapy, radiotherapy, post-operative nausea and vomiting (1 time only) or hyperemesis gravadarum. AND patient is unable to use ondansetron ODT or ondansetron tablets. **Ondansetron 24mg:** patient has a diagnosis of nausea and vomiting associated with cancer chemotherapy. AND prescriber provides rationale why generic ondansetron 8 mg tablets cannot be used to achieve the desired dose. **Sancuso:** patient has a diagnosis of nausea and vomiting associated with cancer chemotherapy. AND prescriber provides documentation of medical necessity for the transdermal formulation. OR patient has had a documented side effect, allergy or treatment failure with generic ondansetron. **Zuplenz:** patient has a diagnosis of nausea and vomiting associated with cancer chemotherapy or radiotherapy. AND prescriber provides documentation of

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		medical necessity for the specialty dosage form (i.e. inability to swallow tablets, dysphagia) AND a clinical rationale as to why ondansetron ODT is not a suitable option for the patient. **CRITERIA FOR APPROVAL (to exceed quantity limit):** **Ondansetron/Zofran 4 mg and 8 mg tablets and ODT, Zuplenz:** For nausea and vomiting associated with chemotherapy or radiation therapy, 3 tablets for each day of chemotherapy/radiation and 3 tablets for each day for 2 days after completion of chemotherapy/radiation may be approved. **Ondansetron/Zofran 4 mg and 8 mg tablets and ODT:** For hyperemesis gravadarum, three tablets per day of 4 mg or 8 mg may be approved for 3 months. **Anzemet:** For nausea and vomiting associated with chemotherapy, 1 tablet for each day of chemotherapy and 1 tablet for 2 days after completion of chemotherapy may be approved. **Granisetron:** For nausea and vomiting associated with chemotherapy, 2 tablets for each day of chemotherapy and 2 tablets for 2 days after completion of chemotherapy may be approved. OR For nausea and vomiting associated with radiation therapy, 2 tablets for each day of radiation may be approved. **Sancuso:** For nausea and vomiting associated with chemotherapy, 1 patch for each chemotherapy cycle may be approved. **Limitations:** Aloxi and Anzemet injection are not considered outpatient medications and are not covered in the pharmacy benefit.
MISCELLANEOUS (PREGNANCY)		

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Diclegis® (10 mg doxylamine succinate and 10 mg pyridoxine hydrochloride) DR tablet *(QL= 4 tablets/day)*	Patient has a diagnosis of nausea and vomiting of pregnancy AND Patient has tried and had an inadequate response to conservative management (i.e. change in dietary habits, ginger, or acupressure) AND Patient has tried and had an inadequate response to generic doxylamine and generic pyridoxine (Vitamin B6) AND Patient has tried and had an inadequate response to generic ondansetron.
NK1 ANTAGONISTS		
Preferred Agents after Clinical Criteria are Met EMEND® (aprepitant) 40 mg (1 cap/28 days) ♣EMEND® (aprepitant) 80 mg (2 caps/28 days) ♣EMEND® (aprepitant) 125 mg (1 cap/28 days) ♣EMEND® (aprepitant) Tri-fold Pack (1 pack/28 days) ♣ *To be prescribed by oncology practitioners ONLY*		**Emend (aprepitant) 80 mg, 125 mg, Tri-Fold pack:** medication will be prescribed by an oncology practitioner. AND patient requires prevention of nausea and vomiting associated with moderate to highly emetogenic cancer chemotherapy. AND The requested quantity does not exceed one 125 mg and two 80 mg capsules OR one Tri-Fold Pack per course of chemotherapy. Patients with multiple courses of chemotherapy per 28 days will be approved quantities sufficient for the number of courses of chemotherapy. **Emend 40mg:** patient requires prevention of postoperative nausea and vomiting. AND The requested quantity does not exceed one 40 mg capsule per surgery or course of anesthesia. Patients with multiple surgeries or courses of anesthesia in a 28 day period will be approved quantities sufficient for the number of surgeries or courses of anesthesia.
THC DERIVATIVES		
	Dronabinol† (compare to Marinol®) Marinol® (dronabinol) Cesamet® (nabilone)	**Pharmacology:** Marinol® is a schedule III cannabinoid agent containing the same active ingredient, tetrahydrocannabinol, as marijuana. While its exact mechanism of action is unknown, it is speculated to inhibit medullary activity as well as suppress prostaglandin and endorphan synthesis. Cesamet® is a schedule II synthetic cannabinoid that acts by activating the endocannabinoid receptors, CB1 and CB2, which are involved in nausea/vomiting regulation. Both Marinol® and Cesamet® are FDA-approved for use in chemotherapy associated nausea and

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		vomiting refractory to conventional antiemetics. In addition, Marinol® is indicated for patients with AIDS-related anorexia or wasting syndrome. **Dronabinol. Marinol:**patient has a diagnosis of chemotherapy-induced nausea/vomiting.AND patient has had a documented side effect, allergy, or treatment failure to at least 2 antiemetic agents, of which, one must be a preferred 5HT3 receptor antagonist. If the request is for Marinol, the patient must additionally have a documented intolerance to generic dronabinol. OR patient has a diagnosis of AIDS associated anorexia. AND patient has had an adequate response, adverse reaction, or contraindication to megestrol acetate. If the request is for Marinol, the patient must additionally have a documented intolerance to generic dronabinol. **Cesamet:** patient has a diagnosis of chemotherapy-induced nausea/vomiting. AND patient has had a documented side effect, allergy, or treatment failure to at least 2 antiemetic agents, of which, one must be a preferred 5HT3 receptor antagonist.
ANTI-HYPERTENSIVES		
ACE INHIBITORS		
BENAZEPRIL† (compare to Lotensin®) CAPTOPRIL† (formerly Capoten®) ENALAPRIL† (compare to Vasotec®) EPANED® (enalapril) oral solution (age < 12 years old) FOSINOPRIL† (formerly Monopril®)	Accupril®*(quinapril) Aceon® (perindopril) Altace®* (ramipril) Epaned® (enalapril) oral solution (age ≥ 12 years old) Lotensin®* (benazepril) Mavik®* (trandolapril) perindopril† (compare to Aceon®) Prinivil®* (lisinopril)	**Epaned Oral Solution (Patients > 12 years old):** patient has a requirement for an oral liquid dosage form (i.e. swallowing disorder, inability to take oral medications). **Other ACE Inhibitors:** patient has had a documented side effect, allergy, or treatment failure to all available preferred generic ACEI. If a medication has an AB rated generic, there must have been a trial of the generic formulation.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
LISINOPRIL† (compare to Zestril®, Prinivil®) MOEXIPRIL† (compare to Univasc®) QUINAPRIL† (compare to Accupril®) RAMIPRIL† (compare to Altace®) TRANDOLAPRIL† (compare to Mavik®)	Univasc®* (moexipril) Vasotec®* (enalapril) Zestril®* (lisinopril)	
ACE INHIBITOR W/ HYDROCHLOROTHIAZIDE		
BENAZEPRIL/HYDROCHLOROTHIAZIDE† (compare to Lotensin HCT®) ENALAPRIL/HYDROCHLOROTHIAZIDE† (compare to Vaseretic®) FOSINOPRIL/HYDROCHLOROTHIAZIDE† (formerly Monopril HCT®) LISINOPRIL/HYDROCHLOROTHIAZIDE† (compare to Zestoretic®, Prinzide®) MOEXIPRIL/HYDROCHLOROTHIAZIDE† (compare to Uniretic®) QUINAPRIL/HYDROCHLOROTHIAZIDE† (compare to Accuretic®)	Accuretic®* (quinapril/HCTZ) Lotensin HCT®* (benazepril/HCTZ) Prinzide®* (lisinopril/HCTZ) Uniretic®* (moexipril/HCTZ) Vaseretic®* (enalapril/HCTZ) Zestoretic®* (lisinopril/HCTZ)	**ACE Inhibitor/Hydrochlorothiazide combinations:** patient has had a documented side effect, allergy, or treatment failure to all available preferred generic ACEI/Hydrochlorothiazide combination. If a medication has an AB rated generic, there must have been a trial of the generic formulation. **Limitations:** Captopril/HCTZ combination not covered. Agents may be prescribed seperately

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ACE INHIBITOR W/CALCIUM CHANNEL BLOCKER		
AMLODIPINE/BENAZEPRIL † (compare to Lotrel®)	Lotrel®* amlodipine/(benazepril) Tarka® (trandolopril/verapamil)	**ACE Inhibitor/Calcium Channel Blocker combination:** patient has had a documented side effect, allergy, or treatment failure with a preferred ACEI/Calcium Channel Blocker combination. If an indication has an AB rated generic, the trial must be the genericformulation.
ANGIOTENSIN RECEPTOR BLOCKERS (ARBs)		
Preferred Agents after Clinical Criteria are Met BENICAR® (olmesartan) § DIOVAN® (valsartan) § IRBESARTAN† (compare to Avapro®) § LOSARTAN† (compare to Cozaar®) § TELMISARTAN† (compare to Micardis®) §	Atacand® (candesartan) Avapro® (irbesartan) candesartan† (compare to Atacand®)§ Cozaar® (losartan) Edarbi® (azilsartan) Tablet *(Qty Limit = 1 tablet/day)* Eprosartan† (compare toTeveten®) § Micardis® (telmisartan) Teveten® (eprosartan) valsartan† (compare to Diovan®)	**Benicar, Diovan, Irbesartan, Losartan, and Telmisartan:** patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR patient has had a documented side effect, allergy, or treatment failure to an angiotensin converting enzyme inhibitor (ACEI), an ACEI combination or any other angiotensin receptor blocker (ARB) or ARB combination. **Atacand, Avapro, Candasartan, Edarbi, Eprosartan, Micardis, and Teveten:** patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization OR patient has had a documented side effect, allergy, or treatment failure with a preferred Angiotensin Receptor Blocker (ARB) or ARB combination. AND If brand name product with generic available, the patient has had a documented intolerance with the generic product. **Cozaar (Brand):** patient has had a documented side effect, allergy, or treatment failure to an angiotensin converting enzyme inhibitor (ACEI), an ACEI combination or any other angiotensin receptor blocker (ARB) or ARB combination. AND patient has had a documented intolerance with the generic product.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		Valsartan: patient has had a documented side effect, allergy, or treatment failure to an angiotensin converting enzyme inhibitor (ACEI), an ACEI combination or any other angiotensin receptor blocker (ARB) or ARB combination. AND patient has had a documented intolerance with the brand product (Diovan)
ANGIOTENSIN RECEPTOR BLOCKER/DIURETIC COMBINATIONS		
Preferred Agents after Clinical Criteria are Met BENICAR HCT® (olmesartan/hydrochorothiazide) § IRBESARTAN/HYDROCHLOROTHIAZIDE† (compare to Avalide®)§ LOSARTAN/HYDROCHLOROTHIAZIDE † (compare to Hyzaar®)§ TELMISARTAN/HYDROCHLOROTHIAZIDE † (compare to Micardis HCT®) § VALSARTAN/HYDROCHLOROTHIAZIDE † (compare to Diovan HCT®)§	**Non- Preferred Agents after Clinical Criteria are Met** Atacand HCT® (candesartan/hydrochlorothiazide) Avalide® (irbesartan/hydrochlorothiazide) candesartan/hydrochlorothiazide † (compare to Atacand HCT®)§ Diovan HCT® (valsartan/hydrochlorothiazide) Edarbyclor® (azilsartan/chlorthalidone) Tablet *(Qty Limit = 1 tablet/day)* Hyzaar® (losartan/hydrochlorothiazide) Micardis HCT® (telmisartan/hydrochlorothiazide) Teveten HCT® (eprosartan/hydrochlorothiazide) §	**Benicar HCT, Irbesartan/HCTZ, Losartan/HCTZ, Telmisartan/HCTZ, and Valsartan/HCTZ:** patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR patient has had a documented side effect, allergy, or treatment failure to an angiotensin converting enzyme inhibitor (ACEI), an ACEI combination or any other angiotensin receptor blocker (ARB) or ARB combination. **Avalide, Diovan HCT, and Micardis HCT:** patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization OR patient has had a documented side effect, allergy, or treatment failure with a preferred Angiotensin Receptor Blocker (ARB) or ARB combination. AND If brand name product with generic available, the patient has had a documented intolerance with the generic product. **Atacand HCT, candasartan/HCTZ, Teveten HCT:** patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR patient has had a documented side effect, allergy, or treatment failure with a preferred ARB/Hydrochlorothiazide

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		combination. AND If the request is for Atacand HCT, the patient has had a documented intolerance with the generic product. **Hyzaar:** patient has had a documented side effect, allergy, or treatment failure to an angiotensin converting enzyme inhibitor (ACEI), an ACEI combination or any other angiotensin receptor blocker (ARB) or ARB combination. AND patient has had a documented intolerance with the generic product. **Edarbyclor:** patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR patient has had a documented side effect, allergy, or treatment failure with a preferred Angiotensin Receptor Blocker (ARB) or ARB combination. AND patient is unable to take the individual components separately
ANGIOTENSIN RECEPTOR BLOCKER/CALCIUM CHANNEL BLOCK COMBINATIONS		
Preferred Agents after Clinical Criteria are Met VALSARTAN/AMLODIPINE† (compare to Exforge®)§ *(QL= 1tab/day)* Exforge® (valsartan/amlodipine)§ *(QL = 1 tab/day)*	Non- Preferred Agents after Clinical Criteria are Met Azor®(olmesartan/amlodipine) *(QL = 1 tablet/day)* amlodipine/telmisartan† (compare to Twynsta®) *(QL = 1 tablet/day)* Twynsta® (amlodipine/telmisartan) *(QL = 1 tablet/day)*	**Valsartan/amlodipine:** patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR patient has had a documented side effect, allergy, or treatment failure to an angiotensin converting enzyme inhibitor (ACEI), an ACEI combination or any other angiotensin receptor blocker (ARB) or ARB combination. **Exforge:** patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization OR

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		patient has had a documented side effect, allergy, or treatment failure with a preferred Angiotensin Receptor Blocker (ARB) or ARB combination. AND If brand name product with generic available, the patient has had a documented intolerance with the generic product. **Azor, Amlodipine/Telmisartan, Twynsta:** The patient has had a documented side effect, allergy, or treatment failure to an angiotensin converting enzyme inhibitor (ACEI), an ACEI combination or any other angiotensin receptor blocker (ARB) or ARB combination. AND patient is unable to take the individual components separately. AND If the request is for Twynsta, the patient has a documented intolerance to generic amlodipine/telmisartan.
ANGIOTENSIN RECEPTOR BLOCKER/DIRECT RENIN INHIBITOR COMBINATIONS		
	Non- Preferred Agents after Clinical Criteria are Met Valturna® (aliskiren/valsartan) *(Qty Limit = 1 tablet/day)*	**Valturna:** patient is NOT a diabetic AND patient has a diagnosis of hypertension. AND patient has had a documented side effect, allergy, or treatment failure to an angiotensin converting enzyme inhibitor (ACEI), an ACEI combination or any other angiotensin receptor blocker (ARB) or ARB combination. OR patient has had a documented treatment failure with Tekturna alone.
ANGIOTENSIN RECEPTOR BLOCKER/CALCIUM CHANNEL BLOCKER/HCTZ COMBO		
Preferred Agents after Clinical Criteria are Met EXFORGE HCT® (amlodipine/valsartan/hydrochlorothiazide) § *(Quantity Limit = 1 tablet/day)*	Non- Preferred Agents after Clinical Criteria are Met Tribenzor® (amlodipine/olmesartan/hydrochlorothiazide) *(QL = 1 tablet/day)*	**Exforge HCT:** patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR patient has had a documented side effect, allergy, or treatment failure to an angiotensin converting enzyme inhibitor (ACEI), an ACEI combination or any other angiotensin receptor blocker (ARB) or ARB combination. **Tribenzor:** The patient has had a documented side effect, allergy, or treatment failure to an angiotensin converting enzyme inhibitor (ACEI), an ACEI

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		combination or any other angiotensin receptor blocker (ARB) or ARB combination. AND patient is unable to take the individual components separately.
BETA BLOCKERS		
SINGLE AGENT ACEBUTOLOL† (compare to Sectral®) ATENOLOL† (compare to Tenormin®) BETAXOLOL† (compare to Kerlone®) BISOPROLOL FUMARATE† (compare to Zebeta®) CARVEDILOL† (compare to Coreg®) LABETALOL† (compare to Trandate®) METOPROLOL TARTRATE† (compare to Lopressor®) METOPROLOL SUCCINATE XL† (compare to Toprol XL®) NADOLOL† (compare to Corgard®)	Betapace®* (sotalol) Betapace AF®* (sotalol) Bystolic® (nebivolol) *(QL = 1 tablet/day for 2.5 mg, 5 mg and 10 mg tablet strengths, 2 tablets/day for 20 mg tab)* Coreg®* (carvedilol) Coreg CR® (carvedilol CR) *(QL = 1 tablet/day* Corgard®* (nadolol) Inderal LA®* (propranolol ER) Innopran XL® (propranolol SR) Kerlone®* (betaxolol) Levatol® (penbutolol) Lopressor®* (metoprolol tartrate) Sectral®* (acebutolol) Tenormin®* (atenolol)	**Non-preferred drugs (except Coreg CR):** patient has had a documented side effect, allergy, or treatment failure to at least three preferred drugs. (If a medication has an AB rated generic, one trial must be the generic formulation.) **Coreg CR:** Indication: Heart Failure: patient has been started and stabilized on Coreg CR. (Note: Samples are not considered adequate justification for stabilization.) OR patient has had a documented side effect, allergy, or treatment failure to metoprolol SR or bisoprolol. AND patient has been unable to be compliant with or tolerate twice daily dosing of carvedilol IR. Indication; Hypertention: patient has been started and stabilized on Coreg CR. (Note: Samples are not considered adequate justification for stabilization.) OR patient has had a documented side effect, allergy, or treatment failure to 3(three) preferred anti-hypertensive beta-blockers. **Limitation:** Inderal XL is not covered as federal rebate is not offered.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
PINDOLOL† (compare to Visken®) PROPRANOLOL† (formerly Inderal®) PROPRANOLOL ER† (compare to Inderal LA®) SOTALOL† (compare to Betapace®, Betapace AF®) TIMOLOL† (formerly Blocadren®) **BETA-BLOCKER/DIURETIC COMBINATION** ATENOLOL/CHLORTHALIDONE † (compare to Tenoretic®) BISOPROLOL/HYDROCHLOROTHIAZIDE† (compare to Ziac®) DUTOPROL® (metoprolol succinate XR/hydrochlorothiazide) METOPROLOL/HYDROCHLOROTHIAZIDE† (compare to Lopressor HCT®) NADOLOL/BENDROFLUMETHIAZIDE† (compare to Corzide®)	Toprol XL®* (metoprolol succinate XL) Trandate®* (labetaolol) Zebeta®* (bisoprolol) Corzide®* (nadolol/bendroflumethiazide) Lopressor HCT®* (metoprolol/HCTZ) Propranolol/HCTZ† (formerly Inderide®) Tenoretic®* (atenolol/chlorthalidone) Ziac®* (bisoprolol/HCTZ)	
CALCIUM CHANNEL BLOCKERS		
SINGLE AGENT **Dihydropyridines** AFEDITAB® CR † (nifedipine SR, compare to Adalat® CC)	Adalat® CC* (nifedipine SR) Cardene® SR (nicardipine SR) (no AB rated generic) Dynacirc® CR (isradipine CR) (no AB rated generic) Isradipine (formerly Dynacirc®)	**Criteria for appproval (except as noted below:)** patient has had a documented side effect, allergy, or treatment failure to at least three preferred drugs. (If a medication has an AB rated generic, one trial must be the generic formulation.) **Nymalize:** patient has been started and stabilized on the requested medication.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
AMLODIPINE † (compare to Norvasc®) FELODIPINE ER† (formerly Plendil®) NICARDIPINE † (formerly Cardene®) NIFEDIAC® CC † (nifedipine SR, compare to Adalat® CC) NIFEDICAL® XL † (nifedipine SR osmotic, compare to Procardia® XL) NIFEDIPINE IR † (compare to Procardia®) NIFEDIPINE SR osmotic † (compare to Procardia® XL) NIFEDIPINE SR † (compare to Adalat® CC) NIMODIPINE † (compare to Nimotop®)	Nimotop®* (nimodipine) Nisoldipine ER† (compare to Sular®) Norvasc®* (amlodipine) Nymalize® (nimodipine) Oral Solution Procardia®* (nifedipine IR) Procardia XL®* (nifedipine SR osmotic) Sular® (nisoldipine)	(Note: samples are not considered adequate justification for stabilization.) OR patient has a medical necessity for a specialty dosage form (i.e. dysphagia, swallowing disorder).
Miscellaneous CARTIA® XT † (diltiazem SR, compare to Cardizem® CD) DILT-CD® † (diltiazem SR, compare to Cardizem® CD)	Calan®* (verapamil) Calan® SR* (verapamil CR) Cardizem®* (diltiazem) Cardizem® CD* (diltiazem SR) Cardizem® LA (diltiazem SR) Covera-HS® (verapamil SR) (no AB rated generic)	
DILT-XR® † (diltiazem SR, compare to Dilacor® XR) DILTIAZEM† (compare to Cardizem®)	Diltiazem ER†/Matzin LA† (compare to Cardizem® LA) Dilacor® XR* (diltiazem SR) Isoptin® SR* (verapamil CR)	

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

Drugs highlighted in yellow denote a change in PDL status.

To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
DILTIAZEM ER† (formerly Cardizem® SR) DILTIAZEM ER† (compare to Tiazac®) DILTIAZEM SR † (compare to Cardizem®CD) DILTIAZEM SR † (compare to Dilacor®XR) TAZTIA® XT † (diltiazem ER, compare to Tiazac®) VERAPAMIL† (compare to Calan®) VERAPAMIL CR† (compare to Calan SR®, Isoptin® SR) VERAPAMIL SR† 120 mg, 180 mg 240 mg and 360 mg (compare to Verelan®) VERAPAMIL SR† 100 mg, 200 mg, 300mg (compare to Verelan PM®)	Tiazac®* (diltiazem ER) Verelan®* (verapamil SR 120 mg, 180 mg, 240 mg and 360 mg) Verelan® PM* (100 mg, 200 mg and 300 mg)	
CALCIUM CHANNEL BLOCKER/OTHER COMBINATION **(preferred after clinical criteria are met)** EXFORGE HCT® (amlodipine/valsartan/hydrochlorothiazide) § *(Quantity Limit = 1 tablet/day)* VALSARTAN/AMLODIPINE† (compare to	Azor® (olmesartan/amlodipine) *(QL = 1 tablet/day)* amlodipine/telmisartan† (compare to Twynsta®) *(QL = 1 tablet/day)* Tribenzor® (amlodipine/olmesartan/hydrochlorothiazide) *(QL = 1 tablet/day)* Twynsta® (amlodipine/telmisartan) *(QL = 1 tablet/day)*	**Azor, Amlodipine/Telmisartan, Tribenzor, Twynsta:** patient has had a documented side effect, allergy, or treatment failure to an angiotensin converting enzyme inhibitor (ACEI), an ACEI combination or any other angiotensin receptor blocker (ARB) or ARB combination AND patient is unable to take the individual components separately. AND If the request is for Twynsta, the pastient has a documented intolerance to generic amlodipine/telmisartan. **Amlodipine/atorvastatin, Caduet:** prescriber must provide a clinically valid reason for the use of the requested medication. For approval of Caduet, the patient must have also had a documented intolerance to the generic quivalent. For combinations containing 40 mg or 80 mg atorvastatin, the individual generic components are available without PA and should be prescribed.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
Exforge®)§ *(Quantity Limit = 1 tablet/day)*	Amlodipine/atorvastatin † (compare to Caduet®) *(Qty Limit = 1 tablet/day)* Caduet® (amlodipine/atorvastatin) *(Qty Limit = 1 tablet/day)* Exforge® (valsartan/amlodipine) *(Quantity Limit = 1 tablet/day)*	**Exforge, Exforge HCT:** patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR patient has had a documented side effect, allergy, or reatment failure to an angiotensin converting enzyme inhibitor (ACEI), an ACEI combination or any other angiotensin receptor blocker (ARB) or ARB combination.
CENTRAL ALPHA AGONISTS		
ORAL **Tablet** CLONDIDNE IR† Tablets (compare to Catapress®) GUANFACINE IR† Tablets (compare to Tenex®) METHYLDOPA† Tablets **Suspension**	Catapres®* (clonidine) Tablet Nexiclon XR® (clonidine) Extended Release Tablets *(Quantity Limit = 3 tablets/day)* Tenex®* (guanfacine) Tablets Nexiclon XR® (clonidine) Extended Release Suspension	**Catapres, Tenex:** Patient has a documented intolerance to the generic product. **Nexiclon XR Tabs:** patient has a diagnosis of hypertension. AND patient has had a documented side effect, allergy, or treatment failure to at least TWO agents (either separately or as a combination product) from the following antihypertensive classes: a thiazide diuretic, a beta blocker, an angiotensin converting enzyme inhibitor (ACEI), angiotensin receptor blocker (ARB), or a calcium channel blocker (CCB). AND patient has been unable to be adherent to or tolerate twice daily dosing of the generic clonidine immediate-release tablets. **Nexiclon XR Oral Susp:** patient has a diagnosis of hypertension AND patient has had a documented side effect, allergy, or treatment failure to at least TWO agents (either separately or as a combination product) from the following antihypertensive classes: a thiazide diuretic, a beta blocker, an angiotensin converting enzyme inhibitor (ACEI), angiotensin receptor blocker (ARB), or a calcium channel blocker (CCB). AND patient has a medical necessity for a specialty dosage form (i.e. dysphagia, swallowing disorder.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
TRANSDERMAL	Catapres-TTS® (clonidine) Transdermal Patch *(Qty Limit = 1 patch/7 days)* Clonidine (compare to Catapres-TTS) Transdermal Patch *(Qty Limit = 1 patch/7 days)*	**Clonidine Patches (generic):** patient has a medical necessity for a specialty topical dosage form (i.e. dysphasia, swallowing disorder, compliance, nausea/vomiting). **Catapres-TTS Patches:** patient has a medical necessity for a specialty topical dosage form (i.e. dysphasia, swallowing disorder, compliance, nausea/vomiting). AND patient has a documented intolerance to the generic product.
GANGLIONIC BLOCKERS		
All products require a PA	Vecamyl®* (mecamylamine) Tablet	**Vecamyl tabs:** Patient has a diagnosis of moderately severe or severe hypertension AND patient has tried and failed, intolerant to, or contraindicated to at least THREE different antihypertension thapies of different mechanism of actions.
RENIN INHIBITOR		
	SINGLE AGENT Tekturna® (aliskiren) *(Quantity Limit = 1 tablet/day)* COMBINATIONS Amturnide® (aliskiren/amlodipine/hydrochlorothiazide) *(Qty Limit = 1 tab/day)* Tekamlo® (aliskiren/amlodipine) *(Qty Limit = 1 tablet/day)* Tekturna HCT® (aliskiren/hydrochlorothiazide) *(Quantity Limit = 1 tablet/day)* Valturna® (aliskiren/valsartan) *(Qty Limit = 1 tablet/day)*	**Tekturna:** patient is NOT a diabetic who will continue on therapy with an ACEI or ARB AND patient has a diagnosis of hypertension. AND patient has had a documented side effect, allergy, or treatment failure with an angiotensin Receptor Blocker (ARB). Note: Approval of an ARB requires a documented side effect, allergy, or treatment failure with an Angiotensin Converting Enzyme (ACE) inhibitor. **Amturnide, Tekalmo, Tekturna HCT:** patient is NOT a diabetic who will continue on therapy with an ACEI or AND patient has a diagnosis of hypertension. AND patient has had a documented side effect, allergy, or treatment failure with an Angiotensin Receptor Blocker (ARB). Note: Approval of an ARB requires a documented side effect, allergy, or treatment failure with an Angiotensin Converting Enzyme (ACE) inhibitor. OR patient has had a documented treatment failure with Tekturna® alone.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		Valturna: patient is NOT a diabetic AND patient has a diagnosis of hypertension. AND patient has had a documented side effect, allergy, or treatment failure to an angiotensin converting enzyme inhibitor (ACEI), an ACEI combination or any other angiotensin receptor blocker (ARB) or ARB combination. OR patient has had a documented treatment failure with Tekturna® alone.
ANTI-INFECTIVES ANTIBIOTICS		
CEPHALOSPORINS 1ST GENERATION		
CAPSULES/TABLETS CEFADROXIL† Capsules, Tablets (formerly Duricef®) CEPHALEXIN† Capsules (compare to Keflex®) **SUSPENSION** CEFADROXIL† Suspension (formerly Duricef®) CEPHALEXIN† Suspension (formerly Keflex®) IV drugs are not managed at this time	Cephalexin® Tablets Keflex®* (cephalexin) Capsules	**Cephalexin Tabs:** patient has had a documented intolerance to cephalexin generic capsules. **Keflex:** patient has had a documented side effect, allergy, or treatment failure to generic cefadroxil and cephalexin. **Limitations:** Cephalexin and Keflex 750 mg dosage strength not covered. Use alternative strengths.
CEPHALOSPORINS 2ND GENERATION		
CAPSULES/TABLETS CEFACLOR† CAPSULE CEFPROZIL† (formerly Cefzil®) TABLET	Cefaclor® ER Tablet Ceftin®* (cefuroxime) tablet	**Cefaclor ER Tabs:** patient has had a documented intolerance to cefaclor capsules. **Ceftin Tabs:** patient has had a documented side effect, allergy, or treatment failure to at least two of the following medications: cefaclor, cefprozil, and cefuroxime.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
CEFUROXIME † (compare to Ceftin®) TABLET **SUSPENSION** CEFPROZIL† (formerly Cefzil®) SUSPENSION IV drugs are not managed at this time	Ceftin® (cefuroxime) suspension	If a product has an AB rated generic, one trial must be the generic formulation. **Cedax Susp, Ceftibuten Susp:** patient is completing a course of therapy which was initiated in the hospital. OR patient has had a documented side effect or treatment failure to two of cefdinir, cefpodoxime and Suprax suspension.
CEPHALOSPORINS 3RD GENERATION		
CAPSULES/TABLETS CEFDINIR† (formerly Omnicef®) CAPSULE CEFPODOXIME PROXETIL† (formerly Vantin®) TABLET SUPRAX® (cefixime) TABLET **SUSPENSION** CEFDINIR† (formerly Omnicef®) SUSPENSION CEFPODOXIME PROXETIL† (formerly Vantin®) SUSPENSION SUPRAX® (cefixime) suspension IV drugs are not managed at this time	Cedax® (ceftibuten) capsule cefditoren† (compare to Spectracef®) tablet ceftibuten†capsule (compare to Cedax®) Spectracef® (cefditoren) tablet Suprax® (cefixime) Capsule Suprax® (cefixime) Chewable Tablets Cedax® (ceftibuten) suspension ceftibuten†suspension (compare to Cedax®)	**Spectracef tablet, Cedax® Capsule, Cefditoren tablet, Ceftibuten capsule:** patient is completing a course of therapy which was initiated in the hospital. OR patient has had a documented side effect, allergy, or treatment failure to both cefpodoxime and cefdinir. AND If the request is for Spectracef, the patient has a documented intolerance with generic cefditoren tablets. **Cedax Susp, Ceftibuten Susp:** patient is completing a course of therapy which was initiated in the hospital. OR patient has had a documented side effect or treatment failure to two of cefdinir, cefpodoxime and Suprax suspension.
KETOLIDES		
		Ketek: member is continuing a course of therapy initiated while an inpatient at a

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Ketek® (telithromycin)	hospital. OR diagnosis or indication for the requested medication is community-acquired pneumonia. AND member is at least 18 years of age at the time of the request. AND member has no contraindication or a history of hypersensitivity or serious adverse event, from any macrolide antibiotic. AND Infection is due to documented Streptococcus pneumoniae (including multi-drug resistant [MDRSP*] s.pneumoniae), Haemophilus influenzae, Moraxella catarrhalis, Chlamydophila pneumoniae, or Mycoplasma pneumoniae AND member has had a documented therapeutic failure with all clinically appropriate alternatives. AND member does not have any of the following medical conditions: myasthenia gravis, hepatitis or underlying liver dysfunction, history of arrhythmias (e.g. QTc prolongation, or antiarrhythmic therapy), uncorrected hypokalemia or hypomagnasemia, clinically significant bradycardia, a history of therapy with Class IA (e.g. quinidine or procainamide) or Class III (e.g. dofetilide) antiarrhythmic medications.
MACROLIDES		
Azithromycin AZITHROMYCIN† tabs, liquid (≤ 5 day supply) (compare to Zithromax®) (Maximum 10 days therapy/30 days)	azithromycin† tablets and liquid (if > 5 day supply) (compare to Zithromax®) (Maximum 10 days therapy/30 days) Azithromycin† packet (compare to Zithromax®) *(QL = 2 grams/fill)* Zithromax®* (azithromycin) tablets and liquid *QL = 5 days supply/RX, maximum 10 days therapy/30 days* Zithromax® (azithromycin) packet	**Non-preferred agents (except as below):** patient has a documented side-effect, allergy, or treatment failure to at least two of the preferred medications. (If a product has an AB rated generic, one trial must be the generic.) OR patient is completing a course of therapy with the requested medication that was initiated in the hospital. **Brand Name Erythromycin Products:** patient has had a documented side effect or treatment failure with one preferred erythromycin product **Azithromycin/Zithromax packets:** A clinically valid reason why the dose cannot

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	(QL=2 grams/fill)	be obtained using generic azithromycin tablets AND If the request is for brand Zithromax, the patient has a documented intolerance to the generic product. **Azithromycin > 5 day supply:** patient has a diagnosis of Lyme Disease AND has had a documented side effect, allergy, or treatment failure to at least two of the following: doxycycline, amoxicillin, or a 2nd generation cephalosporin. For early Lyme disease, without neurologic or rheumatologic (arthritis) complications, the length of authorization is up to 10 days. For neurologic or rheumatologic Lyme disease, the length of authorization is up to 28 days OR patient has a diagnosis of Cystic Fibrosis. (length of authorization up to 6 months) OR patient has a diagnosis of HIV/immunocompromised status and azithromycin is being used for MAC or Toxoplasmosis treatment or prevention. (length of authorization up to 6 months) OR patient has a diagnosis of bacterial sinusitis AND has had a documented side effect, allergy, or treatment failure to penicillin, amoxicillin, or sulfamethoxazole/trimethoprim (Bactrim). (length of authorization up to 10 days) OR patient has a diagnosis of severe bronchiectasis with frequent exacerbations (length of authorization up to 6 months) **Dificid:** patient's diagnosis or indication is Clostridium difficile associated diarrhea (CDAD) AND patient has had a side-effect, allergy, treatment failure or contraindication to metronidazole. OR prescriber provides a clinically compelling rationale why metronidazole is not appropriate for the patient. (E.g. patient has severe Clostridium difficile infection, history of recurrent infections). AND patient has had a side-effect, allergy, treatment failure or contraindication to oral vancomycin capsules (Vancocin).
Clarithromycin CLARITHROMYCIN† (compare to Biaxin®)	Zmax® Suspension (azithromycin extended release for oral suspension) *QL = 5 days supply/RX, maximum 10 days therapy/30 days* Biaxin®* (clarithromycin) Biaxin XL® (clarithromycin SR) Clarithromycin SR† (compare to Biaxin® XL)	
Erythromycin E.E.S®† (erythromycin ethylsuccinate) ERY-TAB® (erythromycin base, delayed release) ERYTHROMYCIN BASE† ERYTHROMYCIN ETHYLSUCCINATE† (compare to E.E.S®) ERYTHROMYCIN W/SULFISOXAZOLE† (compare to Pediazole®)	Eryped® (erythromycin ethylsuccinate) Erythrocin (erythromycin stearate) PCE Dispertab® (erythromycin base) Pediazole®* (erythromycin-sulfisoxazole)	
Fidaxomicin IV drugs are not managed at this time	Dificid® (fidaxomicin) tablet *(Quantity limit =2 tablets per day, 10 day supply per 30 days)*	

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
OXAZOLIDINONES		
IV form of this medication not managed at this time	Sivextro® (tedizolid) (*Quantity limit = 1 tabs/day)* Zyvox® (linezolid) *(QL = 56 tablets per 28 days)* Zyvox® (linezolid) suspension (*QL = 60 ml/day, maximum 28 days supply)*	**Criteria for Approval:** patient has been started on intravenous or oral linezolid or tedizolid in the hospital and will be finishing the course of therapy in an outpatient setting OR patient has a documented blood, tissue, sputum, or urine culture that is positive for Vancomycin-Resistant Enterococcus (VRE) species. OR patient has a documented blood or sputum culture that is positive for Methicillin-Resistant Staphylococcus species OR patient has a documented tissue or urine culture that is positive for Methicillin-Resistant Staphylococcus AND patient has had a documented treatment failure with trimethoprim/sulfamethoxazole OR there is a clinically valid reason that the patient cannot be treated with trimethoprim/sulfamethoxazole.
PENICILLINS (ORAL)		
SINGLE ENTITY AGENTS **Natural Penicillins** PENICILLIN V POTASSIUM† (formerly Veetids®) tablets, oral solution **Penicillinase-Resistant Penicillins** DICLOXACILLIN† Capsules **Aminopenicillins** AMOXICILLIN† (formerly Amoxil®) capsules, tablets, chewable tablets, suspension AMPICILLIN† (formerly Principen®) capsules, suspension	Moxatag® (amoxicillin extended release) tablet *QL =1 tablet/day*	**Augmentin:** patient has had a documented intolerance to the generic formulation of the requested medication. OR patient is < 12 weeks of age and requires the 125 mg/5 mL strength of Augmentin. **Amoxicillin/Clavulanate ER, Augmentin XR, Moxatag**: prescriber must provide a clinically valid reason for the use of the requested medication. Additionally, for approval of brand Augmentin XR, the patient must have a documented intolerance to generic Amoxicillin/Clavulanate ER **Limitations:** Brand Augmentin® Chewable tablets do not offer Federal Rebate and therefore cannot be provided.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
COMBINATION PRODUCTS AMOXICILLIN/CLAVULANATE† (compare to Augmentin ®) tablets, chewable tablets, suspension AMOXICILLIN/CLAVULANATE† 600-42.9mg/5ml (formerlay Augmentin ES®) suspension	Amoxicillin/clavulanate† ER (compare to Augmentin XR®) tablets Augmentin®*♣ (amoxicillin/clavulanate) tablets, suspension Augmentin XR® (amoxicillin/clavulanate) tablets PA will be granted for 125 mg/5 mL strength for patients < 12 weeks of age	
QUINOLONES		
CIPROFLOXACIN† (compare to Cipro®) tabs, oral suspension LEVOFLOXACIN † (compare to Levaquin®) tabs, sol OFLOXACIN† IV drugs are not managed at this time	Avelox® (moxifloxacin HCL) Avelox ABC PACK® (moxifloxacin HCL) Cipro® * (ciprofloxacin) tabs, oral suspension Cipro XR® (ciprofloxacin) ciprofloxacin ER† (compare to Cipro XR®) Factive® (gemifloxacin) Levaquin®* (levofloxacin) tabs,sol moxifloxacin† (compare to Avelox®) Noroxin® (norfloxacin) ProQuin XR® (ciprofloxacin)	**Noroxin:** patient is completing a course of therapy with the requested medication that was initiated in the hospital. OR patient has had a documented side effect, allergy, or treatment failure to ciprofloxacin immediate-release tablets/solution or ofloxacin. **Cipro, Cipro XR, ciprofloxacin ER ProQuin XR:** patient has had a documented side effect, allergy, or treatment failure to generic ciprofloxacin immediate-release tablets or oral suspension. AND If the request is for Cipro XR or Cipro the patient has had a documented intolerance to the generic equivalent. **Avelox, Moxifloxacin, Factive:** patient is completing a course of therapy with the requested medication that was initiated in the hospital. OR patient has had a documented side effect, allergy, or treatment failure to levofloxacin. AND If the request is for Avelox, the patient has had a documented intolerance to generic moxifloxacin. **Levaquin (brand):** patient has a documented intolerance with the generic levofloxacin

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
RIFAMYCINS		
	Xifaxan ® (rifaximin) 200 mg Tablets *(Qty limit depends on indication)* Xifaxan ® (rifaximin) 550 mg Tablets *(Qty limit depends on indication)*	**Criterial for Approval: Based on Indication:** **Hepatic Encephalopathy (Xifaxan 550 mg Tablets Only):** patient has a diagnosis of hepatic encephalopathy. AND Patient has had a documented side effect, allergy, treatment failure or contraindication to lactulose. AND Quantity limit is 2 tablets/day (550 mg tablets only). **Traveller's Diarrhea (Xifaxan 200 mg Tablets Only**): patient has a diagnosis of traveller's diarrhea caused by noninvasive strains of Escherichia coli. AND Patient has had a documented side effect, allergy, treatment failure or contraindication with a fluoroquinolone. AND Quantity limit is 9 tablets/RX (200 mg tablets only). **Small Intestinal Bacterial Overgrowth (Xifaxan 550 mg or 200 mg Tablets):** patient has a diagnosis of SIBO. AND Patient has attempted dietary modification and has had a documented side effect, allergy, treatment failure or ontraindication to (alone or in combination) one of the following: Amoxicillin-clavulanate, cephalosporin, metronidazole, fluoroquinolone, tetracycline, and trimethoprim-sulfamethoxazole. AND Quantity limit is 800 mg to 1,200 mg/day. **Irritable Bowel Syndrome (Xifaxan 550 mg or 200 mg Tablets):** patient has a diagnosis of irritable bowel syndrome without constipation or with symptoms of bloating. AND Patient has attempted dietary modification and has had a documented side effect, allergy, treatment failure or contraindication to two of the following classes (one of which must be an antibiotic): • Antibiotics (alone or in combination: amoxicillin-clavulanate, cephalosporin, metronidazole, fluoroquinolone, tetracycline, trimethoprim-sulfamethoxazole) • SSRIs • TCAs • Antispasmodics • Antidiarrheals • Cholestyramine resin AND Quantity limit is 1,200 mg to 1,650 mg/day.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		Inflammatory Bowel Disease: Crohn's Disease (Xifaxan 550 mg or 200 mg Tablets): patient has a diagnosis of Crohn's Disease. AND Patient has had a documented side effect, allergy, treatment failure or contraindication to two of the following: 6-mercaptopurine, aminosalicylates, azathioprine, corticosteroids, fluoroquinolone and/or metronidazole. AND Quantity limit is 600 mg to 1,600 mg/day. **Inflammatory Bowel Disease: Ulcerative Colitis (Xifaxan 200 mg Tablets):** patient has a diagnosis of Ulcerative Colitis. AND Patient has had a documented side effect, allergy, treatment failure or contraindication to two of the following: 6-mercaptopurine, aminosalicylates, azathioprine, corticosteroids, fluoroquinolone and/or metronidazole. AND Quantity limit is 800 mg/day (4 x 200 mg tablets/day). **Clostridium difficile Diarrhea (Xifaxan 200 mg Tablets):** patient has a diagnosis of C. difficile diarrhea. AND Patient has had a documented side effect, allergy, treatment failure or contraindication to metronidazole. AND Quantity limit is 800 mg/day (4 x 200 mg tablets/day).
VANCOMYCIN		
IV vancomycin products are not managed at this time	Vancocin® (vancomycin) Capsules Vancomycin† (compare to Vancocin®) Capsules	**Criteria for Approval:** patient's diagnosis or indication is enterocolitis caused by Staphylococcus aureus. OR patient's diagnosis or indication is antibiotic-associated pseudomembranous colitis caused by Clostridium AND patient has had a therapeutic failure, adverse reaction or contraindication to metronidazole OR prescriber provides a clinically compelling rationale why metronidazole is

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		not appropriate for the patient. (e.g. patient has severe Clostridium difficile infection, history of recurrent infections). AND For approval of brand Vancocin, the patient must meet the above criteria and have a documented intolerance to the generic.
ANTI-INFECTIVES ANTIFUNGAL		
ALLYLAMINES		
	terbinafine† tabs (compare to Lamisil®) *QL = 30 tablets/month* Lamisil® (terbinafine) granules *(QL: 125 mg packet (1 or 2 per day depending on dose) 187.5 mg packet (1 per day) post PA approval)* Lamisil® tablets (terbinafine HCL) *QL = 30 tablets/month*	**Terbinafine Tabs:** The patient has a diagnosis of a fingernail/toenail onychomycosis infection (confirmed with a positive KOH stain, PAS stain, or fungal culture or physician clinical judgment). AND patient meets at least 1 of the following criteria: Pain to affected area that limits normal activity, Diabetes Mellitus, Patient is immunocompromised, Patient has diagnosis of systemic dermatosis, Patient has significant vascular compromise AND quantity requested does not exceed 30 tablets per month for a maximum of 3 months OR patient has a diagnosis of a Tinea capitis infection (confirmed with a positive KOH stain, PAS stain, or fungal culture). AND quantity requested does not exceed 30 tablets per month for a maximum of 6 weeks. OR patient has a diagnosis of a Tinea pedis, Tinea cruris, or Tinea corporis infection (confirmed with a positive KOH stain, PAS stain, or fungal culture). AND patient has a documented side-effect, allergy, or treatment failure to at least THREE different topical antifungal medications (one of the trials must have included a topical terbinafine product). AND quantity requested does not exceed 30 tablets per month for a maximum of 1 month. For approval of Lamisil, the patient must have a documented intolerance to generic terbinafine.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		Lamisil Granules: patient has a diagnosis of a Tinea capitis infection (confirmed with a positive KOH stain, PAS stain, or fungal culture). AND patient has a requirement for an oral liquid dosage form. AND patient had a documented side effect, allergy, or treatment failure with Griseofulvin suspension
AZOLES		
FLUCONAZOLE† (compare to Diflucan®) tabs, suspension KETOCONAZOLE† (formerly Nizoral®) tabs CLOTRIMAZOLE Troche† (compare to Mycelex®) IV drugs are not managed at this time.	Diflucan®* (fluconazole) tabs, suspension itraconazole† (compare to Sporanox®) caps Noxafil® (posaconazole) oral suspension Noxafil® (posaconazole) DR Tablets *(QL=93 tablets/30 days)* Onmel® (itraconazole) 200 mg tablet *(QL=1 tab/day)* Oravig® (miconazole) buccal tabs *(QL=1 tab/day; 14 tabs per RX ONLY)* Sporanox® (itraconazole) caps, solution VFend® (voriconazole) tabs, suspension voriconazole† (compare to VFend®) tabs, suspension	**Itraconazole 100mg/Sporanox:** patient has a diagnosis of invasive aspergillosis, blastomycosis, or histoplasmosis OR The patient has a diagnosis of a fingernail/toenail onychomycosis infection (confirmed with a positive KOH stain, PAS stain, fungal culture or physician clinical judgment) AND has a documented side-effect, allergy, contraindication, or treatment failure to oral terbinafine AND meets at least 1 of the following criteria: Pain to affected area that limits normal activity, Diabetes Mellitus, Patient is immunocompromised o Patient has diagnosis of systemic dermatosis, Patient has significant vascular compromise OR patient is completing a course of therapy with the requested medication that was initiated in the hospital. OR patient has a documented side-effect, allergy, or treatment failure to at least ONE of the preferred medications. For approval of Sporanox®capsules, the patient must have a documented intolerance to generic itraconazole. For approval of Sporanox solution, the patient must have a medical necessity for a liquid dosage form. **Onmel 200mg:** patient has a diagnosis of a toenail onychomycosis infection (confirmed with a positive KOH stain, PAS stain, fungal culture or physician clinical judgment) AND has a documented side-effect, allergy, contraindication, or treatment failure to oral terbinafine AND there is a clinical reason that itraconazole 100 mg generic capsules cannot be used AND meets at least 1 of the

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		following criteria: Pain to affected area that limits normal activity, Diabetes Mellitus, Patient has significant vascular compromise **Limitations:** Coverage of Onychomycosis agents will NOT be approved solely for cosmetic purposes. **Voriconazole/Vfend:** Patient has a diagnosis of invasive aspergillosis. OR patient is completing a course of therapy with the requested medication that was initiated in the hospital. OR patient has a documented side-effect, allergy, or treatment failure to ONE of the preferred medications AND itraconazole. AND For approval of Vfend® tablets, the patient must have a documented intolerance to generic voriconazole. AND For approval of voriconazolesuspenion, the patient must have a medical necessity for a liquid dosage form. For approval of Vfend® suspension, the patient must additionally have a documented intolerance to generic voriconazole suspension. **Noxafil:** patient has a diagnosis of HIV/immunocompromised status (neutropenia secondary to chemotherapy, hematopoietic stem cell transplant recipients) AND Noxafil is being used for the prevention of invasive Aspergillosis/Candida infections. OR patient is completing a course of therapy with the requested medication that was initiated in the hospital. OR Oral Suspension ONLY patient has a documented side-effect, allergy, or treatment failure to ONE of the preferred medications AND itraconazole AND the patient is being treated for oropharyngeal candidiasis. **Diflucan (brand):** For approval of Diflucan brand name product, the patient must have a documented intolerance to generic fluconazole. Oravig: The indication for use is treatment of oropharyngeal candidasis. AND patient has had a documented side effect, allergy, treatment failure/inadequate response to both nystatin suspension and clotrimazole troche. OR patient is unable to be compliant with the nystatin suspension and/or clotrimazole troche dosing

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		schedules.
ANTI-INFECTIVES ANTIMALARIALS: QUININE		
	Quinine sulfate† (compare to ualaquin®) Qualaquin® (quinine sulfate)	**Criteria for Approval**: diagnosis or indication is for the treatment of malaria. (Use for leg cramps not permitted.) AND If the request is for brand Qualaquin, the patient has a documented intolerance to the generic equivalent.
ANTI-INFECTIVES ANTI-VIRALS		
HERPES (ORAL)		
ACYCLOVIR† (compare to Zovirax®) VALACYCLOVIR † (compare to Valtrex®)	famciclovir † (compare to Famvir®)§ Famvir® (famciclovir) Sitavig® (acyclovir) Buccal Tablet *QL = 2 tablets/30 days* Valtrex®* (valacyclovir) Zovirax®*(acyclovir) §	**Famciclovir, Zovirax:** patient has a documented side effect or allergy, or treatment failure (at least one course of ten or more days) with acyclovir AND valacyclovir. **Famvir:** patient has a documented side effect or allergy, or treatment failure (at least one course of ten or more days) with acyclovir AND valacyclovir. AND patient has a documented intolerance to generic famciclovir. **Sitavig:** patient has a diagnosis of recurrent herpes labialis (cold sores). AND patient is immunocompetent AND patient has a documented side effect or treatment failure with acyclovir AND valacyclovir. **Valtrex:** patient has a documented intolerance to generic valacyclovir
INFLUENZA MEDICATIONS		
Preferred Agents after Clinical Criteria are Met		**Tamiflu, Relenza:** Tamiflu and Relenza will NOT require prior-authorization at

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
RELENZA® (zanamivir) *QL= 20 blisters / 30 days* TAMIFLU® (oseltamivir) *QL=10 capsules/30 days(45 mg & 75 mg caps) 20 capsules / 30 days (30 mg caps) 180 ml (6 mg/ml) / 30 days (suspension)*		this time when prescribed within the following quantity limits: **Relenza:** 20 blisters per 30 days **Tamiflu:** 75mg or 45mg: 10 caps per 30 day **Tamiflu:** 30mg: 20 caps per 30 days **Tamiflu:** Suspension (6mg/ml): 180ml (3 bottles) per 30 days **Limitations:** Amantadine, Flumadine and rimantadine are not CDC recommended for use in influenza treatment or chemoprophylaxis at this time and are not covered for this indication. For information regarding amantadine see "Parkinsons Medications". Flumadine/rimantadine is not covered for any indication.
INFLUENZA VACCINES		
SEASONAL Influenza Vaccine INJECTION **Inactivated Influenza Vaccine, Trivalent (IIV3), Standard Dose (egg based)** AFLURIA® Injection FLUARIX® Injection FLULAVAL® Injection FLUVIRIN® Injection FLUZONE® Injection FLUZONE INTRADERMAL® Injection	**Inactivated Influenza Vaccine, Trivalent (ccIIV3), Standard Dose (cell culture based) (NOT egg free)** Flucelvax® Injection **Recombinant Influenza Vaccine, Trivalent (RIV3) (egg FREE)** Flublok® Injection	**Flumist:** Flumist is being requested for influenza prophylaxis during flu season AND The patient is between the ages of 19 and 49 years old, AND Prescriber provides documentation of a contraindication to an intramuscular injection (e.g., currently on warfarin; history of thrombocytopenia) or other compelling information to support the use of this dosage form. **EXCLUDED FROM APPROVAL:** Hypersensitivity (severe allergy) to any FluMist component including eggs and egg products. Children and adolescents aged 2 – 17 years receiving aspirin therapy (increased risk of Reye's Syndrome). History of Guillain-Barre Syndrome. People with a medical condition that places them at high risk for complications from influenza, including those with chronic heart or lung disease, such as asthma or reactive airways disease; people with medical conditions such as

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
Inactivated Influenza Vaccine, Trivalent (IIV3), High Dose (egg based) FLUZONE HIGH-DOSE® Injection **Inactivated Influenza Vaccine, Quadrivalent (IIV4), Standard Dose (egg based)** FLUARIX® QUADRIVALENT Injection FLULAVAL® QUADRIVALENT Injection FLUZONE® QUADRIVALENT Injection	**SEASONAL Influenza Vaccine NASAL** **Live Attenuated Influenza Vaccine, Quadrivalent (LAIV4) (egg based)** FluMist® Quadrivalent Intranasal	diabetes or kidney failure; or people with illnesses that weaken the immune system, or who take medications that can weaken the immune system. Children <5 years old with a history of recurrent wheezing Pregnant women **Flueclvax:** Flucelvax is being requested for influenza prophylaxis during flu season AND patient is > 18 years old. AND Prescriber provides clinical rationale why one of the preferred influenza vaccines cannot be used. **Flublok:** Flublok is being requested for influenza prophylaxis during flu season AND patient is between the ages of >18 and < 50 years old. AND patient has an egg allergy.
ANTI-MIGRAINE TRIPTANS		
Single Agent **ORAL** SUMATRIPTAN† (compare to Imitrex®) *Quantity Limit = 18 tablets/month (25 mg), 9 tablets/month (50 mg, 100 mg)* **After Sumatriptan Trial** NARATRIPTAN† (compare to Amerge®) § *(Quantity Limit = 9 tablets/month)* RIZATRIPTAN ODT† (compare to Maxalt-MLT®) §	Amerge® (naratriptan) 1 mg, 2.5 mg *Quantity Limit = 9 tablets/month* Axert® (almotriptan) *Quantity Limit = 6 tablets/month* Frova® (frovatriptan) 2.5 mg *Quantity Limit = 9 tablets/month* Imitrex®* (sumatriptan) *Quantity Limit = 18 tablets/month (25 mg), 9 tablets/month (50 mg, 100 mg),* Maxalt® (rizatriptan) 5 mg, 10 mg tablet *Quantity Limit = 12 tablets/month* Maxalt-MLT® (rizatriptan ODT) *Quantity Limit = 12 tablets/month*	**Amerge, Axert, Frova, Imitrex, Maxalt, Maxalt MLT, Relpax, Rizatriptan, Zomig, Zomig ZMT, Zolmitriptan, Zolmitriptan ODT:** patient has had a documented side effect, allergy, or treatment failure to Sumatriptan, Naratriptan and Rizatriptan ODT. If the request is for brand Maxalt, Zomig, or Zomig ZMT, the patient must also have a documented intolerance to the generic product. **Naratriptan, Rizatriptan ODT:** patient has had a documented side effect, allergy, or treatment failure with Sumatriptan. **Treximet:** patient had a documented side effect, allergy or treatment failure with 2 preferred Triptans, AND paitent is unable to take the individual components (sumatriptan and naproxen) seperately. **Zomig Nasal Spray:** patient has had a documented side effect, allergy or treatment failure of Imitrex Nasal Spray

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
Quantity Limit = 12 tablets/month **NASAL SPRAY** IMITREX® (sumatriptan) *Quantity Limit =12 units/month (5 mg nasal spray),* *6 units/month (20 mg nasal spray)* **INJECTABLE** IMITREX® (sumatriptan) *Quantity Limit =4 injections/month (4 or 6 mg injection)*	Relpax® (eletriptan) 20 mg, 40 mg *Quantity Limit = 12 tablets/month* rizatriptan† (compare to Maxalt®) *Quantity Limit = 12 tablets/month* Zomig® (zolmitriptan) tablets *Quantity Limit = 12 tablets/month (2.5 mg), 6 tablets/month (5 mg)* Zomig® ZMT (zolmitriptan ODT) *Quantity Limit = 12 tablets/month (2.5 mg), 6 tablets/month (5 mg)* Zolmitriptan† (compare to Zomig®) tablets *Quantity Limit = 12 tablets/month (2.5 mg), 6 tablets/month (5 mg)* Zolmitriptan† ODT (compare to Zomig® ZMT) *Quantity Limit = 12 tablets/month (2.5 mg), 6 tablets/month (5 mg)* Sumatriptan† (compare to Imitrex®) *Quantity Limit =12 units/month (5 mg nasal spray),* *6 units/month (20 mg nasal spray)* Zomig® (zolmitriptan) *Quantity Limit = 12 units/month (2.5 or 5 mg nasal spray)* Alsuma® (sumatriptan) 6 mg/0.5ml *Quantity Limit =4 injections/month*	**Sumatriptan Nasal Spray:** patient has had a documetned intolerance to brand Imitrex. **Alsuma, Sumatriptan, Sumavel Dose Pro Injections**: patient has had a documented intolerance to brand Imitrex. **To exceed quanitity limits:** patient is takiing a medication for migraine prophylaxis.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
Combination Product (Oral)	sumatriptan (compare to Imitrex®) *Quantity Limit =4 injections/month (4 or 6 mg injection)* Sumavel DosePro® (sumatriptan) 6 mg/0.5ml, 4 mg/0.5 ml *Quantity Limit =4 injections/month* Treximet® (sumatriptan/naproxen) *Quantity Limit = 9 tablets/month*	
ANTI-OBESITY		
Effective 10/12/2011, anti-obesity agents (weight loss agents) are no longer a covered benefit for all Vermont Pharmacy Programs. This change is resultant from Drug Utilization Review (DUR) Board concerns regarding safety and efficacy of these agents.		
ANTI-PSYCHOTIC ATYPICAL & COMBINATIONS (CHILDREN < 18 YEARS OLD)		
Preferred After Clinical Criteria Are Met **TABLETS/CAPSULES** OLANZAPINE† (compare to Zyprexa®) *FDA maximum recommended dose = 20 mg/day,* *Quantity limit = 1.5 tabs/day (2.5 mg, 5 mg, 7.5 mg & 10 mg tabs)*	Abilify® (aripiprazole) *FDA maximum recommended dose = 30 mg/day,* *Quantity limit = 1.5 tabs/day (5 mg, 10 mg & 15 mg tabs)* Clozapine† (compare to Clozaril®) *FDA maximum recommended dose = 900 mg/day*	Criteria for approval: (Children < 18 years old) Note: all requests for patients < 5 years old will be reviewed by the DVHA Medical Director. **Target symptoms or Diagnosis that will be accepted for approval:** Target Symptoms - Grandiosity/euphoria/mania; Obsessions/compulsions; Psychotic symptioms; Tics (motor or vocal). Diagnosis- Autism with Aggression and/or irritability; Bipolar Disorder; Intellectual Disability with Aggression and/or

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
RISPERIDONE† (compare to Risperdal®) *FDA maximum recommended dose = 16 mg/day* QUETIAPINE† (compare to Seroquel®) *FDA maximum recommended dose = 800 mg/day* ZIPRASIDONE† (compare to Geodon®) *FDA maximum recommended dose = 160 mg/day* **Preferred Agents after Clinical Criteria are Met** **ORAL SOLUTIONS** RISPERIDONE† (compare to Risperdal®) oral solution *FDA maximum recommended dose = 16 mg/day*	Clozaril® *(clozapine)* *FDA maximum recommended dose = 900 mg/day* Geodon® (ziprasidone) *FDA maximum recommended dose = 160 mg/day* Invega® (paliperidone) *FDA maximum recommended dose = 12 mg/day* *Quantity limit = 1 tab/day (3mg, 9mg), 2 tabs/day (6mg)* Risperdal® (risperidone) *FDA maximum recommended dose = 16 mg/day* Seroquel® (quetiapine) *FDA maximum recommended dose = 800 mg/day* Seroquel XR® (quetiapine XR) *FDA maximum recommended dose = 800 mg/day* *Quantity Limit = 1 tab/day* *(150 mg & 200 mg tablet strengths), 2 tabs/day (50 mg strength)* Zyprexa® (olanzapine) *FDA maximum recommended dose = 20 mg/day,* *Quantity limit = 1.5 tabs/day (2.5 mg, 5 mg, 7.5 mg & 10 mg tabs)* Abilify® (aripiprazole) oral solution *FDA maximum recommended dose = 25 mg/day* Risperdal® (risperidone) oral solution	Irribility; Obsessive Compulsive Disorder; Schizophrenia/Schizoaffective Disorder; Tourette's Syndrome. **Preferred after clinical criteria are met: Tablets & Capsules:** **Olanzapine, Risperidone, Ziprasidone:** patient has been started and stabilized on the requested medication (Note: samples are not considered adequate justification for stabilization). OR medication is being requsted for one of the target symptions or patient diagnoses listed above. **Quetiapine:** patient has been started and stabilized on the requested medication (Note: samples are not considered adequate justification for stabilization). OR medicaiton is being requested for one of the target symptoms or patient diagnoses listed above. Note: Quetiapine will not be approved for indication of insomnia, for sleep or as a hypnotic. **Risperdone Oral Sol:** patient has been started and stabilized on the requested medication (Note: samples are not considered adequate justification for stabilization). OR medication is being requested for one of the target symptoms or patient diagnoses listed above. **Non-Preferred:** **Invega:** patient has been started and stabilized on the requested medication (Note: samples are not considered adequate justification for stabilization). OR medication is being requested for one of the target symptoms or patient diagnoses listed above AND patient had had a documented side effect, allergy or treatment failure with at least two prefrred after clinical criteria are met products (typical or atypical antipsychotics) (see tables), one of which is risperidone. **Cloazaril, Geodon, Risperdal, Seroquel, Zyprezxa:** patients meets clinical criteria for the generic equivalent AND patient has a documented intolerance to

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ORALLY DISINTEGRATING TABLETS	*FDA maximum recommended dose = 16 mg/day* Versacloz® (clozapine) Oral Suspension *FDA maximum recommended dose = 900 mg/day* *Quantity limit = 18 ml/day* Abilify® Discmelt (aripiprazole) *FDA maximum recommended dose = 30 mg/day,* *Quantity limit = 2 tabs/day (10 mg & 15 mg tabs)* clozapine orally disintegrating tablets† (Compare to FazaClo®) *FDA maximum recommended dose = 900 mg/day* FazaClo® (clozapine orally disintegrating tablets) *FDA maximum recommended dose = 900 mg/day* Olanzapine orally disintegrating tablets† (compare to Zyprexa Zydis®) *FDA maximum recommended dose = 20 mg/day,* *Quantity limit = 1.5 tabs/day (5 mg & 10 mg tabs)* Risperdal® M-Tab (risperidone orally disintegrating tablets) *FDA maximum recommended dose = 16 mg/day* Risperidone† ODT (compare to Risperdal® M-Tab) *FDA maximum recommended dose = 16 mg/day* Zyprexa Zydis® (olanzapine orally disintegrating tablets) *FDA maximum recommended dose = 20 mg/day,* *Quantity limit = 1.5 tabs/day (5 mg & 10 mg tabs)*	the generic equivalent. **Clozapine:** patient has been started and stabilized on the requested medication. (Note samples are not considered adequate justification for stabilization) OR medication is being requested for one of the target symptoms or patient diagnoses listed above AND patient has had a documented side effect, allergy or treatment failure with at least three other antipsychotic medications (typical or atypical antipsychotics), two of which are preferred after clinical criteria are met products (see tables) **Seroquel XR:** patient has been started and stabilized on the requested medication. (Note samples are not considered adequate justification for stabilization) OR medication is being requested for one of the target symptoms or patient diagnoses listed above AND patient has not been able to be adherent to a twice daily dosing schedule of quetiapine immediate release resulting in a significant clinical impact. **Abilify:** patient has been started and stabilized on the requested medication. (Note samples are not considered adequate justification for stabilization) OR indication or use is treatment of autism with aggression and/or irritability, intellectual disability with aggression and/or irritability or Tourette's syndrome/tics (motor or vocal) AND tha patient has had a documented side effect, allergy or treatment failure with risperidone OR indication or use is treatment of autism with aggression and/or irritability, intellectual disability with aggression and/or irritability or Tourette's syndrome/tics (motor or vocal AND the prescriber feels that risperidone would not be an appropriate alternative for the patient because of pre-existing medical conditions such as obesity or diabetes. OR medication is being requested for one of the other target symptoms or patient diagnoses listed above. AND patient has had a documented side effect, allergy or treatment

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		failure with at least two preferred after clinical criteria are met products (typical or atypical antipsychoticw) (see table), one of which is risperdone. OR prescriber feels that neither risperidone nor quetiapine would be appropriate alternatives for the patient because of pre-existing medical conditions such as obesity or diabetes. **Abilify Oral Solution:** patient has been started and stabilized on the requested medication (Note: samples are not considered adeequate justification for stabilization), OR medication is being requested for one of the target symptoms or patient diagnoses listed above AND patient has had a documented side effect, allergy or treatment failure with risperidone oral solution OR prescriber feels that risperidone would not be an appropriate alternative for the patient because of pre-existing medical conditions such as obesity or diabetes. **Risperdal:** patient meets clinical criteris for the generic equivalent AND patient has a documented intolerance to the generic product risperidone. **Versacloz Oral Solution:** patient has been started and stabilized on the requested medication (Note: samples are not considered adequate justification for stabilization) OR medication is being requested for one of the target symptoms or patient diagnoses listed above AND patient has had a documented side effect, allergy or treatment failure with at least three other antipsychotic medications (typical or atypical antipsychotics). AND patient is unable to use clozapine orally disintegrating tablets. **Olanzapine ODT, Risperdal M-Tabs, Risperidone ODT, Zyprexa Zydis:** patient meets clinical criteria for non-orally disintegrating oral dosage forms of the same medication AND Medical necessity for a specialty dosage form has been provided AND if the request is for Risperdal M-tabs or Zyprexa Zydis, the patietn has a documented intolerance to the generic equivalent. **Clozapine ODT, FazaClo:** patient has been started and stabilized on any form of

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		the requested medicaton (Note: samples are not considered adequate justification for stabilization) AND Mediccal necessity for a specialty dosage form has been provided OR medication is being requested for one of the target symptoms or patient diagnoses listed above AND patient has had a documented side effect, allergy or treatment failure with at least three other antipsychotic medications (typical or atypical antipsychotics) AND Medical necessity for a specialty dosage form has been provided AND if the request is for a brand product with a generic equivalent, the patient has a documetned intolerance to generic product. **Abilify Discmetl:** patient has been started and stabilized on any form of the rqeusted medication. (Note: samples are not considred adequate justificaton for stabilization) AND Medical necessity for a specialty dosage form has been provided OR medication is being requested for one of the target symptoms or patient diagnoses listed above AND patient has had a documented side effect, allergy or treatment failure with Risperdal M-tab OR prescriber feels that risperidone would not be an appropriate alternative for the patient because of pre-existing medical conditions such as obesity or diabetes AND Medical necessity for a specialty dosage form has been provided. **Limitations:** Approval for use in Children < 18 years old will not be granted for the following medications or dosage forms due to no FDA approval for use in children and little or no literature to support their use in this population. Exceptions will be made for patients who have been started and stabilized on the requested medication or dosage form (Note: samples are not considered adequate justification for stabilization): Fanapt, Latuda, Saphris, Geodon Im, Abilify IM, Olanzapine IM, Zyprexa IM, Abilify Maintena, Invega Sustenna, Risperdal Consta, Zyprexa Relprevv, Symbyax, Olanzapine/fluoxetine.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ANTI-PSYCHOTIC ATYPICAL & COMBINATIONS (CHILDREN ≥ 18 YEARS OLD)		
TABLETS/CAPSULES CLOZAPINE† (compare to Clozaril®) *FDA maximum recommended dose = 900 mg/day* OLANZAPINE† (compare to Zyprexa®) *FDA maximum recommended dose = 20 mg/day,* *Quantity limit = 1.5 tabs/day (2.5 mg, 5 mg, 7.5 mg & 10 mg tabs)* RISPERIDONE† (compare to Risperdal®) *FDA maximum recommended dose = 16 mg/day* QUETIAPINE† (compare to Seroquel®) > 50 mg/day *FDA maximum recommended dose = 800 mg/day* ZIPRASIDONE† (compare to Geodon®) *FDA maximum recommended dose = 160 mg/day*	Abilify® (aripiprazole) *FDA maximum recommended dose = 30 mg/day,* *Quantity limit = 1.5 tabs/day (5 mg, 10 mg & 15 mg tabs)* Clozaril®* *(clozapine)* *FDA maximum recommended dose = 900 mg/day* Fanapt® (iloperidone) *FDA maximum recommended dose = 24 mg/day* *Quantity limit = 2 tablets/day* Geodon®* (ziprasidone) *FDA maximum recommended dose = 160 mg/day* Invega® (paliperidone) *FDA maximum recommended dose = 12 mg/day* *Quantity limit = 1 tab/day (3mg, 9mg), 2tabs/day(6mg)* Latuda® (lurasidone) *FDA maximum recommended dose = 160 mg/day* *Quantity limit = 1 tablet/day all strengths except 80 mg = 2 tablets/day* Quetiapine† (compare to Seroquel®) ≤ 50 mg/day (adults ≥ 18 years old) Risperdal®* (risperidone) *FDA maximum recommended dose = 16 mg/day* Saphris® (asenapine) sublingual tablet *FDA maximum recommended dose = 20 mg/day*	**Fanapt:** The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR The indication for use is the treatment of schizophrenia/schizoaffective disorder or bipolar disorder. AND The patient has had a documented side effect, allergy or treatment failure with at least three preferred products (typical or atypical antipsychotics). **Invega:** patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) (Prior therapy with injectable Invega Sustenna® is not considered to be started and stabilized for oral Invega. Patients transferring to oral therapy from Invega Sustenna® should transition to oral risperidone unless patient previously failed such treatment) OR The indication for use is the treatment of schizophrenia/schizoaffective disorder. AND The patient has had a documented side effect, allergy or treatment failure with at least three preferred products (typical or atypical antipsychotics), one of which is risperidone. **Saphris:** patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) (Prior therapy with injectable Invega Sustenna® is not considered to be started and stabilized for oral Invega. Patients transferring to oral therapy from Invega Sustenna® should transition to oral risperidone unless patient previously failed such treatment) OR The indication for use is the treatment of schizophrenia/schizoaffective disorder. AND The patient has had a documented side effect, allergy or treatment failure with at least three preferred products

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Seroquel® (quetiapine) *FDA maximum recommended dose = 800 mg/day* Seroquel XR® (quetiapine XR) *FDA maximum recommended dose = 800 mg/day* *Quantity Limit = 1 tab/day* *(150 mg & 200 mg tablet strengths), 2 tabs/day (50 mg strength)* ZYPREXA®* (olanzapine) *FDA maximum recommended dose = 20 mg/day,* *Quantity limit = 1.5 tabs/day (2.5 mg, 5 mg, 7.5 mg & 10 mg tabs)* Abilify® (aripiprazole) oral solution *FDA maximum recommended dose = 25 mg/day* Risperdal® (risperidone) oral solution *FDA maximum recommended dose = 16 mg/day* Versacloz® (clozapine) Oral Suspension *FDA maximum recommended dose = 900 mg/day* *Quantity limit = 18 ml/day*	(typical or atypical antipsychotics), one of which is risperidone. **Clozaril, Geodon, Risperdal, Zyprexa:** patient has a documented intolerance to the generic equivalent. **Latuda:** The patient is pregnant and the diagnosis is schizophrenia/schizoaffective disorder or Bipolar I depression. OR The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR The indication for use is schizophrenia/schizoaffective disorder. AND The patient has had a documented side effect, allergy or treatment failure with at least three preferred products (typical or atypical antipsychotics), one of which is ziprasidone. OR The indication for use is schizophrenia/schizoaffective disorder. AND The patient has had a documented side effect, allergy or treatment failure with ziprasidone and the prescriber feels that neither risperidone nor quetiapine would be appropriate alternatives for the patient because of pre-existing medical conditions such as obesity or diabetes. OR The indication for use is Bipolar I depression. AND The patient has had a documented side effect, allergy or treatment failure with generic quetiapine. OR The indication for use is Bipolar I depression. AND The prescriber feels that quetiapine would not be an appropriate alternative for the patient because of pre-existing medical conditions such as obesity or diabetes.
ORAL SOLUTIONS RISPERIDONE† (compare to Risperdal®) oral solution *FDA maximum recommended dose = 16 mg/day*	Abilify® IM (aripiprazole intramuscular injection) *FDA maximum recommended dose = 30 mg/day* Olanzapine† intramuscular injection (compare to Zyprexa® IM) *FDA maximum recommended dose = 30 mg/day* Zyprexa® IM (olanzapine intramuscular injection) *FDA maximum recommended dose = 30 mg/day*	**Quetiapine/Seroquel < or = 50mg/day:** The patient is being prescribed > 50 mg/day with combinations of tablet strengths. OR The indication for use is Adjunct treatment of Major Depressive Disorder (MDD) and the patient has had a documented inadequate response to at least 3 different antidepressants from 2 different classes (SSRI, SNRI, tricyclic and/or Miscellaneous Antidepressant categories). Trazodone dosed at < 150 mg/day would not be considered a trial for

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
SHORT-ACTING INJECTABLE PRODUCTS GEODON® IM (ziprasidone intramuscular injection) *FDA maximum recommended dose = 40 mg/day* **LONG-ACTING INJECTABLE PRODUCTS** **ORALLY DISINTEGRATING TABLETS**	Abilify Maintena® (aripiprazole monohydrate) *FDA maximum recommended dose = 400 mg/month* *Quantity limit = 1 vial/28 days* Invega Sustenna® (paliperidone palmitate) *FDA maximum recommended dose = 234 mg/month* Risperdal® Consta (risperdone microspheres) *FDA maximum recommended dose = 50 mg/14 days* Zyprexa Relprevv® (olanzapine pamoate) *FDA maximum recommended dose = 600 mg/month* *Quantity limit = 1 vial/28 days (405 mg) or 2 vials/month (210 or 300 mg)* Abilify® Discmelt (aripiprazole) *FDA maximum recommended dose = 30 mg/day,* *Quantity limit = 2 tabs/day (10 mg & 15 mg tabs)* clozapine orally disintegrating tablets† (Compare to FazaClo®) *FDA maximum recommended dose = 900 mg/day* FazaClo® (clozapine orally disintegrating tablets) *FDA maximum recommended dose = 900 mg/day* Olanzapine orally disintegrating tablets† (compare to Zyprexa Zydis®) *FDA maximum recommended dose = 20 mg/day,* *Quantity limit = 1.5 tabs/day (5 mg & 10 mg tabs)* Risperdal® M-Tab (risperidone orally disintegrating tablets) *FDA maximum recommended dose = 16 mg/day* Risperidone† ODT (compare to Risperdal® M-Tab) *FDA maximum recommended dose = 16 mg/day* Zyprexa Zydis® (olanzapine orally disintegrating	this indication. OR The indication for use is Adjunct treatment of any anxiety disorder (panic, agoraphobia, social phobia, obsessive-compulsive disorder, PTSD, Acute Stress Disorder, Generalized Anxiety Disorder) and the patient has had a documented inadequate response to at least 3 different antidepressants from 2 different classes (SSRI, SNRI, tricyclic and/or Miscellaneous Antidepressant categories) or at least 2 antidepressants from the SSRI, SNRI, tricyclic and/or Miscellaneous Antidepressant categories and buspirone. Trazodone dosed at < 150 mg/day and bupropion would not be considered trials for this indication. OR The indication for use is a mental health indication (other than the two above indications or a sleep disorder). AND If the request if for brand Seroquel, the patient has a documented intolerance to generic quetiapine. **Note:** Quetiapine in doses of < 50 mg/day will not be approved for indications of insomnia, for sleep or as a hypnotic. **Seroquel XR:** The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR The indication for use is schizophrenia/schizoaffective disorder or bipolar disorder (bipolar mania, bipolar depression, bipolar maintenance). OR The indication for use is Adjunct treatment of Major Depressive Disorder (MDD) and the patient has had a documented inadequate response to at least 3 different antidepressants from 2 different classes (SSRI, SNRI, tricyclic and/or Miscellaneous Antidepressant categories). Trazodone dosed at < 150 mg/day would not be considered a trial for this indication. OR The indication for use is Adjunct treatment of any anxiety disorder (panic, agoraphobia, social phobia, obsessive-compulsive disorder, PTSD, Acute Stress Disorder, Generalized Anxiety Disorder) and the patient has had a documented inadequate response to at least 3 different antidepressants from 2 different

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	tablets) *FDA maximum recommended dose = 20 mg/day, Quantity limit = 1.5 tabs/day (5 mg & 10 mg tabs)* olanzapine/fluoxetine† (compare to Symbyax®) *FDA maximum recommended dose = 18 mg/75 mg (per day)* Symbyax® (olanzapine/fluoxetine) *FDA maximum recommended dose = 18 mg/75 mg (perday)*	classes (SSRI, SNRI, tricyclic and/or Miscellaneous Antidepressant categories) or at least 2 antidepressant from the SSRI, SNRI, tricyclic and/or Miscellaneous Antidepressant categories and buspirone. Trazodone dosed at < 150 mg/day and bupropion would not be considered trials for this indication. AND The patient has not been able to be adherent to a twice daily dosing schedule of quetiapine immediate release resulting in a significant clinical impact **Abilify:** The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR The indication for use is schizophrenia/schizoaffective disorder or bipolar disorder. AND The patient has had a documented side effect, allergy or treatment failure with at least three preferred products (typical or atypical antipsychotics) OR The patient has had a documented side effect, allergy or treatment failure with ziprasidone and the prescriber feels that neither risperidone nor quetiapine would be appropriate alternatives for the patient because of pre-existing medical conditions such as obesity or diabetes. OR The indication for use is Adjunct treatment of Major Depressive Disorder (MDD) and the patient has had a documented inadequate response to at least 3 different antidepressants from 2 different classes (SSRI, SNRI, tricyclic and/or Miscellaneous Antidepressant categories). Trazodone dosed at <150 mg/day would not be considered a trial for this indication. OR The indication for use is Adjunct treatment of any anxiety disorder (panic, agoraphobia, social phobia, obsessive- compulsive disorder, PTSD, Acute Stress Disorder, Generalized Anxiety Disorder) and the patient has had a documented inadequate response to at least 3 different antidepressants from 2 different classes (SSRI, SNRI, tricyclic and/or Miscellaneous Antidepressant categories) or at least 2 antidepressant from the SSRI, SNRI, tricyclic and/or Miscellaneous Antidepressant categories and buspirone. Trazodone dosed at <150 mg/day and bupropion would not be considered trials

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		for this indication. AND The patient has had a documented side effect, allergy or treatment failure with one preferred atypical antipsychotic product being used as adjunctive therapy. OR The indication for use is treatment of aggression, psychosis, or agitation secondary to Alzheimer's disease or other dementias AND the patient has had a documented side effect, allergy or treatment failure with two preferred products (typical or atypical antipsychotics). (Note: Please consider FDA Black Box Warning) OR The indication or use is treatment of irritability associated with autistic disorder AND the patient has had a documented side effect, allergy or treatment failure with risperidone. OR The indication or use is treatment of Tourette's syndrome AND the patient has had a documented side effect, allergy or treatment failure with guanfacine or clonidine and also risperidone. **Abilify Oral Solutions:** The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR The indication for use is Adjunct treatment of Major Depressive Disorder (MDD) and the patient has had a documented inadequate response to at least 3 different antidepressants from 2 different classes (SSRI, SNRI, tricyclic and/or Miscellaneous Antidepressant categories). Trazodone dosed at < 150 mg/day would not be considered a trial for this indication. OR The indication for use is Adjunct treatment of any anxiety disorder (panic, agoraphobia, social phobia, obsessive-compulsive disorder, PTSD, Acute Stress Disorder, Generalized Anxiety Disorder) and the patient has had a documented inadequate response to at least 3 different antidepressants from 2 different classes (SSRI, SNRI, tricyclic and/or Miscellaneous Antidepressant categories) or at least 2 antidepressant from the SSRI, SNRI, tricyclic and/or Miscellaneous Antidepressant categories and buspirone. Trazodone dosed at <150 mg/day and bupropion would not be considered trials for this indication. AND The patient

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		has had a documented side effect, allergy or treatment failure with preferred risperidone oral solution being used as adjunctive therapy. OR The indication for use is schizophrenia/schizoaffective disorder or bipolar disorder. OR The indication for use is treatment of aggression, psychosis, or agitation secondary to Alzheimer's disease or other dementias. (Note: Please consider FDA Black Box Warning) OR The indication or use is treatment of irritability associated with autistic disorder. OR The indication or use is treatment of Tourette's syndrome AND the patient has had a documented side effect, allergy or treatment failure with guanfacine or clonidine. AND The patient has had a documented side effect, allergy or treatment failure with preferred risperidone oral solution. **Risperdal Oral Solution:** The patient has a documented intolerance to the generic product risperidone. **Versacloz Oral Solution**: The patient has a medical necessity for a non-solid oral dosage form and is unable to use clozapine orally disintegrating tablets. **NON-PREFERRED SHORT-ACTING INJECTABLE PRODUCTS**: Medical necessity for a specialty dosage form has been provided. AND The patient has had a documented side effect, allergy, or treatment failure with Geodon IM. In addition, for approval of Zyprexa® IM, the patient must have had a documented intolerance to generic olanzapine IM. **Risperdal Consta Inj:** The patient has been started and stabilized on the medication OR Medical necessity for a specialty dosage form has been provided (non-compliance with oral medications) AND Tolerability has been established previously with oral risperidone. **Invega Sustenna Inj:** The patient has been started and stabilized on the medication OR Medical necessity for a specialty dosage form has been provided (non-compliance with oral medications) AND Tolerability has been established previously with oral/injectable risperidone or oral paliperidone.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
COMBINATION PRODUCTS		**Zyprexa Relprevv:** The patient has been started and stabilized on the medication OR Medical necessity for a specialty dosage form has been provided (non-compliance with oral medications) AND Tolerability has been established previously with oral olanzapine. **Abilify Maintena:** The patient has been started and stabilized on the medication OR Document clinically compelling information supporting the choice of a non-preferred agent on a General Prior Authorization Request Form. Document clinically information supporting the prescribing of Quetiapine in doses of < 50 mg/day on a Quetiapine Prior Authorization Request Form. Medical necessity for a specialty dosage form has been provided (non-compliance with oral medications) AND Tolerability has been established previously with oral aripiprazole for at least 2 weeks. **ORALLY DISINTEGRATING TABLETS:** Medical necessity for a specialty dosage form has been provided. AND If the request is for FazaClo, Risperdal M-Tab or Zyprexa Zydis, the patient has a documented intolerance to the generic equivalent. **COMBINATION PRODUCTS:** The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR The patient has had a documented side effect, allergy or treatment failure with two preferred products (ziprasidone, risperidone, and quetiapine). OR The prescriber provides a clinically valid reason for the use of the requested medication. AND If the request is for brand product, the patient has a documented intolerance to the generic product.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ANTI-PSYCHOTIC: TYPICALS		
ORAL TABLETS/CAPSULES CHLORPROMAZINE† (formerly Thorazine®) FLUPHENAZINE† (formerly Prolixin®) HALOPERIDOL† (compare to Haldol®) LOXAPINE† (compare to Loxitane®) NAVANE® (thiothixene) (20 mg ONLY) PERPHENAZINE† (formerly Trilafon®) THIORIDAZINE† (formerly Mellaril®) THIOTHIXENE† (compare to Navane®) TRIFLUOPERAZINE† (formerly Stelazine®) **LONG ACTING INJECTABLE PRODUCTS** FLUPHENAZINE DECANOATE† (formerly Prolixin® decanoate) HALOPERIDOL DECANOATE † (compare to Haldol® decanoate)	Haldol®* (haloperidol) Loxitane®* (loxapine) Navane®* (thiothixene) 2 mg, 5 mg, 10 mg Haldol® decanoate* (haloperidol decanoate)	**Criteria for Approval** **Oral:** patient has had a documented side effect, allergy or treatment failure with at least two preferred products (If a product has an AB rated generic, one trial must be the generic) **Long Acting Injectable Products:** for approval of haldol deconaoate, the patient has a documented intolerance to the generic product.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
BONE RESORPTION INHIBITORS		
ORAL BISPHOSPHONATES TABLETS/CAPSULES ALENDRONATE† (compare to Fosamax®)	Actonel® (risedronate) Altelvia (risedronate) Delayed Release Tablet *(Quantity Limit = 4 tablets/28 days)* Binosto® (alendronate) 70 mg effervescent tablet *(Quantiy Limit=4 tablets/28 days)* Boniva® (ibandronate) *(Quantity Limit = 150 mg tablet/1 tablet per 28 days)* Didronel® (etidronate) Etidronate† (compare to Didronel®) Fosamax®* (alendronate) Fosamax Plus D® (alendronate/vitamin D) Ibandronate† (compare to Boniva®) *(Quantity Limit = 150 mg tablet/1 tablet per 28 days)* Risedronate† (compare to Actonel®) Skelid® (tiludronate) Boniva® Injection (ibandronate) *(QL = 3 mg/3 months (four doses)/year)* ibandronate Injection† (compare to Boniva®) *(QL=3 mg/3 months (four doses)/year)*	**Actonel, Risedronate:** patient has a diagnosis/indication of Paget's Disease AND patient has had a documented side effect, allergy, or treatment failure (at least a six-month trial) to generic alendronate OR patient has a diagnosis/indication of postmenopausal osteoprosis, osteoprosis in men or glucocorticoid induced osteoporosis AND patient has had a documented side effect, allergy, or treatment failure (at least a 1 year trial) to generic alendronate. Treatment failure is defined as documented continued bone loss or fracture after one or more years despite treatment with an oral bisphosphonate AND if the rqeust is for brand Actonel, the patient has also had a documented intolerance to generic risedronate **Atelvia, Boniva Oral, Ibandronate:** patient has a diagnosis/indication of postmenopausal osteoporosis AND patient has had a documented side effect, allergy or treatment failure (at leas 1 year trial) to generic alendronate. Treatment failure is defined as documented continued bone loss or fracture fter one or more years despite treatmetn with an oral bisphosphonate AND if the request if for brand Boniva oral, the patient has also had a documented intolerance to generic Ibandronate **Binosto:** patient has a diagnosis/indication of postmenopausal osteoporosis or osteoporosis in men. AND prescriber provides documentation of medical necessity for the specialty dosage form (i.e. inability to swallow tablets, dysphagia).
INJECTABLE BISPHOSPHONATES	Reclast® Injection (zoledronic acid) *(Quantity Limit = 5 mg (one dose)/year)*	**Calcitonin Nasal Spray (generic), Fortical, Miacalcin Nasal Spray:** patient is started and stabilized on the requested medicaton. If the request is for generic Calcitonin Nasal Spray, the patient has had a docmented intolerance to brand

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ESTROGEN AGONIST/ANTAGONIST RALOXIFENE† (compare to Evista®) Tablet *(QL=1 tablet/day)* **INJECTABLE RANKL INHIBITOR** **CALCITONIN NASAL SPRAY** **CALCITONIN INJECTION** **PARATHYROID HORMONE INJECTION**	Zoledronic Acid Injection† (compare to Reclast®) *(QL=5 mg (one dose)/year)* Evista® (raloxifene) Tablet *(QL = 1 tablet/day)* Prolia® Injection (denosumab) *(QL=60 mg/6 months (two doses)/year)* Xgeva® (denosumab) *(QL=120 mg/28 days)* Calcitonin† Nasal Spray (compare to Miacalcin®) Fortical®† (calcitonin) Miacalcin® (calcitonin) Miacalcin® (calcitonin) Forteo® (teriparatide) *(Quantity Limit = 1 pen (3 ml)/28 days)* *(Lifetime max duration of treatment = 2 years)*	Miacalcin. Note: Calcitonin Nasal Spray (brand and generic) no longer recommended for osteoporosis. **Miacalcin Injection:** patient has a diagnosis/indication of Paget's Disease **Evista Tablets:** patient has had a documented intolerance to generic raloxifene. **Fosamax Tablets:** patient has had a documented iintolerance to generic alendronate. **Fosamax Plus D:** there is a clinical reason why the patient is unable to take generic alendronate and vitamin D seperately. **Didronel, Etidronate, Skelid:** patient has a diagnosis/indication of Paget's Disease AND patient has had a documented side effect, allergy, treatment failure (at least a six-month trial) to generic alendronate. If a medication has an AB rated generic, there must have also been a trial of the generic formulation. **Forteo:** patient has a diagnosis/indication of postmenopausal osteoporosis in females, primary or hypogoandal osteoporosis in males or glucocorticoid induced osteoporosis AND patient has had a documented side effect, allergy, or treatment failure to an oral bisphosphonate. Treatmetn failure is defined as documented continued bone loss or fracture after one or more years despite treatment with an oral bisphosphonate. AND prescriber has verified taht the patient has been counseled about osteosarcoma risk AND the quantity requested does not exceed 1 pen (3ml) per 28 days with a lifetime maximum duration of treatment of 2 years. **Boniva Injection, Ibandronate Injection:** patient has a diagnosis/indication of postmenopausal osteoprosis AND patient has had a documented side effect or treatment failure to a preferred bisphosphonate. Treatment failure is defined as documented continued bone loss or fracture after one or more years despite treatment with an oral bisphosphonate AND quantity requested does not exceed

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		four (4) 3mg doses per year. **Prolia Injection:** diagnosis or indication is osteopenia in men at high risk for fracture receiviing androgen deprivation therapy for nonmetastatic prostate cancer OR diagnosis or indication is osteopenia in women at high risk for fracture receiving adjuvant aromatase ingibitor therapyp for breast cancer OR patient has a diagnosis/indication of postmenopausal osteoporosis AND patient has had a documented side effect, allergy, or treatment failure to a preferred bisphosphonate. Treatment failure is defined as documented continued bone loss or fracture after one or mroe years despite treatment with an oral bisphosphonate AND quantity requested does not exceed 1 syringe per 6 months. **Reclast Injection, Zoledronic Acid Injection:** patient has a diagnosis/indication of Paget's disease of bone OR patient has a diagnosis/indication of postmenopausal osteoporosis OR patient is male with a diagnosis of osteoporosis OR patient has a diagnosis of glucocorticoid induced osteoporosis AND patient has had a documented side effect or treatment failure to a preferred bisphosphonate. Treatment failure is defined as documented continued bone loss or fracture after one or more years despite treatment with an oral bisphosphonate AND quantity requested dose not exceed a single 5mg dose per year AND if the reclast, the patient has a documented intolerance to generic zoledronic acid injection. **Xgeva Injection:** diagnosis or indication is bone metastases from solid tumors (e.g. prostate, breast, thyroid, non-small lung cancer)

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
BOTULINUM TOXINS		
	BOTOX® (onabotulinumtoxinA) Myobloc® (rimabotulinumtoxinB) **Available after a BOTOX® trial for select indications:** Dysport® (abobotulinumtoxinA) Xeomin® (incobotulinumtoxinA)	**BOTOX (onabotulinumtoxinA):** The indication for use is: o Strabismus and blepharospasm associated with dystonia, including essential blepharospasm, VII cranial nerve disorders/hemifacial spasm o Focal dystonias, including cervical dystonia, spasmodic dysphonia, oromandibular dystonia o Limb spasticity (e.g., due to cerebral palsy, multiple sclerosis, or other demyelinating CNS diseases) o Focal spasticity (e.g., due to hemorrhagic stroke, anoxia, traumatic brain injury) o Axillary Hyperhidrosis (if member has failed an adequate trial of topical therapy) o Overactive bladder or detrusor overactivity (if member has failed an adequate trial of at least TWO urinary antispasmodics (either short- or long-acting formulations) o Chronic migraine (>15 days per month with headache lasting 4 hours a day or longer) and the member has failed or has a contraindication to an adequate trial of at least TWO medications for migraine prophylaxis from at least two different classes (tricyclic antidepressants, beta-blockers, calcium channel blockers or anticonvulsants). For re-approval after 3 months, the patient must have had an improvement in symptoms. AND The patient is >12 years of age if for blepharospasm or strabismus, >16 years of age for cervical dystonia, and >18 years of age for hyperhidrosis, chronic migraine or overactive bladder/detrusor overactivity. **Dysport (abobotulinumtoxinA):** The patient has a diagnosis of cervical dystonia or spasmodic torticollis AND The patient is >18 years of age AND The patient has had a treatment failure with BOTOX. **Myobloc (rimabotulinumtoxinB):** The patient has a diagnosis of focal dystonias, including cervical dystonia, spasmodic dysphonia, oromandibular dystonia AND

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		The patient is >16 years of age **Xeomin (incobotulinumtoxinA):** The patient has a diagnosis of cervical dystonia or blepharospasm. AND The patient is >18 years of age AND The patient has had a documented intolerance or treatment failure with BOTOX. **LIMITATIONS:** Coverage of botulinum toxins will not be approved for cosmetic use (e.g., glabellar lines, vertical glabellar eyebrow furrows, facial rhytides, horizontal neck rhytides, etc.). (BOTOX Cosmetic (onabotulinumtoxinA) is not covered) **IMPORTANT NOTE:** Botulinum neurotoxins are used to treat various disorders of focal muscle spasm and excessive muscle contractions, such as focal dystonias. When injected intramuscularly, botulinum neurotoxins produce a presynaptic neuromuscular blockade by preventing the release of acetylcholine from the nerve endings. As a consequence of the chemistry and clinical pharmacology of each botulinum neurotoxin product, botulinum neurotoxins are not terchangeable, even among same sterotype products. Units of biological activity are unique to each preparation and cannot be compared or converted into units of another. It is important that providers recognize there is no safe dose conversion ratio—i.e., one unit of BOTOX (onabotulinumtoxinA, formerly type A) does not equal one unit of Myobloc (rimabotulinumtoxinB, formerly type B) does not equal one unit of Dysport (abobotulinumtoxinA) does not equal one unit of Xeomin (incobotulinumtoxinA). Failure to understand the unique characteristics of each formulation of botulinum neurotoxin can result in under or over dosage. It is expected that use of these products will be based on each product's individual dosing, efficacy and safety profiles.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
BPH AGENTS		
ALPHA BLOCKERS DOXAZOSIN† (compare to Cardura®) TAMSULOSIN† (compare to Flomax®) *Quantity Limit = 2 capsules/day* TERAZOSIN† (formerly Hytrin®)	alfuzosin ER† (compare to Uroxatral®) Quantity Limit = 1 tablet/dayCardura®* (doxazosin) Cardura XL® (doxazosin) *Quantity Limit = 1 tablet/day* Flomax®* (tamsulosin) *Quantity Limit = 2 capsules/day* Rapaflo® (silodosin) *Quantity Limit = 1 capsule/day* Uroxatral® (alfuzosin) *Quantity Limit = 1 tablet/day*	**Cardura, Cardura XL:** The patient has had a documented side effect, allergy or treatment failure with two alpha blockers, one of which must be generic doxazosin. **Flomax:** The patient has had a documented side effect, allergy or treatment failure with two preferred alpha blockers, one of which must be generic tamsulosin. **alfuzosin ER, Rapaflo, Uroxatral:** The patient has had a documented side effect, allergy or treatment failure with two preferred alpha blockers. In addition, for approval of Uroxatral, the patient must have a documented intolerance to generic alfuzosin ER.
ANDROGEN HORMONE INHIBITORS FINASTERIDE† (compare to Proscar®) *(QL = 1 tablet/day)*	Avodart® (dutasteride) (*QL = 1 capsule/day)* finasteride† (compare to Proscar®) females; males age < 45 *(QL = 1 tablet/day)* Proscar® *(finasteride) *(QL = 1 tablet/day)*	**Avodart:** The patient has a diagnosis of BPH (benign prostatic hypertrophy) AND the patient has a documented side effect, allergy or treatment failure to generic finasteride. **Proscar:** The patient has a diagnosis of BPH (benign prostatic hypertrophy) AND the patient has a documented intolerance to generic finasteride. **Finasteride for males age < 45:** The patient has a diagnosis of BPH (benign prostatic hypertrophy)
COMBINATION PRODUCT	Jalyn® (dutasteride/tamsulosin) (*QL = 1 capsule/day)*	**Jalyn:** The patient has a diagnosis of BPH (benign prostatic hypertrophy) AND the patient has a documented treatment failure/inadequate response to combination therapy with generic tamsulosin and finasteride. **LIMITATIONS:** Coverage of androgen hormone inhibitors will not be approved for cosmetic use in men or women (male-pattern baldness/alopecia or hirsutism). (This includes Propecia (finasteride) and its generic equivalent whose only FDA approved indication is for treatment of male pattern hair loss.) Current clinical

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		guidelines recommend the use of Cialis (tadalafil) only in men with concomitant erectile dysfunction or pulmonary hypertension. Medicaid programs do not receive Federal funding for drugs used in the treatment of erectile dysfunction so Cialis will not be approved for use in BPH.
CARDIAC GLYCOSIDES		
DIGOXIN† DIGOXIN† Oral Solution LANOXIN® (digoxin)		
CHEMICAL DEPENDENCY		
ALCOHOL DEPENDENCY		
ACAMPROSATE† (compare to Campral®) DISULFIRAM† 250 mg, 500 mg tab (compare to Antabuse®)	Antabuse®* (disulfiram) Campral®* (acamprosate) Revia®* (naltrexone oral)	**Alcohol/Opiate Dependency:** Revia, Antabuse, Campral, Vivitrol: The patient has had a documented intolerance to the generic equivalent product OR For Vivitrol, there is documented intolerance to or failure of trial of oral naltrexone.
NALTREXONE oral † (compare to Revia®)	Vivitrol® (naltexone for extended-release injectable suspension) *(QL = 1 injection (380 mg) per 30 days)*	**Alcohol/Opiate Dependency:** Vivitrol: Diagnosis of alcohol dependency AND An inadequate response, adverse reaction, or contraindication to 1 out of 3 oral formulations used for alcohol dependence including: oral naltrexone, acamprosate, and disulfiram OR a compelling clinical reason for use (e.g. multiple hospital admissions for alcohol detoxification) AND Patient should be opiate free for > 7 – 10 days prior to initiation of Vivitrol OR Diagnosis is prevention of relapse to opioid dependency AND The patient has failed

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		buprenorphine/buprenorphine-naloxone/Suboxone therapy or is not a candidate for buprenorphine/buprenorphine-naloxone/Suboxone therapy (eg. Patient is opiate free and prescriber wishes to prevent relapse to opioid dependence without using maintenance therapy) or patient requires injectable therapy (compliance, tolerance, etc). AND Patient should be opiate free for > 7 – 10 days prior to initiation of Vivitrol ALSO Available only through the Pharmacy Benefit (J-Code 2315 blocked from Medical Benefit) from a pharmacy provider that will deliver directly to the physician's office (Medicare Part B to be billed first if applicable)
OPIATE DEPENDENCY		
NALTREXONE oral † (compare to Revia®) **Preferred Agent after Clinical Criteria are Met** SUBOXONE® sublingual FILM (buprenorphine/nalaxone) *QL = 2 films per day (8 mg strength), 3 films per day (2 mg strength)or* *1 film per day (4 mg and 12 mg strengths)* *(Maximum daily Dose = 16 mg/day)* ***Maximum days supply for Suboxone is 14 days*** Note: Methadone for opiate dependency can only be prescribed through a Methadone Maintenance	buprenorphine† sublingual TABLET(formerly Subutex®) *QL = 3 tablets per day (2 mg strength) or 2 tablets/day (8 mg strength)* *(Maximum Daily Dose = 16 mg/day)* Revia®* (naltrexone oral) buprenorphine/nalaxone† (formerly Suboxone®) sublingual TABLET *QL = 2 tablets per day (8 mg strength) or 3 tablets per day (2 mg strength)* *(Maximum daily Dose = 16 mg/day)* Bunavail® (*QL= 1film per day(2.1/0.3mg, 6.1/1mg), 2films per day (4.2/0.7mg)* Zubsolv® *(QL=1 film per day of all strengths)* **Maximum days supply for buprenorphine/naloxone or buprenorphine is 14 days** **For Prevention of Relapse to Opioid Dependency**	**Opiate Dependency:** Suboxone, Buprenorphine/Naloxone, Buprenorphine: Diagnosis of opiate dependence confirmed (will not be approved for alleviation of pain). AND Prescriber has an DATA 2000 waiver ID number ("X-DEA license") in order to prescribe AND A "Pharmacy Home" for all prescriptions has been selected (Pharmacy located or licensed in VT) AND Requests for Buprenorphine/Naloxone SL tablet, Bunavail or Zubsolv after documented intolerance of Suboxone Film must include a completed MedWatch form that will be submitted by DVHA to the FDA. AND If buprenorphine (formerly Subutex) is being requested, Patient is either pregnant and history (copy of positive pregnancy test) has been submitted (duration of PA will be one 1 month post anticipated delivery date) OR Patient is breastfeeding a methadone or morphine dependent baby and history from the neonatologist or pediatrician has been submitted.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
Clinic	Vivitrol® (naltrexone for extended-release injectable suspension) (QL = 1 injection (380 mg) per 30 days)	
CONSTIPATION: CHRONIC, IBS-C OR OPIOID INDUCED		
Bulk-Producing Laxatives PSYLLIUM† **Osmotic Laxatives** LACTULOSE† POLYETHYLENE GLYCOL 3350 (PEG)† (compare to Miralax®) **Stimulant Laxative** BISACODYL† SENNA† **Stool Softener** DOCUSATE†	Amitiza® (lubiprostone) *(Qty Limit = 2 capsules/day)* Linzess® (linaclotide) *(Qty limit = 1 capsule/day)* Relistor® (methylnatrexone)	**Amitiza:** The patient has a diagnosis of chronic idiopathic constipation (CIC) (24 mcg capsules) OR The patient is a woman and has a diagnosis of irritable bowel syndrome with constipation (IBS-C) (8 mcg capsules) AND The patient has had documented treatment failure to lifestyle and dietary modification (increased fiber and fluid intake and increased physical activity). AND The patient has had documented side effect, allergy or treatment failure to a 1 week trial each of at least 2 preferred laxatives from the Bulk-Producing Laxative or Osmotic Laxative categories (see below). **Linzess:** The patient is 18 years of age or older. AND The patient has a diagnosis of chronic idiopathic constipation (CIC) (145 mcg capsules) OR The patient has a diagnosis of irritable bowel syndrome with constipation (IBS-C) (290 mcg capsules) AND The patient has had documented treatment failure to lifestyle and dietary modification (increased fiber and fluid intake and increased physical activity). AND The patient has had documented side effect, allergy or treatment failure to a 1 week trial each of at least 2 preferred laxatives from the Bulk-Producing Laxative or Osmotic Laxative categories (see below). **Relistor:** The patient must have documented opioid-induced constipation and be receiving palliative care AND The patient must have had documented treatment failure to a 1 week trial of at least 2 preferred laxatives from 2 different laxative classes (see below) used in combination.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
CONTRACEPTIVES: VAGINAL RING		
NUVARING® (etonogestrel/ethinyl estradiol vaginal ring)		
CORONARY VASODILATORS/ANTIANGINALS		
ORAL		
ISOSORBIDE DINITRATE† tablet(compare to Isordil®) ISOSORBIDE DINITRATE† ER tablet ISOSORBIDE MONONITRATE† tablet (compare to Ismo®,Monoket®) ISOSORBIDE MONONITRATE† ER tablet (compare to Imdur®) NITROGLYCERIN† SL tablet NITROGLYCERIN† ER capsule NITROLINGUAL PUMP SPRAY® NITROGLYCERIN SPRAY LINGUAL† (compare to Nitroglycerin	Dilatrate-SR® (isosorbide dinitrate SR capsule) Imdur®* (isosorbide mononitrate ER tablet) Ismo®* (isosorbide mononitrate tablet) Isosorbide dinitrate SL tablet Isordil®* (isosorbide dinitrate tablet) Monoket®* (isosorbide mononitrate tablet) BiDil® (isosorbide dinitrate/hydralazine) Ranexa® (ranolazine) *(Quantity Limit = 3 tablets/day (500 mg), 2 tablets/day (1000 mg)))*	**Dilatrate-SR, Imdur:** The patient has had a side effect, allergy, or treatment failure to at least two of the following medications: isosorbide dinitrate ER tablet, isosorbide mononitrate ER tablet, nitroglycerin ER capsule or Nitro-time. If a product has an AB rated generic, one trial must be the generic formulation. **Ismo, Isordil, Monoket, Isosorbide dinitrate SL tablet:** The patient has had a side effect, allergy, or treatment failure to at least two of the following medications: isosorbide dinitrate tablet or isosorbide mononitrate tablet. If a product has an AB rated generic, one trial must be the generic formulation **Bidil:** The prescriber provides a clinically valid reason why the patient cannot use isosorbide dinitrate and hydralazine as separate agents. **Ranexa:** The patient has had a diagnosis/indication of chronic angina. AND The

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
Pump Spray®) NITROMIST® Lingual Spray NITROQUICK® (nitroglycerin SL tablet) NITROSTAT® (nitroglycerin SL tablet) NITRO-TIME® (nitroglycerin ER capsule)		patient has had a documented side effect, allergy, or treatment failure with at least one medication from two of the following classes: beta-blockers, maintenance nitrates, or calcium channel blockers. AND The patient does not have any of the following conditions: Hepatic insufficiency, Concurrent use of medications which may interact with Ranexa: CYP450 3A4 inducers (rifampin, rifabutin, rifapentin, phenobarbital, phenytoin, carbamazepine, St.John's wort) CYP450 3A4 inhibitors (diltiazem, verapamil, ketoconazole, protease inhibitors, grapefruit juice, macrolide antibiotics) Note: doses of digoxin or drugs metabolized by CYP450 2D6 (TCAs, some antipsychotics) may need to be adjusted if used with Ranexa. AND The dose requested does not exceed 3 tablets/day (500 mg) or 2 tablets/day (1000 mg).
TOPICAL		
NITREK® (nitroglycerin transdermal patch) NITRO-BID® (nitroglycerin ointment) NITROGLYCERIN TRANSDERMAL PATCHES† (compare to Nitro-Dur®)	Nitro-Dur®* (nitroglycerin transdermal patch)	**Nitro-Dur:** patient has had a side effect, allergy, or treatment failure to Nitrek or generic nitroglycerin transdermal patches.
CORTICOSTEROIDS: ORAL		
CORTISONE ACETATE tablets DEXAMETHASONE† tablets, elixir, intensol, solution	Celestone® (betamethasone) oral solution Cortef®* (hydrocortisone) tablets Flo-Pred® (prednisolone acetate) oral suspension	**Rayos:** The patient has had a trial of generic immediate release prednisone and has documented side effects that are associated with the later onset of activity of immediate release prednisone taken in the morning.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
DEXPAK® tabs (dexamethasone taper pack) HYDROCORTISONE† tab (compare to Cortef®) MEDROL® (methylprednisolone) 2mg tablets METHYLPREDNISOLONE† (compare to Medrol®) tabs METHYLPREDNISOLONE DOSE PACK† (compare to Medrol Dose Pack®) tabs ORAPRED® ODT (prednisolone sod phosphate) (age < 12 yrs) PREDNISOLONE† 3 mg/ml oral solution, syrup (compare to Prelone®) PREDNISOLONE SODIUM PHOSPHATE† 3 mg/ml oral solution (compare to Orapred®) PREDNISOLONE SOD PHOSPHATE ORAL SOLUTION† 6.7mg/5ml (5mg/5ml base) (compare to Pediapred®) PREDNISONE† intensol, solution, tablets	Medrol®* (methylprednisolone) tablets Medrol Dose Pak®* (methylprednisolone) tabs Millipred® (prednisolone) tablets Millipred® (prednisolone sodium phos) oral solution Millipred DP® (prednisolone) dose pack tablets Orapred®* oral solution* (prednisolone sod phos) Orapred® ODT (prednisolone sod phos) (age ≥ 12 yrs) Pediapred®* (prednisolone sod phosphate) oral solution prednisolone sodium phosphate oral solution 25 mg/5ml Rayos® (prednisone) Delayed Release Tablet *(Quantity limit = 1 tablet/day)* Veripred® 20 oral solution (prednisolone sodium phosphate)	**All Others:** The patient has been started and stabilized on the requested medication. OR The patient has a documented side effect, allergy, or treatment failure to at least two preferred medications. If a product has an AB rated generic, one trial must be the generic formulation.
COUGH AND COLD PREPARATIONS		
All generics MUCINEX ® (guaifenesin)	Hydrocodone/chlorpheniramine (compare to Tussionex®) *(QL = 60 ml/RX)*	**Tussionex, TussiCaps, Hydrocodone/chlorpheniramine suspension (generic):** The patient has had a documented side effect, allergy, or treatment failure to two

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Tussionex® (hydrocodone/chlorpheniramine) *(QL = 60 ml/RX)* TussiCaps® (hydrocodone/chlorpheniramine) *(QL = 12 capsules/RX)* All other brands	of the following generically available cough or cough/cold products: hydrocodone/homatropine (compare to Hycodan), promethazine/codeine (previously Phenergan with Codeine), guaifenesin/codeine (Cheratussin AC) or benzonatate. AND patient is 6 years old of age or greater. AND The quantity requested does not exceed 60 ml (Tussionex) or 12 capules (TussiCaps). AND If the request is for Tussionex, the patient has a documented intolerance to generic hydrocodone/chlorpheniramine suspension. **All Other Brands:** The prescriber must provide a clinically valid reason for the use of the requested medication including reasons why any of the generically available preparations would not be a suitable alternative.
CYSTIC FIBROSIS MEDICATIONS		
	Cayston® (aztreonam) inhalation solution (Quantity Limit = 84 vials/56 days; maximum days supply = 56 days) (3 vials/day for 28 days, then 28 days off) Bethkis® (tobramycin) inhalation solution (Quantity Limit = 56 vials/56 days; maximum days' supply = 56 days) (2 vials/day for 28 days, then 28 days off) Kalydeco® (ivacaftor) tablets (Quantity Limit = 2 tablets/day, maximum days' supply = 30 days)	**Bethkis, Cayston, Pulmozyme, TOBI, tobramycin inhalation solution, TOBI Podhaler:** The diagnosis or indication is cystic fibrosis.AND For approval of Bethkis or generic tobramycin inhalation solution, the patient has a documented intolerance to branded TOBI. **Kalydeco:** The patient has a diagnosis of Cystic Fibrosis. AND Patient has one of the following mutations on at least one allele in the cystic fibrosis transmembrane conductance regulator gene: G551D, G1244E, G1349D, G178R, G551S, S1251N, S1255P, S549N, or S549R (documentation provided). AND The patient is > 6 years old. Note: Renewal of Prior Authorization will require documentation of member response.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Pulmozyme® (dornase alfa) inhalation solution (Quantity Limit =60/30 days; maximum days supply=30 days) TOBI® (tobramycin) Podhaler Capsules for inhalation (Quantity Limit = 224 capsules/56 days; maximum days' supply = 56 days) (4 capsules twice daily for 28 days, then 28 days off) TOBI® (tobramycin) inhalation solution (Quantity Limit = 56 vials/56 days; maximum days supply = 56 days) (2 vials/day for 28 days, then 28 days off) Tobramycin inhalation solution† (compare to Tobi®) (Quantity Limit = 56 vials/56 days; maximum days' supply = 56 days)(2 vials/day for 28 days, then 28 days off)	
DERMATOLOGICAL AGENTS		
ACTINIC KERATOSIS THERAPY		
ALDARA® (imiquimod) 5 % Cream	Diclofenac Sodium 3 % Gel (compare to Solaraze®)	**Imiquimod (generic) cream:** The patient has had a documented intolerance to

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
FLUOROURACIL† (compare to Efudex®) 5% cream, 5%, 2% solution FLUOROURACIL (compare to CARAC®) 0.5% cream CARAC® (fluorouracil) 0.5% cream FLUOROPLEX® (fluorouracil) 1% cream *C=cream, F=foam, G=gel, L=lotion, O=ointment, S=solution*	*Qty Limit = 1 tube/30 days* Efudex®* (fluorouracil) 5% cream, solution Imiquimod† (compare to Aldara®) 5 % cream Picato® (ingenol mebutate) 0.015 % Gel *Qty Limit = 3 tubes* Picato® (ingenol mebutate) 0.05 % Gel *Qty Limit = 2 tubes* Solaraze® (diclofenac sodium) 3 % Gel *Qty Limit = 1 tube/30 days* Zyclara (imiquimod) 3.75 % Cream *Qty Limit = 56 packets/6 weeks* Zyclara (imiquimod) 2.5%, 3.75 % Cream Pump *Qty Limit = 2 pumps/8 weeks*	brand Aldara **Efudex:** The patient has had a documented intolerance with generic topical fluorouracil 5% cream or solution **Picato:** The diagnosis or indication is actinic keratosis AND The patient has had a documented side effect, allergy, contraindication or treatment failure with a generic topical fluorouracil product. OR The patient has had a documented side effect, allergy, contraindication or treatment failure with preferred brand Aldara **Solaraze Gel, Diclofenac Gel:** The diagnosis or indication is actinic keratosis AND The patient has had a documented side effect, allergy, contraindication or treatment failure with generic topical fluorouracil product. **Zyclara Cream:** The diagnosis or indication is actinic keratosis on the face or scalp AND The patient has had a documented side effect, allergy, or treatment failure with 5-fluorouracil and Aldara or generic imiquimod 5% cream. OR The treatment area is greater than 25 cm2 on the face or scalp. AND The patient has had a documented side effect, allergy, or treatment failure with 5-fluorouracil.
ANTIOBIOTICS TOPICAL		
Single Agent BACITRACIN† MUPIROCIN OINTMENT† (compare to Bactroban®) **Combination Products** BACITRACIN-POLYMYXIN†	Altabax® (retapamulin) *QL = 1 tube* Bactroban® (mupirocin) Cream Bactroban®* (mupirocin) Ointment Centany® Ointment (mupirocin) Gentamicin Cream or Ointment Mupirocin cream† (compare to Bactroban®)	**Altabax:** The patient is being treated for impetigo. AND The patient has had a documented side effect, allergy, or treatment failure with mupirocin ointment AND MRSA (methicillin resistant staph aureus) has been ruled out by culture **Bactroban Cream or Ointment, mupirocin cream, Centany Ointment:** The patient has had a documented intolerance with generic mupirocin ointment AND If the request is for brand Bactroban Cream, the patient has also had a documented intolerance to the generic equivalent. **Cortisporin Cream or Ointment, Gentamicin Cream or Ointment:** The patient has had a documented side-effect, allergy or treatment failure with at least one

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
NEOMYCIN-BACITRACIN-POLYMYXIN† Note: Bactroban® Nasal Ointment is not included in this managed category *C=cream, F=foam, G=gel, L=lotion, O=ointment, S=solution*	Cortisporin® Cream (neomycin-polymyxin-hydrocortisone) Cortisporin® Ointment(bacitracin-neomycin-polymyxin-hydrocortisone) Neosporin®* (neomycin-bacitracin-polymyxin) Polysporin®* (bacitracin-polymixin) **All other branded products**	preferred generic topical antibiotic **Neosporin/ Polysporin:** The patient has had a documented intolerance with a generic equivalent of the requested medication
ANTIFUNGALS: ONYCHOMYCOSIS		
	Ciclopirox † 8 % solution (compare to Penlac® Nail Lacquer) QL =6.6 ml/90 days Penlac® Nail Lacquer (ciclopirox 8 % solution) QL = 6.6 ml/90 Kerydin® Jublia® QL=48 weeks treatment	**Ciclopirox, Jublia, Kerydin, Penlac Sol:** The patient meets at least 1 of the following criteria: Pain to affected area that limits normal activity, Diabetes Mellitus, Patient is immunocompromised, Patient has diagnosis of systemic dermatosis, Patient has significant vascular compromise **LIMITATIONS:** Coverage of Onychomycosis agents will NOT be approved solely for cosmetic purposes. Kits with multiple drug products or non-drug items not covered. **Jublia/Kerydin/Penlac additional criteria:** Must have a documented intolerance to generic ciclopirox
ANTIFUNGALS: TOPICAL		
Single Agent CICLOPIROX † (compare to Loprox®) 0.77% C, Sus, G; 1%Sh CLOTRIMAZOLE†(formerly Lotrimin®) 1% C, S	Ertaczo® (sertaconazole) 2% C Exelderm® (sulconazole) 1% C, S Extina® (ketoconazole) 2% F Ketoconazole† (compare to Extina®) 2 % Foam Kuric®* (ketoconazole) 2% C	**All Brands (except Vusion):** The patient has had a documented side effect, allergy, or treatment failure to at least TWO different preferred generic topical antifungal agents. (If a product has an AB rated generic, one trial must be the generic equivalent of the requested product.) OR The patient has a contraindication that supports the need for a specific product or dosage form of a brand topical

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ECONAZOLE † (formerly Spectazole®) 1% C KETOCONAZOLE † (compare to Kuric®, Nizoral®) 2% C, 2% Sh MICONAZOLE † all generic/OTC products NYSTATIN † O, C, P (compare to Mycostatin®, Nystop®, Pedi-Dri®, Nyamyc®) TOLNAFTATE † (compare to Tinactin®) 1% C, P, Sp, S **Combination Products** CLOTRIMAZOLE W/BETAMETHASONE † (compare to Lotrisone®) C, L NYSTATIN W/TRIAMCINOLONE † (formerly Mycolog II®) C, O *C=cream, F=foam, G=gel, L=lotion, P=powder, S=solution, Sh=shampoo, Sp=spray, Sus=suspension*	Lamisil RX/OTC® (terbinafine) 1% C, S, Sp, G Loprox®* (ciclopirox) 0.77% C, S, G; 1% Sh Lotrimin AF®* OTC (clotrimazole) 1% C, S, L Luzu® (luliconazole) 1% Cream Mentax®/ Lotrimin Ultra® OTC (butenafine) 1% C Mycostatin®* (nystatin) C, P Naftin® (naftifine) 1% & 2% C, 1%, 2% G Nizoral®* (ketoconazole) 2% Sh Nizoral A-D® OTC (ketoconazole) 1% Sh Nystop®, Pedi-Dri®, Nyamyc®* (nystatin) P Oxistat® (oxiconazole) 1% C, L Tinactin®/Tinactin AT OTC* (tolnaftate) 1% C, P, Sp, S Xolegel® (ketoconazole) 2% G Lotrisone®* (clotrimazole w/betamethasone) C, L Vusion® (miconazole w/zinc oxide) O *(QL=50 g/30 days)* **All other branded products** **Note**: Please refer to "Dermatological: Antifungals: Onychomycosis" for ciclopirox solution and Penlac® Nail Lacquer	antifungal. **Ketoconazole Foam:** The patient has had a documented side effect, allergy, or treatment failure to at least TWO different preferred generic topical antifungal agents. **Vusion:** The patient has a diagnosis of diaper dermatitis complicated by documented candidiasis AND The patient is at least 4 weeks of age. AND The patient has had two trials (with two different preferred antifungal agents) used in combination with a zinc oxide diaper rash product resulting in documented side effects, allergy, or treatment failures. **Limitations:** Foam products (e.g. Ecoza (econazole nitrate)) not covered. Other topical dosage preparations preferred.
ANTIVIRALS: TOPICAL		
ABREVA OTC (docosanol) 10% C *C=cream, O=ointment* Note: See Anti-Infectives: Antivirals: Herpes: Oral for	Acyclovir (compare to Zovirax®) 5 % O Denavir® (penciclovir) 1% C Zovirax® (acyclovir) 5% C, O	**Denavir:** The patient has a diagnosis of oral herpes simplex infection and a failure of both oral antiviral and Abreva OTC. **Acyclovir, Zovirax:** If prescribed for the treatment of oral herpes simplex infection,

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
Sitavig®	Xerese® (acyclovir 5%/hydrocortisone 1%) C	the patient has had a documented side effect, allergy, or treatment failure (at least one course of four or more days) with Denavir. ** Topical antiviral therapy offers minimal clinical benefit in the treatment of genital herpes and its use is discouraged by the CDC so topical antiviral therapy will not be approved for this indication. **
CORTICOSTEROIDS: LOW POTENCY		
ALCLOMETASONE 0.05% C, O† (compare to Aclovate®) DESONIDE† 0.05% C, L, O (compare to DesOwen®) FLUOCINOLONE 0.01% C, S, oil† (compare to Derma-Smoothe, Synalar®) HYDROCORTISONE† 0.5%, 1%, 2.5% C; 1%, 2.5% L, 0.5%, 1%, 2.5% O HYDROCORTISONE ACETATE† 1% C; 1% O (all generics) *C=cream, F=foam, G=gel, L=lotion, O=ointment, S=solution*	Aclovate®* (alclometasone) 0.05% C, O Capex® (fluocinolone) 0.01% shampoo Derma-Smoothe®* (fluocinolone 0.01%) oil Desonate® (desonide) 0.05% G DesOwen®* (desonide) 0.05% C, L, O Nucort 2% lotion (hydrocortisone acetate) Synalar®* (fluocinolone) 0.01% S Verdeso® (desonide) 0.05% F **All other brands**	**CRITERIA FOR APPROVAL (NON-PREFERRED AGENTS):** The patient has a documented side effect, allergy, or treatment failure to at least two different preferred agents of similar potency. (If a product has an AB rated generic, one trial must be the generic.) **LIMITATIONS:** Corticosteroid spray formulations (eg. Topicort Spray) not covered – use alternate dosage forms.
CORTICOSTEROIDS: MEDIUM POTENCY		
BETAMETHASONE DIPROPIONATE† 0.05% L (formerly Diprosome®) BETAMETHASONE VALERATE† 0.1% C, L	Cloderm® (clocortolone) 0.1% C Cordran® (all products)	**CRITERIA FOR APPROVAL (NON-PREFERRED AGENTS):** The patient has a documented side effect, allergy, or treatment failure to at least two different

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
(formerly Beta-Val®) FLUOCINOLONE† 0.025% C, O (compare to Synalar®) FLUTICASONE † 0.05% C; 0.005% O (compare to Cutivate®) HYDROCORTISONE BUTYRATE† 0.1% C, O, S (compare to Locoid®) HYDROCORTISONE VALERATE† 0.2% C, O (compare to Westcort®) MOMETASONE FUROATE† 0.1% C, L, O (compare to Elocon®) TRIAMCINOLONE ACETONIDE† 0.025%, 0.1% C, L, O (formerly Aristocort® or Kenalog®)	Cutivate®*(fluticasone) 0.05% C; 0.005% O Cutivate®(fluticasone) 0.05% L Dermatop® (prednicarbate) 0.1% C, O desoximetasone 0.05% C, O (compare to Topicort®) Elocon®* (all products) fluticasone† (compare to Cutivate®) 0.05%, L Locoid®* (hydrocortisone butyrate) 0.1% C, O, S Locoid® (hydrocortisone butyrate) 0.1% L Luxiq® (betamethasone valerate) F prednicarbate† (compare to Dermatop®) 0.1% C, O Synalar®* (fluocinolone) 0.025% C, O Topicort®* (desoximetasone) 0.05% C, O Trianex®* (triamcinolone) 0.05% O Westcort®* (hydrocortisone valerate) all products **All other brands**	preferred agents of similar potency. (If a product has an AB rated generic, one trial must be the generic.) **LIMITATIONS:** Corticosteroid spray formulations (eg. Topicort®Spray) not covered – use alternate dosage forms.
CORTICOSTEROIDS: HIGH POTENCY		
AUGMENTED BETAMETHASONE† 0.05% C (compare to Diprolene® AF) BETAMETHASONE VALERATE† 0.1% O (formerly Beta-Val®) DESOXIMETASONE† 0.05% G; 0.25% C, O (compare to Topicort®) FLUOCINONIDE† 0.05% C, G, O, S (formerly Lidex®)	Amcinonide† (formerly Cyclocort®) Apexicon E® (diflorasone) 0.05% C Diflorasone diacetate† 0.05% C (compare to Apexicon E®) Diprolene® AF* (augmented betamethasone) 0.05% C Halog® (halcinonide) all products Topicort®* (desoximetasone) 0.05% G; 0.25% C, O	**CRITERIA FOR APPROVAL (NON-PREFERRED AGENTS):** The patient has a documented side effect, allergy, or treatment failure to at least two different preferred agents of similar potency. (If a product has an AB rated generic, one trial must be the generic.) **LIMITATIONS:** Corticosteroid spray formulations (eg. Topicort Spray) not covered – use alternate dosage forms.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
TRIAMCINOLONE ACETONIDE† 0.5% C, O (formerly Aristocort®) *C=cream, F=foam, G=gel, L=lotion, O=ointment, S=solution*	**All other brands**	
CORTICOSTEROIDS: VERY HIGH POTENCY		
ALPHATREX (augmented betamethasone)0.05% G APEXICON (diflorasone) 0.05% O AUGMENTED BETAMETHASONE† 0.05% L, O (compare to Diprolene®) 0.05% G CLOBETASOL PROPIONATE† (compare to Temovate®/Cormax®) CLOBETASOL PROPIONATE† 0.05% F (compare to Olux®) CORMAX (clobetasol propionate) 0.05% C, O, S DIFLORASONE DIACETATE† 0.05% O (compare to Apexicon®, formerly Psorcon E®) HALOBETASOL PROPRIONATE† (compare to Ultravate®) *C=cream, F=foam, G=gel, L=lotion, O=ointment, S=solution*	Clobetasol propionate† (compare to Clobex®) 0.05% L, Sh clobetasol propionate emulsion† (compare to Olux E®) 0.05% F Clobex® (clobetasol propionate) 0.05% L, shampoo, spray Diprolene®* (augmented betamethasone) 0.05% L, O fluocinonide † (compare to Vanos®)0.1% C Olux® * /Olux E® (clobetasol propionate) 0.05% F Temovate®* (clobetasol propionate) 0.05% C, G, O, S Vanos® (fluocinonide) 0.1% C Ultravate®* (halobetasol propionate) 0.05% C, O **All other brands**	**CRITERIA FOR APPROVAL (NON-PREFERRED AGENTS)**: The patient has a documented side effect, allergy, or treatment failure to at least two different preferred agents of similar potency. (If a product has an AB rated generic, one trial must be the generic.) **LIMITATIONS:** Corticosteroid spray formulations (eg. Topicort Spray) not covered – use alternate dosage forms.
GENITAL WART THERAPY		
ALDARA® (imiqumod 5%)	Imiquimod† 5 % (compare to Aldara®) cream Condylox® Gel (podofilox gel)	**Condylox gel, Veregan:** The patient has had a documented side effect, allergy, or treatment failure with Aldara **Condylox Solution:** The patient has had a documented intolerance to generic podofilox solution.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
PODOFILOX SOLUTION† (compare to Condylox®)	Condylox®* solution (podofilox solution) Veregan® (sinecatechins ointment) (Quantity limit = 15 grams (1 tube)/per 30 days) Zyclara® (imiquimod 3.75%) Cream (Quantity limit = 56 packets)/per 8 weeks) Zyclara® (imiquimod 3.75%) Cream Pump (Quantity limit = 2 pumps/per 8 weeks)	**Imiquimod (generic) cream:** The patient has had a documented intolerance to brand Aldara
IMMUNOMODULATORS **Effective 11/1/06: PA required for Elidel / Protopic/tacrolimus for children < 2 years. Quantity Limit = 30 gm / fill, 90 gm / 6 mos. Step Therapy required (previous trial of topical steroid for patients ≥ 2 yrs). Protopic/tacrolimus ointment concentration limited to 0.03% for age < 16 years old.**		
ELIDEL® (pimecrolimus) § PROTOPTIC® (tacrolimus) §	Elidel® (pimecrolimus) (age < 2 yrs) Protopic® (tacrolimus) (age < 2 yrs) Tacrolimis Ointment† (compare to Protopic®) All Patient	**Criteria for Approval Age < 2 years** (requests will be approved for up to 6 months): The patient has a diagnosis of atopic dermatitis (eczema). AND The patient has had a documented side effect, allergy, or treatment failure with at least one moderate to high potency topical corticosteroid within the last 6 months. AND The quantity requested does not exceed 30 grams/fill and 90 grams/6 months. AND If the request is for generic tacrolimus ointment, the patient has a documented intolerance to brand Protopic. **Criteria for Approval Age > 2 years** (requests will be approved for up to 1 year): The patient has a diagnosis of atopic dermatitis (eczema). AND The patient has had a documented side effect, allergy, or treatment failure with at least one moderate to high potency topical corticosteroid within the last 6 months. AND The quantity requested does not exceed 30 grams/fill and 90 grams/6 months. AND If the request is for generic tacrolimus ointment, the patient has a

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		documented intolerance to brand Protopic.
SCABICIDES AND PEDICULOCIDES		
SCABICIDES ACTICIN† (permethrin 5 %) *C* PERMETHRIN† 5 % (compare to Elimite®) *C*	Eurax® (crotamiton 10 %) *C, L* Lindane† *L* Lindane† *Sh*	**NON-PREFERRED SCABICIDES:** The patient has had a documented side effect or allergy to permethrin cream or treatment failure with two treatments of permethrin cream.
PEDICULICIDES (lice treatment) PERMETHRIN† 1 % *CR, L* PIPERONYL BUTOXIDE AND PYRETHRINS† *G, S, Sh* **Preferred after clinical criteria are met (1 OTC step via electronic PA)** NATROBA® (spinosad 0.9 %) *Ss*§ *C=cream, CR=crème rinse, G=gel, L=lotion, S=solution, Sh=shampoo, Sp=spray, Ss=suspension*	Malathion †*L* (compare to Ovide®) Ovide® (malathion) *L* Sklice® (Ivermectin 0.5 %) *L* Spinosad† (compare to Natroba) *Ss* Ulesfia® (benzyl alcohol 5%) *L* All other brand and generic Scabicides and Pediculicides	**Natroba:** The patient has had a documented side effect or allergy to OTC permethrin and piperonyl butoxide and pyrethrins or treatment failure with one treatment of OTC permethrin or piperonyl butoxide and pyrethrins. **Non-Preferred Pediculicides:** The patient has had a documented side effect or allergy to OTC permethrin and piperonyl butoxide and pyrethrins and Natroba or treatment failure with two treatments of OTC permethrin and/or piperonyl butoxide and pyrethrins and one treatment of Natroba. For approval of Ovide® Lotion, the patient must also have a documented intolerance to the generic equivalent product.
DESMOPRESSIN: INTRANASAL/ORAL		
Intranasal	DDAVP® (desmopressin) Nasal Solution or Spray 0.01%	**CRITERIA FOR APPROVAL:** Intranasal: The diagnosis or indication for the requested medication is (1) Diabetes Insipidus, (2) hemophilia type A, or (3) Von

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
Oral DESMOPRESSIN†	Desmopressin † Nasal Solution or Spray 0.01 % (compare to DDAVP®) Minirin † (desmopressin) Nasal Spray 0.01% Stimate® (desmopressin) Nasal Solution 1.5 mg/ml DDAVP®* (desmopressin) tablets	Willebrand disease AND If the request is for brand DDAVP, the patient has a documented intolerance to generic desmopressin spray or solution. **CRITERIA FOR APPROVAL:** non-preferred oral: The diagnosis or indication for the requested medication is (1) Diabetes Insipidus and/or (2) primary nocturnal enuresis AND The patient has had a documented intolerance to generic desmopressin tablets **LIMITATIONS:** Desmopressin intranasal formulations will not be approved for the treatment of primary nocturnal enuresis (PNE) due to safety risks of hyponatremia. Oral tablets may be prescribed for this indication.
DIABETIC TESTING SUPPLIES		
MONITORS/METERS		
Please refer to the DVHA website for covered Diabetic testing supplies.		**CRITERIA FOR APPROVAL:** The prescriber demonstrates that the patient has a medical necessity for clinically significant features that are not available on any of the preferred meters/test strips. **LIMITATIONS:** Talking monitors are not covered under the pharmacy benefit.
TEST STRIPS/LANCETS		
DIABETIC TEST STRIPS Please refer to the DVHA website for covered Diabetic testing supplies.		**CRITERIA FOR APPROVAL:** The prescriber demonstrates that the patient has a medical necessity for clinically significant features that are not available on any of the preferred meters/test strips. **LIMITATIONS:** Talking monitors are not covered under the pharmacy benefit.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
LANCETS All brands and store brands		
EPINEPHRINE: AUTO-INJECTOR		
EPIPEN® 2-PAK INJ 0.3 MG (epinephrine 0.3 mg/0.3 ml (1:1000)) EPIPEN-JR® 2-PAK INJ 0.15 MG (epinephrine 0.15 mg/0.3 ml (1:2000))	All other branded and generic products.	**CRITERIA FOR APPROVAL:** The patient has a documented intolerance to the preferred product.
ESTROGENS: VAGINAL		
Estradiol ESTRACE VAGINAL® Cream ESTRING® Vaginal Ring VAGIFEM® Vaginal Tablets **Conjugated Estrogens** PREMARIN VAGINAL® Cream **Estradiol Acetate** FEMRING® Vaginal Ring		

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
FIBROMYALGIA AGENTS		
	Savella® (milnacipran) tablet, titration pack *Quantity Limit = 2 tablets/day* Cymbalta® (duloxetine) Duloxetine† (compare to Cymbalta®) Lyrica® (pregabalin)	**Savella:** The diagnosis or indication is treatment of fibromyalgia.AND The patient has had a documented side effect, allergy, or treatment failure to TWO drugs from the following: gabapentin, tricyclic antidepressant, SSRI antidepressant, SNRI antidepressant, miscellaneous antidepressant, cyclobenzaprine or Lyrica. **Cymbalta/Duloxetine:** The patient has had a documented side effect, allergy, or treatment failure to TWO drugs from the following: gabapentin, tricyclic antidepressant, SSRI antidepressant, SNRI antidepressant, miscellaneous antidepressant, cyclobenzaprine, Lyrica® or Savella® (this indication not processed via automated step therapy) AND if the request is for duloxetine, the patient has had a documented intolerance with brand Cymbalta. **Lyrica:** The patient has had a documented side effect, allergy, or treatment failure to TWO drugs from the following: gabapentin, tricyclic antidepressant, SSRI antidepressant, SNRI antidepressant, miscellaneous antidepressant, cyclobenzaprine or Savella®, if medication is being used for fibromyalgia (this indication not processed via automated step therapy) AND If the request is for the oral solution, the patient is unable to use Lyrica capsules (eg. swallowing disorder).

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
GASTROINTESTINAL		
INFLAMMATORY BOWEL DISEASE INJECTABLES		
HUMIRA® (adalimumab) *Quantity limit = 6 syringes/28 days for the first month (Crohn's starter kit);2 syringes/28 days subsequently* REMICADE® (infliximab)	Cimzia® (certolizumab pegol) *Quantity limit = 1 kit/28 days (starter X 1, then regular)* Entyvio® (vedolizumab) *Quantity limit = 300mgX 3/42 days, 300mg X 1 every 56 days thereafter* Simponi® (golimumab) SC *3 of 100mg prefilled syringe or autoinjextor X 1, then 100mg/28days* Tysabri® (natalizumab)	**NOTE:** Crohn's Disease Self-Injectables (Humira and Cimzia) must be obtained and billed through our specialty pharmacy vendor, Briova. Please see the Humira and Cimzia Prior Authorization/Patient Enrollment Form for instructions. Briova may supply Remicade upon request or you may continue to obtain through your usual supplier. Briova will not be supplying Tysabri at this time – please continue to obtain through your usual supplier. **Clinical Criteria (Crohn's Disease)** **Humira, Remicade, Cimzia, Tysabri, Entyvio:** • Patient has a diagnosis of Crohn's disease and has already been stabilized on the medication. OR • Diagnosis is moderate to severe Crohn's disease and at least 2 of the following drug classes resulted in an adverse effect, allergic reaction, inadequate response, or treatment failure (i.e. resistant or intolerant to steroids or immunosuppressants): aminosalicylates, antibiotics, corticosteroids, and immunomodulators such as azathioprine, 6-mercaptopurine, or methotrexate. Note: Humira and Cimzia have been shown to be effective in patients who have been treated with infliximab but have lost respone to therapy. **Cimzia additional criteria:** • Patient age > 18 years AND • The prescriber must provide a clinically valid reason why Humira cannot be used.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		Tysabri additional criteria: • The patient has a documented side effect, allergy, treatment failure, or contraindication to BOTH, Remicade and Humira. **Entyvio additional criteria:** • Patient age > 18 years AND • The patient has a documented side effect, allergy, treatment failure (including corticosteroid dependence despite therapy), or contraindication to BOTH Remicade and Humira **Clinical Criteria (Ulcerative Colitis)** **Humira, Remicade:** • Patient has a diagnosis of Ulcerative Colitis and has already been stabilized on the medication. OR • The patient has a diagnosis of Ulcerative Colitis and has had a documented side effect, allergy or treatment failure with at least 2 of the following 3 agents: aminosalicylates (e.g. sulfasalazine, mesalamine, etc), corticosteroids, or immunomodulators (e.g. azathioprine, 6-mercaptopurine, cyclosporine, etc.). **Entyvio:** • Patient has a diagnosis of ulcerative colitis and has already been stabilized on the drug OR • Age > 18 years AND a diagnosis of ulcerative colitis AND • has demonstrated corticosteroid dependence or has had an inadequate response to or failed to tolerate oral aminosalicylates, oral corticosteroids, azathioprine, or 6-mercaptopurine. ANDThe prescriber must provide a clinically valid reason why Humira and Remicade cannot be used.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		Simponi: • Patient has a diagnosis of Ulcerative Colitis and has already been stabilized on Simponi OR • Patient age > 18 years AND Patiet has a diagnosis of Ulcerative Colitis and has demonstrated corticosteroid dependence or has had an inadequate response to or failed to tolerate oral aminosalicylates, oral corticosteroids, azathioprine, or 6-mercaptopurine. AND the prescriber must provide a clinically valid reason why Humira cannot be used.
H.PYLORI COMBINATION THERAPY		
	Helidac® (bismuth subsalicylate, metronidazole, tetracycline) *(Quantity limit=224 caps & tabs/14 days)* Lansoprazole, amoxicillin, clarithromycin (compare to Prevpac®) *(Quantity limit = 112 caps & tabs/14 days)* Omeclamox-Pak® (omeprazole, clarithromycin, amoxicillin) *(Quantity limit = 80 caps & tabs/10 days)* Prevpac® (lansoprazole, amoxicillin, clarithromycin) *(Quantity limit = 112 caps & tabs/14 days)* Pylera® (bismuth subcitrate, metronidazole,	**CRITERIA FOR APPROVAL:** The patient has a documented treatment failure with combinations of individual proton pump inhibitors or H2 antagonists given together with two appropriate antibiotics OR The patient has been unable to be compliant with individual agents prescribed separately. AND For approval of brand Prevpac®, the patient has a documented intolerance to the generic equivalent combination product.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	tetracycline) capsules *(Quantity limit=120 capsules/10 days)*	
H-2 BLOCKERS		
FAMOTIDINE† (compare to Pepcid®) tablet RANITIDINE† (compare to Zantac®) tablet **SYRUPS AND SPECIAL DOSAGE FORMS** CIMETIDINE † ORAL SOLUTION RANITIDNE† syrup (compare to Zantac®)	CIMETIDINE† (compare to Tagamet®) tablet Pepcid®* (famotidine) tablet § ranitidine† capsule § Tagamet®* (cimetidine) tablet § Zantac®* (ranitidine) tablet § famotidine† (compare to Pepcid®) oral suspension § Nizatidine †Oral Solution (compare to Axid®) Pepcid® (famotidine) Oral Suspension §	**Nizatidine capsule, Pepcid tablet, ranitidine capsule, Tagamet tablet, Zantac tablets:** The patient has had a documented side effect, allergy, or treatment failure to at least one preferred medication. If a medication has an AB rated generic, the trial must be the generic formulation. For approval of ranitidine capsules, the patient must have had a trial of ranitidine tablets. **Famotidine Oral Suspension, Nizatidine Oral Solution, Pepcid Oral Suspension:** The patient has had a documented side effect, allergy, or treatment failure to ranitidine syrup or cimetidine oral solution. If a medication has an AB rated generic, there must have been a trial of the generic formulation. **Cimetidine tablet** current users as of 05/29/2015 would be grandfathered
INFLAMMATORY BOWEL AGENTS (ORAL & RECTAL PRODUCTS)		
MESALAMINE PRODUCTS **Oral** APRISO® (mesalamine capsule extended-release) ASACOL® (mesalamine tablet delayed-release) DELZICOL® (mesalamine capsule delayed-release) *(QL = 6 capsules/day)*	Asacol HD® (mesalamine tablet delayed release)	**Azulfidine, Colazal:** patient has had a documented intolerance to the generic equivalent of the requested medication. **Asacol HD:** The patient has had a documented side effect, allergy, or treatment failure with two (2) preferred oral mesalamine products. **Entocort EC:** The patient had a documented intolerance to the generic budesonide 24 hr capsules. **Giazo:** The diagnosis is ulcerative colitis AND The patient is male and > 18 years

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
LIALDA® (mesalamine tablet extended-release) PENTASA® (mesalamine cap CR) **Rectal** CANASA® (mesalamine suppository) MESALAMINE ENEMA† (compare to Rowasa®) **CORTICOSTEROIDS** **ORAL** BUDESONIDE 24HR (compare to Entocort EC®) *QL = 3 capsules/day* UCERIS® (budesonide) ER Tablet *QL = 1 tablet/day* **OTHER** BALSALAZIDE† (compare to Colazal®) DIPENTUM® (olsalazine) SULFASALAZINE† (compare to Azulfidine®)	Sfrowasa® (mesalamine enema sulfite free) Entocort EC®* (budesonide 24 hr cap) *QL = 3 capsules/day* Azulfidine®* (sulfasalazine) Colazal®* (balsalazide) Giazo® (balsalazide disodium) tablet *QL = 6 tablets/day*	old. AND The patient has a documented intolerance to generic balsalazide. **Sfrowasa:** The patient has had a documented intolerance to mesalamine enema. **LIMITATIONS:** Kits with non-drug products are not covered.
PROKINETIC AGENTS		
Tablets METOCLOPRAMIDE† tabs (compare to Reglan®) **Oral Solution**	Reglan®* (metoclopramide)	**Reglan:** The patient has had a documented intolerance to generic metoclopramide tablets.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
METOCLOPRAMIDE† (formerly Reglan®) oral sol **Orally Disintegrating Tablets**	Metozolv ODT® (metoclopramide) *(QL= 4 tabs/day)*	**Metozolv ODT:** The patient has a medical necessity for a disintegrating tablet formulation (i.e. swallowing disorder, inability to take oral medications) AND Generic metoclopramide oral solution cannot be used
PROTON PUMP INHIBITORS		
ORAL CAPULES/TABLETS OMEPRAZOLE† 20 mg or 40 mg RX capsule (compare to Prilosec®) *(Quantity limit = 1 capsule/day)* PANTOPRAZOLE† tablets (compare to Protonix®) *(Quantity limit=1 tab/day)* lansoprazole† generic RX 30mg capsules (compare to Prevacid®) § *(Quantity limit = 1 cap/day)*	Aciphex® (rabeprazole) tablets *(Quantity limit=1 tab/day)* Dexilant® (dexlansoprazole) capsules *(Quantity limit=1 cap/day)* Esomeprazole® Strontium capsules *(Quantity limit = 1 cap/day)* lansoprazole† generic RX 15mg capsules (compare to Prevacid®) capsules § *(Quantity limit = 1 cap/day)* Nexium® (esomeprazole) capsules § *(Quantity limit=1 cap/day)* omeprazole † ♣ generic 10 mg RX capsules § (compare to Prilosec®) *(Quantity limit=1 cap/day)* omeprazole † generic OTC tablets *(Quantity limit=1 tab/day)* omeprazole magnesium† generic OTC 20 mg capsules	**Nexium powder for suspension, Prevacid Solutabs (for patients > 12 years old), Prilosec packet, and Protonix packet:** The patient has a requirement for a non-solid oral dosage form (e.g. an oral liquid, dissolving tablet or sprinkle). **Aciphex Sprinkle:** The patient has a requirement for a non-solid oral dosage form AND The member has had a documented side effect, allergy, or treatment failure to omeprazole capsule opened and sprinkled omeprazole or lansoprazole suspension or Prevacid solutab. **Other non-preferred medications:** The member has had a documented side effect, allergy, or treatment failure to Omeprazole RX 20 mg or 40 mg generic capsules, Lansoprazole RX 30mg AND Pantoprazole generic tablets. If the request is for Prevacid 24 hr OTC or Prevacid RX, the patient must also have a documented intolerance to lansoprazole generic RX capsules. If the request is for brand Zegerid RX capsules, the patient must also have a documented intolerance to the generic equivalent.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	§ *(Quantity limit=1 cap/day)* omeprazole/sodium bicarb capsules RX (compare to Zegerid®) § *(Quantity limit=1 cap/day)* Prevacid® RX (lansoprazole) capsules *(Quantity limit=1 cap/day)* Prevacid® 24 hr OTC (lansoprazole) capsules *(Quantity limit=1 cap/day)* Prilosec OTC® 20mg (omeprazole magnesium) tablets *(Quantity limit = 1 tablet/day)* Prilosec®* RX (brand) (omeprazole) capsules *(Quantity limit=1 cap/day)* Protonix®* (pantoprazole) tablets *(Quantity limit=1 tab/day)* rabeprazole (compare to Aciphex®) tablets *(Quantity limit = 1 tab/day)* Zegerid RX ® (omeprazole/sodium bicarb) caps, oral, suspension *(Quantity limit=1 cap/day)* Aciphex® Sprinkle (rabeprazole) DR Capsule *(Quantity limit=1 cap/day)* Nexium® (esomeprazole) powder for suspension § *(Quantity limit=1 packet/day)* Prevacid Solutabs® (lansoprazole) *(Quantity limit=1 tab/day)* Prilosec® (omeprazole magnesium) packet *(Quantity limit=2 packets/day)* Protonix® (pantoprazole) packet *(Quantity limit=1*	**CRITERIA FOR APPROVAL (twice daily dosing):** **Gastroesophageal Reflux Disease (GERD)** – If member has had an adequate trial (e.g. 8 weeks) of standard once daily dosing for GERD, twice daily dosing may be approved. **Zollinger-Ellison (ZE) syndrome** – Up to triple dose PPI may be approved. **Hypersecretory conditions (endocrine adenomas or systemic mastocytosis)** – Double dose PPI may be approved. **Erosive Esophagitis, Esophageal stricture, Barrett's esophagitis (complicated GERD)** – Double dose PPI may be approved. **Treatment of ulcers caused by H. Pylori** – Double dose PPI may be approved for up to 2 weeks. **Laryngopharyngeal reflux** – Double dose PPI may be approved. **LIMITATIONS:** First-Lansoprazole® and First-Omeprazole Suspension Kits not covered as Federal Rebate no longer offered. Nexium 24HR OTC (esomeprazole) capsules OTC Plan Exclusion - these products are not covered

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
SUSPENSION & SPECIAL DOSAGE FORMS	*packet/day)*	
GAUCHER'S DISEASE MEDICATIONS		
	Cerdelga *(Quantity limit=2 caps/day)* Cerezyme® (imiglucerase for injection) Elelyso® (taliglucerase alfa for injection) Vpriv® (velaglucerase alfa for injection) Zavesca® ****Maximum days supply per fill for all drugs is 14 days****	**CRITERIA FOR APPROVAL:** The diagnosis or indication is Gaucher disease (GD) type I. AND The diagnosis has been confirmed by molecular or enzymatic testing. **Cerdelga additional criteria:** • Testing to verify if CYP2D6 extensive metabolizer (EM), intermediate metabolizer (IM), poor metabolizer (PM), ultra-rapid metabolizer (URM), or if CYP2D6 genotype cannot be determined **Zavesca additional criteria:** • For whom enzyme replacement therapy is not a therapeutic option (e.g. due to allergy, hypersensitivity, or poor venous access) • Not approved for pediatric population ≥ 18
GOUT AGENTS		
SINGLE INGREDIENT COLCHICINE **SINGLE INGREDIENT URICOSURIC AGENTS** PROBENECID†	Colcrys® (colchicine) tablet *QL = 3 tablets/day (gout) or 4 tablets/day (FMF)*	**Colcrys:** The diagnosis or indication for the requested medication is Familial Mediterranean Fever (FMF) OR The diagnosis or indication for the requested medication is gout AND The patient has had a documented side effect or

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
XANTHINE OXIDASE INHIBITORS ALLOPURINOL† (compare to Zyloprim®) **COMBINATION PRODUCTS** COLCHICINE/PROBENECID† **PEG-URICASE AGENTS**	Uloric® (febuxostat) *QL (40 mg tablets) = 1 tablet/day* Zyloprim®* (allopurinol) Krystexxa (pegloticase) Vials for IV Infusion *QL = 2 vials/28 days*	treatment failure with at least one drug from the NSAID class. OR The patient is not a candidate for therapy with at least one drug from the NSAID class due to one of the following: The patient is 60 years of age or older, Patient has a history of GI bleed, Patient is currently taking an anticoagulant (warfarin or heparin), Patient is currently taking an oral corticosteroid, Patient is currently taking methotrexate **Krystexxa:** The diagnosis or indication is treatment of chronic gout AND The patient has had a documented side effect, allergy, treatment failure or a contraindication to BOTH allopurinol and febuxostat. NOTE: Treatment failure is defined as inability to reduce serum uric acid levels to <6 mg/dl with allopurinol doses of 600 mg/day taken consistently. Additionally, renal impairment is not considered a contraindication to allopurinol use. **Note:** after preliminary review by the Clinical Call Center, the request will be forwarded to the DVHA Medical Director for final approval. **Uloric:** The diagnosis or indication is treatment of gout AND The patient has had a documented side effect, allergy, treatment failure or a contraindication to allopurinol. NOTE: Treatment failure is defined as inability to reduce serum uric acid levels to < 6 mg/dl with allopurinol doses of 600 mg/day taken consistently. Additionally, renal impairment is not considered a contraindication to allopurinol use. **Zyloprim:** The patient has had a documented intolerance to generic allopurinol
GROWTH STIMULATING AGENTS		
Must be obtained through Specialty Pharmacy Provider, Briova (Please see Growth Stimulating Agents Prior Authorization/Enrollment Form for instructions.)		

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
NORDITROPIN®	Genotropin® Humatrope® Nutropin®/Nutropin® AQ Omnitrope® Saizen® Tev-Tropin® **Specialized Indications – See Specific Criteria** Increlex® (mecasermin) Serostim® Zorbtive®	**Criteria for Approval Pediatric:** 1) The patient must have one of the following indications for growth hormone: Turner syndrome confirmed by genetic testing. Prader-Willi Syndrome confirmed by genetic testing. Growth deficiency due to chronic renal failure. Patient who is Small for Gestational Age (SGA) due to Intrauterine Growth Retardation (IUGR)and catch up growth not achieved by age 2 (Birth weight less than 2500g at gestational age of <37 weeks or a birth weight or length below the 3rd percentile for gestational age). OR Pediatric Growth Hormone Deficiency confirmed by results of two provocative growth hormone stimulation tests (insulin, arginine, levodopa, propranolol, clonidine, or glucagon) showing results (peak level) <10ng/ml. 2) The requested medication must be prescribed by a pediatric endocrinologist (or pediatric nephrologist if prescribed for growth deficiency due to chronic renal failure). 3) Confirmation of non-closure of epiphyseal plates (x-ray determining bone age) must be provided for females > age 12 and males > age 14. 4) Initial requests can be approved for 6 months. Subsequent requests can be approved for up to 1 year with documentation of positive response to treatment with growth hormone. **Criteria for Approval Adult:** The patient must have one of the following indications for growth hormone: Panhypopituitarism due to surgical or radiological eradication of the pituitary. OR Adult Growth Hormone Deficiency confirmed by one growth hormone stimulation test (insulin, arginine, levodopa, propranolol, clonidine, or glucagon) showing results (peak level) <5ng/ml. Growth hormone deficient children must be retested after completion of growth. **LIMITATIONS:** Coverage of Growth Hormone products will not be approved for

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		patients who have Idiopathic Short Stature. **GENOTROPIN, HUMATROPE, NUTROPIN, NUTROPIN AQ, OMNITROPE, SAIZEN, TEV-TROPIN:** The patient has a documented side effect, allergy, or treatment failure to Norditropin **Increlex:** Member has growth hormone gene deletion AND neutralizing antibodies to growth hormone, OR primary insulin-like growth factor (IGF-1) deficiency (IGFD), defined by the following: o Height standard deviation score < -3 AND Basal IGF-1 standard deviation score < -3 AND Normal or elevated growth hormone level Member is ≥ 2 years old (safety and efficacy has not been established in patients younger than 2), AND Member has open epiphysis, AND Member is under the care of an endocrinologist or other specialist trained to diagnose and treat growth disorders. **Serostim:** A diagnosis of AIDS associated wasting/anorexia **Zorbtive:** A diagnosis of short bowel syndrome. Concomitant use of specialized nutritional support (specialty TPN) Prescription by gastroenterologist (specialist)
HEMOPHILIA FACTORS		
*****Must be obtained through Specialty Pharmacy Provider, Briova*****		
All Factors	None	

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
HEPATITIS C AGENTS		
*****Must be obtained through Specialty Pharmacy Provider, Briova*** Initial PA: 3 months; subsequent maximum 3 months**		
Preferred Agents after Clinical Criteri are Met HARVONI® (ledipasvir/sofosbuvir) OLYSIO® (simeprevir) 150 mg Capsules *(QL = 1capsule/day)(Mximum 12 weeks/lifetime)* PEG-INTRON/PEG-INTRON REDIPEN (peginterferon alfa-2b) *(QL= I kit(4 pens per) 28 days)* PEG-INTRON REDIPEN PAK 4 (peginterferon alfa-2b) *(QL= I kit(4 pens per) 28 days)* RIBASPHERE† 200 mg tabs Ribavirin† 200 mg tablets SOVALDI® (sofosbuvir) 400 mg Tablet (*QL = 1 tablet/day)(Maximum 24 weeks/lifetime unless hepatocellular carcinoma (48 weeks))* (sofosbuvir)	Non-Preferred Agents after Clincal Criteri are Met COPEGUS® (ribavirin 200 mg tabs) INFERGEN (interferon alfacon-1) MODERIBA® 200 mg/400 mg Dose Pak (ribavirin) PEGASYS® (peginterferon alfa-2a)*(QL=4 vials/28 days)* PEGASYS CONVENIENCE PAK®(peg-interferon alfa-2a)*(QL=1 kit/28 days)* PEGASYS PROCLICK (peginterferon alfa-2a) REBETOL® (ribavirin 200mg capsule) REBETOL ORAL SOLUTION® (ribavirin 40 mg/ml) RIBAPAK DOSEPACK® (ribavirin) ribavirin † 200 mg capsules RIBASPHER†E 400 and 600 mg tabs(ribavirin) VIEKIRA PAK® (ombitasvir, paritaprevir, ritonavir	**Direct Acting Agents: Harvoni, Olysio, Sovaldi and Viekira pak:** • Hep C PA form must be completed and clinical documentation supplied. All requests will be reviewed on a case by case basis by the DVHA Medical Director. Combination therapy will be either approved or denied in its entirety. • Member must have Metavir fibrosis score of 3 or 4 • Prescriber must be a hepatologist, gastroenterologist or infectious disease specialist • See PA form for detailed requirements and for documentation required **Peg-Intron:** Diagnosis is hepatitis C AND the patient has a documented side effect, allergy or treatment failure to Pegasys **Non-preferred Ribavirin Brands/strengths:** The patient is unable to use generic ribavirin 200 mg tablets **Quantity Limits** Peg-Intron Redipen-4 pens per 28 days

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	tablet with dasabuvir tablet)	
HEREDITARY ANGIOEDEMA MEDICATIONS		
Preferred Agents after Clinical Criteria are Met Kalbitor® (ecallantide) *(QL = 6 vials (2 packs) per fill*	Berinert® (human C1 inhibitor) Cinryze® (human C1 inhibitor) *(QL = 16 vials/28 days for prophylaxis; 4 vials per fill for acute attacks)* Firazyr® (icatibant) Prefilled Subcutaneous Syringe *(QL = 3 syringes (9 ml)/fill)*	**Berinert:** The diagnosis or indication is treatment of an acute Hereditary Angioedema (HAE) attack. (Approval may be granted so that 2 doses may be kept on hand). **Cinryze:** The diagnosis or indication is prophylaxis of Hereditary Angioedema (HAE) attacks. AND The patient has had a documented side effect, allergy, treatment failure or a contraindication to androgen therapy (i.e. danazol). OR The medication is to be used for the treatment of an acute Hereditary Angioedema (HAE) attack. **Firazyr:** The diagnosis or indication is treatment of an acute Hereditary Angioedema (HAE) attack. **Kalbitor:** The diagnosis or indication is treatment of an acute Hereditary Angioedema (HAE) attack. (Approval may be granted so that 2 doses may be kept on hand).

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
INTERLEUKIN (IL)-1 RECEPTOR BLOCKERS		
Preferred Agents after Clinical Criteria are Met Ilaris® (canakinumab) *(QL = 1 vial/56 days)(CAPS diagnosis)* *(QL = 2 vials/28 days)(sJIA diagnosis*	Arcalyst® (rilonacept) *(QL = 2 vials for loading dose, then 1 vial per week)*	**Ilaris:** The diagnosis is Cryopyrin-Associated Periodic Syndrome (CAPS) OR The diagnosis is Familial Cold Autoinflammatory Syndrome (FCAS) OR The diagnosis or indication for the requested medication is Muckle-Wells Syndrome (MWS) AND The patient is > 4 years old OR The diagnosis is systemic juvenile idiopathic arthritis (sJIA) with active systemic features and varying degrees of synovitis with continued disease activity after initial therapy (Initial therapy defined as 1 month of anakinra (Kineret), 2 weeks of glucocorticoid monotherapy (oral or IV) or one month of NSAIDs). AND patient is > 2 years of age. **Arcalyst:** The diagnosis is Cryopyrin-Associated Periodic Syndrome (CAPS) OR The diagnosis is Familial Cold Autoinflammatory Syndrome (FCAS) OR The diagnosis is Muckle-Wells Syndrome (MWS) AND The patient is > 12 years old AND The patient must have a documented side effect, allergy, treatment failure or a contraindication to Ilaris (canakinumab) **Note:** Medical Records to support the above diagnosis must accompany the Prior Authorization Request.Authorization for continued use shall be reviewed at least every 12 months to confirm patient has experienced disease stability or improvement while on therapy.
LIPOTROPICS:		
BILE ACID SEQUESTRANTS		

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
CHOLESTYRAMINE† powder (compare to Questran®) CHOLESTYRAMINE LIGHT† powder (compare to Questran Light®) PREVALITE† powder (cholestyramine light) COLESTIPOL† tablets, granules (compare to Colestid®)	Questran®* powder (cholestyramine) Questran Light®* powder (cholestyramine light) Colestid®* tablets, granules (colestipol) Welchol® (colesevelam)	**Questran:** The patient has had a documented intolerance to cholestyramine powder **Questran Light:** The patient has had a documented intolerance to cholestyramine light powder **Colestid:** The patient has had a documented intolerance to colestipol tablets or granules **Welchol:** If being prescribed for lipid reduction, the patient has had a documented side effect, allergy, or treatment failure to cholestyramine and colestipol. OR If being prescribed for lipid reduction, the patient has had a documented side effect, allergy, or treatment failure to cholestyramine and colestipol.
FIBRIC ACID DERIVATIVES		
GEMFIBROZIL† (compare to Lopid®) 600 mg **On statin concurrently or after gemfibrozil trial** TRICOR® (fenofibrate nanocrystallized) § 48 mg, 145 mg *Quantity Limit = 1 tablet/day* TRILIPIX (fenofibric acid) §45 mg, 135 mg delayed release capsule *Quantity Limit = 1 capsule/day*	Antara® (fenofibrate micronized) 43 mg, 30 mg, 90 mg, 130 mg fenofibrate tablets†(compare to Lofibra® tablets) § 54 mg, 160 mg fenofibrate capsule† (compare to (Lipofen®) § 50 mg, 150 mg fenofibrate micronized capsule†(compare to Lofibra® capsules) 67 mg, 134 mg, 200 mg fenofibrate micronized† (compare to Antara®) § 43 mg, 130 mg fenofibrate nanocrystallized† (compare to Tricor®) 48 mg, 145 mg fenofibric acid § 35 mg, 105 mg	**Lopid:** The patient has had a documented intolerance to generic gemfibrozil. **Tricor, Trilipix:** The patient has been started and stabilized on either Tricor or TriLipix (Note: samples are not considered adequate justification for stabilization.) OR The patient is taking a statin concurrently. OR The patient has had a documented side effect, allergy, or treatment failure to gemfibrozil. **Antara, fenofibrate, fenofribrate micronized, fenofibric acid, Fenoglide, Fibricor, Lipofen, Lofibra and Triglide:** The patient is taking a statin concurrently and has had a documented side effect, allergy, or treatment failure with Tricor or TriLipix. (If a product has an AB rated generic, there must have been a trial with the generic formulation.) OR The patient has had a documented side effect, allergy, or treatment failure to gemfibrozil and Tricor or TriLipix. (If a product has an AB rated generic, there must have been a trial with the generic formulation.) **Fenofibrate nanocrystallized (generic for Tricor), fenofibric acid (generic for**

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Quantity Limit = 1 capsule/day fenofibric acid (compare to Trilipix®) 45 mg, 135 mg delayed release capsule *Quantity Limit = 1 capsule/day* Fenoglide® (fenofibrate MeltDose) 40 mg, 120 mg Fibricor® (fenofibric acid) § 35 mg, 105 mg *Quantity Limit = 1 capsule/day* Lipofen® (fenofibrate) 50 mg, 150 mg Lofibra® (fenofibrate micronized) Capsules 67mg, 134 mg, 200 mg Lofibra® (fenofibrate) Tablets 54 mg, 160 mg Lopid®* (gemfibrozil) 600 mg Triglide® (fenofibrate) 50 mg, 160 mg	**Trilipix):** The patient is taking a statin concurrently, OR The patient has had a documented side effect, allergy, or treatment failure to gemfibrozil. AND The patient has had a documented intolerance with the brand equivalent. **Note regarding fibrates:** For patients receiving statin therapy, fenofibrate appears less likely to increase statin levels and thus may represent a safer choice than gemfibrozil for coadministration in this group of patients - Am J Med 2004;116:408-
HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMA (HoFH) AGENTS		
All products require a PA	Juxtapid® (lomitapide) Capsule *QL = 5 and 10 mg caps (1 per day), 20 mg cap (3 per day)* Kynamro® (mipomersen) Syringe for Subcutaneous Injection *QL = 4 syringes(4 ml)/28 days* Maximum days' supply per fill for all drugs is 28 days	**CRITERIA FOR APPROVAL:** Patient has a diagnosis of homozygous familial hypercholesterolemia (HoFH) AND Medication will be used as adjunct to a low-fat diet and other lipid-lowering treatments AND Patient does not have any of the following contraindications to therapy: ▪ Pregnancy (Juxtapid) ▪ Concomitant use with strong or moderate CYP3A4 inhibitors (Juxtapid) ▪ Moderate or severe hepatic impairment or active liver disease including unexplained persistent abnormal liver function tests (Juxtapid, Kynamro) AND

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		Patient has tried and had an inadequate response, intolerance or contraindication to BOTH atorvastatin and Crestor AND After preliminary review by the Clinical Call Center, the request will be forwarded to the DVHA Medical Director for final approval. Note: Re-approval requires confirmation that the patient has responded to therapy (i.e. decreased LDL levels) AND the patient does not have any contraindications to therapy.
NICOTINIC ACID DERIVATIVES		
IMMEDIATE RELEASE PRODUCTS NIACIN† NIACOR®† (niacin) **EXTENDED RELEASE PRODUCTS** NIASPAN® (niacin extended release)	Niacin extended release† (compare to Niaspan®)	**CRITERIA FOR APPROVAL:** The patient has a documented intolerance to the branded product.
HIGH INTENSITY STATINS		
ATORVASTATIN† 40 or 80 mg (compare to Lipitor®) *(QL = 1 tablet/day)* CRESTOR® 20 or 40 mg (rosuvastatin calcium) *(QL = 1 tablet/day)*	Lipitor®* (atorvastatin) 40 or 80 mg *(QL = 1 tablet/day)*	**Lipitor 40 or 80 mg:** The patient has had a documented intolerance to generic atorvastatin.
MODERATE INTENSITY STATINS		

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
CRESTOR® 5 or 10 mg (rosuvastatin calcium) *(QL = 1 tablet/day)* LOVASTATIN† 40 mg (compare to Mevacor®) *(QL = 1 tablet/day)* PRAVASTATIN† 40 or 80 mg (compare to Pravachol®)) *(QL = 1 tablet/day* SIMVASTATIN† 20 or 40 mg (compare to Zocor®) *(QL = 1 tablet/day*	Altoprev® 40 or 60 mg (lovastatin SR) *(QL = 1 tablet/day)* atorvastatin† 10 or 20 mg (compare to Lipitor®) *(QL = 1 tablet/day)* fluvastatin† 40 mg (compare to Lescol®) *(QL = 2 tabs/day)* Lescol® 40 mg (fluvastatin) *(QL = 2 tabs/day)* Lescol® XL 80 mg (fluvastatin XL) *(QL = 1 tablet/day)* Lipitor® (atorvastatin) 10 or 20 mg *(QL = 1 tablet/day)* Livalo® 2 or 4 mg (pitavastatin) *(QL = 1 tablet/day)* Mevacor®* 40 mg (lovastatin)) *(QL = 1 tab/day)* Pravachol®* 40 or 80 mg (pravastatin)*(QL = 1 tab/day)* Zocor®* (simvastatin) 20 or 40 mg *(QL = 1 tablet/day)*	**Atorvastatin/Lipitor 10 or 20 mg:** The patient has had a documented side effect, allergy, or contraindication to generic simvastatin OR The patient has had an inadequate response to a six week trial of simvastatin 40 mg/day AND If the request is for Lipitor, the patient has had a documented intolerance to generic atorvastatin. **Altoprev 40 or 60 mg, fluvastatin 40 mg BID, Lescol 40 mg BID, Lescol XL, Livalo 2 or 4 mg:** The patient has had a documented side effect, allergy, or contraindication to all 3 of generic lovastatin, pravastatin and simvastatin. OR The patient has had inadequate responses to six week trial of each of lovastatin 40 mg/day, pravastatin 80mg/day, simvastatin 40 mg/day and Crestor 10 mg/day. AND If the request is for Lescol, the patient has had a documented intolerance to generic fluvastatin. **Mevacor 40 mg, Pravachol 40 or 80 mg, Zocor 20 or 40 mg:** The patient has had documented intolerance to the generic equivalent
LOW INTENSITY STATINS		
LOVASTATIN† 10 or 20 mg (compare to Mevacor®) *(QL = 1 tablet/day)* PRAVASTATIN† 10 or 20 mg (compare to Pravachol®)) *(QL = 1 tablet/day* SIMVASTATIN† 5 or 10 mg (compare to Zocor®) *(QL = 1 tablet/day)*	Altoprev® 20 mg (lovastatin SR) *(QL = 1 tablet/day)* fluvastatin† 20 or 40 mg (compare to Lescol®) *(QL = 1 tab/day (20mg) or 2 tabs/day (40 mg))* Lescol® 20 or 40 mg(fluvastatin) *(QL = 1 tab/day (20mg) or 2 tabs/day (40 mg))* Livalo® 1 mg (pitavastatin) *(QL = 1 tablet/day)* Mevacor®* 10 or 20 mg (lovastatin)) *(QL = 1 tablet/day)* Pravachol®* 20 mg (pravastatin) *(QL = 1 tab/day)* Zocor®* (simvastatin) 5 or 10 mg *(QL = 1 tablet/day)*	**Altoprev 20 mg, fluvastatin 20 or 40 mg, Lescol 20 or 40 mg, Livalo 1 mg:** The patient has had a documented side effect, allergy, or contraindication to all 3 of generic lovastatin, pravastatin and simvastatin. OR The patient has had inadequate responses to six week trial of each of lovastatin 20 mg/day, pravastatin 20 mg/day and simvastatin 10 mg/day. AND If the request is for Lescol, the patient has had a documented intolerance to generic fluvastatin. **Mevacor 10 or 20 mg, Pravachol 20 mg, Zocor 5 or 10 mg:** The patient has had documented intolerance to the generic equivalent. **LIMITATIONS: Simvastatin 80 mg:** initiation of simvastatin 80 mg or titration to

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		80 mg is not recommended by the FDA due to the increased risk of myopathy, including rhabdomyolysis. Patients may only continue on this dose when new to Medicaid if the patient has been taking this dose for 12 or more months without evidence of muscle toxicity. If the request is for Zocor 80 mg, the patient must have met the prior treatment length requirement and have a documented intolerance to the generic equivalent.
MISCELLANEOUS/COMBOS		
SIMCOR® (simvastatin/extended release niacin) *(Qty Limit = 1 tablet/day)*	**Miscellaneous** Lovaza® (omega-3-acid ethyl esters) Omega-3-acid ethyl esters† (compare to Lovaza®) Vascepa® (icosapent ethyl) *(QL = 4 capsules/day)* **Cholesterol Absorption Inhibitors/Combinations** *Liptruzet® (ezetimibe/atorvastatin)* *(QL = 1 tablet/day)* *Vytorin® (ezetimibe/simvastatin)* *(QL = 1 tablet/day)* *Zetia® (ezetimibe)* *(Qty Limit = 1 tablet/day)* **Other Statin Combinations** Advicor® (lovastatin/extended release niacin) *(Qty Limit = 1 tablet/day)* Amlodipine/atorvastatin † (compare to Caduet®)	**Lovaza, Vascepa, Omega-3-acid ethyl esters:** The patient has been started and stabilized on this medication (Note: samples are not considered adequate justification for stabilization.) OR The patient has triglyceride levels > 500 mg/dL AND The patient has a documented contraindication, side effect, allergy, or treatment failure to a fibric acid derivative and niacin. AND If the request is for brand Lovaza, the patient has a documented intolerance to the generic equivalent. **Amlodipine/atorvastatin, Caduet:** The prescriber must provide a clinically valid reason for the use of the requested medication. For approval of Caduet, the patient must have also had a documented intolerance to the generic equivalent. For combinations containing 40mg or 80 mg atorvastatin, the individual generic components are available without PA and should be prescribed. **Advicor:** The patient is unable to take the individual drug components separately. **Juvisync:** The patient has had a documented side effect, allergy, contraindication or treatment failure with metformin. AND The patient has been started and stabilized on Januvia and simvastatin combination therapy as individual agents. **Liptruzet, Vytorin:** The patient has had an inadequate response to atorvastatin or Crestor. AND If the request is for Vytorin 10/80, the patient has been taking this

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	(Qty Limit = 1 tablet/day) Caduet® (atorvastatin/amlodipine) *(Qty Limit = 1 tablet/day)* *Juvisync® (sitagliptin/simvastatin)* *(Qty limit = 1 tablet/day)*	dose for 12 or more months without evidence of muscle toxicity. **Zetia:** The patient has a documented side effect, allergy or contraindication (eg. drug interaction) to a statin. OR The patient has a diagnosis of homozygous sitosterolemia. OR The patient has had an inadequate response to atorvastatin or Crestor.
MISCELLANEOUS		
PREFRRED AFTER CLINICAL CRITERIA ARE MET Carbaglu® dispersible tablets (carglumic acid) *(Maximum days supply per fill = 14 days)* GLYCOPYRROLATE 1 mg, 2 mg tablets (compare to Robinul®, Robinul Forte®) **Preferred After Clinical Criteria Are Met** MAKENA® (hydroxyprogesterone caproate) injection 250 mg/ml 5 ml vials Maximum fill = 5 ml/fill (35 day supply)	Benlysta® (belimumab) Vials *(Maximum days supply per fill = 28 days)* Elaprase® (idursulfase) *(QL = calculated dose/week)* Gattex® (teduglutide) Vials Maximum days' supply = 30 days Cuvposa® oral solution (glycopyrrolate)* **Maximum days supply per fill is 30 days** Glycate® 1.5 mg tablet (glycopyrrolate) *Quantity limit = 5 tablets/day* Robinul® 1 mg tablet (glycopyrrolate) Robinul® Forte 2 mg tablet (glycopyrrolate) Hetlioz® (tasimelteon) 20 mg oral capsule *Quantity limit =1 capsule/day* * Maximum days supply per fill is 30 days* Korlym® tablets (mifepristone)	**Benylsta:** The diagnosis or indication is active systemic lupus erythematosus (SLE) AND The patient is positive for autoantibodies (anti-nuclear antibody (ANA) and/or anti-double-stranded DNA (anti-dsDNA). AND The patient has had a documented inadequate response or intolerance to at least TWO of the following agents: NSAIDs, hydroxychloroquine, prednisone, azathioprine, methotrexate, mycophenolate. **Note:** The efficacy of Benlysta® has not been evaluated in patients with severe active lupus nephritis or severe active central nervous system lupus. Benlysta has not been studied in combination with other biologics or intravenous cyclophosphamide. Use of Benlysta is not recommended in these situations. **Carbaglu:** The diagnosis or indication for the requested medication is hyperammonemia due to N-acetylglutamate synthetase (NAGS) deficiency AND The prescriber is a specialist in metabolic disorders (e.g., medical geneticist) or prescriber is in consultation with a specialist. Note: after preliminary review by the Clinical Call Center, the request will be forwarded to the DVHA Medical Director for final approval. **Elaprase (Hunter's Syndrome Injectable**): The diagnosis or indication for the

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Quantity limit = 4 tablets/day Otrexup® or Rasuvo® Single-dose auto-injector for subcutaneous use (methotrexate) *(Quantity Limit = 4 syringes/28 days)* Myalept® (metreleptin) vial for subcutaneous injection *QL = one vial/day (Maximum days' supply per fill = 30 days)* Nuedexta® capsules (dextromethorphan/quinidine) *Quantity limit = 2 capsules/day* Samsca® tablets (tolvaptan) *Quantity limit = 15 mg tablets (1 tablet/day), 30 mg tablets (2 tablets/day)* Signifor® (pasireotide) Ampules *QL (all strengths) = 2 ml (2 amps)/day* Maximum days' supply = 30 days Solesta® submucosal injection gel 50 mg/15 ml *(Quantity Limit = 4 syringes/28 days)* Soliris® (eculizumab) *(Quantity Limit = 12 vials(360 ml) /28 days) Maximum days' supply per fill = 28 days* Somatuline® Depot Injection (lanreotide) *(Quantity Limit = 0.2 ml/28 days (60 mg syringe), 0.3 ml/28 days (90 mg syringe) and 0.5 ml/28 days (120 mg syringe))* Lysteda® tablets (tranexamic acid) *Quantity limit = 30 tablets/28 days tranexamic acid† (compare to*	requested medication is Hunter's Syndrome **Gattex:** Patient has a diagnosis of short bowel syndrome AND Patient is receiving specialized nutritional support administered intravenously (i.e. parenteral nutrition) AND Patient is 18 years of age or older AND Patient does not have an active gastrointestinal malignancy (gastrointestinal tract, hepatobiliary, pancreatic), colorectal cancer, or small bowel cancer. AND After preliminary review by the Clinical Call Center, the request will be forwarded to the DVHA Medical Director for final approval. Note: Re-approval requires evidence of decreased parenteral nutrition support from baseline. **Cuvposa:** The diagnosis or indication for the requested medication is Sialorrhea or a neurologic condition associated with excessive drooling (e.g. cerebral palsy, mental retardation, Parkinson's disease). AND The dose cannot be obtained from the tablet formulation. AND (For patients >18 years of age) The patient has had a documented side effect, allergy, treatment failure, or a contraindication to scopolamine patches. **Glycate:** The indication for use is adjunctive therapy in the treatment of peptic ulcer. AND The patient has had a documented intolerance to generic glycopyrrolate. **Robinul, Robinul Forte:** The patient has had a documented intolerance to generic glycopyrrolate. **Hetlioz:** Patient has documentation of Non-24-Hour Sleep-Wake Disorder (Non-24) AND Patient has documentation of total blindness AND Patient has had a documented side effect, allergy or treatment failure with Rozerem and at least one OTC melatonin product. **Korlym:** Patient is ≥18 years of age AND Patient has a diagnosis of endogenous Cushing's syndrome AND Patient is diagnosed with type 2 diabetes mellitus or

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Lysteda®) *Quantity limit = 30 tablets/28 days* Xenazine® tablets (tetrabenazine) *(Maximum 1 month supply per fill Quantity limit = 50 mg/day at initial approval (12.5 mg tablets ONLY), up to100 mg/day at subsequent approvals (12.5 mg or 25 mg tablets)*	glucose intolerance AND Patient has hyperglycemia secondary to hypercortisolism AND Patient has failed or is not a candidate for surgery AND Patient has a documented side effect, allergy, treatment failure or contraindication to at least 2 adrenolytic medications (eg. ketoconazole, etomidate) AND Patient does not have any of the following contraindications to Korlym: Pregnancy (pregnancy must be excluded before the initiation of therapy or if treatment is interrupted for >14 days in females of reproductive potential. Nonhormonal contraceptives should be used during and one month after stopping treatment in all women of reproductive potential) OR Patient requires concomitant treatment with systemic corticosteroids for serious medical conditions/illnesses (immunosuppression for organ transplant) OR Patient has a history of unexplained vaginal bleeding OR Patient has endometrial hyperplasia with atypia or endometrial carcinoma OR Patient is concomitantly taking simvastatin, lovastatin, or a CYP3A substrate with a narrow therapeutic index (e.g., cyclosporine, dihydroergotamine, ergotamine, fentanyl, pimozide, quinidine, sirolimus, or tacrolimus). Note: after preliminary review by the Clinical Call Center, the request will be forwarded to the DVHA Medical Director for final approval. **Makena:** Patient is 16 years of age or older AND Patient has a history of singleton spontaneous preterm birth AND Patient is having a singleton (single offspring) pregnancy AND Therapy will be started between 16 weeks, 0 days and 27 weeks, 0 days of gestation AND Therapy will be continued until week 37 (through 36 weeks, 6 days) of gestation or delivery, whichever occurs first. **Otrexup, Rasuvo:** The patient has a diagnosis of rheumatoid arthritis (RA), polyarticular juvenile idiopathic arthritis (pJIA) or psoriasis. AND The patient has been intolerant to oral methotrexate AND The patient has been unable to be compliant with a non-auto-injector form of injectable methotrexate (includes

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		difficulty with manual dexterity). **Myalept:** Patient has a diagnosis of congenital or acquired generalized lipodystrophy AND Patient has one or more of the following metabolic abnormalities AND is refractory to current standards of care for lipid and diabetic management: Insuline reisistance (definced as requiring > 200 units per day), Hypertriglyceridemia, Diabetes AND Prescription is written by or in consultation with an endocrinologist AND The prescriber is registered in the MYALEPT REMS program. Note: after preliminary review by the Clinical Call Center, the request will be forwarded to the DVHA Medical Director for final approval. Reauthorization for continued use criteria: Patient has experienced an objective response to therapy • Sustained reduction in hemoglobin A1c (HbA1c) level from baseline OR • Sustained reduction in triglyceride (TG) levels from baseline **Nuedexta:** The diagnosis or indication is pseudobulbar affect (PBA) secondary to amyotrophic lateral sclerosis (ALS) or multiple sclerosis (MS) AND The patient does not have any contraindications to use: Concomitant use with quinidine, quinine, or mefloquine: History of quinidine, quinine or mefloquine-induced thrombocytopenia, hepatitis MAOI use within 14 days of starting Nuedexta : Prolonged QT interval, congenital long QT syndrome, Torsades de Pointes, or heart failure : Complete atrioventricular (AV) block or patients at high risk for AV block: Concomitant use with drugs that prolong QT interval and are metabolized by CYP2D6 (eg. thioridazine, pimozide) **Samsca:** The agent is being used for the treatment of euvolemic or hypervolemic hyponatremia AND Despite optimal fluid restriction, the patient's serum sodium < 120 mEq/L or the patient is symptomatic with a serum sodium < 125 mEq/L. AND The treatment will be initiated or is being reinitiated in a hospital setting where serum sodium can be monitored

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		Signifor: Patient has a diagnosis of (pituitary) Cushing's disease AND Patient is 18 years of age or older AND Pituitary surgery is not an option or has not been curative AND After preliminary review by the Clinical Call Center, the request will be forwarded to the DVHA Medical Director for final approval. Note: Re-approval requires confirmation that the patient has experienced an objective response to therapy (i.e., clinically meaningful reduction in 24-hour urinary free cortisol levels and/or improvement in signs or symptoms of the disease). **Solesta:** The diagnosis or indication is treatment of fecal incontinence. AND The patient is 18 years of age or older AND The patient has had an inadequate response with conservative therapy, including diet, fiber supplementation, and anti-diarrheal medication **Soliris:** The patient has a diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) documented by flow cytometry. AND The patient has received the meningococcal vaccine at least 2 weeks prior to therapy initiation. OR The patient has a diagnosis of atypical hemolytic uremic syndrome (aHUS). AND The patient has received the meningococcal vaccine at least 2 weeks prior to therapy initiation. Authorization for continued use shall be reviewed to confirm that the patient has experienced an objective response to the therapy. **Somatuline:** The diagnosis or indication for the requested medication is Acromegaly. **Lysteda, Tranexamic acid:** The diagnosis or indication is clinically significant heavy menstrual bleeding AND The patient has been started and stabilized on oral tranexamic acid within the previous 360 days OR The patient does not have a contraindication to therapy with oral tranexamic acid (i.e., active thrombotic disease, history of thrombosis/thromboembolism, or an intrinsic risk of thrombosis/thromboembolism), and if oral tranexamic acid is to be used concomitantly with an estrogen containing hormonal contraceptive product, the

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		risks of combination therapy have been discussed with the patient. AND The patient has had a documented side effect, allergy, contraindication, or an inadequate response with at least one oral contraceptive or progestin containing product despite an adequate trial of at least 90 days, or a rationale for why these products cannot be used (e.g. actively attempting to conceive). AND The patient has had a documented side effect, allergy, contraindication, or an inadequate response with at least one regulary scheduled (not PRN) NSAID or a rationale for why these products cannot be used (e.g. actively attempting to conceive). AND If the request is for brand Lysteda, the patient has had a documented intolerance to the generic product. **Xenazine:** The diagnosis or indication for the requested medication is Huntington's disease with chorea. AND Age > 18 years.
MOOD STABILIZERS		
LITHIUM CARBONATE† (formerly Eskalith®) LITHIUM CARBONATE SR† (compare to Lithobid®, formerly Eskalith CR®) LITHIUM CITRATE SYRUP†	Equetro® (carbamazepine SR) Lithobid®* (lithium carbonate SR)	**Lithobid:** The patient has had a documented side effect, allergy, or treatment failure with the generic equivalent of the requested medication. **Equetro:** The patient has had a documented side effect, allergy, or treatment failure with a carbamazepine product from the anticonvulsant therapeutic drug category

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
MUCOSAL COATING AGENTS		
ALUMINUM HYDROXIDE†(formerly Amphojel®) EPISIL® (wound barrier) GELCLAIR® (povidone sodium hyaluronate glycyrrhetinic acid gel) MYLANTA/DIPHENYDRAMINE/LIDOCAINE VISCOUS (aka "Magic Mouthwash") Or other similar single or combination products	MuGard® (mucoadhesive oral wound rinse) *(QL = 4 bottles/month)*	**MuGard:** Patient is receiving radiation and/or chemotherapy. AND The patient has had a documented side effect, allergy or treatment failure with at least one oral mucosal coating agent (e.g. aluminum hydroxide suspension, Mylanta) or a topical anesthetic (e.g. viscous lidocaine or diphenhydramine solutions) or combinations of similar agents. **Additional criteria for viscous lidocaine:** • Due to a FDA safety alert, viscous lidocaine will require prior authorization for children ≤3 years of age.
MULTIPLE SCLEROSIS MEDICATIONS		
Self-injectables (Avonex®, Betaseron®, Rebif®, Extavia® & Copaxone®) & Aubagio®, Gilenya® & Tecfidera® must be obtained through Specilty Pharmacy Provider, Briova		
INJECTABLES **Interferons** AVONEX® (interferon *B*-1a) BETASERON® (interferon *B*-1b) REBIF® (interferon *B*-1a)	Extavia® (interferon beta-1b) Copaxone® 40 mg (glatiramer)*(QL = 12 syringes(12 ml)/28 days)* Tysabri® (natalizumab)	**Ampyra:** Patient has a diagnosis of multiple sclerosis. AND Patient age > 18 years. **Aubagio:** Patient is at least 18 years of age or older AND Patient has a diagnosis of relapsing forms of multiple sclerosis (relapsing-remitting multiple sclerosis and progressive-relapsing multiple sclerosis) AND Patient does not have any of the following contraindications to teriflunomide: Severe hepatic impairment Current treatment with leflunomide (Arava) Patients who are pregnant or women of childbearing potential not using reliable contraception

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
Other COPAXONE® 20 mg (glatiramer acetate) *(QL = 1 kit/30 days)* **ORAL** TECFIDERA® (dimethyl fumarate) *(QL = 2 capsules/day, maximum 30 day supply per fill)* **Preferred After Clinical Criteria Are Met** AMPYRA® (dalfampridine) tablet *(QL = 2 tablets/day, maximum 30 day supply per fill)*	Aubagio® (teriflunamide) tablet *(QL = 1 tablet/day, maximum 28 day supply per fill)* Gilenya® (fingolimod) capsule *(QL = 1 capsule/day, maximum 28 day supply per fill)*	**Copaxone 40 mg Syringe:** Patient has a diagnosis of multiple sclerosis. AND The patient has a documented side effect, allergy, treatment failure, or contraindication to at least one preferred drug (not Copaxone 20 mg). AND The patient is unable to tolerate or be compliant with Copaxone 20 mg daily dosing. **Extavia:** Patient has a diagnosis of multiple sclerosis. AND The provider provides a clinical reason why Betaseron cannot be prescribed. **Gilenya:** Patient has a diagnosis of relapsing multiple sclerosis. AND Patient has tolerated first dose under observation for a minimum of 6 hours with hourly pulse and blood pressure measurement and pre and post electrocardiogram. **Tysabri:** Patient has a diagnosis of relapsing multiple sclerosis and has already been stabilized on Tysabri OR Diagnosis is relapsing multiple sclerosis and the patient has a documented side effect, allergy, treatment failure, or contraindication to at least two preferred drugs. OR Diagnosis is relapsing multiple sclerosis and the patient has a documented side effect, allergy, treatment failure, or contraindication to one preferred drug and has tested negative for anti-JCV antibodies.
NEUROGENIC ORTHOSTATIC HYPOTENSION		
FLUDROCORTISONE† MIDODRINE†	Northera®	**Quantity Limits:** • Initial 2 weeks approval • Continued therapy approvals based on documentation of continued benefit clinically and as evidenced by positional blood pressure readings

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		Clinical Criteria: • diagnosis of neurogenic orthostatic hypotension caused by primary autonomic failure (Parkinson's disease, multiple system atrophy, or pure autonomic failure), dopamine beta-hydroxylase deficiency, or non-diabetic autonomic neuropathy, AND • the presentation of symptoms including dizziness, lightheadedness, and the feeling of "blacking out" AND • Failure of multiple non-pharmacologic measures as appropriate(e.g. removal of offending medications, compression stockings, increased fluid and salt intake) AND • Failure, intolerance or contra-indication to fludrocortisone AND midodrine
NUTRITIONALS, LIQUID ORAL SUPPLEMENTS		
	ALL Note: Nutritional supplements administered via tube feeds may be provided through the Medical Benefit	**EleCare, EleCare Jr:** The patient is an infant or child who needs an amino acid-based medical food or who cannot tolerate intact or hydrolyzed protein. AND The product is being requested for the dietary management of protein maldigestion, malabsorption, severe food allergies, short-bowel syndrome, eosinophilic GI disorders, GI-tract impairment, or other conditions for which an amino acid-based diet is required. **All Others:** Requested nutritional supplement will be administered via tube feeding. OR Patient has one of the following conditions where feeding is difficult or malabsorption or maldigestion occurs: AIDS, Cancer, Celiac Disease, Cerebral Palsy, Chronic Diarrhea, Cognitive Impairment, Cystic Fibrosis, Dementia (includes Alzheimer's), Developmental Delays, Difficulty with

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		chewing/swallowing food, Inflammatory Bowel Disease, Parkinson's, Short Gut. OR Patient has experienced unplanned weight loss or is extremely low weight (see further definitions below) OR Patient has demonstrated nutritional deficiency identified by low serum protein levels (albumin or pre-albumin levels to be provided) (albumin <3.5 g/dL /pre-albumin <15 mg/dL) **Unplanned Weight Loss/Low Weight Table:** **Adult:** Involuntary loss of > 10 % of body weight within 6 months Involuntary loss of > 5% of body weight within 1 month Loss of > 2% of body weight within one week BMI of < 18.5 kg/m2 **Elderly:** (>65): Involuntary loss of > 10 % of body weight within 6 months Involuntary loss of > 5 % of body weight within 3 months Loss of > 2 % of body weight within one month BMI of < 18.5 kg/m2 **Children:** < 80 % of expected weight-for-height < 90 % of expected height-for-age Mid-upper arm circumference/head circumference ratio < 0.25 **Limitations:** Infant formulas are not covered under the pharmacy benefit. Please contact WIC.
ONCOLOGY: ORAL (select)		
ALL – see Oncology:Oral order form for details of medication that must be obtained through Briova, DVHA's specialty pharmacy provider		

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
OPHTHALMICS		
ANTIBIOTICS		
QUINOLONES CIPROFLOXACIN HCL† (compare to Ciloxan®) solution OFLOXACIN† (compare to Ocuflox®) solution **MACROLIDES** ERYTHROMYCIN† ointment ILOTYCIN† (erythromycin) ointment **AMINOGLYCOSIDES** **Single Agent** AK-TOB† (tobramycin) solution GARAMYCIN† (gentamicin) ointment GENTAK† (gentamicin) ointment, solution GENTAMICIN† ointment, solution TOBRAMYCIN † solution (compare to Tobrex®) **Combination** TOBRAMYCIN W/DEXAMETHASONE† (compare to Tobradex®) suspension	Besivance® (besifloxacin) suspension Ciloxan®*(ciprofloxacin) ointment, solution gatifloxacin 0.5% solution (compare to Zymaxid®) Iquix® (levofloxacin 1.5 %) (preservative free) solution levofloxacin† 0.5 % (compare to Quixin®) solution Moxeza® (moxifloxacin 0.5%) (preservative free) solution Ocuflox®*(ofloxacin) solution Quixin® (levofloxacin 0.5 %) solution Vigamox® (moxifloxacin 0.5%) (preservative free) solution Zymar® (gatifloxacin 0.3%) solution Zymaxid® (gatifloxacin 0.5%) solution Azasite®(azithromycin) solution All other brands Garamycin® (gentamicin) solution Tobrex® solution* (tobramycin)	**Aminoglycosides: Single Agent:** The patient has had a documented side effect, allergy or treatment failure with at least ONE preferred ophthalmic aminoglycoside. (If a product has an AB rated generic, there must have also been a trial of the generic formulation) Combination Product: The patient has had a documented intolerance with generic tobramycin/dexamethasone ophthalmic. **Macrolides:** The patient has had a documented side effect, allergy or treatment failure with generic erythromycin. (If a product has an AB rated generic, there must have also been a trial of the generic formulation) **Miscellaneous Antibiotics:** The patient has had a documented side effect, allergy or treatment failure with at least TWO preferred ophthalmic miscellaneous antibiotics. (If a product has an AB rated generic, there must have also been a trial of the generic formulation) **Quinolones:** The patient has had a documented side effect, allergy or treatment failure with ciprofloxacin or ofloxacin. AND If the request is for Quixin or Zymaxid, the patient also has a documented intolerance to the generic equivalent OR The request is for Vigamox or Zymar as part of a regimen to prevent postoperative infection in patients receiving any ophthalmologic surgery.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Tobrex® ointment (tobramycin)	
MISCELLANEOUS **Single Agent** BACITRACIN ointment SULFACETAMIDE SODIUM† (compare to Bleph-10®) solution **Combination** AK-POLY-BAC† (bacitracin/polymyxin) ointment BACITRACIN ZINC W/POLYMYXIN B† (formerly Polysporin®) ointment NEOMYCIN/BACITRACIN/POLYMYXIN (formerly Neosporin®) ointment NEOMYCIN/POLYMYXIN W/DEXAMETHASONE† (compare to Maxitrol®) ointment, suspension NEOMYCIN/POLYMYXIN W/GRAMICIDIN† solution (compare to Neosporin®) NEOMYCIN/POLYMYXIN W/HYDROCORTISONE suspension NEOMYCIN/POLYMYXIN/BACITRACIN/ HYDROCORTISONE† ointment	Tobradex®* (tobramycin/dexamethasone) suspension Tobradex® (tobramycin/dexamethasone) ointment TobraDex ST®(tobramycin/dexamethasone) suspension Zylet® (tobramycin/loteprednol) suspension Pred-G® (gentamicin/prednisolone) suspension Pred-G® S.O.P. (gentamicin/prednisolone) ointment Bleph-10®* (sulfacetamide) solution Blephamide® (sulfacetamide/prednisolone acetate) suspenion Blephamide® S.O.P. (sulfacetamide/prednisolone acetate) oint Maxitrol®* (neomycin/polymyxin/dexamethasone) suspension, ointment Neosporin®* (neomycin/polymyxin/gramicidin) soln Poly-pred® (neomycin/polymyxin B/prednisolone acetate) suspension Polytrim®* (polymyxin B/trimethoprim) soln All other brands	

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
POLYMYXIN B W/TRIMETHOPRIM† (compare to Polytrim®) solution SULFACETAMIDE W/PREDNISOLONE SOD PHOSPHATE solution		
ANTIHISTAMINES		
KETOTIFEN† 0.025 % (eg. Alaway®, Zaditor® OTC, others) *(Quantity Limit = 1 bottle/month)* **After trial of ketotifen 0.025 %** PATADAY® § (olopatadine 0.2%)/PATANOL®§ (olopatadine 0.1%) *(Qunatity Limit = 1 bottle/month)*	Azelastine † (compare to Optivar®) *(QL = 1 bottle/month)* Bepreve® (bepotastine besilate) *(QL = 1 bottle/month)* Elestat® (epinastine) *(Quantity Limit = 1 bottle/month)* Epinastine† (compare to Elestat®) *(QL = 1 bottle/month)* Emadine® (emedastine) *(Quantity Limit = 2 bottles/month)* Lastacaft® (alcaftadine) *(QL = 1 bottle/month)* Optivar® (azelastine) *(QL = 1 bottle/month)*	**Pataday/Patanol:** The patient has had a documented side effect, allergy, or treatment failure to ketotifen. **Azelastine, Bepreve, Elestat, Epinastine, Optivar:** The patient has had a documented side effect, allergy, or treatment failure to Pataday or Patanol. If the product has a generic equivalent, the patient must also have had a documented intolerance to the generic equivalent. **Lastacaft, Emadine:** The patient is pregnant and the diagnosis is allergic conjunctivitis OR The patient has had a documented side effect, allergy, or treatment failure to ketotifen. AND The patient has had a documented side effect, allergy, or treatment failure to Patanol/Pataday
CORTICOSTEROIDS: TOPICAL		
DEXAMETHASONE SODIUM PHOSPHATE 0.1% Sol† FLUOROMETHOLONE 0.1% S† PREDNISOLONE ACETATE 1% S† *E=emulsion, G=gel,O=ointment, S=suspension, Sol=solution*	Alrex® (loteprednol) 0.2% S Durezol® (difluprednate) 0.05% E FML® (fluorometholone) 0.1% O FML Forte® (fluorometholone) 0.25% S FML Liquifilm®/Flarex® (fluorometholone) 0.1% S Lotemax® (loteprednol) 0.5% O (pres. free) Lotemax® (loteprednol) 0.5% G,S Pred Forte®/Omnipred® (prednisolone acetate) 1% S	**Lotemax Oint:** The patient has had a documented side effect, allergy, or treatment failure with one preferred generic ophthalmic corticosteroid. OR The patient has a documented hypersensitivity to the preservative benzalkonium chloride. **All Others:** The patient has had a documented side effect, allergy, or treatment failure with one preferred generic ophthalmic corticosteroid. (If a product has an AB rated generic, there must have been a trial of the generic formulation)

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Pred Mild® (prednisolone acetate) 0.12% S Vexol® (rimexolone) 1% S All other brands	
CYSTARAN		
	Cystaran® (cysteamine) 0.44% ophthalmic solution *(QL=4 bottles (60 ml)/ 28 days)* *Maximum days' supply/RX = 28 days*	**Cystaran:** The indication for use is corneal cystine accumulation in patients with cystinosis.
DRY EYE SYNDROME		
Generic OTC Ocular Lubricants ARTIFICIAL TEARS† Ointment ARTIFICIAL TEARS† Solution REFRESH TEARS† Solution TEARS NATURALE† Solution LUBRIFRESH P.M.† Ointment And all other generics	Restasis® (cyclosporine ophthalmic emulsion) 0.05% *(QL=60 vials per 30 days).*	**CRITERIA FOR APPROVAL:** The patient has a diagnosis of moderate to severe keratoconjunctivitis sicca (dry eye syndrome) or Sjogren syndrome with suppressed tear production due to ocular inflammation AND The member does not have any of the following contraindications or exclusions to therapy: A) An active ocular infection B) Concurrent topical anti-inflammatory drugs C) Concurrent punctal plug use AND The patient has had a documented side effect, allergy, or treatment failure to two ocular lubricants (e.g., artificial tears, lubricant gels, etc.). **Limitations:** OTC branded ocular lubricants are not covered (as part of DVHA's comprehensive OTC policy). There is no PA opportunity for branded OTC ocular lubricants.
GLAUCOMA AGENTS/MIOTICS		
ALPHA-2 ADRENERGIC **Single Agent** ALPHAGAN P® 0.1 %, 0.15 % (brimonidine tartrate) BRIMONIDINE TARTRATE† 0.2 % (formerly	apraclonidine† (compare to Iopidine®) brimonidine tartrate 0.15 % † (compare to Alphagan P®) Iopidine® (apraclonidine)	**ALPHA 2 ADRENERGIC AGENTS:** Single Agent: The patient has had a documented side effect, allergy or treatment failure with at least one preferred ophthalmic alpha 2 adrenergic agent. If the request is for brimonidine tartrate 0.15%, the patient must have a documented intolerance of brand name Alphagan

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
Alphagan®)		P 0.15%.
Combination COMBIGAN® (brimonidine tartrate/timolol maleate)	Simbrinza® (brinzolamide 1% and brimonidine 0.2%) Susp	**Combination Product: Simbrinza:** The patient has had a documented treatment failure with either an alpha adrenergic agent or a carbonic anhydrase inhibitor. **BETA BLOCKERS:** The patient has had a documented side effect, allergy or treatment failure with at least one preferred ophthalmic beta blocker.
BETA BLOCKER BETAXOLOL HCL† (formerly Betoptic®) CARTEOLOL HCL† (formerly Ocupress®) LEVOBUNOLOL HCL† (compare to Betagan®) TIMOLOL MALEATE† (compare to Istalol®, Timoptic®) TIMOLOL MALEATE †gel (compare to Timotic XE®)	Betagan®* (levobunolol) Betimol® (timolol) Betoptic S® (betaxolol suspension) Istalol®* (timolol) Metipranolol (formerly Optipranolol®) Timoptic®* (timolol maleate) Timoptic XE®* (timolol maleate gel)	**PROSTAGLANDIN INHIBITORS** **Lumigan, Rescula:** The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR The patient has had a documented side effect, allergy or treatment failure with generic latanoprost and Travatan Z. **Travoprost:** The patient has had a documented intolerance to Travatan Z. **Zioptan:** The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR The patient has had a documented side effect, allergy or treatment failure with generic latanoprost and Travatan Z. OR The patient has a sensitivity to preservatives used in ophthalmic preparations
PROSTAGLANDIN INHIBITORS LATANOPROST† (compare to Xalatan®) TRAVATAN Z® (travoprost) (BAK free)	Lumigan® 0.01 %/0.03 % (bimatoprost) Rescula® (unoprostone) Travoprost® (travoprost) Xalatan®* (latanoprost) Zioptan® (tafluprost)	**Xalatan:** The patient has a documented intolerance to the generic product. AND The patient has had a documented side effect, allergy or treatment failure with Travatan Z. **CARBONIC ANHYDRASE INHIBITORS** **Single Agent:** The patient has had a documented side effect, allergy or treatment failure with a preferred carbonic anhydrase inhibitor.
CARBONIC ANHYDRASE INHIBITOR **Single Agent**	Azopt® (brinzolamide 1%) Trusopt®* (dorzolamide 2 %)	**Combination Product:** **Cosopt:** The patient has had a documented intolerance to the generic equivalent product. **Cosopt PF:** The patient has had a documented intolerance to the preservatives in the

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
DORZOLAMIDE 2 % (compare to Trusopt®) **Combination** DORZOLAMIDE w/TIMOLOL (compare to Cosopt®)	Cosopt®* (dorzolamide w/timolol) Cosopt PF® (dorzolamide w/timolol) (pres-free) Simbrinza® (brinzolamide 1% and brimonidine 0.2%) Susp Miochol-E® (acetylcholine)	generic combination product. **Simbrinza:** The patient has had a documented treatment failure with either an alpha adrenergic agent or a carbonic anhydrase inhibitor.
MISCELLANEOUS DIPIVEFRIN HCL† (compare to Propine®) ISOPTO® CARBACHOL (carbachol) ISOPTO® CARPINE (pilocarpine) PILOCARPINE HCL† (formerly Pilocar®) PILOPINE® HS (pilocarpine) gel PHOSPHOLINE IODIDE® (echothiophate) PROPINE® (dipivefrin)		**Miscellaneous:** The patient has had a documented side effect, allergy or treatment failure with a preferred miscellaneous ophthalmic agent. If a product has an AB rated generic, there must have also been a trial of the generic formulation)
MAST CELL STABILIZERS		
	Alocril® (nedocromil sodium)	**Criteria for Approval:** The patient has had a documented side effect, allergy, or

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
CROMOLYN SODIUM† (formerly Crolom®)	Alomide® (lodoxamide)	treatment failure with generic cromolyn sodium
NON-STEROIDAL ANTI-INFLAMMATORY DRUGS (NSAIDs)		
ACULAR® (ketorolac 0.5% ophthalmic sol.) ACULAR LS ® (ketorolac 0.4% ophthalmic sol.) FLURBIPROFEN † 0.03% ophthalmic sol.	Acuvail (ketorolac 0.45 %) Ophthalmic Solution *(Quantity Limit = 30 unit dose packets/15 days)* Bromday® ophthalmic sol (bromfenac 0.09%) Bromfenac† 0.09 % ophthalmic sol (compare to Bromday®) (once daily) Bromfenac† 0.09 % ophthalmic sol (formerly Xibrom®) Diclofenac† 0.1% ophthalmic sol (compare to Voltaren®) Ketorolac† 0.4 % ophthalmic sol (compare to Acular LS®) Ketorolac† 0.5 % ophthalmic sol (compare to Acular®) Ilevro® ophthalmic susp. (nepafenac 0.3%) Nevanac® ophthalmic susp. (nepafenac 0.1%) Ocufen®* ophthalmic sol. (flurbiprofen 0.03%) Prolensa® ophthalmic sol. (bromfenac 0.07%) Voltaren® (diclofenac 0.1% ophthalmic sol	**Acuvail:** The patient has had a documented side effect, allergy, or treatment failure to Acular or Acular LS OR The patient has a documented hypersensitivity to the preservative benzalkonium chloride. **Bromday, Bromfenac, Diclofenac, Ilevro, Nevanac, Prolensa, Voltaren:** The patient has had a documented side effect, allergy, or treatment failure to Acular or Acular LS. In addition, if a product has an AB rated generic, there must have also been a trial of the generic formulation. **Ketorolac 0.4 %/0.5 %:** The patient has had a documented intolerance to brand Acular/Acular LS ophthalmic solution. **Ocufen:** The patient has had a documented intolerance to generic flurbiprofen ophthalmic solution.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
OTIC ANTI-INFECTIVES		
Anti-infective Single Agent OFLOXACIN† 0.3% Otic Soln (formerly Floxin®) **Anti-infective/Corticosteroid Combination** CIPRODEX® (ciprofloxacin 0.3%/dexamethasone 0.1%) otic suspension NEOMYCIN/POLYMYXIN B SULFATE/HYDROCORTISONE† (compare to Cortisporpin otic®) CORTOMYCIN† (neomycin/polymyxin B sulfate/hydrocortisone) Otic soln, susp	Ciprofloxacin† 0.2% (compare to Cetraxal®) otic solution *(Qty limit = 14 unit dose packages/ 7 days)* Cipro-HC® (ciprofloxacin 0.2%/hydrocortisone 1%) otic suspension Coly-Mycin S®/Cortisporin TC® (neomycin/colistin/thonzium/hydrocortisone) Cortisporin otic®* (neomycin/polymyxin B sulfate /hydrocortisone) otic solution/suspension	**Ciprofloxacin 0.2%:** The patient has a documented side effect, allergy, or treatment failure to one of the following: any generic neomycin/polymyxin B/hydrocortisone product, Ciprodex otic suspension, or generic ofloxacin otic solution. **Cipro-HC, Coly-Mycin S, Cortisporin TC:**The patient has had a documented side effect, allergy, or treatment failure to neomycin/polymyxin B sulfate/hydrocortisone and one other preferred product. **Cortisporin Otic:** The patient has had a documented intolerance to the generic product. **Acetasol HC, Acetic Acid/Hydrocortisone, Auralgan, Myoxin, Otic Care, Otic Edge, PR Otic, Treagan,TriOxin, Zinotic/Zinotic ES:** The patient has had a documented side effect, allergy, or treatment failure to at least TWO preferred otic anti-infectives.
Miscellaneous Agents ACETIC ACID† Otic soln ACETIC ACID-ALUMINUM ACETATE† Otic soln VOSOL® (acetic acid 2%) Otic soln	Acetasol HC† (acetic acid 2%/hydrocortisone 1% otic soln) Acetic Acid/Hydrocortisone† Otic Soln Auralgan®/Otic Care®/ Otic Edge®/PR Otic® /Treagan® (acetic acid/antipyrine/benzocaine/polycosanol) TriOxin®/ Myoxin	**Vosol HC:** The patient has had a documented side effect, allergy, or treatment failure to at least TWO preferred otic anti-infectives. In addition, the patient has had a documented intolerance to a generic acetic acid/hydrocortisone product **LIMITATION:** Cetraxal no longer covered due to Federal Rebate not offered.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	(benzocaine/chloroxylenol/hydrocortisone susp) Vosol HC® (acetic acid 2%/hydrocortisone 1% otic soln)	
OVER THE COUNTER (OTC) MEDICATIONS		
Please refere to the DVHA website for covered OTC categories not alreqady managed on the PDL. Many categories limited to generics ONLY and other categoires not covered. No PA process for non-covered OTCs.		
PANCREATIC ENZYME PRODUCTS		
CREON® DR Capsule ZENPEP® DR Capsule	Pancreaze® DR Capsule Pancrelipase† 5,000 (compare to Zenpep® 5,000) Pertzye® DR Capsule Ultresa® DR Capsule Viokace® DR Capsule	**Pancrelipase 5,000 (generic):** The patient has a documented intolerance to brand Zenpep 5,000 **All others:** The patient has been started and stabilized on the requested product. OR The patient has had treatment failure or documented intolerance with both Creon and Zenpep.
PARKINSON'S: NON ERGOT DOPAMINE RECEPTOR AGONIST		
DOPAMINE PRECURSOR CARBIDOPA/LEVODOPA† (compare to Sinemet®) CARBIDOPA/LEVODOPA† ER (compare to Sinemet® CR)	Parcopa®* (carbidopa/levodopa ODT) Sinemet®* (carbidopa/levodopa) Sinemet CR®*(carbidopa/levodopa ER)	**Sinemet, Sinemet CR, Mirapex, Parcopa, Parlodel, Requip, Eldepryl:** The patient has had a documented intolerance to the generic product. **Amantadine tablets:** The patient has had a documented intolerance to generic amantadine capsules.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
CARBIDOPA/LEVODOPA† ODT (compare to Parcopa®) **DOPAMINE AGONISTS (ORAL)** BROMOCRIPTINE† (compare to Parlodel®) PRAMIPEXOLE † (compare to Mirapex®) ROPINIROLE† (compare to Requip®)	Mirapex®* (pramipexole) Mirapex ER® (pramipexole ER) *QL = 1 tab/day* Parlodel® (bromocriptine) Requip®* (ropinirole) Requip XL® (ropinirole XL) *QL = 1 tab/day (all strengths except 12 mg), QL = 2 tabs/day (12 mg)* ropinirole XL† (compare to Requip XL®) *QL = 1 tab/day (all strengths except 12 mg), QL = 2 tabs/day (12 mg)*	**Azilect:** The diagnosis or indication is Parkinson's disease. AND The patient has had a documented side effect, allergy, or treatment failure with selegiline. AND The dose requested does not exceed 1 mg/day **carbidopa/levodopa/entacapone**: The patient has had a documented intolerance to brand Stalevo. **Mirapex ER, Requip XL, ropinirole:** The diagnosis or indication is Parkinson's disease. Requests will not be approved for Restless Leg Syndrome (RLS) AND The patient has had an inadequate response (i.e. wearing off effect or "off" time) with the immediate release product. OR The patient has not been able to be adherent to a three times daily dosing schedule of the immediate release release product resulting in a significant clinical impact. AND If the requested product has an AB rated generic, the patient has a documented intolerance to the generic product.
DOPAMINE AGONISTS (TRANSDERMAL)	Neupro® (rotigotine) transdermal patch *(Quantity Limit = 1 patch/day)* *(2mg, 4 mg, 6 mg and 8 mg patches)*	**Neupro:** The patient is ≥18 years of age AND The patient has a diagnosis of Parkinson's disease. AND The patient has had a documented side effect, allergy, contraindication or treatment failure to generic immediate release ropinirole or pramipexole AND ropinirole XL or Mirapex ER. OR The prescriber provides medical necessity for the transdermal formulation (eg. swallowing disorder or difficulty taking oral medications).
COMT INHIBITORS COMTAN® (entacapone) ENTACAPONE† (compare to Comtan®)	Tasmar® (tolcapone)	**Tasmar:** The diagnosis or indication is Parkinson's disease. AND The patient has had a documented side effect, allergy, or treatment failure with Comtan.
MAO-B INHIBITORS SELEGILINE† (compare to Eldepryl®)	Azilect® (rasagiline) (QL = 1 mg/day) Eldepryl® (selegiline) Zelapar® (selegiline ODT) *(QL = 2.5 mg/day)*	**Zelapar:** The diagnosis or indication is Parkinson's disease. AND The patient is on current therapy with levodopa/carbidopa. AND Medical necessity for disintegrating tablet administration is provided (i.e. inability to swallow tablets or drug interaction with oral selegiline). AND the dose requested does not

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
OTHER AMANTADINE† capsules (formerly Symmetrel®) (PA required for ≤ 10 day supply) STALEVO® (carbidopa/levodopa/entacapone)	Amantadine† tablets (formerly Symmetrel®) (Quantity limit PA also required for ≤ 10 day supply) carbidopa/levodopa/entacapone† (compare to Stalevo®)	exceed 2.5mg/day **Limitations:** To prevent the use of amantadine in influenza treatment/prophylaxis, days supply < 10 days will require PA.
PHOSPHODIESTERASE-4 (PDE-4) INHIBITORS		
	Daliresp® tablet (roflumilast) *Quantity limit = 1 tablet/day* Otezla® tablet (apremilast) *(Starter pack – Quantity limit = 27 tablets/14 days)* *(30 mg tablets – Quantity limit = 2 tablets/day)* *** Maximum days' supply per fill = 30)**	**Daliresp:** The indication for the requested medication is treatment to reduce the risk of COPD exacerbations in patients with severe COPD associated with chronic bronchitis and a history of exacerbations. AND The patient has had a documented side effect, allergy, treatment failure, or a contraindication to at least one inhaled long-acting anticholinergic AND at least one inhaled long-acting beta-agonist. AND The patient has had a documented side effect, allergy, treatment failure, or a contraindication to at least one inhaled corticosteroid. **Otezla:** The patient has a diagnosis of psoriatic arthritis AND The patient is 18 years of age or older AND The patient has had inadequate response to, intolerance to, or contraindication to methotrexate.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
PHOSPHODIESTERASE-5 (PDE-5) INHIBITORS		
Effective 7/1/06, phosphodiesterase-5 (PDE-5) inhibitors are no longer a covered benefit for all Vermont Pharmacy Programs for the treatment of erectile dysfunction. This change is resultant from changes set into effect January 1, 2006 and as detailed in Section 1903 (i)(21)(K) of the Social Security Act (the Act), precluding Medicaid Federal Funding for outpatient drugs used for the treatment of sexual or erectile dysfunction. Sildenafil will remain available for coverage via prior-authorization for the treatment of Pulmonary Arterial Hypertension.		
	Adcirca® (tadalafil) *(Quantity Limit = 2 tablets/day)* Revatio® (sildenafil) (*Quantity Limit = 3 tablets/day)* Revatio® (sildenafil citrate) vial *(Quantity Limit = 3 vials/day, maximum 14 days supply per fill)* sildenafil citrate† (compare to Revatio®) tablet *(Quantity Limit = 3 tablets/day)* Viagra® (sildenafil) (*Quantity Limit = 3 tablets/day)*	**Adcirca (tadalafil) 20 mg, Revatio (sildenafil citrate) 20 mg, sildenafil citrate 20 mg:** Clinical diagnosis of pulmonary hypertension AND No concomitant use of organic nitrate-containing products AND For approval of Revatio, the patient has a documented intolerance to the generic equivalent. **Viagra (sildenafil citrate) 25 mg, 50 mg, and 100 mg:** Clinical diagnosis of pulmonary hypertension AND No concomitant use of organic nitrate-containing products AND Inadequate response to Revatio (sildenafil) 20 mg or currently maintained on a sildenafil dose of 25 mg TID or higher **Revatio IV:** Clinical diagnosis of pulmonary hypertension AND No concomitant use of organic nitrate-containing products AND The patient has a requirement for an injectable dosage form. AND Arrangements have been made for IV bolus administration outside of an inpatient hospital setting.
PLATELET INHIBITORS		
AGGREGATION INHIBITORS CILOSTAZOL† (compare to Pletal®) CLOPIDOGREL†75 mg (compare to Plavix®)	Brilinta® (ticagrelor) Tablet *QL = 2 tablets/day* Plavix®* 75 mg (clopidogrel bisulfate) Pletal®* (cilostazol)	**Agrylin, Persantine, Plavix, Pletal:** The patient has had a documented intolerance to the generic formulation of the medication. **Brilinta:** The patient is started and stabilized on the medication. (Note: samples are

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
EFFIENT® (prasugrel) Tablet *QL = 1 tablet/day* TICLOPIDINE† (formerly Ticlid®) **OTHER** AGGRENOX® (dipyridamole/Aspirin) ANAGRELIDE† (compare to Agrylin®) ASPIRIN† DIPYRIDAMOLE† (compare to Persantine®)	Zontivity® (vorapaxar) Tablet *QL = 1 tablet/day* Agrylin®* (anagrelide) Persantine®* (dipyridamole)	not considered adequate justification for stabilization.) OR The patient has had a documented side effect, allergy, inadequate response or has a contraindication to at least one preferred platelet inhibitor. **Zontivity:** The patient is started and stabilized on the medication. (Note: samples are not considered adequate justification for stabilization.) OR The patient has a history of myocardial infarction (MI) or peripheral arterial disease (PAD) AND The indication for use is reduction of thrombotic cardiovascular events. AND The medication is being prescribed in combination with aspirin and/or clopidogrel. **Limitations:** Plavix/clopidogrel 300mg is not an outpatient dose and is not covered in the pharmacy benefit.
POST-HERPETIC NEURALGIA AGENTS		
	Gralise® (gabapentin) tablet, starter pack *Quantity Limit = 3 tablets/day* *(Maximum 30 day supply per fill)*	**Gralise:** The patient has a diagnosis of post-herpetic neuralgia (PHN) AND The patient has had a documented side effect, allergy, contraindication or treatment failure with at least one drug from the tricyclic antidepressant class. AND The patient has had an inadequate response to the generic gabapentin immediate-release.
PSORIASIS		
INJECTABLES		
NOTE: Psoriasis Self-Injectables (Enbrel and Humira) must be obtained and billed through our specialty pharmacy vendor, Briova. Stelara may either be obtained and billed through our specialty pharmacy vendor, Briova or through the medical benefit. Please see the Enbrel, Humira or Stelara Prior Authorization/Patient Enrollment Form for instructions. Briova may supply Remicade upon request or you may continue to obtain through your usual supplier.		

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
Preferred Agents After Clinical Criteria Are Met ENBREL® (etanercept) *Quantity limit = 8 syringes/28 days for the first 3 months; then 4 syringes/28 days(50 mg) or 8 syringes/28 days (25 mg) subsequently* HUMIRA® (adalimumab) *Quantity limit = 4 syringes/28 days for one month month; 2 syringes/28 days subsequently*	Non-Pref. Agents After Clinical Criteria Are Met Remicade® (infliximab) Stelara® (ustekinumab) *(Quantity limit = 45 mg (0.5 ml) or 90 mg (1 ml) per dose)* *(90 mg dose only permitted if pt weight > 100 kg)*	**Enbrel:** The prescription must be written by a dermatologist AND The patient has a documented diagnosis of moderate to severe plaque psoriasis and has already been stabilized on Enbrel OR The prescription must be written by a dermatologist AND The patient has a documented diagnosis of moderate to severe plaque psoriasis affecting > 10% of the body surface area (BSA) and/or has involvement of the palms, soles, head and neck, or genitalia and has had a documented side effect, allergy, inadequate treatment response, or treatment failure to at least 2 different categories of therapy [i.e. at least 2 topical agents and at least 1 oral systemic agent, (unless otherwise contraindicated)] from the following categories: Topical agents: emollients, keratolytics, corticosteroids, calcipotriene, tazarotene, etc. Systemic agents: methotrexate, sulfasalazine, azathioprine, cyclosporine, tacrolimus, mycophenylate mofetil, etc. Phototherapy: ultraviolet A and topical psoralens (topical PUVA), ultraviolet A and oral psoralens (systemic PUVA, narrow band ultraviolet B (NUVA), etc. **Humira:** The prescription must be written by a dermatologist AND The patient has a documented diagnosis of moderate to severe plaque psoriasis and has already been stabilized on Humira OR The prescription must be written by a dermatologist AND The patient has a documented diagnosis of moderate to severe plaque psoriasis affecting > 10% of the body surface area (BSA) and/or has involvement of the palms, soles, head and neck, or genitalia and has had a documented side effect, allergy, inadequate treatment response, or treatment failure to at least 2 different categories of therapy [i.e. at least 2 topical agents and at least 1 oral systemic agent, (unless otherwise contraindicated)] from the following categories: Topical agents: emollients, keratolytics, corticosteroids, calcipotriene, tazarotene, etc. Systemic agents: methotrexate, sulfasalazine,

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		azathioprine, cyclosporine, tacrolimus, mycophenylate mofetil, etc. Phototherapy: ultraviolet A and topical psoralens (topical PUVA), ultraviolet A and oral psoralens (systemic PUVA, narrow band ultraviolet B (NUVA), etc. **Remicade:** The prescription must be written by a dermatologist AND The patient has a documented diagnosis of moderate to severe plaque psoriasis and has already been stabilized on Remicade OR The prescription must be written by a dermatologist ANDThe patient has a documented diagnosis of moderate to severe plaque psoriasis affecting > 10% of the body surface area (BSA) and/or has involvement of the palms, soles, head and neck, or genitalia and has had a documented side effect, allergy, inadequate treatment response, or treatment failure to at least 2 different categories of therapy [i.e. at least 2 topical agents and at least 1 oral systemic agent, (unless otherwise contraindicated)] from the following categories:Topical agents: emollients, keratolytics, corticosteroids, calcipotriene, tazarotene, etc. Systemic agents: methotrexate, sulfasalazine, azathioprine, cyclosporine, tacrolimus, mycophenylate mofetil, etc.Phototherapy: ultraviolet A and topical psoralens (topical PUVA), ultraviolet A and oral psoralens (systemic PUVA, narrow band ultraviolet B (NUVA), etc. The prescriber must provide a clinically valid reason why either Enbrel® or Humira® cannot be used. **Stelara:** The prescription must be written by a dermatologist AND The patient has a documented diagnosis of moderate to severe plaque psoriasis and has already been stabilized on Stelara OR The prescription must be written by a dermatologist AND The patient has a documented diagnosis of moderate to severe plaque psoriasis affecting > 10% of the body surface area (BSA) and/or

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		has involvement of the palms, soles, head and neck, or genitalia and has had a documented side effect, allergy, inadequate treatment response, or treatment failure to at least 2 different categories of therapy [i.e. at least 2 topical agents and at least 1 oral systemic agent, (unless otherwise contraindicated)] from the following categories: Topical agents: emollients, keratolytics, corticosteroids, calcipotriene, tazarotene, etc. Systemic agents: methotrexate, sulfasalazine, azathioprine, cyclosporine, tacrolimus, mycophenylate mofetil, etc.Phototherapy: ultraviolet A and topical psoralens (topical PUVA), ultraviolet A and topical psoralens (topical PUVA), ultraviolet A and oral psoralens (systemic PUVA, narrow band ultraviolet B (NUVA), etc.The prescriber must provide a clinically valid reason why either Enbrel® or Humira® cannot be used.
NON-BIOLOGICS		
ORAL CYCLOSPORINE † (all brand and generic) METHOTREXATE † (all brand and generic) METHOXSALEN† (compare to Oxsoralen-Ultra®) SORIATANE® (acitretin) capsules **TOPICAL** CALCIPOTRIENE† Solution (compare to Dovonex®) CALCIPOTRIENE® Ointment (formerly Dovonex®) DOVONEX® (calcipotriene cream) PSORIATEC®, DRITHO-SCALP® (anthralin cream)	Acitretin† (compare to Soriatane®) capsules Oxsoralen-Ultra® (methoxsalen) Calcipotriene† cream (compare to Dovonex®) Calcitrene® (calcipotriene) ointment calcitriol† (compare to Vectical®) Ointment *(Quantity Limit = 200 g (2 tubes)/week)* Calcipotriene/betamethasone ointment† (compare to Taclonex®)	**Acritretin Capsules:** The patient has a documented intolerance to brand Soriatane capsules. **Calcitrene Ointment:** The patient has a documented intolerance to Calcipotriene ointment. **Calcipotriene Cream:** The patient has a documented intolerance to the brand Dovonex cream. **Dovonex Solution:** The patient has a documented intolerance to the generic product. **Oxsoralen-Ultra:** The patient has a documented intolerance to the generic equivalent. **Taclonex or calcipotriene/betamethasone diproprionate Ointment or Scalp Suspension:** The patient has had an inadequate response to a 24 month trial of a betamethasone dipropionate product and Dovonex (or generic calcipotriene),

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
TAZORAC® (tazarotene cream, gel)	*(QL for initial fill = 60 grams)* Dovonex®* solution (calcipotriene) Sorilux® (calcipotriene) foam Taclonex® (calcipotriene/betamethasone ointment/scalp suspension) *(QL for initial fill = 60 grams)* Vectical® Ointment (calcitriol) *(Quantity Limit = 200 g (2 tubes)/week)*	simultaneously, with significant non-adherence issues. AND The patient has had a documented side effect, allergy, or treatment failure with Tazorac 0.05% or 0.1% cream or gel. Note: If approved, initial fill of Taclonex® or calcipotriene/betamethasone diproprionate will be limited to 60 grams. **Vectical Ointment, Calcitriol Ointment:** The patient ≥ 18 years of age AND The patient has a diagnosis of mild-to-moderate plaque psoriasis AND The patient has demonstrated inadequate response, adverse reaction or contraindication to calcipotriene AND If the request is for brand Vectical, the patient has hads a documented intolerance to the generic product. **Sorilux:** The patient ≥ 18 years of age AND The patient has a diagnosis of plaque psoriasis AND The patient has demonstrated inadequate response or intolerance to other dosage forms of calcipotriene (brand or generic) **Limitations:** Kits with non-drug or combinations of 2 drug products are not covered.
PULMONARY AGENTS		
ANTICOLINERGICS: INHALED		
METERED DOSE INHALER (SINGLE AGENT) **Short Acting** ATROVENT HFA® (ipratropium) *Quantity Limit = 2 inhalers/25 days* **Long Acting** SPIRIVA® (tiotropium)	Tudorza® Pressair (aclidinium bromide) *Quantity Limit = 1 inhaler/30 days*	**Anoro Ellipta:** patient has a diagnosis of COPD (not FDA approved for asthma). **Duoneb Nebulizer:** The patient has a documented intolerance to generic ipratropium/albuterol nebulizer.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
Quantity Limit = 1 capsule/day NEBULIZER (SINGLE AGENT) IPRATROPIUM SOLN FOR INHALATION METERED DOSE INHALER (COMBO PRODUCT) **Short Acting** COMBIVENT® (ipratropium/albuterol) *Quantity Limit = 2 inhalers/30 days* COMBIVENT® RESPIMAT (ipratropium/albuterol) *Quantity Limit = 1 inhaler (4 grams)/30 days* **Long Acting** **All require PA.** NEBULIZER (COMBINATION PRODUCT) IPRATROPIUM/ALBUTEROL† (compare to Duoneb®)	Anora® Ellipta (umeclidinium/vilanterol) *Quantity Limit = 1 inhaler (60 blisters)/30 days* Duoneb®* (ipratropium/albuterol)	
ANTIHISTAMINES: INTRANASAL		
	SINGLE AGENT Astelin® (azelastine) Nasal Spray *Quantity Limit = 1 bottle (30 ml)/30 days* Astepro® (azelastine 0.15 %) Nasal Spray *Quantity Limit = 1 bottle (30 ml)/30 days*	**ASTELIN, ASTEPRO, AZELASTINE, DYMISTA, OLOPATADINE,** **PATANASE:** The diagnosis or indication for the requested medication is allergic rhinitis. AND The patient has had a documented side effect, allergy, or treatment failure to loratadine (OTC) OR cetirizine (OTC) AND a preferred nasal corticosteroid used in combination. AND If the request is for Astepro, the

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	azelastine (compare to Astelin®) Nasal Spray *Quantity Limit = 1 bottle (30 ml)/30 days* azelastine 0.15 % (compare to Astepro®) Nasal Spray *Quantity Limit = 1 bottle (30 ml)/30 days* Olopatadine † 0.6% (compare to Patanase®) Nasal Spray *Quantity Limit = 1 bottle (31 gm)/30 days* Patanase® (olopatadine 0.6%) Nasal Spray *Quantity Limit = 1 bottle (31 gm)/30 day* COMBO WITH CORTICOSTEROID Dymista® (azelastine/fluticasone) Nasal Spray *Quantity Limit = 1 bottle (23 gm)/30 days*	patient has a documented intolerance to the generic equivalent.
ANTIHISTAMINES: 1ST GENERATION		
All generic antihistamines All generic antihistamine/decongestant combinations	All brand antihistamines (example: Benadryl®) All brand antihistamine/decongestant combinations (example: Deconamine SR®, Rynatan®, Ryna-12®)	**CRITERIA FOR APPROVAL:** The prescriber must provide a clinically valid reason for the use of the requested medication including reasons why any of the generically available products would not be a suitable alternative.
ANTIHISTAMINES: 2ND GENERATION		
SINGLE AGENT TABLET	Clarinex® (desloratadine) 5 mg tablet Claritin®* tablets OTC (loratadine) 10 mg	**FEXOFENADINE 60MG/180 MG TABLETS:** The diagnosis or indication for the requested medication is allergic rhinitis or chronic idiopathic urticaria. AND The patient has had a documented side effect, allergy, or treatment failure to

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
LORATADINE † (OTC) (Allergy Relief®, Alavert®) (compare to Claritin®) 10 mg tablet CETIRIZINE† OTC (formerly Zyrtec®) 5 mg, 10 mg tablets **After loratadine OTC and cetirizine OTC trials** FEXOFENADINE † 60 mg, 180 mg (OTC) tablets (formerly Allegra®) **COMBINATION WITH PSEUDOEPHEDRINE** LORATADINE/PSEUDOEPHEDRINE SR 12hr 5 mg/120 MG † (OTC) (Alavert Allergy/Sinus®) (compare to Claritin D® 12 hr) LORATADINE/PSEUDOEPHEDRINE SR 24hr 10 mg/240 MG †(OTC) (compare to Claritin D® 24 hr) **SINGLE AGENT ORAL LIQUID** LORATADINE † (OTC) syrup (Allergy Relief®) (compare to Claritin®) CETIRIZINE † (OTC, RX) syrup **CHEWABLE/ORALLY DISINTEGRATING TABLET**	desloratadine† (compare to Clarinex®) 5 mg tablet Levocetirizine† (compare to Xyzal®) 5 mg tablet Xyzal® (levocetirizine) 5 mg tablet All other brands Cetirizine/Pseudoephedrine SR 12hr 5 mg/120 mgOTC† Clarinex-D® 12 hr (desloratadine/pseudoephedrine 2.5 mg/120 mg) Clarinex-D® 24 hr (desloratadine/pseudoephedrine 5 mg/240 mg) Claritin-D 12 hr®*§ (loratadine/pseudoephedrine 5 mg/120 mg) Claritin-D 24 hr®*§ (loratadine/pseudoephedrine 10 mg/240 mg) Clarinex Syrup® (desloratadine) Claritin OTC Syrup®* (loratadine) Levocetirizine (compare to Xyzal®) Solution Xyzal® (levocetirizine) Solution Zyrtec®* Children's Allergy (only one NDC) Certirizine † OTC Chewable Tablets 5 mg, 10 mg	loratadine (OTC) AND cetirizine (OTC). **CLARINEX TABLETS, CLARITIN TABLETS, DESLORATADINE TABLETS, LEVOCETIRIZINE TABLETS, XYZALTABLETS:** The diagnosis or indication for the requested medication is allergic rhinitis or chronic idiopathic urticaria.AND The patient has had a documented side effect, allergy, or treatment failure to loratadine (OTC) AND cetirizine (OTC). AND The patient has had a documented side effect, allergy, or treatment failure to fexofenadine. AND If the request is for Clarinex or Xyzal, the patient must also have a documented intolerance to the generic equivalent tablets. **CERTIRIZINE CHEWABLE TABLETS, CLARINEX REDITABS, CLARITIN CHEWABLE TABLETS, CLARITIN REDITABS, DESLORATADINE ODT, ZYRTEC ALLERGY OTC DISINTEGRATING TABLETS:** The diagnosis or indication for the requested medication is allergic rhinitis or chronic idiopathic urticaria.AND The patient has had a documented side effect, allergy, or treatment failure to loratadine (OTC) rapidly disintegrating tablets or requires less than a 10 mg dose of loratadine. AND If the request is for Clarinex Reditabs, the patient must also have a documented intolerance to the generic equivalent tablets **CLARINEX SYRUP, CLARITIN OTC SYRUP, LEVOCETIRIZINE SOLUTION, XYZAL SOLUTION, ZYRTEC CHILDREN'S ALLERGY** **ORAL LIQUID :** The diagnosis or indication for the requested medication is allergic rhinitis or chronic idiopathic urticaria.AND The patient has had a documented side effect, allergy, or treatment failure to loratadine syrup AND cetirizine syrup. AND If the request is for Xyzal, the patient must also have a documented intolerance to levocetirizine solution.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
LORATADINE † (OTC) (Allergy Relief®, Alavert®) rapidly disintegrating tablet (RDT) (compare to Claritin®) 10 mg	Clarinex Reditabs®§ (desloratadine) 2.5 mg, 5 mg Claritin (loratadine) OTC Chewable Tablets®§ 5 mg Claritin (loratadine) OTC Reditabs®§ 5 mg, 10 mg* Desloratadine ODT (compare to Clarinex Reditabs®) 2.5 mg, 5 mg Zyrtec Allergy® OTC (cetirizine orally disintegrating tablet) 10 mg All other brands	**CETIRIZINE D, CLARINEX-D, CLARITIN-D:** The diagnosis or indication for the requested medication is allergic rhinitis. AND The patient has had a documented side effect, allergy, or treatment failure to loratadine-D (OTC). **LIMITATIONS:** Many Allegra® and Zyrtec® brand products as well as Claritin capsules are not covered as no Federal Rebate is offered. Fexofenadine suspension not covered as no Federal Rebate is offered. Fexofenadine/pseudoephedrine combination products) (brand and generic) are not covered – individual components may be prescribed separately.
BETA-ADRENERGIC AGENTS		
METERED-DOSE INHALERS (SHORT-ACTING) PROAIR® HFA (albuterol) PROVENTIL® HFA (albuterol) MAXAIR® Autohaler (pirbuterol)	Ventolin® HFA (albuterol) Xopenex® HFA (levalbuterol) Arcapta® Neohaler (indacaterol) *(criteria for LABA must also be met)* *Quantity Limit = 1 capsule/day*	**Metered Dose Inhalers (Long-Acting):** Effective 11/1/06, prior-authorization will be required for long-acting beta-adrenergic (LABA) MDIs for patients who have not been on a controller medication in the past 6 months or who do not have a diagnosis of COPD. **Foradil, Serevent:** The patient has a diagnosis of COPD OR The patient has a diagnosis of asthma and is prescribed an inhaled corticosteroid as a controller medication.
METERED-DOSE INHALERS (LONG-ACTING) FORADIL® (formoterol) *(after criteria for LABA are met)* *Quantity Limit = 60 capsules/month* SEREVENT® DISKUS (salmeterol xinafoate) *(after criteria for LABA*	Striverdi Respimat® Accuneb®* (albuterol sulfate neb solution 0.63 mg/3 ml and 1.25 mg/3 ml) Levalbuterol † neb solution (compare to Xopenex®) (all ages) Xopenex® neb solution (age > 12 yrs)	**Arcapta, Striverdi :** The patient has a diagnosis of COPD (not FDA approved for asthma). AND The patient has a documented side effect, allergy, or treatment failure to either Foradil or Serevent. **Accuneb nebulizer solution 0.63 mg/3 ml and 1.25 mg/3 ml:** The patient must have had a documented intolerance to the generic formulation.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
are met) *Quantity Limit = 60 blisters/30 days*		**Levalbuterol nebulizer solution (age < 12 years):** The patient must have had a documented intolerance to the brand Xopenex nebulizer solution. **Levalbuterol nebulizer solution (age > 12 years):** The patient must have had a documented side effect, allergy, or treatment failure to albuterol nebulizer. AND The patient must have had a documented intolerance to the brand Xopenex nebulizer solution.
NEBULIZER SOLUTIONS (SHORT-ACTING) ALBUTEROL † 0.63 mg/3 ml and 1.25 mg/3 ml neb solution (compare to Accuneb®) ALBUTEROL † 2.5 mg/3 ml neb solution ALBUTEROL † 5 mg/ml neb solutionXOPENEX® neb solution (levalbuterol HCL) (age ≤ 12 yrs)	Brovana® (arformoterol) *QL = 2 vial/day* Perforomist® (formoterol) *QL = 2 vial/day*	**Xopenex nebulizer solution (age >12 years):** The patient must have been started and stabilized on the requested medication. OR The patient must have had a documented side effect, allergy, or treatment failure to albuterol nebulizer. **Brovana or Perforomist Nebulizer Solution:** The patient must have a diagnosis of COPD. AND The patient must be unable to use a non-nebulized long-acting bronchodilator or anticholinergic (Foradil, Serevent or Spiriva) due to a physical limitation
NEBULIZER SOLUTIONS (LONG-ACTING)	Brethine®* (terbutaline) metaproterenol tablets/syrup † terbutaline tablets † (compare to Brethine®)	**Metaproterenol tablets/syrup:** The patient has had a documented side effect, allergy or treatment failure with generic albuterol tablets/syrup. **Terbutaline, Brethine tablets:** The medication is not being prescribed for the prevention/treatment of preterm labor. AND If Brethine is requested, the patient must have had a documented side effect, allergy, or treatment failure to generic terbutaline tablets.
TABLETS/SYRUP (SHORT-ACTING) ALBUTEROL † tablets/syrup	Vospire ER®* (albuterol)	
TABLETS (LONG-ACTING) ALBUTEROL ER † tablets		**Ventolin HFA, Xopenex HFA:** The patient must have had a documented side effect, allergy, or treatment failure to ONE preferred short acting metered dose inhaler. **Vospire ER tablets:** The patient must have had a documented side effect, allergy, or treatment failure to generic albuterol ER tablets.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
CORTICOSTEROIDS/COMBINATIONS: INHALED		
METERED DOSE INHALERS (SINGLE AGENT) AEROSPAN® (flunisolide HFA) *(QL = 6 inhalers (53.4 gm)/90 days)* ASMANEX® 110 or 220 mcg/inh (mometasone furoate) *(QL =3 inhalers/90 days)* FLOVENT® DISKUS (fluticasone propionate) *(QL = 3 inhalers/90 days)* FLOVENT® HFA (fluticasone propionate) *(QL = 36 gm(3 inhalers)/90 days)* PULMICORT FLEXHALER® (budesonide) *(QL = 6 inhalers/90 days)* QVAR® 40 mcg/inh (beclomethasone) *(QL = 17.4 gm (2 inhalers)/90 days)* QVAR® 80 mcg/inh (beclomethasone) *(QL = 58.4 gm (8 or 6 inhalers)/90 days)* **METERED DOSE INHALERS (COMBINATION PRODUCT)** ADVAIR® DISKUS (fluticasone/salmeterol) *(QL = 3 inhalers/90 days)*	Alvesco® (ciclesonide) *(QL = 18.3 gm (3 inhalers)/90 days)) (80 mcg/inh)* *(QL =36.6 gm (6 inhalers)/90 days)) (160 mcg/inh)*	**Metered-dose inhalers (single agent):** The patient has been started and stablized on the medication. OR The patient has had a documented side effect, allergy, or treatment failure to at least two preferred agents.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ADVAIR® HFA (fluticasone/salmeterol) *(QL = 36 gm (3 inhalers)/90 days)* DULERA® (mometasone/formoterol) *(QL = 39 gm (3 inhalers)/90 days)* SYMBICORT® (budesonide/formoterol) *(QL = 30.6 gm (3 inhalers)/90 days)* **NEBULIZER SOLUTIONS** PULMICORT RESPULES® (budesonide) (age ≤ 12 yrs)	Breo Ellipta® (fluticasone furoate/vilanterol) *(QL = 180 blisters(3 inhalers)/90 days)* Budesonide Inh Suspension (compare to Pulmicort Respules®) (all ages) Pulmicort Respules® (budesonide) (age > 12 years)	**Breo Ellipta:** The patient has a diagnosis of COPD (Note: Will not be approved for use in asthma). AND The patient has had a documented side effect, allergy,or treatment failure to Advair or Symbicort. **Budesonide Inh Suspension (all ages):** The patient requires a nebulizer formulation. AND The patient has a documented intolerance to the brand product. **Pulmicort Respules (age > 12 years):** The patient requires a nebulizer formulation.
CORTICOSTEROIDS: INTRANASAL		
SINGLE AGENT FLUTICASONE Propionate† (compare to Flonase®) *QL = 16 gm (1 inhaler)/30 days* NASONEX® (mometasone) *QL = 17 gm (1 inhaler)/30 days*	Beconase AQ® (beclomethasone) *QL =50 gm (2 inhalers)/30 days* budesonide † (compare to Rhinocort Aqua®) *QL = 8.6 gm (1 inhaler)/30 days* Flonase®* (fluticasone propionate) *QL = 16 gm (1 inhaler)/30 days* flunisolide † 25 mcg/spray (formerly Nasalide®) *QL = 50 ml (2 inhalers)/30 days* flunisolide† 29 mcg/spray (formerly Nasarel®) *QL = 50 ml (2 inhalers)/30 days* Nasacort AQ® (triamcinolone) *QL = 16.5 gm (1 inhaler)/30 days* Omnaris® (ciclesonide)	**Beconase AQ, Budesonide, Flonase, Flunisolide 25 mcg/spray, Flunisolide 29 mcg/spray, Nasacort AQ, Omnaris, QNASL, Rhinocort Aqua, triamcinolone, Veramyst, Zetonna:** The patient has had a documented side effect, allergy, or treatment failure to BOTH preferred nasal glucocorticoids. If the request is for Nasacort AQ® or Rhinocort Aqua®, the patient has also had a documented intolerance to the generic equivalent. **Dymista:** The diagnosis or indication is allergic rhinitis. AND The patient has had a documented side effect, allergy, or treatment failure to loratadine (OTC) OR cetirizine (OTC) AND a preferred nasal corticosteroid used in combination. **Limitations:** Nasacort Allergy OTC not covered as no Federal Rebate is offered. Nasacort AQ RX available after PA obtained.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	QL = 12.5 gm (1 inhaler)/30 days QNASL® (beclomethasone diproprionate) HFA *QL = 8.7 gm (1 inhaler)/30 days* Rhinocort Aqua® (budesonide) *QL = 8.6 gm (1 inhaler)/30 days* triamcinolone † (compare to Nasacort AQ®) *QL = 16.5 gm (1 inhaler)/30 days* Veramyst® (fluticasone furoate) *QL = 10 gm (1 inhaler)/30 days* Zetonna® (ciclesonide) *QL = 6.1 gm (1 inhaler)/30 days* **COMBINATION WITH ANTIHISTAMINE** Dymista® (azelastine/fluticasone) *QL = 23 gm (1 inhaler)/30 days*	
LEUKOTRIENE MODIFIERS		
Preferred After Clinical Criteria Are Met Montelukast sodium† (compare to Singulair®) tablets§ Montelukast sodium† (compare to Singulair®) chews§ 4mg for ages 2-5, 5mg for age 6-14 Montelukast sodium† (compare to Singulair®) granules§ ages 6months-23months	Accolate® (zafirlukast) § *Quantity Limit = 2 tablets/day* Singulair® (montelukast sodium) § tablets, chew tabs, granules *Quantity Limit = 1 tablet or packet per day* zafirlukast (compare to Accolate®) § Zyflo (zileuton) *Quantity Limit = 2 tablets/day* Zyflo CR® (zileuton SR) *Quantity Limit = 4 tablets/day*	**Montelukast:** • The diagnosis or indication for the requested medication is asthma. • The diagnosis or indication for the requested medication is allergic rhinitis. The patient has had a documented side effect, allergy, or treatment failure to a second generation non-sedating antihistamine and a nasal corticosteroid. • The diagnosis or indication for the requested medication is urticaria. The patient has had a documented side effect, allergy, or treatment failure to at least TWO preferred 2nd generation antihistamines (i.e. loratadine (OTC), cetirizine (OTC), fexofenadine).

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		• If the request is for brand Singulair tablets, chew tablets or granules; the patient has a documented intolerance to the generic equivalent montelukast preparation. **Zafirlukast, Accolate:** The diagnosis or indication for the requested medication is asthma. AND If the request is for Accolate, the patient has a documented intolerance to generic zafirlukast. **Zyflo/Zyflo CR:** The diagnosis or indication for the requested medication is asthma. AND The patient has had a documented side effect, allergy, or treatment failure to Accolate or Singulair/Montelukast. **Montelukast chewable and granules:** Will only be approved for appropriate FDA approved age and indications.
SYNAGIS		
	SYNAGIS® (palivizumab) *Quantity Limit = 1 vial/month (50 mg) or 2 vials/month (100 mg)*	**CRITERIA FOR APPROVAL:** Infants born at 28 weeks of gestation or earlier (i.e., ≤ 28 weeks, 6 days) and under twelve months of age at the start of the RSV season (maximum 5 doses). Infants born at 29-32 weeks (i.e., between 29 weeks, 0 days and 31 weeks, 6 days) of gestation and under 1 year of age at the start of the RSV season who develop chronic lung disease of prematurity defined as a requirement for >21% oxygen for at least the first 28 days after birth (maximum 5 doses). Children under 24 months of age with chronic lung disease of prematurity defined as born at 31 weeks, 6 days or less who required >21% oxygen for at least the first 28 days after birth and continue to require medical support (chronic corticosteroid therapy, diuretic therapy, or supplemental oxygen) during the 6-month period before the start of the second RSV season (maximum 5 doses).

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		Children under 12 months of age with hemodynamically significant congenital heart disease (CHD) (dosing continues in the RSV season through the end of the month the infant reaches 12 months old -maximum 5 doses): Acyanotic heart disease and receiving medication to control congestive heart failure and will require cardiac surgical procedures, Moderate to severe pulmonary hypertension , Cyanotic heart disease and recommended for Synagis therapy by Pediatric Cardiologist Infants under 12 months of age with either: (dosing continues in the RSV season through the end of the month the infant reaches 12 months old -maximum 5 doses) Congenital abnormalities of the airways that impairs the ability to clear secretions from the upper airway because of ineffective cough, Neuromuscular condition that impairs the ability to clear secretions from the upper airway because of ineffective cough Infants and children less than 24 months of age who will undergo a heart transplant during the RSV season Infants and children less than 24 months of age who are profoundly immunocompromised during the RSV season (e.g. undergoing organ or stem cell transplant or receiving chemotherapy). **EXCLUDED FROM APPROVAL:** Infants and children with hemodynamically insignificant heart disease. Infants with cardiac lesions adequately corrected by surgery, unless they continue to require medication for congestive heart failure. Infants with mild cardiomyopathy who are not receiving medical therapy. Breakthrough hospitalization for RSV disease (Synagis therapy should be discontinued for the season once hospitalization for RSV has occurred).

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		Infants and children with Down syndrome unless other indications above are present. Infants and children with cystic fibrosis unless other specific conditions are present This drug must be obtained and billed through our specialty pharmacy vendor for Synagis, Wilcox Home Infusion, and processed through the DVHA POS prescription processing system using NDC values. Under no circumstances will claims processed through the medical benefit be accepted.
XOLAIR		
	Xolair® (omalizumab) 150 mg subcutaneous injection vial *Quantity limit = 6 vials every 28 days*	**Criteria for Approval:** Patient must have a diagnosis of moderate to severe persistent asthma. AND patient is 12 years of age or older AND Patient has tried and failed an inhaled oral corticosteroid (with or without chronic pral corticosteroid therapy) or has a contraindication to an inhaled corticosteroid. AND Patient has tried and failed a leukotriene receptor antagonist or has a contraindication to a leukotriene receptor antagonist. AND Patient has tried and failed a long acting beta-agonist or has a contraindication to a long acting beta-agonist. AND A pulmonologist/allergist/immunologist consult has been obtained within the past year. AND Patient has tested positive to at least one perennial aeroallergen by a skin or blood test (i.e.: RAST, CAP, intracutaneous test). AND Patient has an IgE level ≥ 30 and ≤ 700 IU/ml prior to beginning therapy with Xolair.This drug must be billed through the DVHA POS prescription processing system using NDC values. J codes will NOT be accepted. **Limitations:** Xolair use will not be approved if requested for prevention of peanut related allergic reaction.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
PULMONARY ARTERIAL HYPERTENSION MEDICATIONS		
ENDOTHELIAN RECEPTOR ANTAGONISTS LETAIRIS® (ambrisentan) Tablet *Quantity Limit = one tablet/day* TRACLEER® (bosentan) Tablet *Quantity Limit = 2 tablets/day* **PROSTANOIDS** **Injection** EPOPROSTENOL † (compare to Flolan®) REMODULIN® (treprostinil sodium injection) VELETRI® (epoprostinil) **Inhalation** TYVASO® (treprostinil inhalation solution) VENTAVIS® (iloprost inhalation solution) **Oral** ORENITRAM® (treprostinil) ER Tablet **sGC STIMULATOR** ****Maximum days supply for all drugs is 30 days****	Opsumit® (macitentan) Tablet *Quantity Limit = one tablet/day* Flolan®* (epoprostenol) Adempas® (riociguat) Tablets *Quantity Limit = 3 tablets/day*	**Adempas:** The patient has a diagnosis of pulmonary arterial hypertension (PAH) WHO Group I with New York Heart Association (NYHA) Functional Class II or III. OR The patient has a diagnosis of chronic thromboembolic pulmonary hypertension (CTEPH, WHO Group 4) AND the patient has persistent or recurrent disease after surgical treatment (e.g., pulmonary endarterectomy) or has CTEPH that is inoperable.AND The patient is 18 years of age or older AND The patient will not use Adempas concomitantly with the following: Nitrates or nitric oxide donors (such as amyl nitrate) in any form. Phosphodiesterase (PDE) inhibitors, including specific PDE-5 inhibitors (such as sildenafil, tadalafil, or vardenafil) or non-specific PDE inhibitors (such as dipyridamole or theophylline) AND The patient is not pregnant AND Female patients are enrolled in the Adempas REMS Program **Flolan:** Clinical diagnosis of pulmonary hypertension AND The patient has had a documented intolerance to the generic epoprostenol. **Opsumit:** Patient has a diagnosis of PAH WHO Group 1 with NYHA Functional Class II or III AND Patient is not pregnant AND Female patients have been enrolled in the Opsumit REMS Program

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
RENAL DISEASE: PHOSPHATE BINDERS		
CALCIUM ACETATE † (compare to Phos Lo®) capsule CALCIUM ACETATE † (compare to Eliphos®) tablet FOSRENOL® (lanthanum carbonate) RENAGEL® (sevelamer)	Eliphos®* (calcium acetate) tablet Phos Lo®* (calcium acetate) capsule Phoslyra® (calcium acetate) oral solution Renvela® (sevelamer carbonate) Oral Suspension Packet *(QL = 2 packs/day (0.8 g strength only))* Renvela® (sevelamer carbonate) tablets Sevelamer carbonate (compare to Renvela®) 800 mg tablet Velphoro® (sucroferric oxyhydroxide) Chew Tablet	**Eliphos, PhosLo :** The patient must have a documented intolerance to the generic equivalent calcium acetate tablet or capsule. **Phoslyra :** The patient has a requirement for a liquid dosage form. **Renvela Oral Suspension Packet:** The patient has a requirement for a liquid dosage form. **Renvela tablet, Sevelamer 800 mg Tablet:** The patient must have a documented side effect, allergy, or inadequate response to Renagel (sevelamer hydrochloride). **Velphoro Chew Tablet:** The patient must have a documented side effect, allergy, or inadequate response to one preferred phosphate binder.
RESTLESS LEG SYNDROME MEDICATIONS		
DOPAMINE AGONISTS (ORAL) PRAMIPEXOLE † (compare to Mirapex®) ROPINIROLE† (compare to Requip®) **DOPAMINE AGONISTS (TRANSDERMAL)**	Mirapex®* (pramipexole) Requip®* (ropinirole) Neupro® (rotigotine) transdermal patch *(Quantity Limit = 1 patch/day)* *(1mg, 2 mg and 3 mg patches ONLY)*	**Mirapex, Requip:** The patient has had a documented intolerance to the generic product. **Horizant:** The patient has a diagnosis of restless legs syndrome (RLS). AND The patient has had a documented side effect, allergy, contraindication or treatment failure to generic immediate release ropinirole AND pramipexole. AND The patient has had an inadequate response or adverse reaction to generic gabapentin immediate-release. **Neupro:** The patient is ≥18 years of age AND The patient has a diagnosis of moderate to severe restless legs syndrome (RLS). AND The patient has had a

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
GAMMA-AMINOBUTYRIC ACID ANALOG	Horizant® (gabapentin enacarbil) ER Tablet *(Quantity Limit = 1 tablet/day)*	documented side effect, allergy, contraindication or treatment failure to generic immediate release ropinirole AND pramipexole. OR The prescriber provides medical necessity for the transdermal formulation (eg. swallowing disorder or difficulty taking oral medications). **Limitations:** Requests for Mirapex ER and Requip XL will not be approved for Restless Leg Syndrome (RLS).
RHEUMATOID, JUVENILE & PSORATIC ARTHRITIS: IMMUNOMODULATORS		
Self-injectables/Oral (Enbrel®, Humira®, Cimzia®, Kineret®, Orencia® Subcutaneous, Simponi®, Stelara® & Xeljanz®) must be obtained through Specialy Pharmacy Provider, Briova		
Preferred after Clinical Criteria are Met **Injectable** ENBREL® (etanercept) *(Quantity limit = 4 syringes/28 days(50 mg) and 8 syringes/28 days (25 mg))* HUMIRA® (adalimumab) *(Quantity limit = 4 syringes/28 days)*	**Non-Preferred after Clinical Criteria are Met** Actemra® (tocilizumab) Intravenous Infusion *(Qty limit = 4 vials/28 days (80 mg vial), 3 vials/28 days (200 mg vial) or 2 vials/28 days (400 mg vial))* Actemra® (tocilizumab) Subcutaneous *(Qty limit = 4 prefilled syringes (3.6ml)/28 days)* Cimzia® (certolizumab pegol) *(Quantity limit = 1 kit/28 days (starter X 1, then regular))* Kineret® (anakinra) *(Quantity limit = 1 syringe/day)* Orencia® (abatacept) Subcutaneous Injection *(Quantity limit = 4 syringes/28 days)* Orencia® (abatacept) Intravenous Infusion	**Humira:** Patient has a diagnosis of rheumatoid arthritis (RA), juvenile idiopathic arthritis or psoriatic arthritis and has already been stabilized on Humira OR Diagnosis is RA, juvenile idiopathic arthritis or psoriatic arthritis, and methotrexate therapy resulted in an adverse effect, allergic reaction, inadequate response, or treatment failure. If methotrexate is contraindicated, another DMARD should be tried prior to approving Humira. Note: Approval should be granted in cases where patients have been treated with infliximab, but have lost response to therapy. **Enbrel:** Patient has a diagnosis of RA, juvenile RA (JRA), or psoriatic arthritis and has already been stabilized on Enbrel. OR Diagnosis is RA, JRA, or psoriatic arthritis, and methotrexate therapy resulted in an adverse effect, allergic reaction, inadequate response, or treatment failure. If methotrexate is contraindicated, another DMARD should be tried prior to approving Enbrel.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
Oral	Remicade® (infliximab) Simponi® (golimumab) Subcutaneous *Qty Limit = 1 of 50 mg prefilled syringe or autoinjector/28 days)* Simponi Aria® (golimumab) 50 mg/4 ml Vial for Intravenous Infusion Stelara® (ustekinumab) *(Quantity limit = 45 mg (0.5 ml) or 90 mg (1 ml) per dose)* *(90 mg dose only permitted for pt weight > 100 kg)* Xeljanz® (tofacitinib) tablet *(Qty limit = 2 tablets/day)* *Maximum 30 days supply*	**Actemra Intravenous Infusion:** Patient has a diagnosis of RA or juvenile RA (JRA) and has already been stabilized on Actemra OR Patient age > 18 years (RA) or > 2 years (JRA). AND Diagnosis is RA or juvenile RA (JRA) and patient has documentation of an inadequate response, adverse reaction or allergic response to methotrexate, or if methotrexate is contraindicated, at least 1 other DMARD (other DMARDs include leflunomide, sulfasalazine, gold, antimalarials, minocycline, D-penicillamine, azathioprine, cyclophosphamide and cyclosporine) AND The prescriber must provide a clinically valid reason why either Humira or Enbrel cannot be used. For RA, patient must have had an inadequate response to one or more TNF inhibitors. **Actemra Subcutaneous:** Patient has a diagnosis of RA and has already been stabilized on Actemra (Subcutaneous or Intravenous) OR Patient age > 18 years (RA) AND Diagnosis is RA and patient has documentation of an inadequate response, adverse reaction or allergic response to methotrexate, or if methotrexate is contraindicated, at least 1 other DMARD (other DMARDs include leflunomide, sulfasalazine, gold, antimalarials, minocycline, D-penicillamine, azathioprine, cyclophosphamide and cyclosporine) AND The prescriber must provide a clinically valid reason why either Humira or Enbrel cannot be used. The patient must have had an inadequate response to one or more TNF inhibitors. **Cimzia:** Patient has a diagnosis of RA or psoriatic arthritis and has already been stabilized on Cimzia OR Patient age > 18 years AND Diagnosis is RA or psoriatic arthritis and patient has documentation of an inadequate response, adverse reaction or allergic response to methotrexate, or if methotrexate is contraindicated, at least 1 DMARD (other DMARDs include leflunomide,

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		sulfasalazine, gold, antimalarials, minocycline, D-penicillamine, azathioprine, cyclophosphamide and cyclosporine) AND The prescriber must provide a clinically valid reason why either Humira or Enbrel cannot be used. **Remicade:** Patient has a diagnosis of RA or psoriatic arthritis and has already been stabilized on Remicade OR Diagnosis is RA or psoriatic arthritis, and methotrexate therapy resulted in an adverse effect, allergic raction, inadequate response, or treatment failure. If methotrexate is contraindicated, another DMARD should be tried prior to approving Remicade. AND The prescriber must provide a clinically valid reason why either Humira or Enbrel cannot be used. **Simponi:** Patient has a diagnosis of RA or psoriatic arthritis and has already been stabilized on Simponi OR Patient age > 18 years AND Diagnosis is RA or psoriatic arthritis, and patient has documentation of an inadequate response, adverse Reaction or allergic response to methotrexate, or if methotrexate is contraindicated, at least 1 DMARD (other DMARDs include leflunomide, sulfasalazine, gold, antimalarials, minocycline, D-penicillamine, azathioprine, cyclophosphamide and cyclosporine) AND The prescriber must provide a clinically valid reason why either Humira or Enbrel cannot be used. **Simponi Aria:** Patient has a diagnosis of RA and has already been stabilized on Simponi Aria OR Patient age > 18 years AND Diagnosis is RA and patient has documentation of an inadequate response, adverse reaction or allergic response to methotrexate, or if methotrexate is contraindicated, at least 1 DMARD (other DMARDs include leflunomide, sulfasalazine, gold, antimalarials, minocycline, D-penicillamine, azathioprine, cyclophosphamide and cyclosporine) AND The patient has not responded adequately to Simponi subcutaneous. AND The prescriber must provide a clinically valid reason why either Humira or Enbrel cannot be used.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		Kineret: Patient has a diagnosis of RA and has already been stabilized on Kineret OR Diagnosis is RA or psoriatic arthritis, and methotrexate therapy resulted in an adverse effect, reaction, inadequate response, or treatment failure. If methotrexate is contraindicated, another DMARD should be tried prior to approving Kineret. Note: Kineret may be used as monotherapy or concomitantly with DMARDs, other than TNF antagonists. Kineret should not be administered concomitantly with any TNF antagonists (i.e. Enbrel, Humira, or Remicade). AND The prescriber must provide a clinically valid reason why either Humira or Enbrel cannot be used. **Xeljanz:** Patient has a diagnosis of RA and has already been stabilized on Xeljanz OR Patient age > 18 years AND Diagnosis is RA and patient has documentation of an inadequate response, adverse reaction or allergic response to methotrexate, or if methotrexate is contraindicated, at least 1 non-biologic DMARD (other DMARDs include leflunomide, sulfasalazine, hydroxychloroquine, azathioprine, and cyclosporine) AND The prescriber must provide a clinically valid reason why either Humira or Enbrel cannot be used. **Orencia Intravenous Infusion:** Patient has a diagnosis of RA or juvenile RA (JRA) and has already been stabilized on Orencia OR Diagnosis is RA or juvenile RA (JRA) and methotrexate therapy resulted in an adverse effect, allergic reaction, inadequate response, or treatment failure. If methotrexate is contraindicated, another DMARD should be tried prior to approving Orencia. Note: Orencia may be used as monotherapy or concomitantly with DMARDs, other than TNF antagonists. Orencia® should not be administered concomitantly with TNFantagonists (i.e. Enbrel, Humira, or Remicade) and is not recommended for use with Kineret. AND The prescriber must provide a clinically valid reason why

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		either Humira or Enbrel cannot be used. AND If the diagnosis is RA, there is a clinically valid reason why Orencia Subcutaneous cannot be used. **Orencia Subcutaneous:** Patient has a diagnosis of RA and has already been stabilized on Orencia OR Diagnosis is RA and methotrexate therapy resulted in an adverse effect, allergic reaction, inadequate Response, or treatment failure. If methotrexate is contraindicated, another DMARD should be tried prior to approving Orencia. Note: Orencia may be used as monotherapy or concomitantly with DMARDs, other than TNF antagonists. Orencia should not be administered concomitantly with TNFantagonists (i.e. Enbrel, Humira, or Remicade) and is not recommended for use with Kineret. AND The prescriber must provide a clinically valid reason why either Humira or Enbrel cannot be used. **Stelara:** Patient has a diagnosis of psoriatic arthritis and has already been stabilized on Stelara OR Diagnosis is psoriatic arthritis, and patient has documentation of an inadequate response, adverse reaction or allergic response to methotrexate, or if methotrexate is contraindicated, at least 1 DMARD (other DMARDs include leflunomide, sulfasalazine, gold, antimalarials, minocycline, D-penicillamine, azathioprine, cyclophosphamide and cyclosporine) AND The prescriber must provide a clinically valid reason why either Humira or Enbrel cannot be used. **Patients with systemic juvenile arthritis (SJRA/SJIA)** and fever are not required to have a trial of a DMARD, including methotrexate.Patients with systemic juvenile arthritis without fever should have a trial of methotrexate, but a trial of another DMARD in case of a contraindication to methotrexate, is not required before Enbre, Humira, Actemra, or Orencia is approved. * Patients with psoriatic arthritis with a documented diagnosis of active axial involvement should have a trial of NSAID therapy, but a trial with DMARD is not required before a TNF-blocker is approved. If no active axial skeletal involvement, then an NSAID trial

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		and a DMARD trial are required (unless otherwise contraindicated) prior to receiving Humira, Enbrel, Remicade, Cimzia, Stelara or Simponi
SILIVA STIMULANTS		
PILOCARPINE (compare to Salagen®) CEVIMELINE† (compare to Evoxac®) EVOXAC® (cevimeline)	Salagen®* (pilocarpine)	Salagen: The patient has had a documented side effect, allergy, or treatment failure to generic pilocarpine
SEDATIVE/HYPNOTICS		
BENZODIAZEPINE		
ESTAZOLAM† (compare to Prosom®) TEMAZEPAM† 15 mg, 30 mg (compare to Restoril®)	Doral® (quazepam) flurazepam† (formerly Dalmane®) Halcion® (triazolam) Prosom®* (estazolam) Quazepam† (compare to Doral®) Restoril®* (temazepam) temazepam† 7.5 mg, 22.5 mg (compare to Restoril®) triazolam† (compare to Halcion®)	**Criteria for Approval:** The patient has had a documented side effect, allergy, or treatment failure with two preferred benzodiazepine sedative/hypnotics. If a product has an AB rated generic, one trial must be the generic.
NON BENZODIAZEPINE, NON BARBITURATE		
ZOLPIDEM † (compare to Ambien®)*(Quantity*	Ambien®* (zolpidem) *(Quantity Limit = 1 tab/day)*	**Ambien:** The patient has had a documented intolerance to generic zolpidem.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
Limit = 1 tab/day) ZALEPLON † (compare to Sonata®) *(Quantity Limit = 1 cap/day (5 mg) or 2 caps/day (10 mg))*	Ambien CR® (zolpidem) *(Quantity Limit = 1 tab/day)* Edluar® (zolpidem) sublingual tablet *(Quantity Limit = 1 tab/day)* eszopiclone† (compare to Lunesta®) *(Quantity Limit = 1 tab/day)* Intermezzo® (zolpidem) Sublingual Tablet *(Quantity Limit = 1 tab/day)* Lunesta® (eszopiclone) *(Quantity Limit = 1 tab/day)* Rozerem® (ramelteon) *(Quantity Limit = 1 tab/day)* Silenor® (doxepin) *(Quantity limit = 1 tab/day)* Sonata®* (zaleplon) *(Quantity Limit = 1 cap/day (5 mg) or 2 caps/day (10 mg))* Zolpidem CR† (compare to Ambien CR®) *(Quantity Limit = 1 tab/day)* Zolpimist® (zolpidem) Spray (5 mg/spray) *(Qty Limit = 1 canister/30 days)*	**Ambien CR, Lunesta, eszopiclone, Zolpidem CR:** The patient has had a documented side effect, allergy or treatment failure to generic zolpidem. If the request is for brand Ambien CR, there has also been a documented intolerance to the generic. If the request is for generic eszopiclone, there has also been a documented intolerance to the brand Lunesta. **Edluar:** The patient has a medical necessity for a disintegrating tablet formulation (i.e. swallowing disorder). AND The patient has a documented intolerance to Zolpimist. **Intermezzo:** The patient has insomnia characterized by middle-of-the night awakening followed by difficulty returning to sleep AND The patient has had a documented inadequate response to zolpidem IR AND zaleplon. **Rozerem:** The patient has had a documented side effect, allergy, contraindication or treatment failure to generic zolpidem. OR There is a question of substance abuse with the patient or family of the patient. Note: If approved, initial fill of Rozerem will be limited to a 14 day supply. **Silenor:** The patient has had a documented side effect, allergy, contraindication or treatment failure to generic zolpidem AND The patient has had a documented intolerance with generic doxepin or there is another clinically valid reason why a generic doxepin (capsule or oral solution) cannot be used. **Sonata:** The patient has had a documented intolerance to generic zaleplon **Zolpimist:** The patient has a medical necessity for a non-oral dosage form (i.e. swallowing disorder).

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
SKELETAL MUSCLE RELAXANTS		
Musculoskeletal Agents **Single Agent** CHLORZOXAZONE† 500 mg tablets (compare to Parafon Forte DSC®) *(Quantity limit = 4 tablets/day)* CYCLOBENZAPRINE†5 mg, 10 mg tablets (compare to Flexeril®) *(Quantity limit = 6 tablets/day (5 mg), 3 tablets/day (10 mg))* METHOCARBAMOL† 500mg, 750 mg tablets (compare to Robaxin®) *(Quantity limit = 8 tablets/day)* ORPHENADRINE CITRATE ER† (previously Norflex®) 100 mg tablet *(Quantity limit = 2 tablets/day)*	Amrix®(cyclobenzaprine sustained-release) 15 mg, 30 mg capsule *(Quantity limit = 1 capsule/day)* carisoprodol 250 mg tablets *(Quantity limit = 4 tablets/day)* carisoprodol†350 mg (compare to Soma®) tablets *(Quantity limit = 4 tablets/day)* cyclobenzaprine 7.5 mg† tab (compare to Fexmid®) *(Quantity limit = 3 tablets/day)* Fexmid® (cyclobenzaprine) 7.5 mg tablet *(Quantity limit = 3 tablets/day)* Flexeril®* (cyclobenzaprine) 5 mg, 10 mg tablets *(Quantity limit = 3 tablets/day)* Lorzone® (chlorzoxazone) 375 mg, 750 mg tablets *(Quantity limit = 4 tablets/day)* metaxalone† (compare to Skelaxin®) 800 mg tablets *(Quantity limit = 4 tablets/day)* Parafon Forte DSC®* (chlorzoxazone) 500 mg tablets *(Quantity limit = 4 tablets/day)* Robaxin®* (methocarbamol) 500mg, 750 mg tablets *(Quantity limit = 8 tablets/day)* Skelaxin® (metaxalone) 800 mg tablets *(Quantity limit = 4 tablets/day)* Soma® (carisoprodol) 250 mg, 350 mg tablets	**Amrix, cyclobenzaprine 7.5 mg, Fexmid**: The prescriber must provide a clinically valid reason why a preferred generic cyclobenzaprine cannot be used. For approval of Fexmid, the patient must also have a documented intolerance to the generic equivalent. **Brand skeletal muscle relaxants with generics available (Flexeril, Parafon Forte DSC, Robaxin):** The patient has had a documented side effect, allergy or treatment failure with two different preferred musculoskeletal agents (One trial must be the AB rated generic). **carisoprodol, carisoprodol/ASA, carisoprodol/ASA/codeine, Soma, metaxolone, Skelaxin:** The patient has had a documented side effect, allergy or treatment failure with two different preferred musculoskeletal agents. Additionally, if a brand name product is requested where an AB rated generic exists, the patient must also have had a documented intolerance to the generic product. **Lorzone:** The patient has had a documented side effect, allergy or treatment failure with two different preferred musculoskeletal agents. **orphenadrine/ASA/caffeine:** The prescriber must provide a clinically valid reason why generic orphenadrine in combination with aspirin (or another analgesic) cannot be used. **Dantrium, Zanaflex tablets:** The patient must have a documented intolerance with the AB rated generic product. **Tizanadine capsules, Zanaflex capsules:** The prescriber must provide a clinically valid reason why generic tizanidine tablets cannot be used. AND If the request is for Zanaflex capsules, the patient must have a documented intolerance to

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
Combination Product *ASA = aspirin* **Maximum duration of therapy all musculoskeletal agents = 90 days** **Antispasticity Agents** BACLOFEN† (formerly Lioresal®) DANTROLENE† (compare to Dantrium®) TIZANIDINE† (compare to Zanaflex®) tablets	*(Quantity limit = 4 tablets/day)* carisoprodol, ASA† (previously Soma Compound®) *(Quantity limit = 4 tablets/day)* carisoprodol, ASA, codeine† (previously Soma Compound with Codeine®) *(Quantity limit = 4 tablets/day)* Orphenadrine, ASA, caffeine† (previously Norgesic®) *(Quantity limit = 4 tablets/day)* Dantrium®* (dantrolene) tizanidine† (compare to Zanaflex®) capsules Zanaflex® (tizanidine) capsules Zanaflex®* (tizanidine) tablets	generic tizanadin e capsules
SMOKING CESSATION THERAPIES		
NICOTINE REPLACEMENT (maximum duration is 16 weeks (2 x 8 weeks)/365 days for non-preferred. For approval of therapy beyond the established maximum duration, the prescriber must provide evidence that the patient is engaged in a smoking cessation counseling program.		
NICOTINE GUM† NICOTINE PATCH OTC† COMMIT LOZENGE® NICORETTE LOZENGE®	Nicoderm CQ Patch® Nicorette Gum® nicotine lozenge† Nicotrol Inhaler® Nicotrol Nasal Spray®	**Nicoderm CQ patch:** The patient has had a documented intolerance to generic nicotine patch. **Nicorette gum:** The patient has had a documented intolerance to generic nicotine gum.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ORAL THERAPY BUPROPION SR† (compare to Zyban®) CHANTIX® (varenicline) (Limited to 18 years and older, Quantity Limit = 2 tabs/day, max duration 24 weeks (2x12 weeks)/365 days)	Zyban®* (bupropion SR) (maximum duration 24 weeks (2 x 12 weeks)/365 days)	**nicotine lozenge:** The patient has had a documented side effect or allergy to Nicorette lozenge or Commit lozenge. **Nicotrol Inhaler:** The patient has had a documented treatment failure with BOTH generic nicotine patch and generic nicotine gum. **Nicotrol Nasal Spray:** The prescriber must provide a clinically valid reason for the use of the requested medication. **Zyban:** The patient has had a documented intolerance to generic bupropion SR. *Smoking Cessation Counseling is encouraged with the use of smoking cessation therapies* *The combined prescribing of long acting (patch) and faster acting (gum or lozenge) nicotine replacement therapy is encouraged for greater likelihood of quit success. **Vermont QUIT LINE** (available free to all patients) 1-800-QUIT-NOW (1-800-784-8669) **GETQUIT™** Support Plan available free to all Chantix® patients 1-877-CHANTIX (242-6849) **Limitations:** Nicotine System Kit® not covered – prescribe multiple strengths separately
TESTOSTERONE: TOPICAL		
ANDROGEL® GEL (testosterone 1% gel packets) *Quantity limit = 1.25 gm packet (1 packet/day)* *2.5 gm packet (1 %) (1 packet/day)* *5 gm packet (2 packets/day)*	Androderm® Transdermal 2.5 mg, 5 mg (testosterone patch) ANDROGEL® GEL (testosterone 1.62% gel packets)	**Andoderm, Axiron, Fortesta, Testim Testosterone Gel 1%, Testosterone Gel 2 %:** The patient has had a documented side effect, allergy, or treatment failure to AndroGel® Gel or Pump **Limitations:** Coverage of testosterone products is limited to males.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Quantity limit = 1.25 gm packet (1.62%) (1 packet/day) *2.5 gm packet (1.62%) (2 packets/day)* ANDROGEL® PUMP (testosterone pump bottles) *Quantity limit = 1 % (4 bottles/30 days)* *1.62% (2 bottles/30 days)* *Quantity limit = 1 patch/day/strength* Axiron (testosterone 2% solution) 90 ml Pump Bottle *Quantiy limit = 2 bottles/30 days* Fortesta® (testosterone 2 % Gel) 60 gm Pump Bottle *Quantity limit = 2 bottles/30 days* Testim® Gel 5 gm (testosterone 1% gel tube) *Quantity limit = 2 tubes/day* Testosterone 1% gel tube (compare to Testim® Gel 5 gm, Vogelxo®, Androgel®) *Quantity limit = 2 tubes/day* Testosterone† 1% Gel Pump (compare to Androgel®, Vogelxo®) *Quantity limit = 4 bottles/30 days* Testosterone 2% gel 60 gm pump bottle (compare to Fortesta®) *Quantity limit = 2 bottles/30 days* Vogelxo® 1% (testosterone 1%) gel, pump *Quantity limit = 2 tubes/day (5 gm gel tubes)* *Quantity limit = 4 bottles/30 days (gel pump bottle)*	

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Maximum day supply all products is 30 days	
THROMBOPOIETIN RECEPTOR AGONISTS		
	Nplate® (romiplostim) Promacta® (eltrombopag)	**FOR APPROVAL:** The patient is at least 18 years of age. AND The diagnosis or indication is chronic immune (idiopathic) thrombocytopenic purpura (ITP). AND The patient's platelet count is less than 30,000/µL (< 30 x 109/L) or the patient is actively bleeding. AND The patient has had a documented side effect, allergy, treatment failure or a contraindication to therapy with corticosteroids. OR The patient has a documented insufficient response following splenectomy.
URINARY ANTISPASMODICS		
SHORT-ACTING AGENTS OXYBUTYNIN† (compare to Ditropan®) **LONG-ACTING AGENTS (after clinical criteria are met)** **ANTIMUSCARINIC** **Twice Daily Oral *(Qty Limit = 2 per day)***	Ditropan®* (oxybutynin) Flavoxate † (formerly Urispas®) Detrol® (tolterodine) Sanctura® (trospium) tolterodine† (compare to Detrol®) trospium† (compare to Sanctura®)	**CRITERIA FOR APPROVAL:** (for patients >21 and <65 years of age): Please note: Patients <21 years of age are exempt from all ORAL ANTIMUSCARINIC Urinary Antispasmodics PA requirements (Exception: An adequate trial of oxybutynin/oxybutynin XL will be required before approval of Ditropan/Ditropan XL and an adequate trial of tolterodine SR will be required before approval of Detrol LA will be granted for all patients) and patients ≥ 65 years of age are exempt from the short acting oxybutynin trial requirement. **Ditropan, flavoxate, Enablex, Vesicar:** The patient has had a documented side effect, allergy, or treatment failure with generic oxybutynin

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
Once Daily Oral *(Qty Limit = 1 per day)* ENABLEX® (darifenacin) VESICARE® (solifenacin) **Transdermal/Topical** **BETA-3 ADRENERGIC AGONISTS** *>NOTE:* ▪ *Patients under the age of 65 must fail an adequate trial of generic oxybutinin before approval will be granted for either Vesicare® or Enablex®.* ▪ *A therapeutic failure on two long acting preferred products is required before a PA will be approved on any non-preferred long acting medication.* *Recipients < 21 years of age are exempt from all ORAL ANTIMUSCARINIC PA Requirements.(Exception: An adequate trial of oxybutinin/oxybutinin XL will be required before approval of*	Detrol LA® (tolterodine SR) Ditropan XL® (oxybutynin XL) oxybutynin XL† (compare to Ditropan® XL) Sanctura XR® (trospium) tolterodine SR† (compare to Detrol LA®) Toviaz® (fesoterodine trospium ER† (compare to Sanctura XR®) Gelnique 3%® (oxybutynin topical gel) *(Qty limit = 1 pump bottle (92gm)per 30 days)* Gelnique 10%® (oxybutynin topical gel) *(Qty limit = 1 sachet/day)* Oxytrol® (oxybutinin transdermal) *(Qty Limit = 8 patches/28 days)* Myrbetriq® (mirabegron) ER Tablet *(Qty limit = 1 tablet/day)*	**Detrol, Detrol LA, Ditropan XL, Oxybutynin XL, Sanctura, Sanctura XR, tolterodine (generic), tolterodine SR (generic), trospium (generic), trospium ER (generic), Toviaz:** The patient has had a documented side effect, allergy, or treatment failure with generic oxybutynin. AND The patient has had a documented side effect, allergy, or treatment failure with 2 preferred long-acting agents. If a medication has an AB rated generic, there must have also been a trial of the generic formulation. **Gelnique 3%, 10%, Oxytrol:** The patient is unable to swallow a solid oral formulations (e.g. patients with dysphagia) OR The patient is unable to be compliant with solid oral dosage forms. **Myrbetriq:** The patient has had a documented side effect, allergy, treatment failure, or contraindication with one preferred long-acting urinary antimuscarinic agent. **Limitations:** Oxytrol (for Women) OTC not covered. Oxytrol RX is available but subject to prior authorization.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
Ditropan®/Ditropan® XL and tolterodine SR before approval of Detrol LA® will be granted)		
VAGINAL ANTI-INFECTIVES		
CLINDAMYCIN CLINDAMYCIN VAGINAL† (clindamycin vaginal cream 2%) **METRONIDAZOLE** METRONIDAZOLE VAGINAL GEL 0.75%† VANDAZOLE† (metronidazole vaginal 0.75%)	Cleocin®* (clindamycin vaginal cream 2%) Cleocin® Vaginal Ovules (clindamycin vaginal suppositories) Clindesse® (clindamycin vaginal cream 2%) Metrogel Vaginal®* (metronidazole vaginal gel 0.75%)	**Cleocin, Clindesse:** The patient has had a documented side effect, allergy, or treatment failure to generic clindamycin vaginal (clindamycin vaginal) **Metrogel Vaginal:** The patient has had a documented side effect, allergy, or treatment failure to generic metronidazole vaginal gel 0.75 % or Vandazole.
VITAMINS: PRENATAL MULTIVITAMINS		
PRENAPLUS PRENATAL PLUS IRON PRENATAL VITAMINS PLUS PRENATATE AM TAB 1MG PRENATE CAP ENHANCE PRENATE CAP ESSENTIAL	All others including DHA containing products	**DHA Containing Prenatal Vitamins:** The patient is unable to obtain a sufficient amount of DHA from diet alone **All Other Non-Preferred:** The prescriber must provide a clinically valid reason for the use of the requested medication including reasons why any of the preferred products would not be a suitable alternative.

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F

Department of Vermont Health Access
Pharmacy Benefit Management Program

Vermont Preferred Drug List and Drugs Requiring Prior Authorization
(includes clinical criteria)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
PRENATE CAP RESTORE PRENATE CHEW .6-.4 PRENATE DHA CAP PRENATE MINI CAP		

This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
Drugs highlighted in yellow denote a change in PDL status.
To search the PDL, press CTRL + F