EFFECTIVE
Version
Updated: 11/17/2023

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 program 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 Preferred 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 categories there may be drugs or drug classes that are subject to Quantity Limit Parameters.

Therapeutic class criteria are listed alphabetically. Within each category the Preferred 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 requires Prior Authorization. Approval of non-preferred brand name products may require trial and failure of at least 2 different generic manufacturers. Drugs used for weight loss, drugs used to promote fertility, and drugs used for cosmetic purposes or hair growth are excluded from coverage under the Vermont Medicaid Pharmacy program.

Change Healthcare **PRESCRIBER Call Center:** PA Requests Tel: 1-844-679-5363; Fax: 1-844-679-5366 Note: Fax requests are responded to within 24 hrs.	**Change Healthcare** **PHARMACY Call Center:** PA Requests Tel: 1-844-679-5362 Available for assistance with claims processing	**Change Healthcare Sr. Account Manager:** Michael Ouellette, RPh Tel: 802-922-9614 E-Mail: mouellette@changehealthcare.com
	DVHA Pharmacy Unit Staff: Tel: 802-241-0140 Fax: 802-879-5651 E-Mail: ahs.dvhaph@vermont.gov	

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

Contents

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ACNE AGENTS		
ORAL AGENTS		
AMNESTEEM (isotretinoin) capsules CLARAVIS (isotretinoin) capsules ZENATANE (isotretinoin) capsules	Absorica® (isotretinoin) capsules Isotretinoin capsules	**Absorica, Isotretinoin:** patient has had a documented side effect, allergy, or treatment failure with at least two isotretinoin preferred products.
TOPICAL AGENTS		
BENZOYL PEROXIDE PRODUCTS BENZOYL PEROXIDE 2.5%, 5%, 10%G; 3%, 5%, 10% CL; 5.3%, 9.8% F	Benzol Peroxide 5%, 10%L	**Single ingredient products:** patient has had a documented side effect, allergy, or treatment failure with two preferred products including one from the same sub-category,if there is one available. If a product has an AB rated generic, there must have been a trial of the generic. **Benzaclin, Benzamycin:** patient must have a documented intolerance to the generic equivalent. **Sodium Sulfacetamide Products:** patient has had a documented side effect, allergy, or treatment failure with two preferred products, one of which must be Klaron lotion. **Clindamycin/Benzoyl peroxide pump, Onexton:** there must be a clinically compelling reason why clindamycin/benzoyl peroxide gel cannot be used. **Limitations:** Kits with non-drug products are not covered
CLINDAMYCIN PRODUCTS CLINDAMYCIN 1% *S, G, L, P* (compare to Cleocin-T)	Clindacin (clindamycin) 1% CL, P, Swab Clindamycin 1%F Clindamycin 1%G (compare to Clindagel) 75mL bottle Cleocin-T® (clindamycin) 1% L	
ERYTHROMYCIN PRODUCTS ERYTHROMYCIN 2% *S, G*	Erygel® (erythromycin 2% Ery (erythromycin 2%) P	
SODIUM SULFACETAMIDE PRODUCTS KLARON® (sodium sulfacetamide 10% L)	Sodium Sulfacetamide 10% L Sodium Sulfacetamide/Sulfur CL, C, P, E Sodium Sulfacetamide/Sulfur W Sumaxin ® (sulfacetamide/sulfur L, P, W)	
COMBINATION PRODUCTS ERYTHROMYCIN / BENZOYL PEROXIDE CLINDAMYCIN/BENZOYL PEROXIDE (compare to Benzaclin®) G	Benzaclin® (clindamycin/benzoyl peroxide) Benzamycin® (erythromycin/benzoyl peroxide) Clindamycin/Benzoyl Peroxide Pump Onexton® (clindamycin/benzoyl peroxide)	
OTHER *C=cream, CL=cleanser, E=emulsion, F=Foam, G=gel, L=lotion, O=ointment, P=pads, S=solution, W=wash, B=bar*	Dapsone 5%, 7.5% G All other brands any topical acne anti-infective medication	

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
TOPICAL – ANDROGEN RECEPTOR INHIBITORS		
All products require PA	Winlevi® (clascoterone) 1% C	**Winlevi:** patient has had a documented side effect, allergy, or treatment failure with two preferred topical acne agents.
TOPICAL - RETINOIDS		
AVITA® (tretinoin) ADAPALENE 0.1% G, 0.3% G DIFFERIN® (adapalene) 0.1% G RETIN-A® (tretinoin) 0.025%, 0.05%, 0.1% C; 0.01%, 0.025% G C= *cream*, G=*gel*, L=*lotion*	Adapalene (compare to Differin®) 0.1% C Adapalene/Benzoyl Peroxide 0.1-2.5% G Altreno™ (tretinoin) 0.05% L Arazlo® (tazarotene) 0.045% L Atralin® (tretinoin) 0.05% G Clindamycin/tretinoin 1.2-0.025% G Fabior® (tazarotene) 0.1% F Plixda® (adapalene) 0.1% swabs Retin-A Micro® (tretinoin microsphere) 0.04%, 0.06%, 0.08%, 0.1% G Tazarotene (compare to Tazorac ®) 0.1%C Tretinoin (compare to Retin-A®) 0.025%, 0.05%, 0.1% C; 0.01%, 0.025% G Tretinoin microsphere (compare to Retin-A Micro®) 0.1%, 0.04% Twyneo® (tretinoin/benzoyl peroxide) 0.1%-3% C	**Altreno, Atralin, Retin-A Micro, Tretinoin, 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 topical tretinoin product (Avita or Retin-A®). **Adapalene Cream:** patient has had a documented side effect, allergy, or treatment failure with adapalene gel. **Arazlo, Fabior, Tazarotene:** patient has had a documented side effect or treatment failure with a preferred topical tretinoin product and adapalene. **Adapalene/benzoyl peroxide gel, Clindamycin/tretinoin gel, Twyneo:** patient has had a documented side effect or treatment failure on combination therapy with the separate ingredients of the combination product **Plixda:** patient has had a documented side effect, allergy, or treatment failure with brand Differin AND a generic adapalene product. **Limitations:** Coverage of topical retinoid products will not be approved for cosmetic use (wrinkles age spots, etc.) (i.e. Avage, Renova, Tri-Luma).
TOPICAL - ROSACEA		
FINACEA® (azelaic acid) 15% *G*, F METRONIDAZOLE 0.75% *C, G, L* *C=cream, F=Foam, G=gel, L=lotion*	All brand metronidazole products (MetroCream® 0.75% *C*, Metrogel® 1% *G*, MetroLotion® 0.75% *L*, Noritate® 1% *C* etc.) Epsolay® (benzoyl peroxide) 5% C Ivermectin (compare to Soolanta®) 1% C Metronidazole 1% *G* Rhofade® (oxymetazoline) 1% C Zilxi® (minocycline) 1.5% F	**Brand name metronidazole products, Metronidazole 1% gel (generic)**: diagnosis or indication is rosacea 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. **Epsolay, Ivermectin, Rhofade:** the patient has had a documented side effect, allergy, or treatment failure with 2 preferred topical rosacea agents. **Zilxi:** diagnosis or indication is rosacea AND patient has had a documented side effect, allergy, or treatment failure with a preferred generic topical metronidazole product and Finacea. **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 rosacea (e.g. pustules, papules, flushing, etc.) or to alter the course of the disease.
ADHD AND NARCOLEPSY CATAPLEXY MEDICATIONS		
SHORT/INTERMEDIATE ACTING STIMULANTS		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
AMPHETAMINE/DETROAMPHETAMINE (compare to Adderall®) DEXMETHYLPHENIDATE (compare to Focalin®) METHYLIN® (compare to Ritalin®) solution METHYLPHENIDATE (compare to Ritalin®) tablets, solution METHYLPHENIDATE SR (compare to Ritalin® SR) PROCENTRA® (dextroamphetamine sulfate) 1 mg/ml oral solution	Adderall® (amphetamine/dextroamphetamine) Amphetamine Sulfate (compare to Evekeo) Desoxyn® (methamphetamine) Dextroamphetamine sulfate 1 mg/ml oral solution Dextroamphetamine IR (Zenzedi 5 or 10 mg, formerly Dexedrine®) Evekeo® (amphetamine sulfate) Evekeo® ODT (amphetamine sulfate) Focalin® (dexmethylphenidate) Methamphetamine (compare to Desoxyn®) Methylphenidate (compare to Ritalin ®) chewable tablets Ritalin® (methylphenidate) Zenzedi® (dextroamphetamine IR) 2.5 mg, 7.5 mg, 15 mg, 20 mg, 30 mg tablets	**Clinical Criteria for ALL non-preferred drugs:** 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 meets additional clinical criteria outlined below. **Focalin, Adderall, Ritalin:** the patient must have 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. **Methylphenidate chewable tablets:** patient has a documented intolerance to methylphenidate and Methylin solution. **Evekeo ODT, Dextroamphetamine oral solution:** patient has a medical necessity for a non-solid oral dosage form. (e.g. swallowing disorder). AND the patient has a documented intolerance Procentra oral solution. **Amphetamine Sulfate, Dextroamphetamine IR, Zenzedi, Evekeo:** the patient has had a documented side-effect, allergy, or treatment failure of at least 2 preferred agents (If a product has an AB rated generic, there must have been a trial of the generic.)
LONG ACTING STIMULANTS		
METHYLPHENIDATE PRODUCTS **ORAL** CONCERTA® (methylphenidate SA OSM IR/ER, 22:78%) DEXMETHYLPHENIDATE SR 24 HR IR/ER, 50:50% (compare to Focalin XR®) METHYLPHENIDATE CR, IR/ER, 30:70% (compare to Metadate CD®) METHYLPHENIDATE SR 24 HR, IR/ER, 50:50% (compare to Ritalin LA®) QUILLICHEW ER ™ (methylphenidate IR/ER, 30:70%) chewable tablets RITALIN LA® (methylphenidate SR 24 HR, IR/ER, 50:50%) **ORAL SUSPENSION** QUILLIVANT XR® (methylphenidate IR/ER, 20:80%) *QTY LIMIT:* 1 bottle/Rx (60ml, 120ml, 150ml)	Adhansia ® XR (methylphenidate IR/ER 20:80%) *QTY LIMIT:* 1 capsule/day Aptensio® XR (methylphenidate DR 24HR IR/ER, 40:60%) Azstarys™ (serdexmethylphenidate/ dexmethylphenidate) Cotempla® XR (methylphenidate IR/ER 25:75%) ODT Focalin® XR (dexmethylphenidate SR 24 HR) Jornay PM™ (methylphenidate ER) capsules *QTY LIMIT:* 1 capsule/day Methylphenidate DR 24HR IR/ER, 40:60% (compare to Aptensio®XR) Methylphenidate SA OSM IR/ER, 22:78% (compare to Concerta®) Relexxii® (methylphenidate ER OSM) IR/ER, 22:78%	**Clinical criterial for ALL non-preferred drugs:** the patient has a diagnosis of ADD, ADHD or narcolepsy AND has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization) OR meets the additional clinical criteria outlined below. **Azstarys, Adhasia XR, Cotempla XR ODT, Jornay PM:** patient has had a documented side-effect, allergy, or treatment failure on 3 preferred long-acting Methylphenidate products. **Aptensio XR, Methylphenidate DR 40:60:** patient has had a documented side effect, allergy, or treatment failure on two preferred long-acting Methylphenidate products. For approval of Methylphenidate DR 40:60, the patient must also have a documented intolerance to brand Aptensio XR. **Focalin XR:** the patient must have had a documented intolerance to the preferred generic equivalent. **Methylphenidate SA OSM:** the patient must have a documented intolerance to brand Concerta. **Relexxi:** Both Concerta and methylphenidate SA OSM must be on a long-term backorder and unavailable from the manufacturer.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
2 bottles/Rx (180ml) **TRANSDERMAL** All products require PA **AMPHETAMINE PRODUCTS** **ORAL** ADDERALL XR® (amphetamine/dextroamphetamine SR 24 HR, IR/ER, 50:50%) AMPHETAMINE/DEXTROAMPHETAMINE SR 24 HR, IR/ER, 50:50% (compare to Adderall XR®) VYVANSE® (lisdexamfetamine) capsule *QTY LIMIT:* 1 cap /day **TRANSDERMAL** All products require PA	Daytrana® (methylphenidate patch) *QTY LIMIT:* 1 patch/day Methylphenidate patch (compare to Daytrana®) *QTY LIMIT:* 1 patch/day Adzenys XR® ODT (amphetamine SR 24 HR, IR/ER, 50:50%) *QTY LIMIT:* 1 cap/day Adzenys ER™ suspension (amphetamine SR 24 HR, IR/ER, 50:50%) Dyanavel ™ suspension (amphetamine/dextroamphetamine SR) *QTY LIMIT*: 240ml/30days Dyanavel® XR (amphetamine/dextroamphetamine SR) chewable tablet Dexedrine CR® (dextroamphetamine 24 HR SR) Dextroamphetamine 24 HR SR (compare to Dexedrine CR®) Mydayis® (mixed amphetamine salts) extended-release capsules Vyvanse® (lisdexamfetamine) chewable tablet *QTY LIMIT*: 1 tab/day Xelstrym™ (dextroamphetamine patch) *QTY LIMIT:* 1 patch/day	**Daytrana patch, Methylphenidate patch:** patient has a documented medical necessity for a specialty non-oral dosage form AND for approval of generic Methylphenidate patch, the patient must have a documented intolerance to brand Daytrana. **Adzenys XR ODT, Adzenys ER suspension, Dynavel XR chewable tablet, Dyanavel XR suspension, Vyvanse Chew:** patient must be unable to tolerate Adderall XR sprinkled onto applesauce or Vyvanse mixed with yogurt, water, or orange juice. **Dexedrine CR, Dextroamphetamine SR, Mydayis:** patient must have a documented intolerance to two preferred amphetamine products. For approval of brand Dexedrine CR, the patient must also have a documented intolerance to the generic equivalent. **Xelstrym:** patient has a documented medical necessity for a specialty non-oral dosage form.
MISCELLANEOUS		
ARMODAFINIL (compare to Nuvigil®) *QTY LIMIT:* 50 mg = 2 tabs/day 150 mg/200 mg/250 mg = 1 tab/day, Max days supply = 30 days ATOMOXETINE (compare to Strattera®) *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 CLONIDINE ER *QTY LIMIT:* 4 tabs/day GUANFACINE ER (Intuniv®)	Intuniv® (guanfacine extended release) tablet *QTY LIMIT:* 1 tablet/day Nuvigil® (armodafinil) *QTY LIMIT:* 50 mg = 2 tablets/day; 150 mg/200 mg/250 mg = 1 tablet/day, Max days supply = 30 days Provigil® (modafinil) *QTY LIMIT:* 100 mg = 1.5 tablets/day; 200 mg = 2 tablets/day Maximum Daily Dose = 400 mg, Max day supply = 30 days QELBREE® (viloxazine hydrochloride) ER capsule	**Intuniv, Nuvigil, Provigil, Strattera:** patient must have a documented intolerance to the generic equivalent. **Qelbree:** The patient has had a documented side effect, allergy, contraindication, or treatment failure to one preferred stimulant OR there is a history of substance abuse with the patient or family of the patient and the patient has had a documented side effect, allergy, or treatment failure to atomoxetine. **Sunosi:** patient has had a documented side effect, allergy, or treatment failure to 2 preferred agents (may be stimulant or non-stimulant) **Wakix** patient has no known risk factors for increased QT prolongation (e.g. cardiac arrhythmias, symptomatic bradycardia, hypokalemia, or congenital prolongation of the QT interval) AND medication is not being used in

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
MODAFINIL (compare to Provigil®) *QTY LIMIT:* 100 mg = 1.5 tablets/day; 200 mg = 2 tablets/day Maximum Daily Dose = 400 mg, Max day supply = 30 days	*QTY LIMIT:* 100 mg = 1 capsule/day 150 mg = 2 capsules/day 200 mg = 3 capsules/day FDA maximum recommended dose = 600 mg/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 Sunosi® (solriamfetol) tablet *QTY LIMIT:* 1 tablet/day FDA maximum recommended dose = 150 mg/day Wakix® (pitolisant) tablet *QTY LIMIT:* 2 tablets/day FDA maximum recommended dose = 35.6 mg/day Xyrem® (sodium oxybate) oral solution *QTY LIMIT:* 540 ml/30 days Xywav™ (calcium, magnesium, potassium, and sodium oxybates) solution QTY LIMIT: 9 g (18 mL)/day	combination with other drugs known to prolong the QT interval (e.g. antipsychotics, erythromycin, tricyclic antidepressants) AND patient has had a documented side effect, allergy, or treatment failure to at least 3 agents (may be preferred or non-preferred; may be stimulant or non-stimulant), one of which must be Sunosi. **Xyrem, Xywav:** patient has had a documented side effect, allergy, or treatment failure to 2 preferred agents (may be stimulant or non-stimulant) and Sunosi AND patient has been enrolled in the REMS program AND for approval of Xywav, the patient must have a documented intolerance to Xyrem.
ALLERGEN IMMUNOTHERAPY		
All products require PA	Oralair® *QTY LIMIT:* 1 tablet/day Palforzia® (peanut allergen powder-dnfp)	**Oralair:** • Patient age ≥10 years and ≤65 years AND • 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 any of the 5 grass species contained in Oralair AND • Patient must have an auto-injectable epinephrine on-hand **Palforzia:** • Patient age ≥ 4 years and ≤ 17 years for initial dose escalation or ≥ 4 years for up-dosing and maintenance • The prescriber is an allergist or immunologist • Prescriber must provide the testing to show that the patient is allergic to peanuts • Patient must not have a recent history of uncontrolled asthma, eosinophilic esophagitis, or other eosinophilic GI disease. • Prescriber, pharmacy, and patient must be registered with the REMS program • Patient must have an auto-injectable epinephrine on-hand • Initial approval will be granted for 6 months and includes approval for initial dose escalation and Up Dosing. Approval for Up Dosing may be

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		extended if the patient was unable to tolerate all the dose levels at 2-week intervals. • For approval of Maintenance Dosing (300mg daily), pharmacy records will be evaluated to assess compliance with once daily therapy and ensure no level was missed during Up Dosing. Documentation must be provided attesting that the patient has not experienced any treatment restricting adverse events (e.g. systemic allergic reactions, severe anaphylaxis).
ALPHA1-PROTEINASE INHIBITORS		
All products require PA	Aralast NP® Glassia® 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		
DONEPEZIL (compare to Aricept®) tablet 5 mg and 10 mg *QTY LIMIT:* 1 tablet/day DONEPEZIL ODT (compare to Aricept® ODT) *QTY LIMIT:* 1 tablet/day GALANTAMINE tablet RIVASTIGMINE (compare to Exelon®) capsule *QTY LIMIT:* 2 capsules/day	Aricept® (donepezil) Tablet *QTY LIMIT:* 1 tablet/day Donepezil (compare to Aricept ®) Tablet 23 mg Galantamine ER capsule (compare to Razadyne® ER) Razadyne ER® (galantamine) capsule	**Donepezil 23mg Tablet, Galantamine ER Capsule, Razadyne ER Capsule:** the 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 a preferred cholinesterase inhibitor. **Adlarity:** medical necessity for a specialty dosage form has been provided AND the patient had a documented side effect, allergy, or treatment failure to Exelon patch. **Aricept:** the patient has a documented intolerance to the generic product. **Galantamine Oral Solution, Rivastigmine patch:** medical necessity for a specialty dosage form has been provided. AND for approval of rivastigmine patch the patient has a documented intolerance to brand Exelon patch.
SOLUTION All products require PA	Galantamine (compare to Razadyne®) Oral Solution	
TRANSDERMAL EXELON® (rivastigmine transdermal) Patch *QTY LIMIT*: 1 patch/day	Adlarity® (donzepezil) patch *QTY LIMIT:* 12 patches/84 days Rivastigmine (compare to Exelon®) patch	

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	QTY LIMIT: 1 patch/day	
IMMUNOGLOBULIN GAMMA 1 (IgG1) MONOCLONAL ANTIBODY		
All products require PA	Aduhelm® (aducanumab-avwa) IV solution Leqembi® (lecanemab-irmb) IV solution	**Aduhelm, Leqembi:** • Patient is 50 years of age or older • Prescriber has assessed and documented baseline disease severity utilizing an objective measure/tool (e.g., MMSE, Alzheimer's Disease Assessment Scale-Cognitive Subscale [ADAS-Cog-13], Alzheimer's Disease Cooperative Study-Activities of Daily Living Inventory-Mild Cognitive, Impairment version [ADCS-ADL-MCI], Clinical Dementia Rating-Sum of Boxes [CDR-SB]). • Patient has mild cognitive impairment (MCI) due to Alzheimer's Disease or mild Alzheimer's dementia as evidenced by the following: o Clinical Dementia Rating (CDR) Global Score of 0.5 o Objective evidence of cognitive impairment at screening o MMSE score between 24 and 30 o PET scan is positive for amyloid beta plaque OR Cerebrospinal fluid (CSF) test is positive for amyloid • Patient has had a recent (within 1 year) brain MRI prior to initiating treatment and prescriber attests to a repeat brain MRI as directed in the labeling (prior to the 7th infusion and 12th infusion for Aduhelm and prior to the 5th, 7th, and 14th infusion for Leqembi). • Patient does not have any of the following within 1 year of treatment initiation: pretreatment localized superficial siderosis, 10 or more brain microhemorrhages, or brain hemorrhage >1 cm • Patient has had a documented treatment failure, as defined by significant disease progression after 1 year of therapy, with a preferred cholinesterase inhibitor, unless contraindicated. • Prescriber has enrolled in the voluntary Alzheimer's Network for Treatment and Diagnostics (ALZ-NET) registry. • For re-approval, the patient must have responded to therapy compared to pre-treatment baseline as evidenced by improvement, stabilization, or slowing in cognitive or functional impairment AND patient has not progressed to moderate or severe disease (there is insufficient evidence in moderate or severe AD).
NMDA RECEPTOR ANTAGONIST		
MEMANTINE Tablets	Memantine oral solution Memantine XR (compare to Namenda® XR) Oral capsule *QTY LIMIT:* 1 capsule/day Namenda® (memantine) tablet Namenda® XR (memantine ER) Oral Capsule *QTY LIMIT:* 1 capsule/day	**Namenda:** Patient has a documented intolerance to the generic. **Memantine XR, Namenda XR:** Patient has not been able to tolerate twice daily dosing of immediate release memantine, resulting in significant clinical impact. **Memantine Oral Solution:** medical necessity for a specialty dosage form has been provided.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
CHOLINESTERASE INHIBITOR/NMDA COMBINATION		
All products require PA	Namzaric® (donepezil/memantine) Capsule *QTY LIMIT:* 1 capsule/day	**Namzaric:** Clinically compelling reason why the individual ingredients of donepezil and memantine cannot be used.
ANALGESICS		
MISCELLANEOUS: TOPICAL AND TRANSDERMAL PATCH		
LIDOCAINE 3% Cream LIDOCAINE 4% OTC Patch LIDOCAINE 4% cream LIDOCAINE 5% Ointment LIDOCAINE 5% patch *QTY LIMIT:* 3 patches/day LIDOCAINE/PRILOCAINE 2.5-2.5% Cream	Qutenza® Patch (capsaicin 8 %) *QTY LIMIT:* 4 patches/90 days Ztlido™ Patch (lidocaine 1.8%) *QTY LIMIT:* 3 patches/day (Note: Please refer to Analgesics: COX IIs and NSAIDs for topical NSAIDS)	**Qutenza, Ztlido:** 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 as well as Lidocaine 5% patch. OR patient has a medical 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 lidocaine 5% patch.
OPIOIDS: SHORT ACTING		
ACETAMINOPHEN W/CODEINE (compare to Tylenol® w/codeine) (age >12 years) BUTALBITAL COMP. W/ CODEINE (age >12 years) CODEINE SULFATE (age >12 years) ENDOCET® (oxycodone w/ acetaminophen) HYDROCODONE (plain, w/acetaminophen, or w/ibuprofen) (some exceptions apply) *QTY LIMIT:* Hydrocodone/APAP 12 tablets/day HYDROMORPHONE tablets (compare to Dilaudid®) MORPHINE SULFATE OXYCODONE (plain) OXYCODONE (w/acetaminophen, w/aspirin or w/ibuprofen) *QTY LIMIT:* Oxycodone/APAP 12 tablets/day TRAMADOL *QTY LIMIT:* 8 tablets/day (Age ≥ 16) TRAMADOL/APAP *QTY LIMIT:* 8 tablets/day (Age ≥18) ****NOTE: As of 5/1/21, a completed safety	Acetaminophen w/hydrocodone: *all branded products* *QTY LIMIT:* = 12 tablets/day Acetaminophen w/oxycodone: *all branded products* *QTY LIMIT:* = 12 tablets/day Actiq® (fentanyl lozenge on a stick: 200 mcg, 400 mcg, 600 mcg, 800 mcg, 1200 mcg, 1600 mcg) Apadaz® (benzhydrocodone/APAP) *QTY LIMIT:* 12 tablets/day Benzhydrocodone/APAP (compare to Apadaz®) *QTY LIMIT:* 12 tablets/day Butorphanol Nasal Spray *QTY LIMIT:* 2 bottles/month Demerol (meperidine) Dilaudid®(hydromorphone) tablets Dilaudid-5®(hydromorphone) oral solution Fentanyl citrate transmucosal (compare to Actiq®) Fentora® (fentanyl citrate buccal tablets) Hydromorphone oral solution (compare to Dilaudid-5®) Meperidine *QTY LIMIT*: 30 tablets/5-day supply per 30 days	**Note:** The initial fill for all short-acting opiates will be limited to 50 Morphine Milligram Equivalents (MME) and 7-day supply for patients ≥ 18 years of age OR 24 MME and 3-day supply for patients ≤ 17 years of age. **Butorphanol Nasal Spray:** documented site effect, allergy, treatment failure, or contraindication to codeine, hydrocodone, morphine, & oxycodone (all 4 generic entities) as single or combination products. OR is unable to use tablet or liquid formulations. **Actiq, Fentanyl transmucosal, Fentora:** 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 immediate release treatment 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 solution and morphine oral solution OR has been started and stabilized on another dosage form of hydromorphone AND if the request is for the branded product, patient has a documented intolerance to the generic product. **Oxycodone (generic) Capsules:** member has a documented intolerance to

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
checklist must be submitted for new patients exceeding 90 MME per day, and existing patients exceeding 120 MME per day (applies to any combination of short and/or long acting opioids)** **Note:** The FDA restricts the use of prescription codeine pain and cough medicines in children. Prior authorization is required for patients <12 years of age.	Nucynta® (tapentadol) Oxycodone (plain) capsules Oxymorphone (compare to Opana®) Pentazocine w/naloxone Seglentis® (celecoxib/tramadol) oral tablet Tramadol oral solution 5mg/ml	generic oxycodone tablets. **Seglentis:** The patient has a documented side effect, allergy, or treatment failure with two or more preferred agents AND the patient is unable to take the individual components separately **Tramadol Oral Solution:** patient has a medical necessity for a non-solid oral dosage form. (e.g. swallowing disorder). **Ultracet:** member has a documented intolerance to the generic formulation **Other Short acting Opioids:** member has had a documented side effect, allergy, or treatment failure to at least 3 medications not requiring prior approval. (If a product has an AB rated generic, one trial must be the generic.) **PA requests to exceed daily cumulative MME limits:** • Non-Opioid alternatives (up to a maximum dose recommended by the FDA) and Non-Pharmacological Treatments have been considered, and any appropriate treatments are documented in the patient's medical records. Such treatments may include, but are not limited to: NSAIDs, Acetaminophen, Acupuncture, Chiropractic, Physical Therapy. • Vermont Prescription Monitoring System (VPMS) has been queried. • Patient education and informed consent have been obtained, and a Controlled Substance Treatment Agreement is included in the patient's medical record. • A reevaluation of the effectiveness and safety of the patient's pain management plan, including an assessment of the patient's adherence to the treatment regimen is completed no less than once every 90 days. • Patient has a valid prescription for or states they are in possession of naloxone. • Patients in nursing homes, receiving or eligible for hospice services, or those with chronic pain associated with cancer or cancer treatment are exempt from these requirements. **Limitations:** APAP containing products: daily doses that result in > 4 grams of acetaminophen/day will reject for PA
OPIOIDS: LONG ACTING		
<u>TRANSDERMAL</u> BUTRANS (buprenorphine) TRANSDERMAL SYSTEM *QTY LIMIT:* 4 patches/28 days (Maximum 28-day fill) FENTANYL PATCH (compare to Duragesic®) *QTY LIMIT:* 12 mcg/hr, 25 mcg/hr, 50 mcg/hr = 15 patches/30 days, 75 mcg/hr, 100 mcg/hr = 30 patches/30 days **<u>BUCCAL</u>**	Buprenorphine patch (compare to Butrans®) *QTY LIMIT:* 4 patches/28 days (Maximum 28-day Fill) Fentanyl patch 37.5 mcg/hr, 62.5 mcg/hr, 87.5 mcg/hr	**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 opioids 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 opioids are NOT intended for use as 'prn' analgesic. LA opioids are NOT indicated for pain in the immediate post-operative period (the first 12-24

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
All products require PA **ORAL** MORPHINE SULFATE CR 12 hr tablet (compare to MS Contin®) *QTY LIMIT:* 90 tablets/strength/30 days **ORAL, ABUSE-DETERRENT FORMULATIONS** XTAMPZA ER® (oxycodone ER) *QTY LIMIT:* 60 caps/strength/30days	Belbuca® (buprenorphine hcl buccal film) *QTY LIMIT:* 56 films/28 days (Maximum 28-day fill) Conzip® (tramadol ER biphasic release) capsule *QTY LIMIT:* 1 capsule/day Hydromorphone XR tablet *QTY LIMIT:* 30 tablets/30 days (8 mg, 12 mg, 16 mg tabs) Methadone5 mg, 10 mg tablets Methadone oral solution (no PA required for patient less than 1 year old) Methadone oral concentrate 10 mg/ml Morphine sulfate SR 24hr capsule *QTY LIMIT:* 60 capsules/strength/30 days Morphine sulfate SR beads 24hr capsule *QTY LIMIT:* 30 capsules/strength/30 days MS Contin® (morphine sulfate CR 12 hr) tablets *QTY LIMIT:* 90 tablets/strength/30 days Oxymorphone ER *QTY LIMIT:* 60 tablets/strength/30 days Nucynta ER® (tapentadol ER) *QTY LIMIT:* 2 tablets/day Tramadol SR *QTY LIMIT:* 1 tablet/day Tramadol ER biphasic-release® capsule *QTY LIMIT:* 150 mg = 1 capsule/day Tramadol ER biphasic-release tablet (formerly Ryzolt®) *QTY LIMIT:* 1 tablet/day Hysingla ER® (hydrocodone bitartrate) *QTY LIMIT:* 1 tablet/ day Oxycodone ER (compare to OxyContin®) *QTY LIMIT:* 90 tablets/strength/30 days	hours following surgery) or if the pain is mild, or not expected to persist for an extended period 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 extended 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. **Belbuca Films, Buprenorphine Patch:** the patient has had a documented intolerance to Butrans patches **Fentanyl patches 37.5mcg/hr, 62.5mcg/hr, 87.5mcg/hr:** provider must submit clinical rationale detailing why the patient is unable to use a combination of the preferred strengths. **Methadone Tablet:** 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 (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 stipulated in 42 CFR 8.12, NOT retail pharmacy.) **Methadone Liquid:** Patient must have a medical necessity for an oral liquid (i.e. swallowing disorder, inability to take oral medications) AND the initial daily dose does not exceed 30mg OR patient has been started and stabilized on the requested oral liquid medication. (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 stipulated in 42 CFR 8.12, NOT retail pharmacy.) **Conzip, Tramadol ER biphasic-release Capsule, Tramadol ER biphasic-release Tablet, Tramadol ER/SR:** 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 the patient must have a documented intolerance to generic tramadol ER/SR. **Oral Non-Preferred (except methadone & tramadol containing products):** the patient has had a documented side effect, allergy, or treatment failure to morphine sulfate CR 12hr tablet (generic) AND generic fentanyl patch. (If a product has an AB rated generic, there must have been a trial of the generic). AND the patient must have a documented side effect, allergy, or treatment failure to the preferred abuse deterrent formulation (Xtampza ER) before OxyContin will be approved. **Hysingla ER:** Available with PA for those unable to tolerate any preferred medications. All requests will go to the DVHA Medical Director for approval. **PA requests to exceed daily cumulative MME limits:** • Non-Opioid alternatives (up to a maximum dose recommended by the FDA) and Non-Pharmacological Treatments have been considered, and any appropriate treatments are documented in the patient's medical records. Such treatments may include, but are not limited to: NSAIDs, Acetaminophen, Acupuncture, Chiropractic, Physical

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
****NOTE: As of 5/1/21, a completed safety checklist must be submitted for new patients exceeding 90 MME per day, and existing patients exceeding 120 MME per day (applies to any combination of short and/or long acting opioids)****	OxyContin® (Oxycodone ER) *QTY LIMIT:* 90 tablets/strength/30 days	Therapy. • Vermont Prescription Monitoring System (VPMS) has been queried. • Patient education and informed consent have been obtained, and a Controlled Substance Treatment Agreement is included in the patient's medical record. • A reevaluation of the effectiveness and safety of the patient's pain management plan, including an assessment of the patient's adherence to the treatment regimen is completed no less than once every 90 days. • Patient has a valid prescription for or states they are in possession of naloxone. • Patients in nursing homes, receiving or eligible for hospice services, or those with chronic pain associated with cancer or cancer treatment are exempt from these requirements. **Limitations:** Methadone 40mg dispersible tablet not approved for retail dispensing.
NSAIDS		
ORAL **SINGLE AGENT** DICLOFENAC POTASSIUM DICLOFENAC SODIUM ETODOLAC FLURBIPROFEN IBUPROFEN INDOMETHACIN INDOMETHACIN ER KETOPROFEN KETOROLAC *QTY LIMIT:* 20 doses/5 day supply every 90 day MECLOFENAMATE SODIUM MEFANAMIC ACID capsules MELOXICAM tabs NABUMETONE NAPROXEN 250 mg, 375 mg, 500 mg NAPROXEN ENTERIC COATED 375 mg, 500 mg NAPROXEN SODIUM 275mg, 550mg NAPROXEN SODIUM OTC 220 mg OXAPROZIN (compare to Daypro®) PIROXICAM (compare to Feldene®) SULINDAC	Cambia® (diclofenac potassium) packet for oral solution *QTY LIMIT:* 9 packets/month Daypro® (oxaprozin) Etodolac ER Feldene® (piroxicam) Fenoprofen 400 mg cap Fenoprofen 600 mg tab Indocin® (indomethacin) suspension Ketoprofen ER Lofena™ (diclofenac) tablet Meloxicam capsule (compare to Vivlodex®) Nalfon® (fenoprofen) 400 mg capsules Naprelan® (naproxen sodium ER) Naproxen oral suspension Naproxen sodium ER Naproxen suspension 125mg/5ml Relafen® DS (nabumetone) Zipsor® (diclofenac potassium) Zorvolex® (diclofenac) Capsules *QTY LIMIT: 3 capsules/day*	**Arthrotec, diclofenac/misoprostol, Duexis:** patient has a documented side effect or treatment failure to 2 or more preferred generic NSAIDs OR patient is not a candidate for therapy with a preferred generic NSAID mono-therapy 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 for approval of diclofenac/misoprostol, the patient must have a documented intolerance to brand Arthrotec **Cambia:** drug is being prescribed for treatment of acute migraine attacks AND patient 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 treatment failure with the generic ibuprofen suspension. **Celebrex**: patient has had a documented intolerance to generic celecoxib. **Pennsaid:** patient has had a documented side effect or inadequate response to Diclofenac gel or topical solution. **Diclofenac Patch, Licart:** patient has had a documented side effect or inadequate response to Diclofenac gel or topical solution AND patient has a documented intolerance to brand Flector Patch. **Duexis, Ibuprofen/famotidine, naproxen/esomeprazole, Vimovo:** patient is unable to take the individual components separately AND for approval of ibuprofen/famotidine or naproxen/esomeprazole, the patient must have a

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ORAL **COX-II Selective** CELECOXIB *QTY LIMIT*: 2 caps/day **INJECTABLE** KETOROLAC Injection (formerly Toradol®) *QTY LIMIT:* 1 dose per fill **NASAL SPRAY** All products require PA **TOPICAL** DICLOFENAC (compare to Voltaren®) gel 1% DICLOFENAC 1.5 % Topical Solution **TRANSDERMAL** Flector® (diclofenac) 1.3 % Patch *QTY LIMIT:* 2 patches/day **NSAID/ANTI-ULCER** All products require PA Note: Please refer to "Dermatological: Actinic Keratosis Therapy" for Solaraze® or Diclofenac 3% Gel	Celebrex® (celecoxib) capsule QTY LIMIT: 2 caps/day Elyxyb™ (celecoxib) oral solution Sprix® (ketorolac) Nasal Spray *QTY LIMIT:* 5 bottles/5 days – once every 90 days Pennsaid® (diclofenac) 2% Topical Solution Diclofenac (compare to Flector®) 1.3% Patch *QTY LIMIT:* 2 patches/day Licart® (diclofenac epolamine) 1.3% Patch QTY LIMIT: 1 patch/day Arthrotec® (diclofenac sodium w/misoprostol) Diclofenac sodium w/misoprostol (compare to Arthrotec®) Duexis® (ibuprofen/famotidine) *QTY LIMIT:* 3 tablets/day Ibuprofen/famotidine (compare to Duexis®) QTY LIMIT: 3 tablets/day Naproxen/esomeprazole (compare to Vimovo®) Vimovo® (naproxen/esomeprazole) *QTY LIMIT:* 2 tablets/day	documented intolerance to the brand name equivalent. **Elyxyb:** drug is being prescribed for treatment of acute migraine attacks AND patient has had a documented side effect or treatment failure to 2 or more preferred generic NSAIDs, one of which must be generic celecoxib 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 treatment failure with the generic ibuprofen suspension. **Lofena, Zipsor, Zorvolex:** patient has had a documented side effect, allergy, or treatment failure to 4 or more preferred generic NSAIDs, one of which must be generic diclofenac. **Meloxicam Capsule:** patient has had a documented side effect, allergy, or treatment failure to 4 or more preferred generic NSAIDs, one of which must be generic meloxicam tablet. **Naproxen suspension:** 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 treatment failure with generic ibuprofen suspension. **Relafen DS:** patient has had a documented side effect, allergy, or treatment failure to 4 or more preferred generic NSAIDs, one of which must be generic nabumetone. **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)). **All other PA requiring NSAIDs:** patient has had a documented side effect or treatment failure to 2 or more preferred generic NSAIDS. (If a product has an AB rated generic, one trial must be the generic.) AND if the request is for a non-preferred extended release formulation, the patient has not been able to adhere to the dosing schedule of the immediate release formulation resulting in significant clinical impact.
ANKYLOSING SPONDYLITIS: INJECTABLES		
Length of Authorization: Initial PA 3 months; 12 months thereafter		
Preferred After Clinical Criteria Are Met		**Clinical Criteria:**

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
INJECTABLE AVSOLA® (infliximab-axxq) biosimilar to Remicade® ENBREL® (etanercept) *QTY LIMIT*:50 mg = 4 syringes/28 days, 25 mg = 8 syringes/28 days HUMIRA® (adalimumab) *QTY LIMIT*:2 syringes/28 days INFLECTRA® (infliximab-dyyb) biosimilar to Remicade® TALTZ® (ixekizumab) *QTY LIMIT*: 80 mg prefilled syringe or autoinjector = 2/28 days for the first month and 1/28 days subsequently **ORAL** XELJANZ® (tofacitinib) tablet *QTY LIMIT:* 2 tablets/day XELJANZ® XR (tofacitinib) tablet *QTY LIMIT:* 1 tablet/day Maximum 30 days supply	Cimzia® (certolizumab pegol) *QTY LIMIT:* 1 kit/28 days (starter X 1, then regular) Cosentyx® (secukinumab) Subcutaneous Remicade® (infliximab) Renflexis™ (infliximab-abda) biosimilar to Remicade® Rinvoq ® (upadactinib) extended release tablet *QTY LIMIT*: 1 tablet/day Simponi® (golimumab) Subcutaneous *QTY LIMIT:* 50 mg prefilled syringe or autoinjector = 1/28 days	**For all drugs:** patient has a diagnosis of ankylosing spondylitis (AS) and has already been stabilized on the medication being requested. OR patient has a confirmed diagnosis of 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. **Additional criteria for Taltz, Xeljanz, Xeljanz XR:** the patient had a trial and failure or contraindication to a preferred TNF Inhibitor **Additional criteria for Cimzia, Cosentyx, Simponi:** the prescriber must provide a clinically valid reason why at least 2 preferred agents cannot be used. **Note:** Patient must be ≥ 18 years of age for Simponi approval as safety and efficacy has not been established in pediatric patients. **Additional criteria for Remicade, Renflexis:** the prescriber must provide a clinically valid reason why at least 2 preferred agents cannot be used, and the patient must be unable to use Avsola or Inflectra. **Additional Criteria for Rinvoq:** the prescriber must provide a clinically valid reason why at least 2 preferred agents cannot be used, one of which must be Xeljanz or Xeljanz XR. * 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 skeletal involvement, then NSAID trial and a DMARD trial are required (unless otherwise contraindicated).
ANTI-ANXIETY: ANXIOLYTICS		
BENZODIAZEPINE		
CHLORDIAZEPOXIDE (formerly Librium®) CLONAZEPAM (compare to Klonopin®) *QTY LIMIT:* 4 tabs/day except 2 mg. 2 mg = 3 tabs/day CLONAZEPAM ODT *QTY LIMIT:* 4 tabs/day except 2 mg. 2 mg = 3 tabs/day DIAZEPAM (compare to Valium®) LORAZEPAM (compare to Ativan®) *QTY LIMIT:* 4 tablets/day OXAZEPAM	Alprazolam (compare to Xanax®) *QTY LIMIT:* 4 tablets/day Alprazolam ER, Alprazolam XR® (compare to Xanax XR®) *QTY LIMIT:* 2 tablets/day Alprazolam ODT *QTY LIMIT:* 3 tablets/day Alprazolam Intensol® (alprazolam concentrate) Ativan® (lorazepam) *QTY LIMIT:* 4 tablets/day Clorazepate tabs (compare to Tranxene T®) Diazepam Intensol® (diazepam concentrate) Klonopin® (clonazepam)	**Non-preferred Benzodiazepines (except for Alprazolam ODT, Intensol Products, and Loreev XR):** 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:** 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). OR patient has a medical necessity for disintegrating tablet administration (i.e. inability to swallow tablets) AND patient has a documented side effect, allergy or treatment failure to clonazepam ODT. **Alprazolam Intensol, Diazepam Intensol, and 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. **Loreev XR:** The patient is receiving a stable dose of lorazepam tablets, evenly

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	QTY LIMIT: 4 tabs/day except 2 mg. 2 mg = 3 tabs/day Lorazepam Intensol® (lorazepam concentrate) Loreev XR™ (lorazepam extended release) Tranxene T® (clorazepate tablets) Valium® (diazepam) Xanax® (alprazolam) *QTY LIMIT: 4* tablets/day Xanax XR® (alprazolam XR) *QTY LIMIT:* 2 tablets/day	divided, three times daily AND medical reasoning for use beyond convenience or enhanced compliance is provided.
NON-BENZODIAZEPINE		
BUSPIRONE (formerly Buspar®) HYDROXYZINE HYDROCHLORIDE (formerly Atarax®) HYDROXYZINE PAMOATE (compare to Vistaril®) (all strengths except 100 mg) MEPROBAMATE	Hydroxyzine Pamoate (100 mg strength ONLY) (compare to Vistaril®) Vistaril® (hydroxyzine pamoate)	**Hydroxyzine Pamote 100mg strength ONLY:** patient is unable to use generic 50 mg capsules. **Vistaril:** patient has a documented intolerance to the generic formulation.
ANTICOAGULANTS		
ORAL		
VITAMIN K ANTAGONIST WARFARIN **DIRECT THROMBIN INHIBITOR** PRADAXA® (dabigatran etexilate) capsule **FACTOR XA INHIBITOR** ELIQUIS® (apixaban) XARELTO® (rivaroxaban) tablet ***Preferred After Clinical Criteria Are Met*** XARELTO® (rivaroxaban) 2.5 mg tablet	Dabigatran Etexilate (compare to Pradaxa®) capsule Pradaxa® (dabigatran etexilate) oral pellets Savaysa® (edoxaban) *QTY LIMIT:* 1 tablet/daily Xarelto® (rivaroxaban) oral suspension	**Dabigatran**: the patient must have a documented intolerance to brand name Pradaxa **Pradaxa pellets:** patient has a medical necessity for a non-solid oral dosage form and prescriber has provided a clinically valid reason why Xarelto suspension cannot be used. **Savaysa:** creatinine clearance is documented to be < 95 ml/min AND prescriber has provided another clinically valid reason why generic warfarin, Pradaxa, Xarelto or Eliquis cannot be used. A yearly creatinine clearance is required with renewal of PA request **Xarelto suspension**: patient has a medical necessity for a non-solid oral dosage form (e.g. swallowing disorder).

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		Xarelto 2.5 mg: Patient has a diagnosis of chronic coronary artery disease (CAD) or peripheral artery disease (PAD) AND medication is being used concurrently with aspirin.
INJECTABLE		
UNFRACTIONATED HEPARIN INJECTABLE HEPARIN **LOW MOLECULAR WEIGHT HEPARINS INJECTABLE** ENOXAPARIN (compare to Lovenox®) *QTY LIMIT:* 2 syringes/day calculated in ml volume **SELECTIVE FACTOR XA INHIBITON INJECTABLE** All products require PA	Fragmin® (dalteparin) Lovenox® (enoxaparin) *QTY LIMIT:* 2 syringes/day calculated in ml volume Arixtra® (fondaparinux) Fondaparinux (compare to Arixtra®)	**Arixtra, Fondaparinux, Lovenox and Fragmin**: patient has a documented intolerance to generic enoxaparin AND if the request is for brand Arixtra, the patient must also have a documented intolerance to generic fondaparinux.
ANTICONVULSANTS		
ORAL		
CARBAMAZEPINE tablets (compare to Tegretol®) CARBAMAZEPINE capsules (compare to Carbatrol®) CARBAMAZEPINE extended release (compare to Tegretol XR®) CELONTIN® (methsuxamide) CLOBAZAM (compare to Onfi®) *QTY LIMIT:* 10 mg = 3 tabs/day, 20 mg = 2 tabs/day, oral suspension = 16mL/day (40mg/day) CLONAZEPAM (compare to Klonopin®) *QTY LIMIT:* 4 tablets/day CLONAZEPAM ODT (formerly Klonopin Wafers®) *QTY LIMIT:* 4 tablets/day DIAZEPAM (compare to Valium®) DILVALPROEX SODIUM capsules (compare to	Aptiom® (eslicarbazepine acetate) *QTY LIMIT:* 200, 400 = 1 tab/day 600 mg, 800 mg = 2 tabs/day Banzel® (rufinamide) *QTY LIMIT:* 400 mg = 8 tabs/day, 200 mg = 16 tabs/day Banzel® (rufinamide) oral suspension *QTY LIMIT:* 80 ml/day (3,200 mg/day) Briviact® (brivaracetam) tablets, oral suspension Carbatrol® (carbamazepine) capsules Clorazepate (compare to Tranxene-T®) tablets Depakote® (divalproex sodium) Depakote ER® (divalproex sodium) Depakote Sprinkles® (divalproex sodium caps)	**Criteria for approval of ALL non-preferred drugs:** patient has been started and stabilized on the requested medication (Note: samples are not considered adequate justification for stabilization.) OR patient meets additional criteria outlined below. **Aptiom:** the diagnosis is 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, one of which is oxcarbazepine. **Banzel, Rufinamide:** 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 have medical necessity for a specialty dosage form AND for approval of generic rufinamide, the patient must have a documented intolerance to brand Banzel. **Briviact:** the diagnosis is adjunctive therapy of partial-onset seizures and the

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
Depakote Sprinkles®) DIVALPROEX SODIUM (compare to Depakote®) DIVALPROEX SODIUM ER (compare to Depakote ER®) EPITOL (carbamazepine) 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) LACOSAMIDE (compare to Vimpat®) tabs, solution LAMOTRIGINE chew tabs (compare to Lamictal® chew tabs) LAMOTRIGINE tabs (compare to Lamictal® tabs) LEVETIRACETAM tabs (compare to Keppra® tabs) LEVETIRACETAM oral solution (compare to Keppra® oral solution) LEVETIRACETAM ER (compare to Keppra XR®) OXCARBAZEPINE tablets (compare to Trileptal®) OXCARBAZEPINE oral suspension (compare to Trileptal®) PHENYTOIN (compare to Dilantin®) PHENYTOIN EX cap (compare to Phenytek®) PREGABALIN capsules (compare to Lyrica) *QTY LIMIT:* 3 capsules/day PRIMIDONE (compare to Mysoline®) TEGRETOL® (carbamazepine) suspension TEGRETOL XR® (carbamazepine) 100 mg ONLY TOPIRAMATE tabs (compare to Topamax® tabs) TOPIRAMATE sprinkle caps (compare to Topamax® Sprinkles) VALPROIC ACID ZONISAMIDE ***<u>Preferred After Clinical Criteria Are Met</u>*** EPIDIOLEX® (cannabidiol) oral solution	Diacomit® (stiripentol) Dilantin® (phenytoin) chewable tablets, capsules, suspension Elepsia™ (levetiracetam) extended release Eprontia™ (topiramate) oral solution Felbamate (compare to Felbatol®) Fintepla® (fenfluramine) oral solution Felbatol® (felbamate) Fycompa® (perampanel) tablets *QTY LIMIT:* 1 tablet/day Keppra®* (levetiracetam) tablets, oral solution Keppra XR® (levetiracetam extended release) Klonopin® (clonazepam) *QTY LIMIT:* 4 tablets/day Lamictal® tabs (lamotrigine tabs) Lamictal® chew tabs (lamotrigine chew tabs) Lamictal ODT® (lamotrigine orally disintegrating tablets) Lamictal XR® tablets (lamotrigine extended release) Lamotrigine ER (compare to Lamictal XR®) Lamotrigine ODT (compare to Lamictal ODT®) Lyrica® (pregabalin) capsules *QTY LIMIT:* 3 capsules/day Lyrica® (pregabalin) oral solution Mysoline® (primidone) Neurontin® (gabapentin) capsules, tablets and solution Onfi® (clobazam) Oral Suspension 2.5 mg/ml *QTY LIMIT:* 16 ml/day Onfi® (clobazam) Tablets *QTY LIMIT:* 10 mg = 3 tabs/day, 20 mg = 2 tabs/day Oxtellar® XR (oxcarbazapine ER) tablet Pregabalin oral solution (compare to Lyrica®) Qudexy® XR (topiramate) capsules Rufinamide (compare to Banzel®) tablet, oral suspension *QTY LIMIT:* 400 mg = 8 tabs/day, 200 mg = 16 tabs/day, oral suspension = 80 ml/day (3200 mg/day) Sabril® (vigabatrin) Spritam® (levetiracetam) tablets for oral suspension	patient has had a documented side effect, allergy, treatment failure/inadequate response, or a contraindication to at least TWO preferred anticonvulsants, one of which is levetiracetam. **Carbatrol, Depakote, Depakote ER, Depakote Sprinkles, Dilantin, Keppra tablets or oral solution, Klonopin, Klonopin Wafers, Lamictal tablets or chew tablets, Lyrica, Mysoline, Neurontin capsules, tablets, solution, Onfi, Phenytek, Tegretol tablets, Tegretol XR (200 mg & 400 mg), Topamax tabs, Topamax sprinkles, Trileptal tablets, Trileptal oral suspension, Vimpat, Zarontin:** patient has had a documented intolerance to the generic equivalent of the requested medication. **Clorazepate, Fycompa, Tranxene-T:** diagnosis is adjunctive therapy of partial-onset seizures OR diagnosis is adjunctive therapy for primary generalized tonic-clonic seizures (Fycompa only) AND the patient has had a documented side effect, allergy, treatment failure, inadequate response, or a contraindication to at least TWO preferred anticonvulsants. AND for approval of Tranxene-T the patient must have a documented intolerance to the generic equivalent. **Diacomit:** Diagnosis or indication is treatment of Dravet Syndrome AND neutrophil and platelet counts have been obtained prior to starting therapy and are monitored periodically thereafter AND Patient is unable to tolerate or has had an inadequate response to valproate and clobazam AND medication will used concurrently with clobazam. **Note:** There are no clinical data to support the use of Diacomit as monotherapy. **Eprontia, Zonisade**: The patient has a medical necessity for a specialty dosage form. **Epidiolex:** The patient is unable to tolerate or has had an inadequate response to at least 2 of the following medications: clobazam, levetiracetam, valproate, lamotrigine, topiramate, rufinamide, or felbamate **Note:** This is processed via automated (electronic step therapy) **Felbamate, Felbatol:** patient information/consent describing aplastic anemia and liver injury has been completed AND 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. **Fintepla:** Diagnosis or indication is treatment of Dravet Syndrome or Lennox-Gastaut Syndrome AND patient has had a documented side effect, allergy, treatment failure/inadequate response or contraindication to at least two preferred anticonvulsants and Epidiolex AND prescriber, pharmacy and patient are registered with the REMS programs AND for reapproval, the patient must have a documented decrease from baseline in seizure frequency per 28 days. **Elepsia XR, Keppra XR, Lamictal XR, Lamotrigine ER, Oxtellar XR, Qudexy XR, Topiramate ER, Topiramate SR, Trokendi XR:** patient has

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Sympazan® (clobazam) films Tegretol® (carbamazepine) tablets Tegretol XR® (carbamazepine) (200 and 400 mg strengths) Tiagabine (compare to Gabitril®) Topamax® (topiramate) tablets Topamax® (topiramate) Sprinkle Capsules Topiramate ER sprinkle capsules (compare to Qudexy® XR) Topiramate SR 24hr (compare to Trokendi®) capsules *QTY LIMIT:* 200 mg = 2 caps/day, all other strengths = 1 cap/day Tranxene-T® (clorazepate) tablets Trileptal® tablets (oxcarbazepine) Trileptal® oral suspension (oxcarbazepine) Trokendi XR® (topiramate SR 24hr) capsules *QTY LIMIT:* 200 mg = 2 caps/day, all other strengths = 1 cap/day Vigabatrin (compare to Sabril®) Vimpat® (lacosamide) tablets, oral solution Xcopri® (cenobamate) tablets *QTY LIMIT:* 200 mg = 2 tabs/day, all other strengths = 1 tab/day Zarontin® (ethosuximide) Zonisade™ (zonisamide) suspension Ztalmy® (ganaxolone) suspension *QTY LIMIT*: 36 mL/day	been unable to be compliant with or tolerate twice daily dosing of the immediate release product. Additionally, if brand Elepsia XR, Keppra XR or Lamictal XR is requested, the patient has a documented intolerance to the generic product. If topiramate ER sprinkle caps are requested, the patient must have a documented intolerance to Qudexy XR. **Lamictal ODT, Lamotrigine ODT:** medical necessity for a specialty dosage form has been provided AND lamotrigine chewable tabs cannot be used. For approval of brand Lamictal ODT, the patient must have a documented intolerance to the generic equivalent. **Lyrica oral solution, Pregabalin oral solution:** the patient is unable to use pregabalin capsules (i.e. swallowing disorder). For approval of brand Lyrica oral solution, the patient must have a documented intolerance to the generic equivalent. **Spritam**: medical necessity for a specialty dosage form has been provided AND patient must have a documented intolerance to levetiracetam oral solution. **Sympazan:** 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 TWO preferred anticonvulsants AND prescriber must provide a clinically compelling reason why the patient is unable to use Clobazam tablets AND Clobazam suspension **Tiagabine generic:** patient has had a documented intolerance to the brand name product. **Sabril, Vigabatrin:** prescriber and patient are registered with the REMS 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. **Xcopri: t**he diagnosis is adjunctive therapy of partial-onset seizures AND the patient is ≥ 18 years of age AND the patient has had a documented side effect, allergy, treatment failure/inadequate response or a contraindication to at least TWO preferred anticonvulsants AND for reapproval, the patient must have a documented decrease from baseline in seizure frequency per 28 days. **Ztalmy:** Diagnosis or indication is for the treatment of seizures associated with cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder (CDD) confirmed by genetic testing (results must be submitted) AND patient has had a documented side effect, allergy, treatment failure, inadequate response or a contraindication to at least TWO preferred anticonvulsants AND for reapproval, the patient must have a documented decrease from baseline in seizure frequency per 28 days. **PA Requests to Exceed *QTY LIMIT* 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.
NASAL		
NAYZILAM® (midazolam) nasal spray (age ≥ 12		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
years) *QTY LIMIT:* 10 units/30 days VALTOCO® (diazepam) nasal spray (age ≥ 6 years) *QTY LIMIT:* 20 units/30 days		
RECTAL		
DIAZEPAM (compare to Diastat®) rectal gel	Diastat® (diazepam) rectal gel	**Diastat:** patient has had a documented intolerance to the generic equivalent
ANTIDEPRESSANTS		
MAO INHIBITORS		
PHENELZINE SULFATE (compare to Nardil®) FDA maximum recommended dose = 90 mg/day TRANYLCYPROMINE FDA maximum recommended dose = 60 mg/day	Emsam® (selegiline) *QTY LIMIT:* 1 patch/day Marplan® (isocarboxazid) Nardil® (phenylzine) FDA maximum recommended dose = 90 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:** 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 antidepressants from 2 of the major antidepressant classes (Miscellaneous, SNRIs, SSRIs, and Tricyclic Antidepressants). OR patient is unable to tolerate oral medication.
MISCELLANEOUS		
BUPROPION SR (compare to Wellbutrin SR®) FDA maximum recommended dose = 400mg/day BUPROPION XL (compare to Wellbutrin XL®) 150 mg, 300 mg FDA maximum recommended dose = 450 mg/day BUPROPION FDA maximum recommended dose = 450 mg/day MAPROTILINE 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 TRAZODONE HCL (formerly Desyrel®) FDA maximum recommended dose = 600 mg/day	Aplenzin® (bupropion hydrobromide) ER tablets *QTY LIMIT:* 1 tablet/day Auvelity™(bupropion/dextromethorphan) *QTY LIMT:* 2 tablets/day Bupropion XL 450mg (compare to Forfivo XL®) *QTY LIMIT:* 1 tablet/day FDA maximum recommended dose = 450 mg/day Forfivo XL® (bupropion SR 24hr) 450 mg tablet *QTY LIMIT:*1 tablet/day FDA maximum recommended dose = 450 mg/day Nefazodone FDA maximum recommended dose = 600 mg/day Remeron® (mirtazapine) FDA maximum recommended dose = 45 mg/day Remeron Sol Tab® (mirtazapine RDT) FDA maximum recommended dose = 45 mg/day Spravato® (esketamine) nasal spray	**Criteria for approval for ALL non-preferred drugs:** The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR The patient meets additional criteria as outlined below. **Aplenzin, Auvelity:** The patient is ≥ 18 years of age AND The patient has had a documented side effect, allergy, or inadequate response to at least 3 different antidepressants from the SSRI, SNRI and/or Miscellaneous Antidepressant categories (may be preferred or non-preferred), one of which must be bupropion. **Bupropion XL 450mg, Forfivo XL**: The patient is unable to take the equivalent dose as generic bupropion XL (150mg & 300mg) AND for approval of brand, the patient must have a documented intolerance to the generic equivalent. **Nefazodone:** The patient is ≥ 18 years of age AND The patient has had a documented side effect, allergy, or inadequate response to at least 3 different antidepressants from the SSRI, SNRI and/or Miscellaneous Antidepressant categories (may be preferred or non-preferred) **Remeron, Remeron SolTab, Wellbutrin SR, and Wellbutrin XL:** The patient has had a documented intolerance to the generic formulation of the requested medication.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
VIIBRYD® (vilazodone) Tablet (Age ≥ 18 years) FDA maximum recommended dose = 40 mg/day	*QTY LIMIT:* not to exceed FDA recommended dose and frequency for corresponding timeframe Trintellix® (vortioxetine) Tablet *QTY LIMIT:* 1 tablet/day Vilazodone (compare to Viibryd®) *QTY LIMIT:* 1 tablet/day FDA maximum recommended dose = 40 mg/day Wellbutrin SR® (bupropion SR) FDA maximum recommended dose = 400 mg/day Wellbutrin XL® (bupropion XL) FDA maximum recommended dose = 450 mg/day Zulresso™ (brexanolone) intravenous solution	**Spravato**: *Diagnosis is treatment resistant depression:* the patient is ≥ 18 years of age AND medication is being used as adjunct treatment with an oral antidepressant AND the patient has a documented treatment failure (defined by at least 8 weeks of therapy) with at least 2 different antidepressants from the SSRI, SNRI, and/or Miscellaneous Antidepressant categories (may be preferred or non-preferred) AND the healthcare site and patient are enrolled in the Spravato® REMS program. Initial approval will be granted for 3 months. For re-approval after 3 months, the patient must have documented improvement in symptoms. *Diagnosis is Major Depressive Disorder (MDD) with Acute Suicidal Ideation or Behavior:* the patient is ≥ 18 years of age AND the medication is being used as adjunct treatment with an oral antidepressant AND the healthcare site and patient are enrolled in the Spravato® REMS program. Approval will be granted for 4 weeks. **Trintellix:** The patient is ≥ 18 years of age AND The diagnosis or indication is MDD AND The patient has had a documented side effect, allergy, or inadequate response (defined by at least 8 weeks of therapy) to at least 2 different antidepressants from the SSRI, SNRI, and/or Miscellaneous Antidepressant categories (may be preferred or non-preferred). **Vilazodone:** Patient is ≥ 18 years of age AND The patient has had a documented intolerance to brand Viibryd. **Zulresso:** Patient is ≥ 18 years of age and ≤ 6 months postpartum AND patient has a diagnosis of postpartum depression (PPD) with documented onset of symptoms occurring in the third trimester or within 4 weeks of delivery AND the patient has a documented treatment failure (defined by at least 8 weeks of therapy) with two different oral antidepressants unless contraindicated or documentation shows that the severity of depression would place the health of the mother or infant at significant risk AND the pharmacy, patient, and healthcare facility are enrolled in the REMS program. Note: Zulresso™ will be approved as a medical benefit ONLY and will NOT be approved if billed through pharmacy point of sale. **Note:** 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		
DULOXETINE (compare to Cymbalta®) capsule *QTY LIMIT:* 2 capsules/day FDA maximum recommended dose = 120 mg/day (MDD and GAD), 60 mg/day all others	Cymbalta® (duloxetine) capsule *QTY LIMIT:* 2 capsules/day FDA maximum recommended dose = 120 mg/day (MDD and GAD), 60 mg/day all others	**Criteria for approval of ALL non-preferred drugs:** The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR The patient meets additional criteria as outlined below.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
VENLAFAXINE ER capsule (compare to Effexor XR®) *QTY LIMIT:* 37.5 mg and 75 mg = 1 capsule/day FDA maximum recommended dose = 225 mg/day VENLAFAXINE IR tablet FDA maximum recommended dose = 225 mg/day	Desvenlafaxine base SR *QTY LIMIT:* 50 mg tablet only = 1 tablet/day FDA maximum recommended dose = 400 mg/day Desvenlafaxine succinate ER (compare to Pristiq®) *QTY LIMIT:* 50 mg tablet only = 1 tablet/day FDA maximum recommended dose = 400 mg/day Drizalma® (duloxetine) sprinkle capsule QTY LIMIT: 2 capsules/day FDA maximum recommended dose = 120 mg/day (MDD and GAD), 60 mg/day all others Effexor XR® (venlafaxine XR) capsule *QTY LIMIT:* 37.5 mg and 75 mg = 1 capsule/day FDA maximum recommended dose = 225 mg/day Fetzima® (levomilnacipran ER) capsule *QTY LIMIT:* 1 capsule/day FDA maximum recommended dose = 120 mg/day Fetzima® (levomilnacipran ER) capsule titration pack *QTY LIMIT:* 1 pack per lifetime FDA maximum recommended dose = 120 mg/day Pristiq® (desvenlafaxine succinate SR) *QTY LIMIT:* 50 mg tablet only = 1 tablet/day FDA maximum recommended dose = 400 mg/day Venlafaxine ER® tablet *QTY LIMIT:* 37.5 mg and 75 mg = 1 tablet/day FDA maximum recommended dose = 225 mg/day	**Venlafaxine ER tablet (generic), Effexor XR Capsule (brand), Desvenlafaxine ER succinate, Pristiq:** The patient has had a documented intolerance to generic venlafaxine ER caps AND if the request is for Pristiq, the patient has a documented intolerance to the generic. **Desvenlafaxine SR (base), Fetzima:** The patient has had a documented side effect, allergy, or inadequate response to at least 2 different antidepressants AND The patient has had a documented intolerance with generic desvenlafaxine succinate ER. **Cymbalta, Drizalma:** There must be a clinically compelling reason why the dosing needs cannot be accomplished with generic duloxetine. **Note:** 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		
CITALOPRAM (compare to Celexa®) tablets, solution FDA maximum recommended dose = 40 mg/day ESCITALOPRAM (compare to Lexapro®) tablets FDA maximum recommended dose = 20mg/day FLUOXETINE (compare to Prozac®) capsules, tablets, solution FDA maximum recommended dose = 80 mg/day FLUVOXAMINE FDA maximum recommended dose = 300 mg/day PAROXETINE hydrochloride tablet (compare to Paxil®) FDA maximum recommended dose = 60 mg/day SERTRALINE (compare to Zoloft®) tablet, solution FDA maximum recommended dose = 200 mg/day,	Brisdelle® (paroxetine mesylate) *QTY LIMIT:* 1 capsule/day Celexa® (citalopram) FDA maximum recommended dose = 40 mg/day Escitalopram solution FDA maximum recommended dose = 20 mg/day Fluoxetine 90 mg FDA maximum recommended dose = 90 mg/week Fluvoxamine CR *QTY LIMIT:* 2 capsules/day FDA maximum recommended dose = 300 mg/day Lexapro® (escitalopram) *QTY LIMIT:*5 mg and 10 mg tablets = 1.5 tabs/day FDA maximum recommended dose = 20mg/day Paroxetine mesylate (compare to Brisdelle®) *QTY LIMIT:* 1 capsule/day	**Celexa, Fluvoxamine CR, Lexapro, Paxil tablet, Pexva, Paroxetine CR, Paxil CR, Prozac, Zoloft:** The patient had a documented side effect, allergy, or treatment failure with 2 preferred SSRIs. One trial must be the generic formulation or IR formulation if CR formulation requested. **Brisdelle, Paroxetine mesylate:** The indication for use is moderate to severe vasomotor symptoms (VMS) associated with menopause. AND The patient has tried and failed generic paroxetine hydrochloride. **Paxil suspension, Escitalopram solution:** 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 liquid SSRI formulations. **Fluoxetine 90mg:** 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. **Sertraline capsules:** Prescriber must provide a clinically compelling reason why the patient is unable to use tablets.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	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) 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 Sertraline capsule 150 mg, 200 mg *QTY LIMIT:* 1 capsule/day Zoloft® (sertraline) *QTY LIMIT:* 25 mg and 50 mg tablets = 1.5 tabs/day FDA maximum recommended dose = 200 mg/day	**Note:** 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.
TRICYCLICS		
AMITRIPTYLINE FDA maximum recommended dose = 300 mg/day AMOXAPINE DOXEPIN capsules, solution IMIPRAMINE FDA maximum recommended dose = 300 mg/day NORTRIPTYLINE (compare to Pamelor®) NORTRIPTYLINE Oral Solution	Anafranil® (clomipramine) Clomipramine (compare to Anafranil®) Imipramine Pamoate capsules Desipramine (compare to Norpramin®) Norpramin® (desipramine) Pamelor® (nortriptyline) Protriptyline Trimipramine (compare to Surmontil®)	**Criteria for approval of ALL non-preferred drugs:** patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR the patient meets additional criteria as outlined below. **Imipramine Pamoate:** The patient has had a documented side effect, allergy, or treatment failure to 3 preferred TCAs, one of which must be imipramine tablets. **Desipramine:** The patient has had a documented side effect, allergy, or treatment failure to nortriptyline. **Clomipramine:** The patient has had a documented side effect, allergy, or treatment failure to 2 or more preferred TCAs OR patient has a diagnosis of obsessive-compulsive disorder AND has had a documented side effect, allergy, or treatment failure to 2 SSRIs. **All other non-preferred agents:** The patient has had a documented side effect, allergy, or treatment failure to 2 or more preferred TCAs. One trial must be the AB rated generic formulation if available **Limitation:** Chlordiazepoxide/amitriptyline and amitriptyline/perphenazine combinations are not covered. Generic agents may be prescribed separately.
ANTI-DIABETICS		
ALPHA-GLUCOSIDASE INHIBITORS		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ACARBOSE	Miglitol	**Miglitol:** Patient must have a documented side effect, allergy or treatment failure to acarbose.
BIGUANIDES & COMBINATIONS		
SINGLE AGENT METFORMIN METFORMIN XR **COMBINATION** GLIPIZIDE/METFORMIN GLYBURIDE/METFORMIN	Glumetza® (metformin ER modified release) Metformin ER modified release (compare to Glumetza®) Metformin oral solution (compare to Riomet®) Metformin ER Osmotic Riomet® (metformin oral solution)	**Glumetza, Metformin ER mod release, Metformin ER osmotic:** patient 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) **Metformin oral solution, Riomet:** prescriber provides documentation of medical necessity for the specialty dosage form (i.e. inability to swallow tablets, dysphagia)
CD3 MONOCLONAL ANTIBODY		
All products require PA	Tzield™ (teplizumab-mzwv) vial for IV infusion	**Tzield:** • Patient is ≥ 8 years of age • Patient has Stage 2 Type 1 Diabetes as documented by the following: o Patient has at least 2 positive pancreatic islet cell autoantibodies (Glutamic acid decarboxylase 65 (GAD) autoantibodies, Insulin autoantibody (IAA), Insulinoma-associated antigen 2 autoantibody (IA-2A), Zinc transporter 8 autoantibody (ZnT8A), or Islet cell autoantibody (ICA) o Dysglycemia without overt hyperglycemia, as demonstrated by at least one of the following: Fasting plasma glucose 110-125 mg/dL, 2-hour postprandial glucose 140-199 mg/dL, or Postprandial glucose level at 30, 60, or 90 minutes > 200 mg/dL • Patient does not have any of the following: o Lymphocyte count less than 1,000 lymphocytes/mcL o Hemoglobin less than 10 g/dL o Platelet count less than 150,000 platelets/mcL o Absolute neutrophil count less than 1,500 neutrophils/mcL o Elevated ALT or AST greater than 2 times the upper limit of normal (ULN) o Bilirubin greater than 1.5 times ULN • Patient has received all age-appropriate vaccines prior to starting Tzield (Live-attenuated vaccines should be administered at least 8 weeks prior to treatment. Inactivated vaccines or mRNA vaccines should be administered at least 2 weeks prior to treatment).
DIPEPTIDYL PEPTIDASE (DPP-4) INHIBITORS		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
SINGLE AGENT JANUVIA® (sitagliptin) ONGLYZA® (saxagliptin) TRADJENTA® (linagliptin) **COMBINATION** JANUMET® (sitagliptin/metformin) JANUMET XR® (sitagliptin/metformin ER) JENTADUETO® (linagliptin/metformin) JENTADUETO® XR (linagliptan/metformin ER)	Alogliptan (compare to Nesina®) *QTY LIMIT:* 1 tab/day Nesina® (alogliptin) *QTY LIMIT:* 1 tab/day Alogliptin/metformin (compare to Kazano®) *QTY LIMIT:* 1 tab/day Alogliptin/pioglitazone (compare to Oseni®) *QTY LIMIT:* 1 tab/day Kazano® (alogliptin/metformin) *QTY LIMIT:* 1 tab/day Kombiglyze XR® (saxagliptin/metformin ER) *QTY LIMIT:* 1 tab/day Oseni® (alogliptin/pioglitazone) *QTY LIMIT:* 1 tab/day	**Alogliptan, Nesina:** patient has had a documented side effect, allergy OR treatment failure with two preferred DPP-4 agents AND for approval of alogliptin, the patient, the patient has had a documented intolerance to the brand name equivalent. **Alogliptin/metformin, Kazano, Kombiglyze XR:** patient has had a documented side effect, allergy OR treatment failure with at least one preferred DPP-4 combination agent AND for approval of Alogliptin/metformin, the patient has had a documented intolerance to the brand name equivalent. **Alogliptin/pioglitazone, Oseni:** patient has had a documented side effect, allergy, OR treatment failure with at least one preferred DPP-4 agent used in combination with pioglitazone AND for approval of Alogliptin/pioglitazone, the patient has had a documented intolerance to the brand name equivalent.
HYPOGLYCEMIA TREATMENTS		
BAQSIMI® (glucagon nasal powder) 3mg *QTY LIMIT:* 2 devices/28 days GLUCAGEN® HYPOKIT® (glucagon for injection) 1mg ZEGALOGUE® (dasiglucagon SC injection) 0.6 mg *QTY LIMIT:* 2 prefilled syringes or auto-injectors/28 days	Glucagon emergency kit Gvoke™ (glucagon SC injection) prefilled syringe, auto-injector 0.5mg, 1mg	**Glucagon Emergency Kit, Gvoke:** Patient has recurrent episodes of symptomatic or severe hypoglycemia (<55 mg/dL) requiring the assistance of another individual AND the preferred formulations would not be suitable alternatives.
INSULINS		
RAPID-ACTING INJECTABLE HUMALOG® (insulin lispro) INSULIN ASPART (compare to Novolog® INSULIN LISPRO (compare to Humalog®) NOVOLOG® (insulin aspart) **SHORT-ACTING INJECTABLE** HUMULIN R® U-500 **INTERMEDIATE-ACTING INJECTABLE** All products require PA	Admelog® (insulin lispro) Afrezza ® Inhaled (insulin human) Apidra® (insulin glulisine) Fiasp® (insulin aspart) Lyumjev® (insulin lispro-aabc) Humulin R® (Regular) U-100 Novolin R® (Regular) U-100 Humulin N® (NPH) Novolin N® (NPH)	**Admelog, Fiasp, Lyumjev:** Preferred formulations of rapid-acting insulin must be on a long-term backorder and unavailable from the manufacturer. **Apidra, Humulin R (U-100), Novolin R:** 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 two preferred formulations of rapid-acting insulin. **Humulin N, Novolin N:** 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 to at least one preferred long-acting agent. **Humulin 70/30, Novolin 70/30:** 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

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
LONG-ACTING ANALOGS INJECTABLE LANTUS® (insulin glargine) LEVEMIR® (insulin detemir) TOUJEO® (insulin glargine) TOUJEO® MAX (insulin glargine) TRESIBA® (insulin degludec) **MIXED INSULINS INJECTABLE** NOVOLOG MIX 70/30® (Protamine/Aspart) HUMALOG MIX 50/50® (Protamine/Lispro) HUMALOG MIX 75/25® (Protamine/Lispro) INSULIN ASPART PROTAMINE/ASPART 70/30 (compare to Novolog Mix 70/30®)	Basaglar® (insulin glargine) Insulin Degludec (compare to Tresiba®) Insulin Glargine (compare to Lantus®) Insulin Glargine-yfgn (compare to Semglee®) Rezvoglar™ (insulin glargine-aglr) Semglee® (insulin glargine-yfgn) Humulin 70/30® (NPH/Regular) Novolin 70/30® (NPH/Regular)	failure to two preferred mixed insulin formulations. **Insulin Degludec:** Tresiba must be on a long-term backorder and unavailable from the manufacturer. **Insulin Glarine, Insuline Glarine-Yfgn, Rezvoglar, Semglee:** Lantus must be on a long-term backorder and unavailable from the manufacturer. **Basaglar:** All formulations of insulin glargine must be on long-term backorder and unavailable from the manufacturer. **AFREZZA INHALED INSULIN:** • Baseline PFT with FEV1 ≥ 70 % predicted • Patient does not have underlying lung disease (Asthma, COPD) • Patient is a non-smoker or has stopped smoking more than six months prior to starting Afrezza • Patient is currently using a long-acting insulin • Patient has failed to achieve HbA1c goal (defined as ≤ 7%) on a short-acting insulin in combination with a long-acting insulin • Initial approval is for 3 months and improved glycemic control must be documented for further approvals
MEGLITINIDES		
NATEGLINIDE REPAGLINIDE		
PEPTIDE HORMONES: GLP-1 RECEPTOR AGONISTS		
Preferred After Clinical Criteria Are Met **SINGLE AGENTS** OZEMPIC® (semaglutide) *QTY LIMIT:* 9mL/84 days TRULICITY® (dulaglutide) *QTY LIMIT: 12 pens/84 days* VICTOZA® (liraglutide) *QTY LIMIT:* 9 pens/90 days **COMBINATION AGENTS** All products require PA	Adlyxin® (lixisenatide) Bydureon® BCise™ (exenatide extended-release) *QTY LIMIT*: 12 pens/84 days Byetta® (exenatide) *QTY LIMIT:* 3 pens/90 days Mounjaro™ (tirzepatide) *QTY LIMIT*: 4 pens/28 days Rybelsus® (semaglutide) tablets *QTY LIMIT: 1 tablet/day* Soliqua® (insulin glargine/lixisenatide) *QTY LIMIT:* 3 pens/25 days	**Clinical criteria for all drugs:** patient has a diagnosis of Type 2 Diabetes Mellitus **Additional criteria for Adlyxin/Byetta/Bydureon BCise, Mounjaro:** patient has a documented side effect, allergy, contraindication, or treatment failure with two preferred GLP-1 Receptor Agonists. Treatment failure is defined as < 1% reduction in HbA1c after 12 weeks at the maximally tolerated dose. **Additional criteria for Rybelsus:** patient has a documented side effect, allergy, contraindication, or treatment failure with one preferred SGLT2 inhibitor AND patient has a documented side effect, allergy, contraindication, or treatment failure with two preferred GLP-1 Receptor Agonists, one of which must be Ozempic, or has a clinically valid reason for being unable to administer an injection (e.g. visual impairment, impaired dexterity). Treatment failure is defined as < 1% reduction in HbA1c after 12 weeks at the maximally tolerated dose. **Soliqua/Xultophy:** patient has a documented side effect, allergy, contraindication,

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
AMYLINOMIMETICS All products require PA	Xultophy® (insulin degludec/liraglutide) Symlin® (pramlintide)	or treatment failure with at least one preferred GLP-1 Receptor Agonist used in combination with Lantus or Levemir. Treatment failure is defined as < 1% reduction in HbA1c after 12 weeks at the maximally tolerated dose. **Symlin:** patient is at least 18 years of age AND patient is on insulin.
SODIUM-GLUCOSE CO-TRANSPORTER 2 (SGLT2) INHIBITORS AND COMBINATIONS		
SINGLE AGENTS FARXIGA® (dapagliflozin) INVOKANA® (canagliflozin) JARDIANCE (empagliflozin) **COMBINATIONS AGENTS** INVOKAMET® (canagliflozin/metformin) SYNJARDY® (empagliflozin/metformin)	Steglatro® (ertugliflozin) *QTY LIMIT*: 1 tab/day Glyxambi® (empagliflozin/ linagliptin) *QTY LIMIT*: 1 tab/day Invokamet® XR (canagliflozin/metformin ER) Qtern® (dapagliflozin/saxagliptin) Segluromet® (ertugliflozin/metformin) *QTY LIMIT*: 2 tabs/day Steglujan® (ertugliflozin/sitagliptin) *QTY LIMIT*: 1 tab/day Synjardy® XR (empagliflozin/metformin ER) *QTY LIMIT*: 1 tab/day Trijardy® XR (empagliflozin/linagliptin/metformin ER) Xigduo XR® (dapagliflozin/metformin ER) *QTY LIMIT:* 5/1000 mg = 2 tabs/day, all other strengths = 1 tab/day	**Steglatro:** Patient has a documented side effect, allergy, or contraindication to two preferred SGLT2 inhibitors. **Invokamet XR/Segluromet/ Synjardy XR, Xigduo XR:** The patient has documentation of a failure of therapy with a preferred SGLT2 inhibitor used in combination with metformin/metformin XR. **Glyxambi/Qtern/Steglujan:** The patient has documentation of a failure of therapy with the combination of a preferred SGLT2 inhibitor plus a preferred DPP-4 inhibitor **Trijardy XR:** patient has documentation of a failure of therapy with a preferred SGLT2 inhibitor, a preferred DDP-4 inhibitor and metformin/metformin XR used in combination.
SULFONYLUREAS 2ND GENERATION		
GLIMEPIRIDE (compare to Amaryl®) GLIPIZIDE (compare to Glucotrol®) GLIPIZIDE ER (compare to Glucotrol XL®) GLYBURIDE GLYBURIDE MICRONIZED	Amaryl® (glimepiride) Glucotrol XL® (glipizide ER) Glynase® (glyburide micronized)	**Criteria for Approval:** Patient must have a documented side effect, allergy or treatment failure to two preferred sulfonylureas. If a product has an AB rated generic, one trial must be the generic.
THIAZOLIDINEDIONES & COMBINATIONS		
PIOGLITAZONE (compare to Actos®) **COMBINATION** All products require PA	Actos® (pioglitazone) Actoplus Met® (pioglitazone/metformin) Duetact® (pioglitazone/glimepiride) *QTY LIMIT:* 1 tablet/day	**Actos:** the patient has a documented intolerance to the generic equivalent. **Actoplus Met, Duetact, Pioglitazone/Metformin, Pioglitazone/Glimepiride:** patient is unable to take as the individual separate agents AND if the request is for Actoplus Met or Duetact, the patient has had a documented intolerance to the generic equivalent.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Pioglitazone/Glimepiride (compare to Duetact®) *QTY LIMIT:* 1 tablet/day Pioglitazone/Metformin (compare to Actoplus Met)	
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 nausea/vomiting: see clinical criteria. Monthly quantity limits apply, PA required to exceed.		
GRANISETRON injection ONDANSETRON injection ONDANSETRON tablet ONDANSETRON ODT ONDANSETRON oral solution 4mg/5mL PALONOSETRON injection	Akynzeo® (nutupitant/palonosetron) Granisetron 1 mg tablets *QTY LIMIT:* 6 tabs/28 days Sancuso® 3.1 mg/24 hr transdermal patch (granisetron) *QTY LIMIT:* 4 patches/28 days Sustol® (granisetron) injection 10 mg/0.4ml *QTY LIMIT:* 4 injections/28 days	**Akynzeo:** Has a diagnosis of nausea and vomiting associated with cancer chemotherapy AND patient has a documented side effect, allergy, or treatment failure of a regimen consisting of a 5-HT3 antagonist, an NK1 antagonist, and dexamethasone. **Granisetron tablets:** The patient has had a documented side effect, allergy, or treatment failure to generic ondansetron. **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. **Sustol:** Patient has a diagnosis of nausea and vomiting associated with cancer chemotherapy or radiotherapy AND prescriber provides documentation of medical necessity for the specialty dosage form (i.e. inability to swallow tablets, dysphagia) AND the patient has a documented side effect, allergy, or treatment failure with Ondansetron injection and Sancuso transdermal. **CRITERIA FOR APPROVAL to Exceed *QTY LIMIT:*** **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.
MISCELLANEOUS (PREGNANCY)		
DICLEGIS® (10 mg doxylamine succinate and 10 mg pyridoxine hydrochloride) DR tablet *QTY LIMIT:* 4 tablets/day	Bonjesta® (20 mg doxylamine succinate and 20 mg pyridoxine hydrochloride ER tablet) *QTY LIMIT:* 2 tablets/day Doxylamine succinate/pyridoxine hydrochloride DR tablet (compare to Diclegis®) QTY LIMIT: 4 tablets/day	**Bonjesta, Doxylamine/Pyridoxone:** patient has a documented intolerance to Diclegis.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
NK1 ANTAGONISTS		
APONVIE® (aprepitant) injection CINVANTI® (aprepitant) injection EMEND® (fosaprepitant) injection ***Preferred After Clinical Criteria Are Met*** EMEND® (aprepitant) 80 mg *QTY LIMIT:* 2 caps/28 days EMEND® (aprepitant) Tri-fold Pack *QTY LIMIT:* 1 pack/28 days	Aprepitant (compare to Emend®) 40 mg *QTY LIMIT:* 1 cap/28 days Aprepitant (compare to Emend®) 80 mg *QTY LIMIT:* 2 caps/28 days Aprepitant (compare to Emend®) 125 mg *QTY LIMIT:* 1 cap/28 days Emend® (aprepitant) oral suspension	**Aprepitant, Emend (aprepitant):** 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. For approval of generic aprepitant, the patient must have a documented intolerance to brand Emend. **Emend oral suspension:** 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 patient has a documented medical necessity for the specialty dosage form (e.g. swallowing disorder)
THC DERIVATIVES		
All products require PA	Dronabinol (compare to Marinol®) Marinol® (dronabinol)	**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 HIV/AIDS associated anorexia. AND patient has had an inadequate 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.
ANTI-HYPERTENSIVES		
ACE INHIBITORS		
BENAZEPRIL (compare to Lotensin®) ENALAPRIL (compare to Vasotec®) tablet ENALAPRIL oral solution (age ≤ 12 years old) FOSINOPRIL LISINOPRIL (compare to Zestril®) QUINAPRIL (compare to Accupril®)	Accupril® (quinapril) Altace® (Ramipril) Captopril Enalapril oral solution (age > 12 years old) Epaned® (enalapril) oral solution Lotensin® (benazepril) Moexepril	**Enalapril (Patients > 12 years old), Epaned Oral Solution:** patient has a requirement for an oral liquid dosage form (i.e. swallowing disorder) AND for approval of Epaned, the patient must have a documented intolerance to the generic equivalent. **Qbrelis Oral Solution:** patient has a requirement for an oral liquid dosage form (i.e. swallowing disorder, inability to take oral medications) AND has a side effect, allergy, or treatment failure to Epaned oral solution.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
RAMIPRIL (compare to Altace®) TRANDOLAPRIL	Perindopril Qbrelis® (Lisinopril) 1mg/ml solution Vasotec® (enalapril) Zestril® (lisinopril)	**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.
ACE INHIBITOR W/ HYDROCHLOROTHIAZIDE		
BENAZEPRIL/HYDROCHLOROTHIAZIDE (compare to Lotensin HCT®) ENALAPRIL/HYDROCHLOROTHIAZIDE (compare to Vaseretic®) FOSINOPRIL/HYDROCHLOROTHIAZIDE LISINOPRIL/HYDROCHLOROTHIAZIDE (compare to Zestoretic®) QUINAPRIL/HYDROCHLOROTHIAZIDE (compare to Accuretic®)	Accuretic® (quinapril/HCTZ) Lotensin HCT® (benazepril/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.
ACE INHIBITOR W/CALCIUM CHANNEL BLOCKER		
AMLODIPINE/BENAZEPRIL (compare to Lotrel®)	Lotrel® amlodipine/(benazepril) Trandolapril/Verapamil ER	**Lotrel:** The patient has had a documented side effect, allergy, or treatment failure to the generic formulation. **Trandolapril/Verapamil ER:** The patient has had a documented side effect, allergy, or treatment failure to amlodipine/benazepril AND the patient is unable to take as the individual separate agents.
ANGIOTENSIN RECEPTOR BLOCKERS (ARBs)		
CANDESARTAN IRBESARTAN (compare to Avapro®) LOSARTAN (compare to Cozaar®) OLMESARTAN (compare to Benicar®) TELMISARTAN (compare to Micardis®) VALSARTAN (compare to Diovan®)	Avapro® (irbesartan) Benicar® (olmesartan) Cozaar® (losartan) Diovan® (valsartan) Edarbi® (azilsartan) Tablet *QTY LIMIT:*1 tablet/day Micardis® (telmisartan)	**Avapro, Benicar, Cozaar, Diovan, Edarbi, and Micardis:** Patient has had a documented side effect, allergy, or treatment failure with TWO preferred Angiotensin Receptor Blocker (ARB) or ARB combinations. AND If brand name product with generic available, the patient has had a documented intolerance with the generic product.
ANGIOTENSIN RECEPTOR BLOCKER/DIURETIC COMBINATIONS		
IRBESARTAN/HYDROCHLOROTHIAZIDE (compare to Avalide®)	Avalide® (irbesartan/hydrochlorothiazide) Benicar HCT® (olmesartan/hydrochlorothiazide)	**Avalide, Benicar HCT, Candesartan/HCTZ, Diovan HCT, Edarbyclor, Hyzaar, Micardis HCT and Telmisartan/HCTZ:** patient has had a

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
LOSARTAN/HYDROCHLOROTHIAZIDE (compare to Hyzaar®) OLMESARTAN/HYDOCHLOROTHIAZIDE (compare to Benicar HCT®) TELMISARTAN/HYDROCHLOROTHIAZIDE (compare to Micardis HCT®) VALSARTAN/HYDROCHLOROTHIAZIDE (compare to Diovan HCT®)	Candesartan/hydrochlorothiazide Diovan HCT® (valsartan/hydrochlorothiazide) Edarbyclor® (azilsartan/chlorthalidone) Tablet *QTY LIMIT:* 1 tablet/day Hyzaar® (losartan/hydrochlorothiazide) Micardis HCT® (telmisartan/hydrochlorothiazide)	documented side effect, allergy, or treatment failure with a preferred ARB/Hydrochlorothiazide combination AND If brand name product with generic available, the patient has had a documented intolerance with the generic product.
ANGIOTENSIN RECEPTOR BLOCKER/CALCIUM CHANNEL BLOCK COMBINATIONS		
OLMESARTAN/AMLODIPINE (compare to Azor®) VALSARTAN/AMLODIPINE (compare to Exforge®) *QTY LIMIT:* 1 tablet/day	Azor®(olmesartan/amlodipine) *QTY LIMIT:* 1 tablet/day Amlodipine/telmisartan *QTY LIMIT:* 1 tablet/day Exforge® (valsartan/amlodipine) *QTY LIMIT:* 1 tablet/day	**Azor, Amlodipine/Telmisartan, Exforge, Olmesartan/amlodipine:** The patient has had a documented side effect, allergy, or treatment failure to a preferred ARB/CCB combination product AND if brand name product with generic available, the patient has had a documented intolerance with the generic equivalent.
ANGIOTENSIN RECEPTOR BLOCKER/CALCIUM CHANNEL BLOCKER/HCTZ COMBO		
VALSARTAN/AMLODIPINE/HCTZ (compare to Exforge HCT®) *QTY LIMIT:* 1 tablet/day	Exforge HCT® (amlodipine/valsartan/hydrochlorothiazide) *QTY LIMIT:* 1 tablet/day Olmesartan/amlodipine/hydrochlorothiazide (compare to Tribenzor®) *QTY LIMIT:* 1 tablet/day Tribenzor® (amlodipine/olmesartan/hydrochlorothiazide) *QTY LIMIT:* 1 tablet/day	**Exforge HCT, Olmesartan/amlodipine/HCTZ, Tribenzor:** patient has had a documented side effect, allergy, or treatment failure to Valsartan/amlodipine/HCTZ.
BETA BLOCKERS		
SINGLE AGENT ACEBUTOLOL ATENOLOL (compare to Tenormin®) BISOPROLOL FUMARATE BYSTOLIC® (nebivolol) CARVEDILOL (compare to Coreg®) LABETALOL METOPROLOL TARTRATE (compare to Lopressor®) METOPROLOL SUCCINATE XL (compare to Toprol XL®)	Betapace® (sotalol) Betapace AF® (sotalol) Betaxolol Carvedilol CR (compare to Coreg®) *QTY LIMIT:* 1 tablet/day Coreg® (carvedilol) Coreg CR® (carvedilol CR) *QTY LIMIT:* 1 tablet/day Corgard® (nadolol)	**Non-preferred drugs (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.) **Carvedilol CR, Coreg CR:** *Indication: Heart Failure:* patient has been started and stabilized on the medication. (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.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
NADOLOL NEBIVOLOL (compare to Bystolic®) PINDOLOL PROPRANOLOL PROPRANOLOL ER (compare to Inderal LA®) SOTALOL (compare to Betapace®, Betapace AF®) ***Preferred After Clinical Criteria Are Met*** HEMANGEOL® oral solution (propranolol) **BETA-BLOCKER/DIURETIC COMBINATION** ATENOLOL/CHLORTHALIDONE (compare to Tenoretic®) BISOPROLOL/HYDROCHLOROTHIAZIDE (compare to Ziac®) METOPROLOL/HYDROCHLOROTHIAZIDE	Inderal LA® (propranolol ER) Inderal XL® (propranolol SR) Innopran XL® (propranolol SR) Kapspargo Sprinkle™ (metoprolol succinate XL) Lopressor® (metoprolol tartrate) Sorine® (sotalol) Tenormin® (atenolol) Timolol Toprol XL® (metoprolol succinate XL) Nadolol/bendroflumethiazide Tenoretic® (atenolol/chlorthalidone) Ziac® (bisoprolol/HCTZ)	*Indication: Hypertension:* patient has been started and stabilized on the medication. (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. **Hemangeol:** indication for use is the treatment of proliferating infantile hemangioma **Kapspargo:** patient is unable to take a solid oral dosage form and has a treatment failure with an immediate release oral solution or crushed tablets.
CALCIUM CHANNEL BLOCKERS		
SINGLE AGENT **DIHYDROPYRIDINES** AMLODIPINE (compare to Norvasc®) FELODIPINE ER NIFEDIPINE IR (compare to Procardia®) NIFEDIPINE SR osmotic (compare to Procardia® XL) NIFEDIPINE SR (compare to Adalat® CC) **NON-DIHYDROPYRIDINES** CARTIA® XT (diltiazem SR, compare to Cardizem® CD)	Isradipine Katerzia ® (amlodipine) oral suspension Levamlodipine Nicardipine Nimodipine Norliqva® (amlodipine) oral solution Nisoldipine ER (compare to Sular®) Norvasc® (amlodipine) Nymalize® (nimodipine) Oral Solution Procardia® (nifedipine IR) Procardia XL® (nifedipine SR osmotic) Sular® (nisoldipine)	**Criteria for approval (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.) **Katerzia:** patient has a medical necessity for a specialty dosage form (i.e. dysphagia, swallowing disorder). **Norliqva, Nymalize:** patient has a medical necessity for a specialty dosage form (i.e. dysphagia, swallowing disorder) and the patient has a had a documented side effect, allergy, or treatment failure to Katerzia.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
DILT-XR® (diltiazem SR) DILTIAZEM (compare to Cardizem®) DILTIAZEM ER 24-hour capsules (compare to Tiazac®) DILTIAZEM SR 24-hour capsules (compare to Cardizem®CD) DILTIAZEM SR 24-hour tablets TAZTIA® XT (diltiazem ER, compare to Tiazac®) VERAPAMIL (compare to Calan®) VERAPAMIL CR (compare to Calan SR®) VERAPAMIL SR 120 mg, 180 mg, 240 mg, and 360 mg (compare to Verelan®) **Note:** Please refer to the Anti-Hypertensives: Angiotensin Receptor Blockers (ARBs) PDL category for ARB/CCB combination therapies	Calan® SR (verapamil CR) Cardizem® (diltiazem) Cardizem® CD (diltiazem SR) Cardizem® LA (diltiazem SR) Diltiazem ER 12-hour capsules Diltiazem ER/Matzin LA (compare to Cardizem® LA) Tiazac® (diltiazem ER) Verapamil SR 100 mg, 200 mg, 300mg (compare to Verelan PM®) Verelan® (verapamil SR 120 mg, 180 mg, 240 mg and 360 mg) Verelan® PM (100 mg, 200 mg and 300 mg)	
CENTRAL ALPHA AGONISTS		
ORAL TABLETS CLONDIDNE IR Tablets (compare to Catapres®) GUANFACINE IR Tablets (compare to Tenex®) **TRANSDERMAL** CLONIDINE Transdermal Patch *QTY LIMIT:* 1 patch/7 days	Methyldopa Tablets	**Methyldopa:** The patient has a documented side effect, allergy, or contraindication to two preferred central alpha agonists.
GANGLIONIC BLOCKERS		
All products require 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 therapies of different mechanism of actions.
RENIN INHIBITOR		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
All products require PA	**SINGLE AGENT** Aliskiren (compare to Tekturna®) *QTY LIMIT:* 1 tablet/day Tekturna® (aliskiren) *QTY LIMIT:* 1 tablet/day **COMBINATIONS** Tekturna HCT® (aliskiren/hydrochlorothiazide) *QTY LIMIT:* 1 tablet/day	**Aliskiren, 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). **Tekturna HCT:** the patient must meet criteria as listed above for Tekturna and is unable to use the individual separate agents.
ANTI-INFECTIVES ANTIBIOTICS		
AMINOGLYCOSIDES		
NEOMYCIN SULFATE	Arikayce® (amikacin inhalation suspension) *QTY LIMIT:* 28 vials (235.2 mL)/28 days	**Arikayce:** Patient is ≥ 18 years of age AND indication for use is treatment of *Mycobacterium avium complex* (MAC) lung disease AND patient has not achieved negative sputum cultures after a minimum of 6 consecutive months of a multidrug background regimen therapy (e.g. macrolide, rifampin, & ethambutol) within the past 12 months. **Note:** Initial approval will be granted for 6 months. For re-approval, the patient must have documentation of clinical improvement AND 3 consecutive monthly negative sputum cultures.
CEPHALOSPORINS 1ST GENERATION		
CAPSULES/TABLETS CEFADROXIL capsules CEPHALEXIN capsules (compare to Keflex®) **SUSPENSION** CEFADROXIL suspension CEPHALEXIN suspension IV drugs are not managed at this time	Cefadroxil tablets Cephalexin tablets	**Cephadroxil tabs:** patient has had a documented intolerance to cefadroxil generic capsules. **Cephalexin Tabs:** patient has had a documented intolerance to cephalexin generic capsules.
CEPHALOSPORINS 2ND GENERATION		
CAPSULES/TABLETS CEFACLOR capsule CEFPROZIL tablet CEFUROXIME tablet	Cefaclor® ER tablet	**Cefaclor ER Tabs:** patient has had a documented intolerance to cefaclor capsules. **Cefaclor Suspension:** patient has a documented side effect, allergy, or treatment failure to Cefprozil suspension.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
SUSPENSION CEFPROZIL suspension IV drugs are not managed at this time	Cefaclor suspension	
CEPHALOSPORINS 3RD GENERATION		
CAPSULES/TABLETS CEFDINIR CAPSULE CEFPODOXIME TABLET **SUSPENSION** CEFDINIR suspension IV drugs are not managed at this time	Suprax® (cefixime) chewable tablets Cefixime suspension Cefpodoxime proxetil suspension Suprax® (cefixime) suspension	**Suprax , chewable tablet:** 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 cefdinir or cefpodoxime. **Cefpodoxime Proxetil Susp, Cefixime Susp, Suprax 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 cefdinir suspension.
CLINDAMYCIN DERIVATIVES		
CLINDAMYCIN (compare to Cleocin®) capsules CLINDAMYCIN (compare to Cleocin®) oral solution	Cleocin (clindamycin) Capsules Cleocin® Ped (clindamycin) oral solution	**Cleocin:** the patient has a documented intolerance to the generic equivalent.
MACROLIDES		
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®) Azithromycin packet (compare to Zithromax®) *QTY LIMIT:* 2 grams/fill Zithromax® (azithromycin) tablets and liquid *QTY LIMIT:* 5 days supply/RX, maximum 10 days, therapy/30 days Zithromax® (azithromycin) packet *QTY LIMIT:* 2 grams/fill	**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. **Azithromycin/Zithromax packets:** A clinically valid reason why the dose cannot be obtained using generic azithromycin tablets or suspension AND If the request is for brand Zithromax, the patient has a documented intolerance to the generic product. **Azithromycin > 5-day supply (criteria for approval based on indication):** *Lyme Disease:* patient 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 *Cystic Fibrosis*: length of authorization up to 12 months *HIV/immunocompromised status:* azithromycin is being used for MAC or
CLARITHROMYCIN tablets	Clarithromycin SR Clarithromycin suspension E.E.S.® (erythromycin ethylsuccinate) ERY-TAB® (erythromycin base, delayed release) ERYTHROMYCIN BASE	

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
IV drugs are not managed at this time	Erythromycin base, delayed release (compare to Ery-tab®) ERYTHROMYCIN ETHYLSUCCINATE (compare to E.E.S.®) Eryped® (erythromycin ethylsuccinate) Erythrocin (erythromycin stearate) Dificid® (fidaxomicin) tablet *QTY LIMIT:* 2 tablets per day, 10-day supply per 30 days	Toxoplasmosis treatment or prevention. (length of authorization up to 6 months) *Bacterial Sinusitis:* patient has had a documented side effect, allergy, or treatment failure to penicillin, amoxicillin, or sulfamethoxazole/trimethoprim (Bactrim). (length of authorization up to 10 days) *Severe Bronchiectasis or COPD with frequent exacerbations:* length of authorization up to 1 year (There is no safety or efficacy data for long-term therapy beyond one year) *Babesiosis:* blood smear or PCR is positive (results must be submitted; positive serology is not sufficient) AND patient is symptomatic (length of authorization up to 10 days) **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 oral vancomycin.
NITROFURANTOIN DERIVATIVES		
NITROFURANTOIN MACROCRYSTALLINE capsules (compare to Macrodantin®) NITROFURANTOIN MONOHYDRATE MACROCYSTALLINE capsules (compare to Macrobid®) NITROFURANTOIN SUSPENSION (age ≤ 12 yrs)	Macrobid® (nitrofurantoin monohydrate macrocrystalline) capsules Macrodantin® (nitrofurantoin macrocrystalline) capsules	**Macrobid, Macrodantin:** the patient has a documented intolerance to the generic equivalent. **Nitrofurantoin susp (age > 12 yrs):** patient must have medical necessity for a liquid formulation (i.e. swallowing disorder)
OXAZOLIDINONES		
IV form of this medication not managed at this time	Linezolid (compare to Zyvox®) *QTY LIMIT:*56 tablets per 28 days Linezolid (compare to Zyvox®) suspension *QTY LIMIT:*60 ml/day, maximum 28 days supply Sivextro® (tedizolid) *QTY LIMIT:*1 tab/day Zyvox® (linezolid) *QTY LIMIT:*56 tablets per 28 days Zyvox® (linezolid) suspension *QTY LIMIT:* 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, sputum, tissue, or urine culture that is positive for Methicillin-Resistant Staphylococcus species AND patient has had a documented treatment failure with trimethoprim/sulfamethoxazole, clindamycin, doxycycline, or minocycline OR there is a clinically valid reason that the patient cannot be treated with one of those agents AND for approval of Zyvox or Sivextro the patient has an intolerance to generic linezolid.
PLEUROMUTILINS		
All products require PA IV form of this medication not managed at this time	Xenleta® (lefamulin acetate) *QTY LIMIT:* 2 tabs/day	**Xenleta:** patient is completing a course of therapy which was initiated in the hospital OR patient is ≥ 18 years of age AND has a confirmed diagnosis of community-acquired bacterial pneumonia (CABP) AND culture and sensitivity (C&S) report shows isolated pathogen is a susceptible to lefamulin (If obtaining

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		a C&S report is not feasible, provider must submit documentation.) AND patient has a documented treatment failure, intolerance, or contraindication to 2 preferred antibiotics AND patient has no known risk factors for increased QT prolongation (e.g. cardiac arrhythmias, symptomatic bradycardia, hypokalemia, or congenital prolongation of the QT interval) AND medication is not being used in combination with other drugs known to prolong the QT interval (e.g. antipsychotics, erythromycin, tricyclic antidepressants). If use of Xenleta® cannot be avoided in these patients, baseline EKG and plan for ongoing monitoring must be documented.
PENICILLINS (ORAL)		
SINGLE ENTITY AGENTS **NATURAL PENICILLINS** PENICILLIN V POTASSIUM tablets, oral solution **PENICILLINASE-RESISTANT PENICILLINS** DICLOXACILLIN Capsules **AMINOPENICILLINS** AMOXICILLIN capsules, tablets, chewable tablets, suspension AMPICILLIN capsules, suspension **COMBINATION PRODUCTS** AMOXICILLIN/CLAVULANATE tablets, chewable tablets, suspension	Amoxicillin/clavulanate ER tablets	**Amoxicillin/Clavulanate ER**: prescriber must provide a clinically valid reason for the use of the requested medication.
QUINOLONES		
CIPROFLOXACIN (compare to Cipro®) tabs CIPRO® (ciprofloxacin) oral suspension LEVOFLOXACIN (compare to Levaquin®) tabs, solution MOXIFLOXACIN tabs IV drugs are not managed at this time	Baxdela™ (delafloxacin) Cipro® (ciprofloxacin) tabs Levaquin® (levofloxacin) tabs, solution Ofloxacin	**Cipro, Levaquin:** the patient has had a documented intolerance to the generic equivalent. **Baxdela:** patient is completing a course of therapy with the requested medication that was initiated in the hospital OR patient is ≥ 18 years of age AND has a confirmed diagnosis of acute bacterial skin and skin structure infection (ABSSSI) AND current culture and sensitivity (C&S) report shows isolated pathogen is a gram-positive or gram-negative organism susceptible to delafloxacin (If obtaining a C&S report is not feasible, provider must submit documentation.) AND member has a documented treatment failure, intolerance

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		or contraindication to 2 preferred antibiotics, one of which must be a fluoroquinolone AND duration of therapy does not exceed 14 days. **Ofloxacin:** patient has had a documented side effect, allergy, or treatment failure with two preferred fluoroquinolones
RIFAMYCINS		
All products require PA	Aemcolo® (rifamycin) delayed release tablets *QTY LIMIT: 12 tablets, max of 3 days* Xifaxan ® (rifaximin) 200 mg tablets *QTY LIMIT:* depends on indication Xifaxan ® (rifaximin) 550 mg tablets *QTY LIMIT:* depends on indication	**Aemcolo:** patient has a diagnosis of traveler'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 or azithromycin. **Xifaxan: 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). **Traveler's Diarrhea (Xifaxan 200 mg Tablets Only**): patient has a diagnosis of traveler'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 or azithromycin. 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 Quantity limit is 1,200 mg to 1,650mg/day for 14 days; maximum of 3 courses will be approved. **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. Quantity limit is 1,200 mg to 1,650 mg/day for 14 days; maximum of 3 courses will be approved. **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, azathioprine, corticosteroids, or methotrexate. AND Quantity limit is 600 mg to 1,600 mg/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 vancomycin AND Quantity limit is 1200mg/day.
TETRACYCLINES		
DOXYCYCLINE MONOHYDRATE 50 MG,	Demeclocycline 150mg, 300mg tabs	**Non-preferred doxycycline/minocycline products (except as listed below):** patient has had a documented side effect, allergy, or treatment failure with a

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
100 MG capsules, tablets DOXYCYCLINE HYCLATE 20MG tablets DOXYCYCLINE HYCLATE 100 MG capsules, tablets DOCYCYCLINE HYCLATE 50MG capsules DOXYCYCLINE MONOHYDRATE suspension 25 MG/5ML MINOCYCLINE 50 MG, 100 MG capsules	Doryx (doxycycline hyclate) delayed release tabs Doxycycline hyclate delayed release tabs Doxycycline monohydrate 40mg cap Doxycycline 75mg, 150mg caps, tabs Minolira® ER (minocycline extended release) tablet QTY LIMIT: 1 tablet/day Minocycline 50 mg, 75 mg, 100 mg tabs Nuzyra® (omadacycline) tabs *QTY LIMIT:* Max 14-day supply Solodyn®(minocycline) tabs ER Tetracycline 250 mg, 500 mg cap Vibramycin® (doxycycline hyclate) cap, suspension Vibramycin® (doxycycline calcium) syrup Ximino® (minocycline) caps ER All other brands	preferred doxycycline/minocycline. If a product has an AB rated generic, the trial must be the generic formulation. **Nuzyra:** patient has been started on intravenous or oral omadacycline in the hospital and will be finishing the course of therapy in an outpatient setting OR the patient has a diagnosis of community-acquired bacterial pneumonia (CABP) or acute bacterial skin and skin structure infections (ABSSSI) AND the patient has had a documented treatment failure with two preferred antibiotics (from any class) OR the provider submits clinical rationale as to why the preferred agents would not be appropriate for the patient. **Oracea:** patient has a diagnosis of Rosacea AND patient has had a documented side effect, allergy, or treatment failure with both a preferred doxycycline and minocycline. **Minolira ER/Solodyn/Ximino:** patient is ≥ 12 years of age AND indication is to treat non-nodular inflammatory lesions of acne vulgaris AND patient has had a documented side effect, allergy, or treatment failure with a preferred minocycline. **Note:** no effect has been demonstrated on non-inflammatory acne lesions. **Vibramycin Suspension, Syrup:** patient has a medical necessity for a liquid dosage form AND a documented failure of preferred doxycycline suspension. **Tetracycline:** patient has had a documented side effect, allergy, or treatment failure with at least two preferred products OR the indication for use is the treatment of H. Pylori infection.
VANCOMYCIN		
All products require PA IV vancomycin products are not managed at this time	Firvanq™ (vancomycin HCl) powder for oral solution *QTY LIMIT:* 1 bottle (150ml) per course of therapy. If more than 150ml is required, use of 300ml bottle is required. Vancocin® Vancomycin (compare to Vancocin®) capsules, oral solution	**Firvanq, Vancomycin oral solution:** The patient has a diagnosis or indication of Clostridium difficile associated diarrhea (CDAD) or staphylococcus enterocolitis AND for approval of Vancomycin oral solution, the patient has a documented intolerance to Firvanq. **Vancocin, Vancomycin capsules:** The patient has a diagnosis or indication of Clostridium difficile associated diarrhea (CDAD) or staphylococcus enterocolitis AND for approval of Vancocin, the patient has a documented intolerance to generic vancomycin capsules.
ANTI-INFECTIVES ANTIFUNGAL		
ALLYLAMINES		
TERBINAFINE tabs (compare to Lamisil®)	Griseofulvin Microsize Tablets Griseofulvin Ultramicrosize Tablets	**Griseofulvin Microsize Tabs/Griseofulvin Ultramicrosize:** patient has had a documented side effect, allergy, or treatment failure with terbinafine tablets

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
QTY LIMIT: 30 tablets/month (therapy limit of 90 days) GRISEOFULVIN MICROSIZE Suspension		and a preferred formulation of griseofulvin.
AZOLES		
FLUCONAZOLE (compare to Diflucan®) tabs, suspension CLOTRIMAZOLE Troche (compare to Mycelex®) IV drugs are not managed at this time.	Cresemba® (isavuconazonium) caps Diflucan® (fluconazole) tabs, suspension Itraconazole (compare to Sporanox®) caps, solution Ketoconazole tabs Noxafil® (posaconazole) oral suspension Noxafil® (posaconazole) DR Tablets *QTY LIMIT:* 93 tablets/30 days Noxafil ® (posaconazole) DR Powder packets Oravig® (miconazole) 50 mg buccal tablet Posaconazole DR Tablets (compare to Noxafil®) *QTY LIMIT:* 93 tablets/30 days Posaconazole oral suspension (compare to Noxafil®) Sporanox® (itraconazole) caps, solution Tolsura® (itraconazole) caps *QTY LIMIT:* 4 caps/day VFend® (voriconazole) tabs, suspension Vivjoa® (oteseconazole) caps Voriconazole (compare to VFend®) tabs, suspension	**Cresemba:** patient is completing a course of therapy that was initiated in the hospital OR patient has a diagnosis of mucormycosis OR patient has a diagnosis of invasive aspergillosis and has had a documented side effect, allergy, contraindication, or treatment failure with voriconazole. **Ketoconazole/Itraconazole 100mg cap/Itraconzaole Solution/Sporanox:** patient has a documented side-effect, allergy, or treatment failure to at least ONE of the preferred medications OR patient is completing a course of therapy that was initiated in the hospital. For approval of Sporanox® capsules, the patient must have a documented intolerance to generic itraconazole. For approval of Itraconazole solution, the patient must have a medical necessity for a liquid dosage form. **Limitations:** Coverage of Onychomycosis agents will NOT be approved solely for cosmetic purposes. **Tolsura:** patient has a diagnosis of aspergillosis intolerant of or refractory to Amphotericin B therapy AND patient has a documented intolerance to both generic itraconazole and voriconazole OR patient has a diagnosis of blastomycosis or histoplasmosis AND the patient has a documented intolerance to itraconazole. **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®, the patient must have a documented intolerance to generic voriconazole. AND For approval of voriconazole suspension, the patient must have a medical necessity for a liquid dosage form. **Noxafil tablet, Posaconazole tablet, Noxafil powder packets:** patient has a diagnosis of HIV/immunocompromised status (neutropenia secondary to chemotherapy, hematopoietic stem cell transplant recipients) AND medication 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. Approval of powder packets will be limited to patients ≤ 12 years of age and < 40kg. **Noxafil oral suspension, posaconazole oral suspension:** • Patient is completing a course of therapy with the requested

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		medication that was initiated in the hospital OR • Patient has a diagnosis of HIV/immunocompromised status (neutropenia secondary to chemotherapy, hematopoietic stem cell transplant recipients) AND medication is being used for the prevention of invasive Aspergillosis/ Candida infections OR • Patient is being treated for oropharyngeal candidiasis and has a documented side-effect, allergy, or treatment failure to fluconazole and itraconazole. **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 candidiasis AND patient has had a documented side effect, allergy, or treatment failure/ inadequate response to both nystatin suspension and clotrimazole troche. **Vivjoa:** the patient is not of reproductive potential AND the patient has recurrent yeast infections despite a treatment course of 7-14 days with a preferred vaginal azole, a longer course of oral fluconazole (e.g. one dose every 3 days for a total of 3 doses), and Brexafemme.
TRITERPENOIDS		
All products require PA	Brexafemme® (ibrexafungerp) tablets	**Brexafemme:** The patient is not pregnant and has been counseled to use effective contraception during treatment and for 4 days after the last dose (if applicable) AND the patient has recurrent yeast infections despite a treatment course of 7-14 days with a preferred vaginal azole AND a longer course of oral fluconazole (e.g. one dose every 3 days for a total of 3 doses)
ANTI-INFECTIVES ANTIMALARIALS		
ATOVAQUONE/PROGUANIL (compare to Malarone®) CHLOROQUINE COARTEM® (artemether/lumefantrine) DARAPRIM® (pyrimethamine) HYDROXYCHLOROQUINE SULFATE MEFLOQUINE PRIMAQUINE QUINIDINE SULFATE ***<u>Preferred After Clinical Criteria Are Met</u>*** KRINTAFEL® (tafenoquine succinate)	Malarone® (atovaquone/proguanil) Pyrimethamine (compare to Daraprim®) Quinine Sulfate (compare to Qualquin®) Qualaquin® (quinine sulfate)	**Krintafel:** the patient is ≥ 16 years of age AND is receiving concurrent antimalarial therapy **Malarone:** patient has a documented intolerance to the generic equivalent **Pyrimethamine:** patient has a documented intolerance to brand Daraprim **Quinine sulfate, Qualaquin**: 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.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ANTI-PARASITICS		
ALBENDAZOLE (compare to Albenza®) BILTRICIDE® (praziquantel) IVERMECTIN (compare to Stromectol®)	Benznidazole Emverm® (mebendazole) Lampit (nifurtimox) Stromectol® (ivermectin)	**Benznidazole, Lampit:** patient must be between 2-12 years of age (Benznidazole) or ≤ 18 years (Lampit) AND patient has a diagnosis of Chagas Disease (American trypanosomiasis) AND length of therapy does not exceed 60 days. **Emverm:** patient has a documented side effect, allergy, treatment failure, or contraindication to albendazole OR indication for use is hookworm infection (e.g. ancyclostomiasis, necatoriasis, uninariasis). **Stromectol:** patient has a documented intolerance to the generic product.
ANTI-INFECTIVES ANTI-VIRALS		
HERPES SIMPLEX VIRUS MEDICATIONS (ORAL)		
ACYCLOVIR (compare to Zovirax®) tablets, capsules ACYCLOVIR suspension (age ≤ 12 yrs) VALACYCLOVIR (compare to Valtrex®)	Famciclovir (compare to Famvir®) Sitavig® (acyclovir) Buccal Tablet *QTY LIMIT:* 2 tablets/30 days Valtrex® (valacyclovir) Zovirax® (acyclovir) tablets, capsules, suspension	**Acyclovir suspension (age > 12 yrs), Zovirax suspension:** patient has a medical necessity for a non-solid oral dosage form AND for approval of brand Zovirax, the patient has a documented intolerance to generic acyclovir suspension. **Famciclovir:** patient has a documented side effect, allergy, or treatment failure (at least one course of seven or more days) with acyclovir or valacyclovir. **Sitavig:** patient has a diagnosis of recurrent herpes labialis (cold sores), having at least 4 episodes in the previous year AND patient has a documented side effect or treatment failure with acyclovir AND valacyclovir. **Valtrex, Zovirax (tabs, caps):** patient has a documented intolerance to the generic equivalent.
INFLUENZA MEDICATIONS		
OSELTAMIVIR (compare to Tamiflu®) *QTY LIMIT:* 45 and 75 mg caps =10 caps/30 days, 30 mg caps = 20 caps/30 days, 6 mg/ml suspension = 180ml/30 days RELENZA® (zanamivir) *QTY LIMIT:* 20 blisters/30 days	Tamiflu® (oseltamivir) *QTY LIMIT:* 45 and 75 mg caps = 10 caps/30 days, 30 mg caps = 20 capsule /30 days, 6 mg/ml suspension = 180 ml/30 days Xofluza™ (baloxavir marboxil)	**Tamiflu:** Patient has a documented intolerance to generic Oseltamivir **Xofluza:** Patient is ≥ 12 years of age AND there is a clinical, patient-specific reason the patient cannot use a preferred agent. **Note:** A maximum of one single dose per 30 days will be approved based on the patient's body weight: 40mg (2 x 20mg tablets) for patients weighing between 40kg and 80kg or 80mg for patients weighing at least 80kg. **Limitations:** Amantadine 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 "Parkinson's Medications".

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
CYTOMEGALOVIRUS (CMV) INFECTION MEDICATIONS		
VALGNCICLOVIR (compare to Valctye®) tablet	Livtencity™ (maribavir) tablets Prevymis® (letermovir) Valcyte® tablets, solution Valganciclovir (compare to Valcyte®) solution	**Livtencity:** Indication is for the treatment of CMV infection in a recipient of a hematopoietic stem cell or solid organ transplant AND infection is refractory to ganciclovir, valganciclovir, cidofovir, or foscarnet (as defined by >1 $\log_{10}$ increase in CMV DNA levels in blood or serum after at least 14 days of therapy) AND medication will not be administered with ganciclovir or valganciclovir. For re-approval beyond 12 weeks, documentation must be submitted detailing continued medical necessity. **Prevymis:** Indication is for the prophylaxis of cytomegalovirus (CMV) infection in adult CMV-seropositive recipients [R+] of an allogenic hematopoietic stem cell transplant AND therapy is initiated between day 0 and day 28 post-transplantation AND therapy will continue through day 100 post-transplantation AND for approval of injection, the patient must be unable to take oral medications. **Valcyte:** the patient has a documented intolerance to generic valganciclovir AND for approval of solution, the patient has a medical necessity for a non-solid oral dosage form. **Valganciclovir solution:** the patient has a medical necessity for a non-solid oral dosage form.
INFLUENZA VACCINES		
<u>INACTIVATED INFLUENZA VACCINE, QUADRIVALENT (IIV4), STANDARD DOSE (EGG BASED)</u> AFLURIA® QUADRIVALENT Injection FLUARIX® QUADRIVALENT Injection FLULAVAL® QUADRIVALENT Injection FLUZONE® QUADRIVALENT Injection	**<u>ADJUVANTED INACTIVATED INFLUENZA VACCINE, QUADRIVALENT (IIV4), STANDARD DOSE (EGG BASED)</u>** Fluad™ Injection **<u>INACTIVATED INFLUENZA VACCINE, QUADRIVALENT (IIV4), HIGH DOSE (EGG BASED)</u>** Fluzone High-Dose® Injection **<u>RECOMBINANT INFLUENZA VACCINE, QUADRIVALENT (RIV4) (EGG FREE)</u>** Flublok® Injection **<u>INACTIVATED INFLUENZA VACCINE, QUADRIVALENT (ccIIV4), STANDARD DOSE</u>**	**Flucelvax Quadrivalent:** Prescriber provides clinical rationale why one of the preferred influenza vaccines cannot be used. **Flublok:** Patient is ≥ 65 years old OR Patient must have a documented severe reaction to egg based influenza vaccine AND the patient is unable to use Flucelvax. **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. **Fluzone High Dose, Fluad:** Patient is ≥ 65 years old OR Prescriber provides clinical rationale why one of the preferred influenza vaccines cannot be used. Note: the CDC and its Advisory Committee on Immunization Practices (ACIP) have not expressed a preference for any flu vaccine formulation for this age group.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	(CELL CULTURE BASED) Flucelvax Quadrivalent® Injection **LIVE ATTENUATED INFLUENZA VACCINE, QUADRIVALENT (LAIV4) (EGG BASED)** Flumist® Quadrivalent Intranasal	
VACCINES - OTHER		
Preferred After Age Limit Is Met ABRYSVO AREXVY GARDASIL SHINGRIX		**Abrysvo:** Covered if ≥ 60 years of age OR the vaccine will be administered during weeks 32 through 36 of pregnancy during September through January. **Arexvy:** Covered if ≥ 60 years of age. **Gardasil**: Covered for 19 years old to 45 years old (those under 19 should be referred to their pediatrician or PCP for state-supplied vaccine) **Shingrix**: Covered if ≥ 50 years of age Vaccines on the Advisory Committee on Immunization Practices (ACIP) list of recommended vaccines for children ≤ 18 years of age are supplied through the Vaccines for Children program administered by the Vermont Department of Health, and are not available through DVHA's pharmacy Programs. • Vaccines on the ACIP list of recommended vaccines for adults ≥ 19 years of age are available at many primary care provider offices and through the pharmacy programs. Vaccines are subject to the same limitations as the ACIP guideline recommendations. Providers who participate in the Blueprint for Health initiative must enroll in the Vaccines for Adults program administered by the Vermont Department of Health. The ACIP guidelines and information about enrollment in these programs can be found at http://healthvermont.gov/hc/imm/provider.aspx •Vaccines not on the recommended list may require Prior Authorization.
MIGRAINE THERAPY: PREVENTATIVE TREATMENTS		
Calcitonin gene-related peptide (CGRP) Inhibitors: Initial approval is 6 months; renewals are 1 year		
Preferred After Clinical Criteria Are Met AIMOVIG® (erenumab-aooe) QTY LIMIT: 1 injection (1mL) per 30 days AJOVY® (fremanezumab-vfrm)	Emgality ® (galcanezumab-gnlm) 100 mg/mL *QTY LIMIT:*300 mg (3 injections) per 30 days, maximum of 6 months per year approved Nurtec® ODT (rimegepant)	**Aimovig, Ajovy, Emgality 120mg/mL:** The patient is 18 years of age or older AND patient has a diagnosis of episodic migraine (4-14 headache days per month with migraine lasting 4 hours or more) or chronic migraine (≥ 15 headache days per month, of which ≥ 8 are migraine days, for at least 3

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
QTY LIMIT: 225 mg (1 injection) per 30 days or 675 mg (3 injections) every 90 days EMGALITY® (galcanezumab-gnlm) 120 mg/mL *QTY LIMIT*: 240 mg (2 injections) for the first 30 days followed by 120 mg (1 injection) per 30 days *Note:* Please refer to "Botulinum Toxins" for Botox	*QTY LIMIT*: 16 tablets/30 days Qulipta™ (atogepant) QTY LIMIT: 30 tablets/30 days Vyepti® (eptinezumab-jjmr)	months) AND patient has failed or has a contraindication to an adequate trial (≥ 60 days) of at least TWO medications for migraine prophylaxis from at least 2 different classes (tricyclic antidepressants, SNRI's, beta-blockers, or anticonvulsants). Initial approval will be granted for 6 months. For re-approval after 6 months, the patient must have documentation of a decrease in the number of headache days per month or decreased use of acute migraine medications such as triptans. Pharmacy claims will also be evaluated to assess compliance with the medication. Clinical justification must be provided if there is an increase in triptan use noted in the patient's profile. **Nurtec ODT, Quilipta, Vyepti:** The patient is 18 years of age or older AND The patient must have a documented side effect, allergy, or treatment failure to two preferred CGRP Inhibitors. Initial approval will be granted for 6 months. For reapproval after 6 months, the patient must have documentation of a decrease in the number of headache days per month or decreased use of acute migraine medications such as triptans. Pharmacy claims will also be evaluated to assess compliance with the medcation. Clinical justification must be provided if there is an increase in triptan use noted in the patient's profile. **Emgality 100mg/mL:** • Patient is 18 years of age or older AND • Patient has a diagnosis of episodic cluster headache as defined by the following: o Severe to very severe unilateral pain felt in the orbital, supraorbital, and/or temporal regions lasting 15-180 minutes (when untreated) o Pain is accompanied by a sense of restlessness or agitation OR at least one of the following signs or symptoms, ipsilateral to the headache: ▪ Conjunctival injection and/or lacrimation ▪ Eyelid edema ▪ Miosis and/or ptosis ▪ Nasal congestion and/or rhinorrhea ▪ Forehead and facial sweating • Patient has ≥ 2 active cluster periods lasting 7 days to 1 year, separated by remission for periods lasting ≥ 3 months AND • Patient has not achieved satisfactory response to adequate doses of corticosteroids (≥ 30mg prednisone or ≥ 16mg dexamethasone daily) started promptly at the start of the cluster period (Failure is defined as the need to use acute/abortive medications (oxygen, triptans, ergotamines, lidocaine) at least once daily for at least 2 days/week after the first full week of steroid therapy) AND • Patient has not achieved satisfactory response to adequate doses of verapamil (480mg/day, titrated up as needed to a max of 960mg/day) given for at least 3 weeks (Failure is defined as the need to use acute/abortive medications (oxygen, triptans, ergotamines, lidocaine) at least once daily for at least 2 days/week after 3 weeks of adequately

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		dosed verapamil) **Note:** this requirement will be waived if the patient's 2 most recent active cluster periods were less than 3 weeks in duration.
MIGRAINE THERAPY: ACUTE TREATMENTS		
GEPANTS		
Preferred After Clinical Criteria Are Met NURTEC® ODT (rimegepant) *QTY LIMIT:* 8 tablets/30 days	Ubrelvy® (ubrogepant) *QTY LIMIT:* 10 tablets/30 days	**Nurtec ODT:** Patient has a documented side effect, allergy, or treatment failure with 2 preferred triptans, unless contraindicated. **Ubrelvy:** Patient has a documented side effect, allergy, or treatment failure with 2 preferred triptans, unless contraindicated AND patient has a documented side effect, allergy, or treatment failure with Nurtec ODT.
DIHYDROERGOTAMINES		
MIGRANAL® (dihydroergotamine mesylate) nasal spray *QTY LIMIT: 8 units/30 days*	Dihydroergotamine mesylate nasal spray (compare to Migranal®) *QTY LIMIT: 8 units/30 days* Trudhesa™ (dihydroergotamine mesylate) nasal spray *QTY LIMIT: 8 units/30 days*	**Dihydroergotamine, Trudhesa:** The patient has a documented intolerance to Migranal nasal spray.
DITANS		
All products require PA	Reyvow® (lasmiditan) *QTY LIMIT:* 8 tablets/30 days	**Reyvow:** Patient has a documented side effect, allergy, or treatment failure with 2 preferred triptans, unless contraindicated AND patient has a documented side effect, allergy, or treatment failure with Nurtec ODT AND counseling has been documented regarding the risks of driving impairment
TRIPTANS		
SINGLE AGENT **ORAL** ELETRIPTAN (compare to Relpax®) *QTY LIMIT:* 12 tablets/30 days FROVATRIPTAN (compare to Frova®) 2.5 mg QTY LIMIT: 9 tablets/30 days NARATRIPTAN *QTY LIMIT:* 9 tablets/30 days SUMATRIPTAN (compare to Imitrex®) *QTY LIMIT:* 25 mg = 18 tablets/30 days, 50 and 100 mg = 9 tablets/30 days	Almotriptan 6.25 mg, 12.5 mg *QTY LIMIT:* 12 tablets/30 days Frova® (frovatriptan) 2.5 mg *QTY LIMIT:* 9 tablets/30 days Imitrex® (sumatriptan) *QTY LIMIT:* 25 mg = 18 tablets/30 days, 50 and 100 mg = 9 tablets/30 days Maxalt® (rizatriptan) 5 mg, 10 mg tablet *QTY LIMIT:* 12 tablets/30 days Maxalt-MLT® (rizatriptan ODT)	**Non-preferred single agents:** The patient has had a documented side effect, allergy, or treatment failure with at least two preferred triptans. If a product has an AB rated generic, there must have also been a trial of the generic formulation. **Sumatriptan/naproxen, Treximet:** patient has had a documented side effect, allergy or treatment failure with 2 preferred Triptans, AND patient is unable to take the individual components separately. **Zolmitriptan Nasal Spray, Zomig Nasal Spray, Imitrex Nasal Spray, Onzetra Xsail, Tosymra:** patient has had a documented side effect, allergy, or treatment failure with Sumatriptan Nasal Spray. For Zolmitriptan Nasal Spray, the patient must also have a documented intolerance to the brand Zomig Nasal Spray. **Imitrex Injection, Zembrace**: patient has had a documented intolerance to

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
RIZATRIPTAN (compare to Maxalt®) *QTY LIMIT:*12 tablets/30 days RIZATRIPTAN ODT (compare to Maxalt-MLT®) *QTY LIMIT:* 12 tablets/30 days ZOLMITRIPTAN (compare to Zomig®) tablets *QTY LIMIT:* 2.5 mg = 12 tablets/30 days, 5 mg = 6 tablets/30 days **NASAL SPRAY** SUMATRIPTAN (compare to Imitrex®) *QTY LIMIT:* 5 mg nasal spray = 12 units/30 days, 20 mg nasal spray = 6 units/ 30 days **NASAL POWDER** All products require PA	*QTY LIMIT:* 12 tablets/30 days Relpax® (eletriptan) 20 mg, 40 mg *QTY LIMIT:* 12 tablets/30 days Zomig® (zolmitriptan) tablets *QTY LIMIT:* 2.5 mg = 12 tablets/30 days, 5 mg = 6 tablets/30 days Zomig® ZMT (zolmitriptan ODT) *QTY LIMIT:* 2.5 mg = 12 tablets/30 days, 5 mg = 6 tablets/30 days Zolmitriptan ODT (compare to Zomig® ZMT) *QTY LIMIT:* 2.5 mg = 12 tablets/30 days, 5 mg = 6 tablets/30 days Imitrex® (sumatriptan) *QTY LIMIT:* 5 mg nasal spray = 12 units/30 days, 20 mg nasal spray = 6 units/ 30 days Tosymra® (sumatriptan) *QTY LIMIT:* 6 units/30 days Zomig® (zolmitriptan) *QTY LIMIT:* 2.5 and 5 mg nasal spray = 12 units/30 days Zolmitriptan (compare to Zomig®) *QTY LIMIT:* 2.5 and 5 mg nasal spray = 12 units/30 days Onzetra Xsail® (sumatriptan succinate) *QTY LIMIT:* 8 doses/30 days Imitrex® (sumatriptan) *QTY LIMIT:* 4 and 6 mg injection = 8 injections (4ml)/30 days Zembrace® SymTouch (sumatriptan) 3 mg/5ml	generic sumatriptan injection. **To exceed quantity limits:** patient is taking a medication for migraine prophylaxis.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
INJECTABLE SUMATRIPTAN (compare to Imitrex®) *QTY LIMIT*: 4 and 6 mg injection = 8 injections (4ml)/30 days **COMBINATION PRODUCT** **ORAL** All products require PA	*QTY LIMIT:* 4 injections/ 30 days Sumatriptan/Naproxen (compare to Treximet®) *QTY LIMIT:* 9 tablets/30 days Treximet® (sumatriptan/naproxen) *QTY LIMIT:* 9 tablets/ 30 days	
ANTI-PSYCHOTIC ATYPICAL & COMBINATIONS (CHILDREN < 18 YEARS OLD)		
Preferred After Clinical Criteria Are Met **TABLETS/CAPSULES** ARIPIPRAZOLE (compare to Abilify®) FDA maximum recommended dose = 30 mg/day LURASIDONE (compare to Latuda®) FDA maximum recommended dose = 80 mg/day OLANZAPINE (compare to Zyprexa®) FDA maximum recommended dose = 20 mg/day RISPERIDONE (compare to Risperdal®) FDA maximum recommended dose = 16 mg/day PALIPERIDONE (compare to Invega®) FDA maximum recommended dose = 12 mg/day QUETIAPINE (compare to Seroquel®) FDA maximum recommended dose = 800 mg/day QUETIAPINE ER (compare to Seroquel® XR) 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 Asenapine (compare to Saphris®) *QTY LIMIT:* 2 tabs/day FDA maximum recommended dose = 20 mg/day Clozapine (compare to Clozaril®) FDA maximum recommended dose = 900 mg/day Clozaril® (clozapine) FDA maximum recommended dose = 900 mg/day Geodon® (ziprasidone) FDA maximum recommended dose = 160 mg/day Invega® (paliperidone) *QTY LIMIT:* 3 and 9 mg = 1 tab/day, 6 mg = 2 tabs/day FDA maximum recommended dose = 12 mg/day Latuda® (lurasidone) FDA maximum recommended dose = 80 mg/day Risperdal® (risperidone) FDA maximum recommended dose = 16 mg/day Seroquel® (quetiapine) FDA maximum recommended dose = 800 mg/day Saphris® (asenapine) *QTY LIMIT*: 2 tabs/day FDA maximum recommended dose = 20 mg/day Seroquel XR® (quetiapine XR) FDA maximum recommended dose = 800 mg/day	**Target symptoms or Diagnosis that will be accepted for approval:** Target Symptoms - Grandiosity/euphoria/mania; Obsessions/compulsions; Psychotic symptoms; Tics (motor or vocal). Diagnosis- Autism with Aggression and/or irritability; Disruptive Mood Dysregulation Disorder; Bipolar Disorder; Intellectual Disability with Aggression and/or Irritability; Major Depressive Disorder with psychotic features; Obsessive Compulsive Disorder; Schizophrenia/Schizoaffective Disorder; Tourette's Syndrome. **Criteria for approval of ALL drugs:** Medication is being requested for one of the target symptoms or diagnoses listed above AND the patient is started and stabilized on the requested medication (Note: samples are not considered adequate justification for stabilization) OR Baseline labs including CBC, fasting glucose or HbA1C, and lipid profile have been completed AND patient meets additional criteria outlined below. Note: all requests for patients < 5 years will be reviewed by the DVHA medical director. **Asenapine, Saphris:** patient has had a documented side effect, allergy or treatment failure with at least two preferred products (typical or atypical antipsychotics) one of which is risperidone. **Abilify, Clozaril, Geodon, Invega, Latuda, Risperdal, Seroquel, Seroquel XR, Zyprexa:** patient has a documented intolerance to the generic equivalent. **Clozapine:** 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 must be preferred agents. **Aripiprazole Oral Solution:** 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. **Versacloz Oral Solution:** patient has had a documented side effect, allergy or

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Zyprexa® (olanzapine) FDA maximum recommended dose = 20 mg/day	treatment failure with at least three other antipsychotic medications (typical or atypical antipsychotics). AND patient is unable to use clozapine orally disintegrating tablets. **Aripiprazole ODT, Olanzapine ODT, Risperidone ODT, Zyprexa Zydis:** Medical necessity for a specialty dosage form has been provided AND if the request is for Zyprexa Zydis, the patient has a documented intolerance to the generic equivalent. **Clozapine ODT:** Medical necessity for a specialty dosage form has been provided AND patient has had a documented side effect, allergy or treatment failure with at least three other antipsychotic medications (typical or atypical antipsychotics)
Preferred After Clinical Criteria Are Met **ORAL SOLUTIONS** RISPERIDONE (compare to Risperdal®) oral solution FDA maximum recommended dose = 16 mg/day	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 *QTY LIMIT*: 18ml/day FDA maximum recommended dose = 900 mg/day	
ORALLY DISINTEGRATING TABLETS All products require PA	Aripiprazole orally disintegrating tablets *QTY LIMIT*: 10 and 15 mg = 2 tabs/day FDA maximum recommended dose = 30 mg/day Clozapine orally disintegrating tablets FDA maximum recommended dose = 900 mg/day Olanzapine orally disintegrating tablets (compare to Zyprexa Zydis®) *QTY LIMIT:* 5 and 10 mg = 1.5 tabs/day FDA maximum recommended dose = 20 mg/day	

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Risperidone ODT FDA maximum recommended dose = 16 mg/day Zyprexa Zydis® (olanzapine orally disintegrating tablets) *QTY LIMIT:* 5 and 10 mg = 1.5 tabs/day FDA maximum recommended dose = 20 mg/day	
ANTI-PSYCHOTIC ATYPICAL & COMBINATIONS (ADULTS ≥ 18 YEARS OLD)		
TABLETS/CAPSULES ARIPIPRAZOLE (compare to Abilify®) FDA maximum recommended dose = 30 mg/day CLOZAPINE (compare to Clozaril®) FDA maximum recommended dose = 900 mg/day LURASIDONE (compare to Latuda®) FDA maximum recommended dose = 160 mg/day OLANZAPINE (compare to Zyprexa®) FDA maximum recommended dose = 20 mg/day PALIPERIDONE (compare to Invega®) FDA maximum recommended dose = 12 mg/day RISPERIDONE (compare to Risperdal®) FDA maximum recommended dose = 16 mg/day QUETIAPINE (compare to Seroquel®) FDA maximum recommended dose = 800 mg/day QUETIAPINE ER (compare to Seroquel® XR) 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 Abilify® Mycite (aripiprazole tablets with sensor) *QTY LIMIT:* 1 tab/day FDA maximum recommended dose=30mg/day Asenapine sublingual tablet (compare to Saphris®) FDA maximum recommended dose = 20 mg/day Clozaril® (clozapine) FDA maximum recommended dose = 900 mg/day Caplyta® (lumateperone) *QTY LIMIT:* 1 capsule/day FDA maximum recommended dose = 42 mg/day Fanapt® (iloperidone) *QTY LIMIT:* 2 tablets/day FDA maximum recommended dose = 24 mg/day Geodon® (ziprasidone) FDA maximum recommended dose = 160 mg/day Invega® (paliperidone) *QTY LIMIT:* 3 and 9 mg = 1 tab/day, 6 mg = 2 tabs/day FDA maximum recommended dose = 12 mg Latuda® (lurasidone) FDA maximum recommended dose = 160 mg/day Nuplazid™ (primavaserin) *QTY LIMIT:* 2 tablets/day FDA maximum recommended dose = 34 mg Rexulti® (brexpiprazole) FDA maximum recommended dose = 3 mg (adjunct of MDD) or 5 mg (schizophrenia) Risperdal® (risperidone) FDA maximum recommended dose = 16 mg/day Saphris® (asenapine) sublingual tablet FDA maximum recommended dose = 20 mg/day	**Criteria for approval of ALL non-preferred drugs:** patient has been started and stabilized on the requested medication (Note: samples are not considered adequate justification for stabilization.) OR patient meets additional criteria outlined below. **Caplyta:** *Indication for use is schizophrenia/schizoaffective disorder:* The patient has had a documented side effect, allergy or treatment failure with at least three preferred products (typical or atypical antipsychotics). *Indication for use is Bipolar Depression:* the patient has had a documented side effect, allergy, or treatment failure with two preferred products (typical or atypical antipsychotics). If the prescriber feels that neither quetiapine or olanzapine/fluoxetine combination would be appropriate alternatives for the patient because of pre-existing conditions such as obesity or diabetes, the patient must have a documented side effect, allergy, or treatment failure with lurasidone. **Fanapt:** 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). **Asenapine, Saphris:** 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 two preferred products (typical or atypical antipsychotics), one of which is risperidone. **Note:** 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). **Abilify, Clozaril, Geodon, Invega, Latuda, Risperdal, Seroquel, Seroquel XR and Zyprexa:** patient has a documented intolerance to the generic equivalent.

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 Vraylar® (cariprazine) *QTY LIMIT:* 1 capsule/day FDA maximum recommended dose = 6 mg/day Zyprexa® (olanzapine) FDA maximum recommended dose = 20 mg/day	**Abilify Mycite:** The patient has not been able to be adherent to aripiprazole tablets resulting in significant clinical impact (documentation of measures aimed at improving compliance is required) AND there is a clinically compelling reason why Abilify Maintena or Aristada cannot be used. Initial approval will be granted for 3 months. For renewal, documentation supporting use of the tracking software must be provided and pharmacy claims will be evaluated to assess compliance with therapy. **Vraylar:** *Indication for use is schizophrenia/schizoaffective disorder*: the patient has had a documented side effect, allergy or treatment failure with three preferred products (typical or atypical antipsychotics) OR *Indication for use is Bipolar I depression:* the patient has had a documented side effect, allergy, or treatment failure with two preferred products (typical or atypical antipsychotics). If the prescriber feels that neither quetiapine or olanzapine/fluoxetine combination would be appropriate alternatives for the patient because of pre-existing conditions such as obesity or diabetes, the patient must have a documented side effect, allergy, or treatment failure with lurasidone. *Indication for use is adjunct treatment of Major Depressive Disorder (MDD):* the patient has had a documented inadequate response to at least 3 different antidepressants from two different classes AND the patient has had a documented side effect, allergy, or treatment failure with two preferred atypical antipsychotic products being used as adjunctive therapy.
ORAL SOLUTIONS RISPERIDONE (compare to Risperdal®) oral solution FDA maximum recommended dose = 16 mg/day	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 *QTY LIMIT:* 18ml/day FDA maximum recommended dose = 900 mg/day	**Lybalvi:** The patient has a documented side effect, allergy, or treatment failure with at least three antipsychotics, one of which must be aripiprazole or lurasidone AND There has been at least a 7-day opioid free interval from last use of short-acting opioids and at least a 14-day opioid free interval from last use of long-acting opioids. **Nuplazid**: The diagnosis or indication is the treatment of hallucinations/delusions associated with Parkinson's Disease psychosis. **Rexulti:** *Indication for use is schizophrenia:* 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 must be aripiprazole OR *Indication for use is adjunct treatment of Major Depressive Disorder (MDD*): the patient has had a documented inadequate response to at least 3 different antidepressants from two different classes AND the patient has had a documented side effect, allergy or treatment failure with two preferred atypical antipsychotic products being used as adjunctive therapy, one of which must be aripiprazole
SHORT-ACTING INJECTABLE PRODUCTS GEODON® IM (ziprasidone intramuscular injection) FDA maximum recommended dose = 40 mg/day		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
OLANZAPINE IM (compare to Zyprexa® IM) FDA maximum recommended dose = 30 mg/day ZYPREXA® IM (olanzapine intramuscular injection) FDA maximum recommended dose = 30 mg/day **LONG-ACTING INJECTABLE PRODUCTS** ABILIFY MAINTENA® (aripiprazole monohydrate) *QTY LIMIT:* 1 vial/28 days FDA maximum recommended dose = 400 mg/month ARISTADA® (aripiprazole lauroxil) *QTY LIMIT:* 441, 662, and 882 mg = 1 syringe/28 days, 1064 mg = 1 syringe/60 days ARISTADA Initio™ (aripiprazole lauroxil) INVEGA SUSTENNA® (paliperidone palmitate) FDA maximum recommended dose = 234 mg/ month PERSERIS® (risperidone) *QTY LIMIT:* 1 syringe/28 days FDA maximum recommended dose = 120 mg/month RISPERDAL® CONSTA (risperidone microspheres) FDA maximum recommended dose = 50 mg/14 days ZYPREXA RELPREVV® (olanzapine pamoate) *QTY LIMIT:* 405 mg = 1 vial/month, 210 and 300 mg = 2 vials/month FDA maximum recommended dose = 600 mg/month ***Preferred After Clinical Criteria Are Met*** INVEGA HAFYERA™ (paliperidone palmitate) FDA maximum recommended dose = 1560 mg/6 months INVEGA TRINZA® (paliperidone palmitate) FDA maximum recommended dose = 819 mg/3 months	Aripiprazole ODT *QTY LIMIT:* 10 and 15 mg = 2 tabs/day FDA maximum recommended dose = 30 mg/day Clozapine orally disintegrating tablets FDA maximum recommended dose = 900 mg/day Olanzapine orally disintegrating tablets (compare to Zyprexa Zydis®) *QTY LIMIT:* 5 and 10 mg = 1.5 tabs/day FDA maximum recommended dose = 20 mg/day Risperidone ODT	**Aripiprazole Oral Solution:** 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. **Invega Hafyera:** The patient is started and stabilized on the medication OR The patient has been adequately treated with Invega Sustenna (paliperidone palmitate 1-month) for at least four months or Invega Trinza (paliperidone palmitate 3-month) following at least one 3-month injection cycle. **Invega Trinza**: The patient is started and stabilized on the medication OR tolerability has been established with Invega Sustenna for at least 4 months. **Note:** This is processed via automated (electronic) step therapy. **ORALLY DISINTEGRATING TABLETS:** Medical necessity for a specialty dosage form has been provided AND If the request is Zyprexa Zydis, the patient has a documented intolerance to the generic equivalent. **COMBINATION PRODUCTS:** The patient has had a documented side effect, allergy, or treatment failure with two preferred products OR The prescriber provides a clinically valid reason for the use of the requested medication. **Secuado:** 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) and Saphris OR The indication for use is the treatment of schizophrenia/schizoaffective disorder AND the patient is unable to take oral medications AND the patient has had a documented side effect, allergy or treatment failure with a preferred long-acting injectable.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ORALLY DISINTEGRATING TABLETS All products require PA	FDA maximum recommended dose = 16 mg/day Zyprexa Zydis® (olanzapine orally disintegrating tablets) *QTY LIMIT:* 5 and 10 mg = 1.5 tabs/day FDA maximum recommended dose = 20 mg/day Lybalvi® (olanzapine/samidorphan) *QTY LIMIT:* 1 tablet/day FDA maximum recommended dose = 20mg/10mg (per day) Olanzapine/fluoxetine FDA maximum recommended dose = 18 mg/75 mg (per day) Secuado (asenapine) transdermal patch *QTY LIMIT:* 1 patch/day FDA maximum recommended dose = 7.6 mg/day	
COMBINATION PRODUCTS All products require PA		
TRANSDERMAL PRODUCTS All products require PA		
ANTI-PSYCHOTIC: TYPICALS		
ORAL HALOPERIDOL LOXAPINE PERPHENAZINE PIMOZIDE TRIFLUOPERAZINE	Chlorpromazine Fluphenazine Molindone Thioridazine Thiothixene	**Chlorpromazine:** patient has a diagnosis of acute intermittent porphyria or intractable hiccups OR patient has had a documented side effect, allergy or treatment failure with at least three preferred products (may be typical or atypical anti-psychotics). **Fluphenazine Oral Solution:** patient has a requirement for an oral liquid dosage form (i.e. swallowing disorder, inability to take oral medications)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
LONG ACTING INJECTABLE PRODUCTS FLUPHENAZINE DECANOATE HALOPERIDOL DECANOATE (compare to Haldol® decanoate)	Haldol® decanoate (haloperidol decanoate)	**Fluphenazine tablets:** patient is transitioning to the decanoate formulation or requires supplemental oral dosing in addition to decanoate OR patient has had a documented side effect, allergy or treatment failure with at least three preferred products (may be typical or atypical anti-psychotics). **All other oral medications:** patient has had a documented side effect, allergy or treatment failure with at least three preferred products (may be typical or atypical anti-psychotics). If a product has an AB rated generic, one trial must be the generic. **Long Acting Injectable Products:** for approval of Haldol decanoate, the patient has a documented intolerance to the generic product.
ANTIRETROVIRAL THERAPY HUMAN IMMUNODEFICIENCY VIRUS (HIV)		
SINGLE PRODUCT REGIMENS		
Tablets (STRs) BIKTARVY® (bictegravir/emtricabine/tenofovir AF) COMPLERA® (emtricitabine/relpivirine/tenofovir) DELSTRIGO® (doravirine/lamivudine/tenofovir) DOVATO® (dolutegravir/lamivudine) EFAVIRENZ/EMTRICITABINE/TENOFOVIR GENVOYA® (elvitegravir/cobicistat/ emtricitabine/tenofovir AF) ODEFSEY® (emtricitabine/relpivirine/ tenofovir AF) SYMFI™ (efavirenz/lamivudine/tenofovir) SYMFI™ LO (efavirenz/lamivudine/tenofovir) TRIUMEQ® (abacavir/lamivudine/dolutegravir) TRIUMEQ® PD tablets for oral suspension (abacavir/lamivudine/dolutegravir) **Long-Acting Injectables** All products require PA	Juluca® (dolutegravir/rilpivirine) Stribild® (elvitegravir/cobicistat/ emtricitabine/tenofovir) Symtuza® (darunavir/cobicistat/emtricitabine/tenofovir AF) Cabenuva® (cabotegravir/rilpivirine) Kit	**Cabenuva:** The patient has been started and stabilized on the requested medication (Note: samples are not considered adequate justification for stabilization.) OR patient is virologically suppressed (HIV-1 RNA < 50 copies per mL) on a stable oral antiretroviral regimen with no history of treatment failure AND medical reasoning beyond convenience or enhanced compliance over preferred agents is provided. **Note:** oral lead-in with Vocabria® (cabotegravir) and Edurant® (rilpivirine) are provided at no charge and sent directly to the prescriber or patient by a specialty distributor and should be dispensed ONLY for those with prior approval for Cabenuva. **Juluca:** The patient has been started and stabilized on the requested medication (Note: samples are not considered adequate justification for stabilization.) OR patient is virologically suppressed (HIV-1 RNA < 50 copies per mL) on a stable oral antiretroviral regimen for at least 6 months AND medical reasoning beyond convenience or enhanced compliance over preferred agents is provided. **Stribild:** • The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR • Genotype testing supporting resistance to other regimens OR • Intolerance or contraindication to preferred combination of drugs AND • Medical reasoning beyond convenience or enhanced compliance over preferred agents AND • CrCl > 70mL/min to initiate therapy OR CrCl > 50mL/min to continue therapy **Symtuza:** The patient has been started and stabilized on the requested

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		medication. (Note: samples are not considered adequate justification for stabilization.) OR Medical reasoning beyond convenience or enhanced compliance over preferred agents (Prezcobix & Descovy)
COMBINATION PRODUCTS - NRTIs		
ABACAVIR/LAMIVUDINE (compare to Epzicom®) ABACAVIR/LAMIVUDINE/ZIDOVUDINE (compare to Trizivir®) LAMIVUDINE/ZIDOVUDINE (compare to Combivir®)	Combivir® (lamivudine/zidovudine) Epzicom® (abacavir/lamivudine) Trizivir® (abacavir/lamivudine/zidovudine)	**Combivir, Epzicom:** patient must have a documented intolerance to the generic equivalent **Trizivir:** The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR The prescriber must provide a clinically compelling reason for the use of the requested medication including reasons why any of the preferred products would not be suitable alternatives
COMBINATION PRODUCTS – NUCLEOSIDE & NUCLEOTIDE ANALOG RTIs		
CIMDUO™ (lamivudine/tenofovir) DESCOVY® (emtricitabine/tenofovir AF) EMTRICITABINE/TENOFOVIR (compare to Truvada®)	Truvada® (emtricitabine/tenofovir)	**Truvada:** patient must have a documented intolerance to the generic equivalent
COMBINATION PRODUCTS – PROTEASE INHIBITORS		
KALETRA® (lopinavir/ritonavir)	Lopinavir/ritonavir (compare to Kaletra®)	**Lopinavir/ritonavir:** patient must have a documented intolerance to brand Kaletra
ENTRY INHIBITORS-CCR5 CO-RECEPTOR ANTAGONISTS		
All products require PA	Selzentry® (maraviroc)	**Selzentry:** The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR The prescriber must provide a clinically compelling reason for the use of the requested medication including reasons why any of the preferred products would not be suitable alternatives.
ENTRY INHIBITORS-FUSION INHIBITORS		
All products require PA	Fuzeon® (enfuvirtide)	**Fuzeon:** The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR The prescriber must provide a clinically compelling reason for the use of the requested medication including reasons why any of the preferred products would not be suitable alternatives.
INTEGRASE STRAND TRANSFER INHIBITORS		
ISENTRESS® (raltegravir potassium) ISENTRESS HD (raltegravir potassium) TIVICAY® (dolutegravir sodium) TIVICAY® PD (dolutegravir sodium)		
NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTI)		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ABACAVIR SULFATE (compare to Ziagen®) EMTRIVA® (emtricitabine) LAMIVUDINE (compare to Epivir®) TENOFOVIR DISOPROXIL FUMARATE (compare to Viread®) 300mg VIREAD® (tenofovir disoproxil fumarate) 150mg, 200mg, 250mg tablet, 40mg/gm powder ZIAGEN® (abacavir sulfate) ZIDOVUDINE (compare to Retrovir®)	Epivir® (lamivudine) Retrovir® (zidovudine) Stavudine Viread® (tenofovir disoproxil fumarate) 300mg tablet Ziagen® (abacavir sulfate) tablet	**Epivir, Retrovir, Viread 300mg, Ziagen:** patient must have a documented intolerance to the generic equivalent **Stavudine:** The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR The prescriber must provide a clinically compelling reason for the use of the requested medication including reasons why any of the preferred products would not be suitable alternatives.
NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NNRTI)		
EDURANT® (rilpivirine) EFAVIRENZ (compare to Sustiva®) INTELENCE® (etravirine) PIFELTRO (doravirine)	Etravirine (compare to Intelence®) Nevirapine (compare to Viramune®) Nevirapine ER (compare to Viramune® ER) Sustiva® (efavirenz) Viramune® ER (nevirapine ER)	**Etravirine:** patient must have a documented intolerance to brand Intelence. **Sustiva:** patient must have a documented intolerance to the generic equivalent **Nevirapine, Nevirapine ER, Viramune ER:** The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR The prescriber must provide a clinically compelling reason for the use of the requested medication including reasons why any of the preferred products would not be suitable alternatives.
PHARMACOENHANCER-CYTOCHROME P450 INHIBITOR		
All products require PA	Tybost® (cobicistat)	**Tybost:** The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR a clinically valid reason beyond compliance or convenience is given for not using a preferred combination drug or a ritonavir- based regimen with similar components
PRE-EXPOSURE PROPHYLAXIS (PrEP) AGENTS		
Apretude® (cabotegravir extended-release) 600mg/3mL IM injection Descovy® (emtricitabine/tenofovir AF) 200mg/25mg tablet Emtricitabine/Tenofovir DF (compare to Truvada®) 200mg/300mg tablet	Truvada® (Emtricitabine/Tenofovir DF) 200mg/300 mg tablet	**Truvada:** The patient has a documented intolerance to the generic equivalent.
PROTEASE INHIBITORS (PEPTICIC)		
ATAZANAVIR (compare to Reyataz®) EVOTAZ® (atazanavir/cobicistat) NORVIR® (ritonavir) RITONAVIR (compare to Norvir®)	Fosemprenavir (compare to Lexiva®) Invirase® (saquinavir mesylate) Lexiva® (fosemprenavir) Reyataz® (atazanavir) Viracept® (nelfinavir)	**Fosemprenavir, Invirase, Lexiva, Viracept:** The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR The prescriber must provide a clinically compelling reason for the use of the requested medication including reasons why any of the preferred products would not be suitable alternatives. **Reyataz:** patient must have a documented intolerance to the generic equivalent

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
PROTEASE INHIBITORS (NON-PEPTIDIC)		
PREZCOBIX® (darunavir/cobicistat) PREZISTA® (darunavir ethanolate)	Aptivus® (tipranavir)	**Aptivus:** The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR The prescriber must provide a clinically compelling reason for the use of the requested medication including reasons why any of the preferred products would not be suitable alternatives.
TREATMENT RESISTANT THERAPIES		
All Products Require PA	Rukobia® (fostemsavir) *QTY LIMIT* = 2 tablets per day Sunlenca® (lenacapavir sodium) Trogarzo™ (ibalizumab-uiyk) *QTY LIMIT:* 10 vials (2000 mg) x 1 dose then 4 vials (800 mg) every 14 days thereafter	**Sunlenca, Rukobia, Trogarzo:** The patient must meet ALL of the following criteria: • ≥ 18 years of age • Prescription is written by or in consultation with an infectious disease specialist. • Viral Load is ≥ 1,000 copies/mL (results must be submitted) • Patient has been compliant but has had an inadequate response to at least 6 months of treatment with anti-retroviral therapy (ART) • Patient has multi-drug resistant HIV-1 infection including documented resistance to at least one medication from each of the following classes: o Protease Inhibitor (PI) o Nucleoside Reverse Transcriptase Inhibitor (NRTI) o Non-nucleoside Reverse Transcriptase Inhibitor (NNRTI) • Medication will be used in combination with ART that includes at least one drug to which the individual's virus is susceptible. Initial approval will be granted for 6 months. For continuation of therapy, there must be a decrease in viral load from baseline AND the patient must continue to be compliant with the optimized background regimen of ART.
BILE SALTS AND BILIARY AGENTS		
URSODIOL capsules	Bylvay™ (odevixibat) Chenodal® (chendiol) Cholbam® (cholic acid) Livmarli® (maralixibat) Ocaliva® (obeticholic acid) Urso® (Urosiol) Ursodiol tablets Urso® Forte (ursodiol)	**Bylvay:** The patient is experiencing moderate to severe pruritis associated with a diagnosis of progressive familial intrahepatic cholestasis (PFIC) confirmed by molecular genetic testing AND the patient does not have a ABCB11 variant resulting in non-functional or complete absence of the bile salt export pump protein (BSEP-3) AND the patient does not have a history of liver transplant or clinical evidence of decompensated cirrhosis AND baseline liver function tests and fat-soluble vitamin (A, D, E, and K) levels have been completed and will be monitored periodically during treatment AND patient has had an inadequate

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		response or contraindication to cholestyramine and ursodiol. For re-approval, there must be documented clinical improvement (e.g. reduced serum bile acid or decreased pruritis). **Chenodal:** The indication for use is with radiolucent stones in well-opacifying gallbladders, in whom selective surgery would be undertaken except for the presence of increased surgical risk due to systemic disease or age AND the patient does not have any of the following contraindications to therapy: women who are pregnant or may become pregnant, known hepatocyte dysfunction or bile ductal abnormalities such as intrahepatic cholestasis, primary biliary cirrhosis or sclerosing cholangitis. **Cholbam:** The indication for use is the treatment of bile acid synthesis disorders due to single enzyme defects OR for the adjunctive treatment of peroxisomal disorders, including Zellweger spectrum disorders, AND the patient exhibits manifestations of liver disease, steatorrhea, or complications from decreased fat-soluble vitamin absorption AND the prescriber is a hepatologist or gastroenterologist. Initial approval will be granted for 3 months. For re-approval after 3 months, there must be documented clinical benefit. **Livmarli:** The patient is experiencing moderate to severe pruritis associated with a diagnosis of Alagille Syndrome (ALGS) AND baseline liver function tests and fat-soluble vitamin (A, D, E, and K) levels have been completed and will be monitored periodically during treatment AND patient has had an inadequate response or contraindication to cholestyramine and ursodiol. For re-approval, there must be documented clinical improvement (e.g. reduced serum bile acid or decreased pruritis). **Ocaliva:** The indication for use is the treatment of primary biliary cholangitis (PBC) AND the patient has had an inadequate response or is unable to tolerate ursodiol. **Urso, Ursodiol tablets, Urso Forte:** The patient must have a documented treatment limiting side effect to generic ursodiol capsules.
BONE RESORPTION INHIBITORS		
ORAL BISPHOSPHONATES TABLETS/CAPSULES ALENDRONATE (compare to Fosamax®) tablets IBANDRONATE *QTY LIMIT:* 150 mg = 1 tablet/28 days	Actonel® (risedronate) Alendronate oral solution Atelvia (risedronate) Delayed Release Tablet *QTY LIMIT:*4 tablets/28 days Fosamax® (alendronate)	**Actonel, Atelvia, Risedronate:** patient has had a documented side effect, allergy, or treatment failure (at least a six-month trial) to generic alendronate tablets and ibandronate AND if the request is for brand, the patient has also had a documented intolerance to generic equivalent. **Alendronate Oral Solution:** prescriber provides documentation of medical necessity for the specialty dosage form (i.e. inability to swallow tablets, dysphagia).

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Fosamax Plus D® (alendronate/vitamin D) Risedronate (compare to Actonel®)	**Evista, Fosamax, Reclast:** patient has a documented intolerance to the generic formulation. **Calcitonin Nasal:** patient is started and stabilized on the requested medication. Note: Calcitonin Nasal Spray (brand and generic) no longer recommended for osteoporosis. **Miacalcin Injection:** patient has a diagnosis/indication of Paget's Disease **Fosamax Plus D:** there is a clinical reason why the patient is unable to take generic alendronate tablets and vitamin D separately. **Forteo, Teriparatide** patient has had a documented side effect, allergy, or treatment failure** to a bisphosphonate AND for approval for Forteo the patient has had a documented intolerance to generic Teriparatide. **Tymlos:** patient has had a documented side effect, allergy, or treatment failure ** to a bisphosphonate and teriparatide AND prescriber has verified that the patient has been counseled about osteosarcoma risk. **Ibandronate Injection:** patient has a diagnosis/indication of postmenopausal osteoporosis AND patient has had a documented side effect or treatment failure** to a preferred bisphosphonate. **Prolia Injection:** patient has had a documented side effect, allergy, or treatment failure** to a preferred bisphosphonate OR medication is being used for osteopenia in women with breast cancer receiving adjuvant aromatase inhibitor therapy OR medication is being used for osteopenia in men receiving androgen depreivation therapy. **Xgeva Injection:** diagnosis or indication is bone metastases from solid tumors (e.g. prostate, breast, thyroid, non-small lung cancer), multiple myeloma, hypercalcemia of malignancy, or giant cell tumor of bone. **Evenity Injection:** diagnosis or indication is postmenopausal osteoporosis AND patient has no history of stroke or MI within the previous year AND patient has had a documented side effect or treatment failure** to a preferred bisphosphonate and Teriparatide. ****Treatment failure is defined as documented continued bone loss or fracture after one or more years despite treatment with a bisphosphonate.
INJECTABLE BISPHOSPHONATES ZOLEDRONIC ACID Injection (compare to Reclast®) 5 mg/100mL QTY LIMIT: 5 mg (one dose)/year ZOLEDRONIC ACID Injection 4mg/5mL concentrate and 4 mg/100mL IV solution	Ibandronate Injection (compare to Boniva®) *QTY LIMIT:* 3 mg/3 months (four doses)/year Reclast® Injection (zoledronic acid) *QTY LIMIT:* 5 mg (one dose)/year	
ESTROGEN AGONIST/ANTAGONIST RALOXIFENE (compare to Evista®) Tablet *QTY LIMIT:* 1 tablet/day	Evista® (raloxifene) Tablet *QTY LIMIT:* 1 tablet/day	
INJECTABLE RANKL INHIBITOR All products require PA	Prolia® Injection (denosumab) *QTY LIMIT:* 60 mg/6 months (two doses)/year Xgeva® (denosumab) *QTY LIMIT:* 120 mg/28 days	
INJECTABLE SCLEROSTIN INHIBITOR All products require PA	Evenity® (romosozumab-aqqg) injection *QTY LIMIT:* 210 mg (2 syringes)/month (Lifetime max duration = 12 months)	
CALCITONIN NASAL SPRAY All products require PA	Calcitonin Nasal Spray (compare to Miacalcin®)	
CALCITONIN INJECTION All products require PA	Miacalcin® (calcitonin) Injection	
PARATHYROID HORMONE INJECTION All products require PA	Forteo® (teriparatide) *QTY LIMIT:* 1 pen (2.4ml/30 days) Teriparatide (compare to Forteo®) *QTY LIMIT:* 1 pen/30 days Tymlos™ (abaloparatide) injection *QTY LIMIT:* 1 pen (1.56ml)/30 days	

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	(Lifetime max duration of treatment = 2 years)	
BOTULINUM TOXINS		
All products require PA	Botox® (onabotulinumtoxinA) Dysport® (abobotulinumtoxinA) Myobloc® (rimabotulinumtoxinB) Xeomin® (incobotulinumtoxinA)	**Criteria for approval of ALL drugs:** The medication is being prescribed for an FDA approved indication AND the patient's age is FDA approved for the given indication AND the patient meets the following additional criteria (if applicable). Initial approval will be granted for 3 months unless otherwise noted. For re-approval, the patient must have documented improvement in symptoms. *Additional criteria for Severe Axillary Hyperhidrosis (Botox only):* the patient failed an adequate trial of topical therapy. *Additional criteria for Overactive bladder or detrusor overactivity (Botox only):* the patient failed an adequate trial of at least TWO urinary antispasmodics (either short- or long-acting formulations) *Additional criteria for Chronic migraine (Botox only):* the patient has ≥ 15 headache days per month, of which ≥ 8 are migraine days, for at least 3 months AND the member has failed or has a contraindication to an adequate trial (≥ 60 days) of at least TWO medications for migraine prophylaxis from at least two different classes (tricyclic antidepressants, SNRI's, beta-blockers, or anticonvulsants). Initial approval will be granted for 6 months. For re-approval after 6 months, the patient must have documentation of a decrease in the number of headache days per month or decreased use of acute migraine medications such as triptans. *Additional criteria for chronic sialorrhea (Myobloc and Xeomin):* the patient has a documented side effect, allergy, treatment failure, or contraindication to at least two anticholinergic agents (e.g. scopolamine, glycopyrrolate). **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)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
BPH AGENTS		
ALPHA BLOCKERS ALFUZOSIN ER *QTY LIMIT:*1 tablet/day DOXAZOSIN (compare to Cardura®) TAMSULOSIN (compare to Flomax®) *QTY LIMIT:* 2 capsules/day TERAZOSIN	Cardura® (doxazosin) Cardura XL® (doxazosin) *QTY LIMIT:*1 tablet/day Flomax® (tamsulosin) *QTY LIMIT:*2 capsules/day Rapaflo® (silodosin) *QTY LIMIT:*1capsule/day Silodosin (compare to Rapaflo®) *QTY 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. **Cialis, Tadalafil:** The patient has a diagnosis of BPH (benign prostatic hypertrophy) AND the patient has a documented treatment failure/inadequate response to a preferred alpha blocker AND the patient has a documented treatment failure/inadequate response to a preferred 5-alpha reductase inhibitor AND for approval of Cialis, the patient must have a documented intolerance to the generic equivalent. Approval will be limited to 5mg daily for a maximum of 26 weeks. **Entadfi:** The patient has a diagnosis of BPH (benign prostatic hypertrophy) AND the patient has a documented treatment failure/inadequate response to a preferred alpha blocker AND the patient has a documented treatment failure/inadequate response to a preferred 5-alpha reductase inhibitor AND the patient has a documented treatment failure/inadequate response to tadalafil. Approval will be limited to a maximum of 26 weeks. **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. **Rapaflo, Silodosin:** The patient has had a documented side effect, allergy or treatment failure with two preferred alpha blockers **Avodart, Proscar:** The patient has a documented intolerance to the generic equivalent. **Dutasteride/tamsulosin, 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 AND is unable to take tamsulosin and dutasteride as the individual separate agents AND for approval of Jalyn, the patient must have a documented intolerance to generic dutasteride/tamsulosin. **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) 1mg and its generic equivalent whose only FDA approved indication is for treatment of male pattern hair loss.).
ANDROGEN HORMONE INHIBITORS DUTASTERIDE (compare to Avodart®) *QTY LIMIT:* 1 capsule/day FINASTERIDE (compare to Proscar®) *QTY LIMIT:*1 tablet/day	Avodart® (dutasteride) *QTY LIMIT:*1 capsule/day Proscar® (finasteride) *QTY LIMIT:*1 tablet/day	
PDE-5 INHIBITORS All products require PA	Cialis® (tadalafil) *QTY LIMIT:*1 tablet/day Tadalafil (compare to Cialis®) *QTY LIMIT:*1 tablet/day	
COMBINATION PRODUCT All products require PA	Dutasteride/tamsulosin (compare to Jalyn®) *QTY LIMIT:*1 capsule/day Entadfi™ (finasteride/tadalafil) *QTY LIMIT:* 1 capsule/day Jalyn® (dutasteride/tamsulosin) *QTY LIMIT:*1 capsule/day	

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
BULK POWDERS		
https://dvha.vermont.gov/sites/dvha/files/doc_library/Covered%20Compounding%20Products.pdf		
CARDIAC GLYCOSIDES		
DIGOXIN DIGOXIN Oral Solution		
CUSHING'S DISEASE		
All products require PA	Isturisa® (osilodrostat) tablets Korlym® tablets (mifepristone) *QTY LIMIT: 4 tablets/day* Signifor® (pasireotide) Ampules *QTY LIMIT: all strengths = 2 ml (2 amps)/day* Maximum day supply = *30 days*	**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 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 (e.g. 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). **Isturisa, 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 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).

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
GASTROINTESTINAL AGENTS: BOWEL PREP AGENTS, CONSTIPATION/DIARRHEA, IRRITABLE BOWEL SYNDROME-CONSTIPATION (IBS-C), IRRITABLE BOWEL SYNDROME-DIARRHEA (IBS-D), SHORT BOWEL SYNDROME, OPIOID INDUCED CONSTIPATION		
Constipation: Chronic, IBS-C, or Opioid-Induced: Length of approval for non-preferred agents: Initial PA of 3 months and & 12 months thereafter		
BULK-PRODUCING LAXATIVES PSYLLIUM **OSMOTIC LAXATIVES** LACTULOSE POLYETHYLENE GLYCOL 3350 (PEG) **STIMULANT LAXATIVE** BISACODYL SENNA **STOOL SOFTENER** DOCUSATE **MISCELLANEOUS** DICYCLOMINE **GUANYLATE CYCLASE-C AGONIST** LINZESS® (linaclotide) 145 mcg and 290 mcg (age ≥ 6 years) *QTY LIMIT*: 1 capsule/day TRULANCE® (plecanatide) (age ≥ 6 years) *QTY LIMIT*: 1 tablet/day **Note:** Linzess® and Trulance® are contraindicated in patients less than 6 years of age due to the risk of serious dehydration. **CIC-2 CHLORIDE CHANNEL ACTIVATORS** AMITIZA® (lubiprostone) (age ≥ 18 years) *QTY LIMIT:* 2 capsules/day **OPIOID ANTAGONISTS** MOVANTIK® (naloxegol)	Linzess® (linaclotide) 72mcg *QTY LIMIT:* 1 capsule/day Lubiprostone (compare to Amitiza®) *QTY LIMIT:* 2 capsules/day Relistor® (methylnaltrexone) tablets *QTY LIMIT:* 3 tablets/day Relistor® (methylnatrexone) injection Symproic® (naldemedine) *QTY LIMIT:* 1 tablet/day Motegrity® (prucalopride) *QTY LIMIT:* 1 tablet/day	**Linzess 72mcg:** The patient has a diagnosis of chronic idiopathic constipation (CIC) AND the patient is unable to tolerate the 145 mcg dose **Lubiprostone:** The patient is 18 years of age or older has had a documented intolerance to brand name Amitiza **Relistor Tablets, Symproic:** The patient is current using an opiate for at least 4 weeks AND has documented opioid-induced constipation AND has had a documented side effect, allergy, or treatment failure to Amitiza and Movantik. **Relistor Injection:** 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 2 preferred laxatives from 2 different laxative classes used in combination. **Ibsrela, Motegrity:** The patient is 18 years of age or older. AND the patient has had a documented side effect, allergy, or treatment failure to Amitiza and either Linzess or Trulance.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
QTY LIMIT: 1 tablet/day **5-HT4 RECEPTOR ANTAGONISTS** All products require PA **NHE3 INHIBITORS** All products require PA	Ibsrela® (tenapanor) *QTY LIMIT:* 2 tablets/day	
Short Bowel Syndrome (SBS): Length of approval: 6 Months		
All products require PA	Gattex® (teduglutide) Vials Maximum day supply = 30 days	**Gattex:** Patient has a diagnosis of short bowel syndrome AND Patient is receiving specialized nutritional support administered intravenously (i.e. parenteral nutrition) AND Patient does not have an active gastrointestinal malignancy (gastrointestinal tract, hepatobiliary, pancreatic), colorectal cancer, or small bowel cancer. Note: Re-approval requires evidence of decreased parenteral nutrition support from baseline.
Antidiarrheal: HIV/AIDs: Length of approval: Initial approval 3 months, subsequent 1 year		
DIPHENOXYLATE/ATROPINE LOPERAMIDE	Mytesi® (crofelemer) 125 mg DR Tablets *QTY LIMIT:* 2 tablets/day	**Mytesi:** 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)
Antidiarrheal: IBS-D: Length of approval: Initial approval 3 months; subsequent 1 year		
All products require PA	Alosetron (compare to Lotronex®) Lotronex® (alosetron) Viberzi® (eluxadoline) Xermelo™ (telotristat ethyl) *QTY LIMIT:* 3 tablets/day	**Lotronex/alosetron:** The patient is a woman and has a diagnosis of severe diarrhea-predominant irritable bowel syndrome (IBS) with symptoms lasting 6 months or longer AND has had anatomic or biochemical abnormalities of the GI tract excluded AND has not responded adequately to conventional therapies such as loperamide and TCA's. For approval of generic alosetron, the patient must have documented intolerance to brand Lotronex. **Viberzi:** The patient has a diagnosis of IBS-D AND does not have any of the following contraindications to therapy A) known or suspected biliary duct obstruction, or sphincter of Oddi disease or dysfunction B) alcoholism, alcohol abuse, alcohol addiction, or drink more than 3 alcoholic beverages/day C) a history of pancreatitis; structural diseases of the pancreas D) severe hepatic impairment (Child-Pugh Class C) AND has not responded adequately to conventional therapies such as loperamide and TCA's. **Xermelo:** The patient has a diagnosis of carcinoid syndrome diarrhea AND had an inadequate treatment response (defined as 4 or more bowel movements per day)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		despite use of a long-acting somatostatin analog for at least 3 consecutive months AND the medication will be used in combination with a long-acting somatostatin analog therapy. For reauthorization, documentation showing a decrease in the number of bowel movements per day is required. **Note:** Xermelo will not be approved in treatment naïve patients or as monotherapy.
BOWEL PREP AGENTS		
CLENPIQ® GAVILTYE-G, GAVILYTE-H, GAVILYTE-N MOVIPREP PEG-3350	Gavilyte-C Golytely Nulytely Plenvu® Suprep® Sutab®	**Non-preferred agents:** The patient has a documented intolerance or treatment failure of at least one preferred agent (defined by failure to complete cleansing of the colon as a preparation for colonoscopy) AND if the product has an AB rated generic, there must have been a trial with the generic formulation.
CONTINUOUS GLUCOSE MONITORS		
Initial approval will be granted for 6 months; renewals up to 1 year thereafter		
Preferred After Clinical Criteria Are Met DEXCOM G6 **Initial prescription:** 1 receiver, 1 wireless transmitter, and 9 sensors **Refill Quantity Limits:** 1 transmitter every 3 months, 1 sensor every 10 days (maximum of 9 sensors every 90 days) DEXCOM G7 **Initial prescription:** 1 receiver, 9 sensors **Refill Quantity Limits:** 1 sensor every 10 days (maximum of 9 sensors every 90 days) FREESTYLE LIBRE 14 DAY (14-DAY SENSORS) **Initial Prescription:** 1 reader, 6 sensors **Refill Quantity Limits:** 1 sensor every 14 days (maximum of 6 sensors every 84 days) FREESTYLE LIBRE 2 (14-DAY SENSORS) **Initial Prescription:** 1 reader, 6 sensors **Refill Quantity Limits:** 1 sensor every 14 days (maximum of 6 sensors every 84 days)	Medtronic Guardian™ Connect **Initial Prescription**: 1 transmitter, 5 sensors **Refill Quantity Limits:** 1 transmitter every year, 1 sensor every 7 days (maximum of 5 sensors every 35 days) Medtronic 670G Guardian Link 3 **Initial Prescription:** 1 transmitter, 5 sensors **Refill Quantity Limits:** 1 transmitter every year, 1 sensor every 7 days (maximum of 5 sensors every 35 days) Medtronic 770G Guardian Link 3 **Initial Prescription:** 1 transmitter, 5 sensors **Refill Quantity Limits:** 1 transmitter every year, 1 sensor every 7 days (maximum of 5 sensors every 35 days) Medtronic 780G Guardian 4 **Initial Prescription:** 1 transmitter, 5 sensors **Refill Quantity Limits:** 1 transmitter	• Patient has a diagnosis of Diabetes Mellitus AND patient age is FDA approved for the requested product AND one of the following criteria are met: ○ The patient requires treatment with insulin OR ○ The patient has a history of problematic hypoglycemia AND medications that could contribute to hypoglycemia (e.g. sulfonureas, meglitinides) have been discontinued AND there is documentation of at least one of the following: Recurrent level 2 hypoglycemic events (glucose <54mg/dL (3.0mmol/L)) that persist despite multiple attempts to adjust medication(s) and/or modify the diabetes treatment plan OR a history of one level 3 hypoglycemic event (glucose <54mg/dL (3.0mmol/L)) characterized by altered mental and/or physical state requiring third party assistance for treatment of hypoglycemia • Approval of non-preferred products will be limited to cases where the CGM is directly integrated with the patient's insulin pump. The make and model of pump must be documented on the prior authorization. **Re-authorization:** • There is documented evidence of compliance to CGM (log data and/or

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
FREESTYLE LIBRE 3 (14-DAY SENSORS) **Initial Prescription:** 6 sensors **Refill Quantity Limits:** 1 sensor every 14 days (maximum of 6 sensors every 84 days)	every year, 1 sensor every 7 days (maximum of 5 sensors every 35 days) Medtronic MiniLink (includes Enlite Serter) **Initial Prescription:** 1 transmitter, 5 sensors **Refill Quantity Limits:** 1 transmitter every year, 1 sensor every 7 days (maximum of 5 sensors every 35 days)	office visit notes required). • Replacement will be considered when medically necessary and not for recent technology upgrades (device must be malfunctioning and out of warranty). • **Initial Renewal Only:** claims history shows a reduction in test strip utilization; for those using the same number of test strips after initiating a CGM, clinical justification needs to be provided for the continued use of a CGM.
CONTRACEPTIVES		
SELECT PRODUCTS: Length of approval: 1 year **MONOPHASIC AGENTS:**		
Due to the extensive list of products, any monophasic BCP not listed as non-preferred is considered preferred.	Beyaz (drospirenone/ethinyl estradiol/levomefol) Blisovi FE 24 (norethindrone/ethinyl estradiol/FE) Drospirenone/ethinyl estradiol/levomefol Kaitlib (norethindrone/ethinyl estradiol/FE) Layolis FE (norethindrone/ethinyl estradiol/FE) Lo-Estrin (norethindrone/ethinyl estradiol) Lo-Estrin FE (norethindrone/ ethinyl estradiol/FE) Melodetta FE (drospirenone/ethinyl estradiol/levomefol) Mibelis FE (norethindrone/ethinyl estradiol/FE) Nexstellis (drospirenone/estetrol) Noretin-Eth Estra-Ferros Fum Tab Chew 0.8-25(24) (norethindrone/ethinyl estradiol/FE) Noretin-Eth Estra-Ferros Fum Tab Chew 1MG-20(24) (norethindrone/ethinyl estradiol/FE) Ogestrel (norgestrel/ethinyl estradiol) Sayfral (drospirenone/ethinyl estradiol/levomefol) Taytulla (norethindrone/ethinyl estradiol/FE) Wymza FE (norethindrone/ethinyl estradiol/FE) Yaz (drospirenone/ ethinyl estradiol) Yasmin 28 (drospirenone/ ethinyl estradiol)	**Non-preferred agents:** Trial with at least three preferred contraceptive products including the preferred formulation of the requested non-preferred agent
BIPHASIC AGENTS		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
AZURETTE (desogestrel/ ethinyl estradiol) BEKYREE (desogestrel/ethinyl estradiol) DESOGESTREL/ETHINYL ESTRADIOL KARIVA (desogestrel/ ethinyl estradiol) KIMIDESS (desogestrel/ethinyl estradiol) NORETHIDRONE/ETHINYL ESTRADIOL 0.5/1-35 PIMTREA (desogestrel/ ethinyl estradiol) SIMLIYA (desogestrel/ethinyl estradiol) VIORELE (desogestrel/ ethinyl estradiol) VOLNEA (desogestrel/ethinyl estradiol)	Lo Loestrin FE (norethindrone/ ethinyl estradiol/FE) Mircette (desogestrel/ ethinyl estradiol)	**Non-preferred agents:** Trial with at least three preferred contraceptive products including the preferred formulation of the requested non-preferred agent
TRIPHASIC AGENTS		
ALYACEN (norethindrone ethinyl estradiol) ARANELLE (norethindrone/ethinyl estradiol) CAZIANT (desogestrel/ ethinyl estradiol) CYCLAFEM (norethindrone/ethinyl estradiol) DASETTA (norethindrone/ethinyl estradiol) ENPRESSE (levonorgestrel/ ethinyl estradiol) LEENA (norethindrone/ethinyl estradiol) LEVONEST (levonorgestrel/ ethinyl estradiol)) NATAZIA (dienogest/estradiol valerate) NORGESTIMATE/ETHINYL ESTRADIOL NORTREL 7/7/7 (norethindrone/ethinyl estradiol) PIRMELLA (norethindrone/ethinyl estradiol) TRI-ESTARYLLA (norgestimate/ ethinyl estradiol) TRI-FEMYNOR (norgestimate/ ethinyl estradiol) TRI-LINYAH (norgestimate/ ethinyl estradiol) TRI-LO-ESTARYLLA (norgestimate/ethinyl estradiol) TRI-LO-MARZIA (norgestimate/ethinyl estradiol) TRI-LO-SPRINTEC (norgestimate/ethinyl estradiol) TRI-PREVIFEM (norgestimate/ ethinyl estradiol) TRI-SPRINTEC (norgestimate/ ethinyl estradiol) TRI-VYLIBRA (norgestimate/ ethinyl estradiol) TRI-VYLIBRA LO (norgestimate/ ethinyl estradiol) TRIVORA (levonorgestrel/ ethinyl estradiol) VELIVET (desogestrel/ ethinyl estradiol)	Estrostep FE (norethindrone/ethinyl estradiol/FE) Tilia FE (norethindrone/ethinyl estradiol/FE) Tri-Legest FE (norethindrone/ethinyl estradiol/FE)	**Non-preferred agents:** Trial with at least three preferred contraceptive products including the preferred formulation of the requested non-preferred agent
EXTENDED CYCLE		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
AMETHIA (levonorgestrel/ ethinyl estradiol) AMETHIA LO (levonorgestrel/ ethinyl estradiol) AMETHYST (levonorgestrel/ ethinyl estradiol) ASHLYNA (levonorgestrel/ ethinyl estradiol) CAMRESE (levonorgestrel/ ethinyl estradiol) CAMRESE LO (levonorgestrel/ ethinyl estradiol) DAYSEE (levonorgestrel/ ethinyl estradiol) INTROVALE (levonorgestrel/ ethinyl estradiol 3MTH) JAIMIESS (levonorgestrel/ ethinyl estradiol) JOLESSA (levonorgestrel/ ethinyl estradiol 3MTH) LEVONORGESTREL/ETHINYL ESTRADIOL TBDSPK 3 month LO-SEASONIQUE (levonorgestrel/ ethinyl estradiol) SIMPESSE (levonorgestrel/ ethinyl estradiol) SEASONIQUE (levonorgestrel/ ethinyl estradiol) SETLAKIN (levonorgestrel/ethinyl estradiol)	Fayosim (levonorgestrel/ ethinyl estradiol) Quartette (levonorgestrel/ ethinyl estradiol) Rivelsa (levonorgestrel/ ethinyl estradiol)	**Non-preferred agents:** Trial with at least three preferred contraceptive products including the preferred formulation of the requested non-preferred agent
PROGESTIN ONLY CONTRACEPTIVES		
CAMILA (norethindrone) DEBLITANE (norethindrone) ERRIN (norethindrone) HEATHER (norethindrone) INCASSIA (norethindrone) JENCYCLA (norethindrone) JOLIVETTE (norethindrone) LYZA (norethindrone) NORA-BE (norethindrone) NORETHINDRONE 0.35MG NORLYNDA (norethindrone) SHAROBEL (norethindrone) TULANA (norethindrone)	Slynd® (drospirenone)	**Non-preferred agents:** Trial with at least three preferred contraceptive products including the preferred formulation of the requested non-preferred agent.
INJECTABLE CONTRACEPTIVES		
MEDROXYPROGESTERONE ACETATE 150MG (IM) VIAL/SYRINGE DEPO-PROVERA 104 (SUB-Q) SYRINGE (medroxyprogesterone acetate)	Depo-Provera (IM) (medroxyprogesterone acetate) 150 mg Susp vial/syringe	**Depo-Provera IM:** Patient must have a documented intolerance to medroxyprogesterone acetate 150mg.
VAGINAL RING		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
NUVARING® (etonogestrel/ethinyl estradiol vaginal ring)	Annovera® (segesterone acetate/ethinyl estradiol vaginal ring) *QTY LIMIT:* 1 ring/year Eluryng (etonogestrel/ethinyl estradiol vaginal ring) Etonogestrel/ethinyl estradiol vaginal ring	**Non-preferred agents:** Trial with at least three preferred contraceptive products including the preferred formulation of the requested non-preferred agent.
LONG ACTING REVERSIBLE CONTRACEPTIVES (LARCs)		
KYLEENA (levonorgestrel) IUD LILETTA (levonorgestrel) IUD MIRENA (levonorgestrel) IUD PARAGARD (copper) IUD SKYLA (levonorgestrel) IUD NEXPLANON (etonogestrel) Implant		
TOPICAL CONTRACEPTIVES		
TWIRLA® (levonorgestrel/ethinyl estradiol) patch XULANE PATCH (norelgestromin/ ethinyl estradiol)	Zafemy (norelgestromin/ ethinyl estradiol) patch	**Zafemy:** Trial with at least three preferred contraceptive products including the preferred formulation of the requested non-preferred agent.
VAGINAL CONTRACEPTIVES		
Please refer to the DVHA website for covered OTC spermicidal gels https://dvha.vermont.gov/sites/dvha/files/documents/providers/Pharmacy/OTCWebList.pdf	Phexxi™ (lactic acid, citric acid, and potassium bitartrate) vaginal gel	**Phexxi:** Use of hormonal contraceptives is contraindicated AND the patient has a documented side effect or allergy to nonoxynol-9
EMERGENCY CONTRACEPTIVES		
AFTERA (levonorgestrel) ECONTRA EZ (levonorgestrel) LEVONORGESTREL MY CHOICE (levonorgestrel) MY WAY (levonorgestrel) NEW DAY (levonorgestrel) OPCICON ONE-STEP (levonorgestrel) OPTION 2 (levonorgestrel)		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
CORONARY VASODILATORS/ANTIANGINALS/SINUS NODE INHIBITORS		
ORAL		
ISOSORBIDE DINITRATE tablet (compare to Isordil®) ISOSORBIDE DINITRATE ER tablet ISOSORBIDE MONONITRATE tablet ISOSORBIDE MONONITRATE ER tablet NITROGLYCERIN SPRAY LINGUAL (compare to Nitrolingual Pump Spray®) NITROSTAT® (nitroglycerin SL tablet) RANOLAZINE SR 12 HR (compare to Ranexa®) *QTY LIMIT:* 500 mg = 3 tablets/day, 1000 mg = 2 tablets/day	Aspruzyo Sprinkle™ (ranolazine) granule *QTY LIMIT*: 500 mg = 3 packets/day, 1000 mg = 2 packets/day BiDil® (isosorbide dinitrate/hydralazine) Dilatrate-SR® (isosorbide dinitrate SR capsule) Isosorbide dinitrate SL tablet Isordil® (isosorbide dinitrate tablet) Nitrolingual Pump Spray® Ranexa® (ranolazine) *QTY LIMIT:* 500 mg = 3 tablets/day, 1000 mg = 2 tablets/day	**Aspruzyo:** the patient has medical necessity for a non-solid oral dosage form. **Dilatrate-SR, Isosorbide dinitrate SL tablet, Isordil:** the patient has had a side effect, allergy, or treatment failure to at least two preferred agents. **Nitrolingual Pump Spray:** the patient has had a side effect, allergy, or treatment failure to Nitroglycerin spray lingual. **Bidil:** The prescriber provides a clinically valid reason why the patient cannot use isosorbide dinitrate and hydralazine as separate agents. **Ranexa:** the patient has a documented intolerance to the generic equivalent.
TOPICAL		
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 generic nitroglycerin transdermal patches.
SINUS NODE INHIBITORS		
All products require a PA	Corlanor® (ivabradine) *QTY LIMIT:* 60 tabs/30 days	**Corlanor Clinical Criteria:** *Diagnosis of stable, symptomatic heart failure:* • Left ventricular ejection fraction of ≤ 35% AND • Resting heart rate ≥ 70 bpm AND • In sinus rhythm AND • Patient has persisting symptoms despite maximally tolerated doses of beta blockers or who have contraindication to beta blocker therapy *Diagnosis of Inappropriate Sinus Tachycardia:* • Patient has persisting symptoms despite maximally tolerated doses of beta blockers or there is a contraindication to beta blocker therapy. *Diagnosis of Postural Orthostatic Tachycardia Syndrome (POTS)* • The patient has a documented side effect, allergy, or treatment failure with at least 2 of the following medications: fludrocortisone, midodrine, beta blocker (metoprolol or propranolol), or pyridostigmine.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
CORTICOSTEROIDS: ORAL		
DEXAMETHASONE tablets, elixir, intensol, solution 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 PREDNISOLONE 3 mg/ml oral solution, syrup 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	Alkindi® Sprinkle (hydrocortisone) granule Cortef® (hydrocortisone) tablets Hemady® (dexamethasone) tablets Medrol® (methylprednisolone) tablets Medrol Dose Pak® (methylprednisolone) tabs Prednisolone sodium phosphate oral solution 25 mg/5ml Rayos® (prednisone) Delayed Release Tablet *QTY LIMIT:* 1 tablet/day	**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. **All Others:** 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		
Please refer to the DVHA website for covered OTC cough & cold products https://dvha.vermont.gov/sites/dvha/files/documents/providers/Pharmacy/OTCWebList.pdf All RX generics **Note:** The FDA restricts the use of prescription codeine pain and cough medicines in children. Prior authorization is required for patients <12 years of age.	Hydrocodone/chlorpheniramine (compare to Tussionex®) *QTY LIMIT:* 60 ml/RX Tussionex® (hydrocodone/chlorpheniramine) *QTY LIMIT:* 60 ml/RX TussiCaps® (hydrocodone/chlorpheniramine) *QTY LIMIT:* 12 capsules/RX All other brands	**Tussionex, TussiCaps, Hydrocodone/chlorpheniramine suspension (generic):** The patient has had a documented side effect, allergy, or treatment failure to two 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 capsules (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.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
CYSTIC FIBROSIS MEDICATIONS		
Preferred After Clinical Criteria Are Met KITABIS® (tobramycin sol) *QTY LIMIT:* 56 vials/56 days; maximum day supply = 56 days (2 vials/day for 28 days, then 28 days off) TOBI® PODHaler (tobramycin capsules for inhalation) *QTY LIMIT:* 224 capsules/56 days; maximum day supply = 56 days (4 capsules twice daily for 28 days, then 28 days off) TOBRAMYCIN inhalation solution (compare to Tobi®) 300mg/5mL *QTY LIMIT:* 56 vials/56 days; maximum day supply = 56 days (2 vials/day for 28 days, then 28 days off)	Bethkis® (tobramycin) inhalation solution *QTY LIMIT*: 56 vials/56 days; maximum day supply = 56 days (2 vials/day for 28 days, then 28 days off) Bronchitol® (mannitol) capsules for inhalation *QTY LIMIT:* 560 capsules/28 days; maximum day supply = 28 days Cayston® (aztreonam) inhalation solution *QTY LIMIT:* 84 vials/56 days; maximum day supply = 56 days (3 vials/day for 28 days, then 28 days off) Kalydeco® (ivacaftor) tablets *QTY LIMIT:* 2 tablets/day, maximum day supply = 30 days Kalydeco® (ivacaftor) packets *QTY LIMIT:* 2 packets/day; maximum day supply = 30 days Orkambi® (lumacaftor/ivacaftor) *QTY LIMIT:* 120/30 days; maximum day supply=30 days Pulmozyme® (dornase alfa) inhalation solution *QTY LIMIT:* 60/30 days; maximum day supply=30 days Symdeko® (tezacaftor/ivacaftor and ivacaftor) *QTY LIMIT:* 56/28 days; maximum day supply = 28 days Tobi® (tobramycin) inhalation solution *QTY LIMIT:* 56 vials/56 days; maximum day supply = 56 days (2 vials/day for 28 days, then 28 days off) Tobramycin inhalation solution 300mg/4mL *QTY LIMIT:* 56 vials/56 days; maximum day supply = 56 days (2 vials/day for 28 days, then 28 days off) Trikafta® (elexacaftor/tezacaftor/ivacaftor) QTY LIMIT: 84/28 days; maximum day supply = 28 days	**Kitabis, Tobramycin inhalation solution (300mg/5mL), Pulmozyme:** diagnosis or indication is cystic fibrosis **Bethkis, TOBI, tobramycin inhalation solutions** (300mg/4mL): Diagnosis or indication is cystic fibrosis and the patient has a documented failure or intolerance to two preferred formulations of tobramycin inhalation solution. **Bronchitol:** Diagnosis or indication is cystic fibrosis AND the patient is 18 years of age or older AND the patient has a documented inadequate response or contraindication to hypertonic saline and Pulmozyme AND the patient has passed the Bronchitol Tolerance Test (BTT) AND the patient has been counseled to use a short-acting beta agonist (SABA) 5-15 minutes prior to each dose. **Cayston:** diagnosis or indication is cystic fibrosis and the patient has had a documented failure, intolerance or inadequate response to inhaled tobramycin therapy alone **Kalydeco:** The patient has a diagnosis of Cystic Fibrosis AND Patient has a mutation on at least one allele in the cystic fibrosis transmembrane conductance regulator gene (CFTR gene) shown to be responsive to Kalydeco per FDA approval (documentation provided). AND The patient is ≥ 1 month old. Note: Renewal of Prior Authorization will require documentation of member response. **TOBI PODHALER:** allowed after a trial of another form of inhaled tobramycin **Orkambi/Symdeko/Trikafta:** The patient has a diagnosis of Cystic Fibrosis AND <u>Initial Criteria</u> • Patient age is FDA approved for the requested medication AND • Patient must have a confirmed mutation in the CFTR gene shown to be responsive to the requested medication per FDA approval (documentation provided) AND • If the patient is under the age of 18, they must have undergone a baseline ophthalmic examination to monitor for lens opacities/cataracts AND • Prescriber is a CF specialist or pulmonologist <u>Ongoing Approval Criteria</u> • Patient has clinically documented improvement in lung function (will be applied to the first renewal request only; requirement waived on subsequent renewals) • Patient has LFTs/bilirubin monitored every 3 months for the first year of therapy and annually after the first year

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		• ALT or AST ≤ 5 X the upper limit of normal or ALT/AST ≤ 3 X the upper limits of normal and bilirubin is ≤ 2 X the upper limit of normal • For patients under the age of 18, have follow up ophthalmic exam at least annually
DERMATOLOGICAL AGENTS		
ACTINIC KERATOSIS THERAPY		
CARAC® (fluorouracil) 0.5% cream FLUOROURACIL (compare to Efudex®) 5% cream IMIQUIMOD 5% Cream *C=cream, F=foam, G=gel, L=lotion, O=ointment, S=solution*	Aldara® (imiquimod) 5 % Cream Diclofenac Sodium 3 % Gel (compare to Solaraze®) *QTY LIMIT:* 1 tube/30 days Efudex® (fluorouracil) 5% cream Fluorouracil 5%, 2% solution Fluorouracil (compare to CARAC®) 0.5% cream 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	**Aldara:** the patient has a documented intolerance to generic imiquimod 5% cream **Efudex cream, Fluorouracil solution:** The patient has a documented intolerance to fluorouracil 5% cream. **Fluorouracil 0.5% cream:** The patient has a documented intolerance to brand Carac. **Diclofenac Gel:** The diagnosis or indication is actinic keratosis AND The patient has had a documented side effect, allergy, contraindication or treatment failure with a preferred 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 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.
ANTIBIOTICS TOPICAL		
SINGLE AGENT BACITRACIN MUPIROCIN OINTMENT (compare to Bactroban®) **COMBINATION PRODUCTS** BACITRACIN-POLYMYXIN NEOMYCIN-BACITRACIN-POLYMYXIN *C=cream, F=foam, G=gel, L=lotion, O=ointment, S=solution*	Centany® Ointment (mupirocin) Gentamicin Cream or Ointment Mupirocin cream (compare to Bactroban®) Xepi cream (ozenoxacin)	**Mupirocin cream, Centany Ointment, Xepi cream:** The patient has had a documented intolerance with generic mupirocin ointment **Gentamicin Cream or Ointment:** The patient has had a documented side-effect, allergy, or treatment failure with at least one preferred generic topical antibiotic
ANTIFUNGALS: ONYCHOMYCOSIS		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
CICLOPIROX 8 % solution *QTY LIMIT:* 6.6 ml/90 days JUBLIA® (efinaconazole 10% solution) *QTY LIMIT:* 48 weeks treatment TAVABOROLE 5% solution *QTY LIMIT:* 48 weeks treatment	Ciclodan® (ciclopirox 8% solution) Kerydin® (tavaborole 5% solution) *QTY LIMIT:* 48 weeks treatment	**Kerydin:** Patient has a documented side effect, allergy, or treatment failure to two preferred topical onychomycosis agents, one of which must be tavaborole. **Ciclodan:** Patient has a documented intolerance to generic ciclopirox 8% solution. **LIMITATIONS:** Coverage of Onychomycosis agents will NOT be approved solely for cosmetic purposes. Kits with multiple drug products or non-drug items not covered.
ANTIFUNGALS: TOPICAL		
SINGLE AGENT BUTENAFINE (compare to Mentax®) 1% C CICLOPIROX 0.77% C, Sus, G; 1% Sh CLOTRIMAZOLE 1% C, S ECONAZOLE 1% C KETOCONAZOLE 2% C, 2% Sh MICONAZOLE all generic/OTC products NYSTATIN O, C, P (compare to Mycostatin®, Nystop®, Nyamyc®) TOLNAFTATE 1% C, P, S **COMBINATION PRODUCTS** CLOTRIMAZOLE W/ BETAMETHASONE C, L NYSTATIN W/TRIAMCINOLONE C, O *C=cream, F=foam, G=gel, L=lotion, P=powder, S=solution, Sh=shampoo, Sp=spray, Sus=suspension*	Ertaczo® (sertaconazole) 2% C Extina® (ketoconazole) 2% F Ketoconazole (compare to Extina®) 2 % Foam Luliconazole 1% C Luzu® (luliconazole) 1% Cream Mentax® 1% C Naftifine (compare to Naftin®) 1% & 2% C, 1% G Naftin® (naftifine) 1% C, 1%, 2% G Nystop®, Nyamyc® (nystatin) P Oxiconazole 1% C Oxistat® (oxiconazole) 1% L Sulconazole 1% C, L Miconazole w/ zinc oxide (compare to Vusion®) O *QTY LIMIT: 50 g/30 days* Vusion® (miconazole w/zinc oxide) O *QTY LIMIT: 50 g/30 days* **All other branded products** **Note**: Please refer to "Dermatological: Antifungals: Onychomycosis" for ciclopirox solution	**All Non-Preferred Agents (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 antifungal. **Miconazole w/ Zinc Oxide, 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.
ANTIVIRALS: TOPICAL		
ACYCLOVIR (compare to Zovirax®) 5 % O ZOVIRAX® (acyclovir) 5% C *C=cream, O=ointment*	Acyclovir (compare to Zovirax®) 5 % O Denavir® (penciclovir) 1% C Docosanol 10% C Xerese® (acyclovir 5%/hydrocortisone 1%) C Zovirax® (acyclovir) 5% O	**Acyclovir cream:** The patient has a documented intolerance to brand Zovirax cream. **Denavir, Docosanol, Xerese:** The patient has a treatment failure with a preferred topical acyclovir product. **Zovirax ointment:** The patient has a documented intolerance to generic acyclovir ointment

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
AXILLARY HYPERHIDROSIS THERAPY		
Xerac-AC (aluminum chloride) 6.25% Solution		
CORTICOSTEROIDS: LOW POTENCY		
ALCLOMETASONE 0.05% C, O DESONIDE 0.05% C, O FLUOCINOLONE 0.01% C, S, oil (compare to Derma-Smoothe, Synalar®) HYDROCORTISONE 0.5%, 1%, 2.5% C; 2.5% L, 0.5%, 1%, 2.5% O *C=cream, F=foam, G=gel, L=lotion, O=ointment, S=solution*	Derma-Smoothe® (fluocinolone 0.01%) oil Desonide 0.05% L Synalar® (fluocinolone) 0.01% S 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.)
CORTICOSTEROIDS: MEDIUM POTENCY		
BETAMETHASONE DIPROPIONATE 0.05% C, L, O BETAMETHASONE VALERATE 0.1% C, L, O BETAMETHASONE VALERATE 0.12% (compare to Luxiq®) F FLUOCINOLONE 0.025% C, O (compare to Synalar®) FLUTICASONE 0.05% C; 0.005% O HYDROCORTISONE VALERATE 0.2% C, O MOMETASONE FUROATE 0.1% C, L, O, S TRIAMCINOLONE ACETONIDE 0.025%, 0.1% C, L, O *C=cream, F=foam, G=gel, L=lotion, O=ointment, S=solution*	Clocortolone 0.1% C (compare to Cloderm®) Cloderm® (clocortolone) 0.1% C Desoximetasone 0.05% C, O (compare to Topicort®) Flurandrenolide C, L, O Fluticasone 0.05%, L Hydrocortisone Butyrate 0.1% C, O, S Kenalog® (triamcinolone) Aerosol Spray Luxiq® (betamethasone valerate) F Prednicarbate 0.1% C, O Synalar® (fluocinolone) 0.025% C, O Topicort® (desoximetasone) 0.05% C, O Triamcinolone Aerosol Spray Trianex® (triamcinolone) 0.05% 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.)
CORTICOSTEROIDS: HIGH POTENCY		
AUGMENTED BETAMETHASONE 0.05% C, L (compare to Diprolene® AF) BETAMETHASONE VALERATE 0.1% C, O DESOXIMETASONE 0.25% C, O (compare to Topicort®) FLUOCINONIDE 0.05% C, G, O, TRIAMCINOLONE ACETONIDE 0.5% C, O	Apexicon E® (diflorasone) 0.05% C Desoximetasone 0.05% G Diflorasone diacetate 0.05% C, O (compare to Apexicon E®) Halcinonide 0.1% C Halog® (halcinonide) all products	**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.)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
C=cream, F=foam, G=gel, L=lotion, O=ointment, S=solution	Topicort® (desoximetasone) 0.05% G; 0.25% C, O, Spray All other brands	
CORTICOSTEROIDS: VERY HIGH POTENCY		
AUGMENTED BETAMETHASONE 0.05% C, L, O (compare to Diprolene®) 0.05% G CLOBETASOL PROPIONATE 0.05%, C, F, G, L, O, S, Shampoo, Spray HALOBETASOL PROPIONATE (compare to Ultravate®) 0.05% C, O *C=cream, F=foam, G=gel, L=lotion, O=ointment, S=solution*	Bryhali® (halobetasol propionate) L Clobetasol propionate emulsion (compare to Olux E®) 0.05% F Diprolene® (augmented betamethasone) 0.05% L, O Fluocinonide (compare to Vanos®)0.1% C Halobetasol (compare to Lexette™) 0.05% F Impeklo™ (clobetasol propionate) 0.05% L Lexette™ (halobetasol) 0.05% F Olux®/Olux E® (clobetasol propionate) 0.05% F Tovet® (clobetasol propionate aerosol) 0.05% F Vanos® (fluocinonide) 0.1% C 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.)
GENITAL WART THERAPY		
IMIQUIMOD 5 % (compare to Aldara®) cream PODOFILOX SOLUTION (compare to Condylox®)	Aldara® (imiquimod) 5% cream Condylox® Gel (podofilox gel) Imiquimod (compare to Zyclara®) 3.75% Cream QTY Limit: 56 packets/8 weeks Imiquimod (compare to Zyclara®) 3.75% Cream Pump *QTY LIMIT:* 2 pumps/ 8 weeks Veregan® (sinecatechins ointment) *QTY LIMIT:* 15 grams (1 tube)/30 days Zyclara® (imiquimod 3.75%) Cream *QTY LIMIT:* 56 packets/8 weeks Zyclara® (imiquimod 2.5%, 3.75%) Cream Pump *QTY LIMIT:* 2 pumps/8 weeks	**Aldara cream, Zyclara cream:** The patient has had a documented intolerance to generic imiquimod **Condylox gel, Veregan:** The patient has had a documented side effect, allergy, or treatment failure with imiquimod. **Imiquimod pump, Zyclara pump:** The patient has had a documented intolerance to generic imiquimod cream and Zyclara cream.
IMMUNOMODULATORS		
ELIDEL® (pimecrolimus) for ages ≥ 2 TACROLIMUS 0.03% Ointment for ages ≥ 2 TACROLIMUS 0.1% Ointment for ages ≥ 16 ***Preferred After Clinical Criteria Are Met***	Cibinqo® (abrocitinib) tablets *QTY LIMIT:* 1 tab/day Maximum 30 days supply Eucrisa® (crisaborole) Ointment Opzelura® (ruxolitinub) cream	**Eucrisa**: The patient has a diagnosis of mild-moderate atopic dermatitis (eczema) AND the patient has had a documented side effect, allergy, or treatment failure (defined as daily treatment for at least one month) with at least one preferred topical calcineurin inhibitor AND the quantity requested does not exceed 60 grams/fill and 180 grams/ 6 months. Trial of calcineurin

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ADBRY (tralokinumab-ldrm) subcutaneous injection *QTY LIMIT:* 6 syringes the first 28 days then 4 syringes every 28 days thereafter DUPIXENT® (dupilumab) subcutaneous injection *QTY LIMIT:* 4 syringes/pens the first 28 days then 2 Syringes/pens every 28 days thereafter ***Note:*** please refer to *Dermatological Agents: Corticosteroids* category for preferred topical corticosteroids.	Pimecrolimus cream (compare to Elidel®) Rinvoq ® (upadactinib) extended-release tablet *QTY LIMIT*: 1 tablet/day Maximum 30 days supply	inhibitor will be waived for patients ≥ 3 months through < 2 years of age. **Opzelura:** • The patient is ≥ 12 years of age AND • The patient has a diagnosis of mild-moderate atopic dermatitis (eczema) AND • The patient has had a documented side effect, allergy, or treatment failure (defined as daily treatment for at least one month) with at least one moderate to high potency topical corticosteroid within the last 6 months, unless contraindicated AND • The patient has had a documented side effect, allergy, or treatment failure (defined as daily treatment for at least one month) of a preferred topical calcineurin inhibitor and crisabarole ointment AND • Patient is not receiving Opzelura in combination with another biologic medication (e.g. dupilumab), oral JAK inhibitor (e.g. upadactinib), or systemic immunosuppressant (e.g. cyclosporine) AND • The quantity requested does not exceed 60 grams/fill; maximum of 8-weeks of continuous use. **Pimecrolimus:** The patient has a documente intolerance to brand Elidel. **Adbry, Cibinqo, Dupixent, Rinvoq**: • The patient's age is FDA approved for the given indication AND • The patient has a diagnosis of moderate to severe atopic dermatitis AND • The prescription is initiated in consultation with a dermatologist, allergist, or immunologist AND • At least 10% of the body's surface area is involved AND • The patient has had a documented side effect, allergy, or treatment failure (defined as daily treatment for at least one month) with at least one moderate to high potency topical corticosteroid and one preferred topical calcineurin inhibitor within the last 6 months AND • Initial approval will be granted for 6 months. For re-approval after 6 months, the prescriber must submit documentation of clinical improvement in symptoms. Renewals may be granted for up to 1 year. **Cibinqo additional criteria:** The patient has a had a documented side effect, allergy, or treatment failure with Adbry or Dupixent AND the patient has a had a documented side effect, allergy, or treatment failure with Rinvoq. **Rinvoq additional criteria:** The patient has a had a documented side effect, allergy, or treatment failure with Adbry or Dupixent.
SCABICIDES AND PEDICULOCIDES		
PERMETHRIN 5 % (compare to Elimite®) C PERMETHRIN 1 % CR, L	Ivermectin 0.5% L	**Non-preferred Scabicides:** The patient has had a documented side effect or allergy to permethrin cream or treatment failure with two treatments of

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
PIPERONYL BUTOXIDE AND PYRETHRINS G, S, Sh NATROBA® (spinosad 0.9 %) Ss *C=cream, CR=crème rinse, G=gel, L=lotion, S=solution, Sh=shampoo, Sp=spray, Ss=suspension*	Lindane Sh Malathion L (compare to Ovide®) Ovide® (malathion) L Spinosad (compare to Natroba) Ss Vanalice® (piperonyl butoxide/pyrethrins) G	permethrin cream. **Non-Preferred Pediculicides:** The patient has had a documented side effect or allergy to OTC permethrin and piperonyl butoxide and pyrethrins and one treatment of 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 All products require PA **ORAL** DESMOPRESSIN	DDAVP® (desmopressin) Nasal Solution or Spray 0.01% Desmopressin Nasal Solution or Spray 0.01 % (compare to DDAVP®) Noctiva™ (desmopressin) Nasal Spray Stimate® (desmopressin) Nasal Solution 1.5 mg/ml Nocdurna® (desmopressin) SL tablets *QTY LIMIT:* 1 tablet/day DDAVP® (desmopressin) tablets	**CRITERIA FOR APPROVAL:** **Intranasal (except as indicated below):** The diagnosis or indication for the requested medication is (1) Diabetes Insipidus, (2) hemophilia type A, or (3) Von Willebrand disease AND If the request is for brand DDAVP, the patient has a documented intolerance to generic desmopressin spray or solution. **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 **Nocdurna, Noctiva:** Patient is ≥18 years of age (Nocdurna) or ≥ 50 years of age (Noctiva) AND the indication for use is the treatment of nocturia due to nocturnal polyuria (defined as nighttime urine production exceeding 1/3 of the 24-hour urine production) causing patient to awaken more than 2 times per night to void for at least 6 months AND patient has eGFR > 50ml/min/1.73m2 AND patient does not have increased risk of severe hyponatremia (e.g. concomitant use of loop diuretics or corticosteroids, diagnosis of CHF, or uncontrolled hypertension) AND serum sodium concentrations are normal before starting therapy AND 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		
Please refer to the DVHA website for covered Diabetic testing supplies. Test strips are subject to a quantity limit of 200 strips per 30 days. https://dvha.vermont.gov/sites/dvha/files/doc_library/		**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. **CRITERIA FOR APPROVAL to Exceed *QTY LIMIT:*** Chart notes must be

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
Vermont%20PDSL%20January%202023_updated%201.20.23.pdf		provided documenting medical necessity. **LIMITATIONS:** Talking monitors are not covered under the pharmacy benefit.
ENDOMETRIOSIS/UTERINE FIBROIDS AGENTS		
LUPRON DEPOT® (leuprolide acetate for depot suspension) *QTY LIMIT:* 3.75 mg kit/month or 11.25 mg kit/3 months SYNAREL® (nafarelin acetate) nasal solution ***Preferred After Clinical Criteria are Met*** MYFEMBREE® (relugolix/estradiol/norethindrone) tablet *QTY LIMIT:* 1 tab/day ORIAHNN® (elagolix and elagolix/estradiol/norethindrone) capsules *QTY LIMIT:* 2 tabs/day ORILISSA® (elagolix) tablets *QTY LIMIT:* 200mg dose = 2 tabs/day; maximum of 6 months; 150mg = 1 tab/day	Lupaneta Pack™ (leuprolide acetate for depot suspension and norethindrone acetate tablets) *QTY LIMIT:* 3.75 mg kit/month or 11.25 mg kit/3 months	**Lupaneta Pack:** patient has a documented intolerance to Lupron Depot and norethindrone tablets used in combination. **Myfembree, Orilissa, Oriahnn:** Patient has a documented side effect, allergy, or treatment failure to at least TWO medications from at least 2 different classes (oral contraceptives, NSAIDs, progestins). **Note:** Use of GnRH receptor antagonists will be limited to 2 years.
EPINEPHRINE: SELF-ADMINISTERED		
EPIPEN-JR INJ 0.15mg EPIPEN INJ 0.3mg EPINEPHRINE INJ (compare to EpiPen-Jr®) (authorized generic, Mylan labeler code 49502 is the only preferred form) 0.15mg EPINEPHRINE INJ (compare to EpiPen®) (authorized generic, Mylan labeler code 49502 is the only preferred form) 0.3mg	Auvi-Q® Inj 0.1mg Auvi-Q® Inj 0.15mg Auvi-Q® Inj 0.3mg Epinephrine Inj 0.15 mg Epinephrine Inj 0.3 mg Symjepi® Inj 0.15mg Symjepi® Inj 0.3mg	**Non-preferred Agents (0.15mg, 0.3mg):** The patient must have a documented intolerance to a preferred epinephrine product. **Auvi-Q 0.1mg:** Patient weight is 7.5kg to 15kg (16.5 to 33 lbs).
ESTROGENS: VAGINAL		
ESTRADIOL		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ESTRACE VAGINAL® Cream ESTRING® Vaginal Ring VAGIFEM® Vaginal Tablets **CONJUGATED ESTROGENS** PREMARIN VAGINAL® Cream **ESTRADIOL ACETATE** FEMRING® Vaginal Ring		
GASTROINTESTINAL		
INFLAMMATORY BOWEL DISEASE BIOLOGICS: Initial approval is 3 months; renewals are 1 year		
Preferred After Clinical Criteria Are Met **INJECTABLE** AVSOLA ® (infliximab-axxq) biosimilar to Remicade® HUMIRA® (adalimumab) *QTY LIMIT*: 6 syringes/28 days for the first month (Crohn's starter kit);2 syringes/28 days subsequently INFLECTRA® (infliximab-dyyb) biosimilar to Remicade® **ORAL**	Cimzia® (certolizumab pegol) *QTY LIMIT:* 1 kit/28 days Entyvio® (vedolizumab) *QTY LIMIT:* 300 mg X 3/42 days, 300 mg X 1 every 56 days thereafter Remicade® (infliximab) Renflexis™ (infliximab-abda) biosimilar to Remicade® Simponi® (golimumab) SC *QTY LIMIT*: 3 of 100 mg prefilled syringe or autoinjector X 1, then 100 mg/28days Skyrizi® (risankizumab-rzaa) *QTY LIMIT:* 360 mg (2.4ml)/56 days after initial IV loading dose Stelara® (ustekinumab) *QTY LIMIT:* 90mg (1 mL)/56 days after initial IV loading dose Tysabri® (natalizumab)	**Clinical Criteria for approval of ALL drugs (Crohn's Disease):** Patient has a diagnosis of moderate to severe Crohn's disease and has already been stabilized on the medication OR patient meets additional criteria outlined below: **Avsola, Humira, Inflectra:** The patient has had a treatment failure with at least one conventional agent (e.g. methotrexate, corticosteroids) OR there is evidence of severely active disease and early introduction of a biologic without prior medication trials is medically necessary. **Cimzia, Entyvio, Simponi, Stelara, Tysabri:** The patient never responded to a 12-week course of anti-TNFα therapy (primary nonresponse) OR the patient previously responded to infliximab (secondary nonresponse) and has a documented side effect, allergy, or treatment failure with adalimumab. **Note:** Initial IV dose for Stelara will be approved through the medical benefit. All subsequent subcutaneous doses may be approved through the pharmacy benefit with quantity limit of 90mg every 8 weeks. **Remicade, Renflexis:** The prescriber must provide a clinically compelling reason why Avsola or Inflectra would not be suitable alternatives. **Skyrizi:** The patient has a documented side effect, allergy, or treatment failure to a 12-week course of therapy with a preferred TNF inhibitor AND the patient has a documented side effect, allergy, or treatment failure to a 12-week course of therapy with either Entyvio or Stelara. **Clinical Criteria for approval of ALL drugs (Ulcerative Colitis):** Patient has a diagnosis of moderate to severe Ulcerative Colitis and has already been

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
XELJANZ® (tofacitinib) tablet *QTY LIMIT*: 2 tablets/day XELJANZ® XR (tofacitinib) tablet *QTY LIMIT*: 1 tablet/day	Rinvoq ® (upadactinib) extended-release tablet *QTY LIMIT:* 1 tablet/day Maximum 30 days supply Zeposia® (ozanimod) capsule *QTY LIMIT:* 1 capsule/day	stabilized on the medication OR patient meets additional criteria outlined below: **Avsola, Humira, Inflectra:** The patient has had a treatment failure with at least one conventional agent (e.g. 5-ASA, corticosteroids) OR there is evidence of severely active disease and early introduction of a biologic without prior medication trials is medically necessary. **Entyvio, Simponi, Stelara, Zeposia:** The patient has had a treatment failure with at least one conventional agent (e.g. 5-ASA, corticosteroids) AND the patient has a documented side effect, allergy, or treatment failure with at least one preferred biologic. **Rinvoq:** The patient has had a treatment failure with at least one conventional agent (e.g. 5-ASA, corticosteroids) AND the patient has a documented side effect, allergy, or treatment failure with a preferred TNF inhibitor AND the patient has a documented side effect, allergy, or treatment failure with Xeljanz or Xeljanz XR. **Xeljanz, Xeljanz XR:** The patient has had a treatment failure with at least one conventional agent (e.g. 5-ASA, corticosteroids) AND the patient has a documented side effect, allergy, or treatment failure with at least one preferred TNF Inhibitor. **Note:** Induction of Xeljanz 10mg twice daily or XR 22mg once daily will be limited to 16 weeks. Treatment should be discontinued after 16 weeks if adequate therapeutic response is not achieved. For patients with loss of response during maintenance treatment with 5mg twice daily or XR 11mg once daily, approval of 10mg twice daily or XR 22mg once daily will be considered and limited to the shortest duration possible.
H. PYLORI COMBINATION THERAPY		
LANSOPRAZOLE, AMOXICILLIN, CLARITHROMYCIN *QTY LIMIT:* 112 caps & tabs/14 days PYLERA® (bismuth subcitrate, metronidazole, tetracycline) capsules *QTY LIMIT:* 120 caps/10 days	Omeclamox-Pak® (omeprazole, clarithromycin, amoxicillin) *QTY LIMIT:* 80 caps & tabs/10 days Talicia® (omeprazole, amoxicillin, rifabutin) delayed release capsules *QTY LIMIT:* 168 caps/14 days	**CRITERIA FOR APPROVAL:** The patient has a documented treatment failure with Lansoprazole, amoxicillin, clarithromycin combo package or Pylera used in combination with a PPI.
H-2 BLOCKERS		
FAMOTIDINE (compare to Pepcid®) tablet	Cimetidine (compare to Tagamet®) tablet Nizatidine capsule Pepcid® (famotidine) tablet	**Cimetidine tablet, Nizatidine capsule, Pepcid tablet:** The patient has had a documented side effect, allergy, or treatment failure to famotidine.
SYRUPS AND SPECIAL DOSAGE FORMS FAMOTIDINE oral suspension (compare to Pepcid®) age ≤ 12 years	Cimetidine oral solution Famotidine (compare to Pepcid®) oral suspension (age	**Cimetidine Oral Solution, Nizatidine oral solution:** Patient has a medical necessity for a liquid dosage form AND the patient has had a documented side effect, allergy, or treatment failure to famotidine oral suspension.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	>12 years) Nizatidine Oral Solution	**Famotidine Oral Suspension (Age >12):** Patient has a medical necessity for a liquid dosage form
INFLAMMATORY BOWEL AGENTS (ORAL & RECTAL PRODUCTS)		
MESALAMINE PRODUCTS **ORAL** APRISO® (mesalamine capsule extended release) LIALDA® (mesalamine tablet extended release) PENTASA ER ® (mesalamine cap CR)	Delzicol® (mesalamine capsule delayed-release) *QTY LIMIT*: 6 capsules/day Mesalamine capsule delayed release (compare to Delzicol®) *QTY LIMIT*: 6 capsules/day Mesalamine capsule extended release 0.375gm (compare to Apriso®) Mesalamine tablet delayed release (compare to Asacol® HD) Mesalamine tablet extended release 1.2 g (compare to Lialda®)	**Azulfidine, Colazal:** patient has had a documented intolerance to the generic equivalent of the requested medication. **Budesonide ER 9mg, Ortikos:** the patient has a documented intolerance to brand-name Uceris. **Delzicol, Mesalamine capsule DR, Mesalamine tablet DR, Mesalamine tablet ER:** The patient has had a documented side effect, allergy, or treatment failure to 2 preferred oral mesalamine products. **sfRowasa, Uceris Rectal Foam:** The patient has had a documented intolerance to mesalamine enema or suppositories. **LIMITATIONS:** Kits with non-drug products are not covered.
RECTAL MESALAMINE ENEMA (compare to Rowasa®) MESALAMINE SUPPOSITORY	sfRowasa® (mesalamine enema sulfite free)	
CORTICOSTEROIDS **ORAL** BUDESONIDE 24HR *QTY LIMIT*: 3 capsules/day UCERIS® (budesonide) ER Tablet QTY LIMIT = 1 tablet/day	Budesonide ER 9 mg tablet (compare to Uceris®) *QTY LIMIT*: 1 tablet/day Ortikos® (budesonide) ER capsule QTY LIMIT: 1 capsule/day	
RECTAL All products require PA	Uceris® Rectal Foam (budesonide)	
OTHER BALSALAZIDE (compare to Colazal®) DIPENTUM® (olsalazine) SULFAZINE SULFAZINE EC SULFASALAZINE (compare to Azulfidine®) SULFASALAZINE DR	Azulfidine® (sulfasalazine) Colazal® (balsalazide)	

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
PROKINETIC AGENTS		
TABLETS METOCLOPRAMIDE tabs (compare to Reglan®) **ORAL SOLUTION** METOCLOPRAMIDE oral solution **NASAL SPRAY** All products require PA	Reglan® (metoclopramide) Gimoti™ (metoclopramide) nasal spray	**Reglan:** The patient has had a documented intolerance to generic metoclopramide tablets. **Gimoti:** The patient has a documented intolerance to metoclopramide tablets and oral solution.
PROTON PUMP INHIBITORS		
ORAL CAPSULES/TABLETS ESOMEPRAZOLE (compare to Nexium®) *QTY LIMIT:* 1 cap/day LANSOPRAZOLE generic RX capsules (compare to Prevacid®) *QTY LIMIT:* 1 cap/day OMEPRAZOLE RX capsules (compare to Prilosec®) *QTY LIMIT:* 1 cap/day PANTOPRAZOLE tablets (compare to Protonix®) *QTY LIMIT:* 1 tab/day	Aciphex® (rabeprazole) tablets *QTY LIMIT:* 1 tab/day Dexilant® (dexlansoprazole) capsules *QTY LIMIT:* 1 cap/day Nexium® (esomeprazole) capsules *QTY LIMIT:* 1 cap/day Omeprazole generic OTC tablets *QTY LIMIT:* 1 tab/day Omeprazole magnesium generic OTC 20 mg capsules *QTY LIMIT:* 1 cap/day Omeprazole/sodium bicarb capsules RX (compare to Zegerid®) *QTY LIMIT:* 1 cap/day Prevacid® RX (lansoprazole) capsules *QTY LIMIT:* 1 cap/day Prevacid® 24 hr OTC (lansoprazole) capsules *QTY LIMIT:* 1 cap/day Protonix® (pantoprazole) tablets *QTY LIMIT:* 1 tab/day Rabeprazole (compare to Aciphex®) tablets *QTY LIMIT:* 1 tab/day Zegerid RX ® (omeprazole/sodium bicarb) caps, oral, suspension *QTY LIMIT:* 1 cap/day	**Nexium powder for suspension (for patients ≥ 12 years old):** The patient has a requirement for a non-solid oral dosage form (e.g. an oral liquid, dissolving tablet or sprinkle). **Aciphex Sprinkle, Prevacid Solutabs, 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). AND the member has had a documented side effect, allergy or treatment failure to Nexium powder for suspension. **Other non-preferred medications:** The member has had a documented side effect, allergy, or treatment failure to ALL preferred PPIs AND if the product has an AB rated generic, there must be a trial of the generic. **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. **Note:** Approval of twice daily dosing for GERD is limited to 12 weeks. For continuation after 12 weeks, there must be a documented attempt to taper to once daily dosing of a PPI with an adjunctive H2 Blocker. The dosing of long-term PPI's should be periodically re-evaluated so that the lowest effective dose can be prescribed to manage the condition. **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.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
SUSPENSION & SPECIAL DOSAGE FORMS NEXIUM® (esomeprazole) powder for suspension (age < 12 years) *QTY LIMIT*: 1 packet/day	Aciphex® Sprinkle (rabeprazole) DR Capsule *QTY LIMIT:* 1 cap/day Lansoprazole ODT (compare to Prevacid Solutab®) *QTY LIMIT:* 1 tab/day Nexium® (esomeprazole) powder for suspension (age ≥ 12 years) *QTY LIMIT*: 1 packet/day Prevacid Solutabs® (lansoprazole) *QTY LIMIT:* 1 tab/day Prilosec® (omeprazole magnesium) packet *QTY LIMIT:* 2 packets/day Protonix® (pantoprazole) packet *QTY LIMIT:* 1 packet/day	**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 are not covered as Federal Rebate is no longer offered.
GAUCHER'S DISEASE MEDICATIONS		
All products require PA	Cerezyme® (imiglucerase for injection) Cerdelga® (eliglustat) *QTY LIMIT:* 2 caps/day Elelyso® (taliglucerase alfa for injection) Vpriv® (velaglucerase alfa for injection) Miglustat (compare to Zavesca®) *QTY LIMIT:* 3 caps/day Zavesca® (miglustat) *QTY LIMIT:*3 caps/day ****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. **Age Limits** **Elelyso, Vpriv:** for patients ≥ 4 years old **Cerezyme:** for patients ≥ 2 years old **Cerdelga, Miglustat, Zavesca:** for patients ≥ 18 years old **Cerezyme/Vpriv additional criteria:** Failure, intolerance or other contraindication to enzyme replacement therapy with Elelyso **Cerdelga additional criteria:** • Testing to verify if CYP2D6 extensive metabolizer (EM), intermediate metabolizer (IM), poor metabolizer (PM), or if CYP2D6 genotype cannot be determined o Dose max: 84mg twice/day if EM or IM o Dose max: 84mg/day if PM o Case by case determination if CYP2D6 cannot be determined **Miglustat, Zavesca additional criteria:** • For whom enzyme replacement therapy is not a therapeutic option

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		(e.g. due to allergy, hypersensitivity, or poor venous access) AND for approval of miglustat, the patient must have a documented intolerance to brand Zavesca.
GOUT AGENTS		
ALLOPURINOL (compare to Zyloprim®) COLCHICINE tablets (compare to Colcrys®) COLCHICINE/PROBENECID PROBENECID	Colcrys® (colchicine) tablet *QTY LIMIT:* 3 tablets/day (gout) or 4 tablets/day (FMF) Colchicine capsules Febuxostat (compare to Uloric®) *QTY LIMIT:* 40 mg tablets = 1 tablet/day Mitigare® (colchicine) capsule *QTY LIMIT:* 2 capsules/day Uloric® (febuxostat) *QTY LIMIT:* 40 mg tablets = 1 tablet/day Zyloprim® (allopurinol)	**Colchicine capsules, Colcrys, Mitgare:** the patient has a documented intolerance to generic colchicine tablets. **Febuxostat, 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		
ACHONDROPLASIA TREATMENTS		
All products require PA	Voxzogo™ (vosoritide)	**Voxzogo:** The patient must have a diagnosis of achondroplasia confirmed with genetic testing AND the medication must be prescribed by a pediatric endocrinologist AND Confirmation of non-closure of epiphyseal plates (x-ray determining bone age) must be provided for females > age 12 and males > age 14 AND Voxzogo will not be used in combination with growth hormone (e.g. somatropin), growth hormone analogs (e.g. somapacitan), or insulin-like growth factor (IGF-1) (e.g. mecasermin) AND patient's standing height, weight, BMI, and upper to lower body ratio will be measured at baseline and monitored throughout therapy. For re-approval, the patient must have an improvement in growth velocity compared to pre-treatment baseline.
GROWTH HORMONE		gro
Preferred After Clinical Criteria Are Met GENOTROPIN® NORDITROPIN®	Nutropin® AQ Omnitrope® Saizen® Skytrofa® (lonapegsomatropin-tcgd) Sogroya® (somapacitan-beco) Zomacton®	**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

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Specialized Indications – See Specific Criteria Increlex® (mecasermin) Serostim® Zorbtive®	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 patients who have Idiopathic Short Stature. **Nutropin AQ, Omnitrope, Saizen, Skytrofa, Zomacton:** The patient has a documented side effect, allergy, or treatment failure to both preferred agents. **Sogroya:** The patient has a documented side effect, allergy, or treatment failure to both preferred agents AND the patient has a documented side effect, allergy, or treatment failure to Skytrofa. **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 AND 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 must be issued by gastroenterologist (specialist)
hATTR TREATMENTS		
All products require PA		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Amvuttra™ (vutrisiran) 25mg/0.5ml injection for subcutaneous use *QTY LIMIT*: 1 syringe (0.5ml) every 3 months Onpattro® (patisiran) 10 mg/5ml intravenous injection Weight < 100kg (0.3 mg/kg every 3 weeks) Weight ≥ 100kg (30 mg every 3 weeks) Tegsedi® (inotersen) 284 mg/1.5ml injection for subcutaneous use *QTY LIMIT*: 4 syringes/28 days Vyndamax® (tafamidis) *QTY LIMIT*: 1 capsule/day Vyndaqel® (tafamidis meglumine) *QTY LIMIT*: 4 capsules/day	**Amvuttra, Onpattro, Tegsedi:** • The patient is ≥ 18 years of age with a diagnosis of polyneuropathy of heredity transthyretin mediated (hATTR) amyloidosis (Documentation of TTR mutation by genetic testing or the presence of amyloid deposits via tissue biopsy has been submitted) AND • The medication is being prescribed by or in consultation with a neurologist AND • Clinical signs and symptoms of the disease (e.g., peripheral/autonomic neuropathy, motor disability, cardiovascular dysfunction, renal dysfunction) are present and other causes of neuropathy have been excluded AND • Patient is receiving vitamin A supplementation AND • Initial approval will be granted for 3 months. For re-approval, the patient must have documentation of clinical improvement or slower progression of the disease than would otherwise be expected. **Vyndamax, Vyndaqel:** • The patient is ≥ 18 years of age with a diagnosis of cardiomyopathy of wild type transthyretin-mediated amyloidosis or heredity transthyretin mediated (hATTR) amyloidosis AND • The presence of amyloid deposits showing cardiac involvement via tissue biopsy or imaging has been submitted AND • The medication is being prescribed by or in consultation with a cardiologist AND • Initial approval will be granted for 6 months. For re-approval, the patient must have a decrease in the frequency of cardiovascular-related hospitalizations or slower progression of the disease than would otherwise be expected.
HEART FAILURE		
ANGIOTENSIN RECEPTOR – NEPRILYSIN INHIBITOR (ARNI)		
ENTRESTO® (valsartan/sacubitril) *QTY LIMIT*: 2 tablets/day		
CARDIAC MYOSIN INHIBITORS		
All procuts require PA	Camzyos® (mavacamten) *QTY LIMIT:* 1 capsule/day	**Camzyos:** • The diagnosis or indication is symptomatic New York Heart Association (NYHA) class II-III obstructive hypertrophic cardiomyopathy (HCM) AND • LVEF ≥ 55% AND Valsalva LVOT peak gradient ≥50mmHg at rest or with provocation AND • The patient has a documented side effect, allergy, or treatment

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		failure at a maximally tolerated dose to at least two of the following: Non-vasodilating beta blocker (e.g., atenolol, bisoprolol, metoprolol, nadolol, propranolol), Nondihydropyridine calcium channel blocker (i.e., diltiazem, verapamil), and Disopyramide AND • The medication will not be used concurrently with disopyramide, ranolazine, verapamil with a beta blocker, or diltiazem with a beta blocker. • Approval will be granted for 12 months. For reapproval, there must be a documented positive clinical response as supported by one of the following: Stable or reduction in New York Heart Association (NYHA) class AND Patient has a left ventricular ejection fraction of greater than or equal to 50%
SODIUM-GLUCOSE CO-TRANSORTER 2 (SGLT2) INHIBITORS		
FARXIGA® (dapagliflozin) *QTY LIMIT:* 1 tab/day		
SOLUBLE GUANYLATE CYCLASE (sGC) STIMULATORS		
All products require PA	Verquvo® (vericiguat) tablet *QTY LIMIT:* 1 tablet/day	**Verquvo:** The diagnosis or indication is symptomatic heart failure (HF) with ejection fraction < 45% AND the patient has been hospitalized for HF within the previous 6 months or required the use of IV diuretics within the past 3 months AND the patient is not pregnant AND the patient is concurrently receiving the maximum tolerated dose of one agent from each of the following classes, unless contraindicated: • ARNI, ACE-I, or ARB • Beta Blocker (metoprolol, carvedilol, or bisoprolol) • Aldosterone antagonist if LVEF ≤ 35% or LVEF ≤ 40% with diabetes mellitus or post myocardial infarction (MI) with HF symptoms
HEMATOPOIETICS		
Colony Stimulating Factors		
Eflapegrastim Products All products require PA **Filgrastim Products** NEUPOGEN® (filgrastim) Vial, Syringe	Rolvedon™ (eflapegrastim-xnst) Syringe Granix® (tbo-filgrastim) Vial, Syringe Leukine® (sargramostim) Nivestym™ (figrastim-aafi) Vial, Syringe Releuko™ (filgrastim-ayow)	**Granix, Leukine, Nivestym, Releuko, Zarxio:** The prescriber must provide a clinically compelling reason for the use of the requested medication including reasons Neupogen would not be a suitable alternative. **Fylnetra, Nyvepria, Rolvedon, Stimufend, Udenyca:** The prescriber must provide a clinically compelling reason for the use of the requested medication including reasons why any of the preferred pegfilgrastim products would not be suitable

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Zarxio® (filgrastim-sndz) Syringe	alternatives.
Pegfilgrastim Products FULPHILA™ (pegfilgrastim-jmdb) Syringe NEULASTA® (pegfilgrastim) Syringe NEULASTA® Onpro® (pegfilgrastim) kit ZIEXTENZO® (pegfilgrastim-bmez)	Fylnetra® (pegfilgrastim-pbbk) Nyvepria (pegfilgrastim-apgf) Stimufend® (pegfilgrastim-fpgk) Udenyca™ (pegfilgrastim-cbqv)	
Erythropoietic Stimulating Agents		
Preferred After Clinical Criteria Are Met EPOGEN® (epoetin alpha) MIRCERA® (methoxypolyethylene glycolepoetin beta)	Aranesp® (darbepoetin alfa) Procrit® (epoetin alpha) Retacrit® (epoetin alpha-epbx)	**Aranesp, Procrit, Epogen, Retacrit:** 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 level 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 for approval of Aranesp or Procrit, or Retacrit the patient has had a documented side effect, allergy, or treatment failure to Epogen. **Mircera:** The diagnosis or indication for the requested medication is anemia due to chronic kidney disease/renal failure AND Hemoglobin level at initiation of therapy is <10g/dl OR For patients currently maintained on therapy, hemoglobin level is ≤11 g/dL in dialysis patients with chronic kidney disease, ≤10 g/dL in non-dialysis patients with chronic kidney disease.
HEMOPHILIA TREATMENTS		
(Factor VII Deficiency)		
All products require PA	Novoseven® RT Sevenfact®	**Novoseven RT:** Medication is being used for the treatment of acute bleeding episodes in a patient with Hemophilia A or B with inhibitors OR Patient has congenital Factor VII deficiency. **Sevenfact:** Medication is being used for the treatment of acute bleeding episodes in a patient with Hemophilia A or B with inhibitors AND there is a clinically compelling reason why Novoseven RT cannot be used.
Hemophilia A (Factor VIII Deficiency)		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ADVATE® AFSTYLA® HEMLIBRA® (emicizumab-kxwh) HEMOFIL® M JIVI® KOATE®-DVI KOVALTRY® NOVOEIGHT® NUWIQ® OBIZUR® RECOMBINATE® XYNTHA®	Adynovate® Altuviiio™ (antihemophilic factor (recombinant), Fc-VWF-XTEN fusion protein-ehtl) Eloctate® Esperoct®	**Adynovate, Elocate, Esperoct:** Documentation must include why the member is unable to use the preferred extended half-life concentrate Jivi. **Altuviiio:** The patient has severe Factor VIII deficiency as evidenced by < 1% of normal circulating factor AND Patient has the following: • Current and continuous use of Factor VIII prophylaxis therapy for the previous 6 months as evidence by claims history or clinical documentation, without breaks in adherence. (Continuous use is defined as routine prophylaxis with defined frequency, e.g. twice weekly, once every two weeks) AND • Current or historical life-threatening hemorrhage despite use of preferred prophylaxis therapy OR Repeated, serious spontaneous bleeding episodes requiring hospitalization.
Hemophilia B (Factor IX Deficiency)		
ALPHANINE® SD ALPROLIX® BENEFIX® IDELVION® IXINITY® PROFILNINE® RIXUBIS®	Kcentra® Rebinyn®	**All Non-Preferred Products:** The prescriber must provide a clinically compelling reason for the use of the requested medication including reasons why any of the preferred products would not be suitable alternatives. For approval of Rebinyn, documentation must include why the member is unable to use a preferred extended half-life concentrate Alprolix or Idelvion.
Von Willebrand Factor		
ALPHANATE® HUMATE-P® WILATE®	Vonvendi®	**All Non-Preferred Products:** The prescriber must provide a clinically compelling reason for the use of the requested medication including reasons why any of the preferred products would not be suitable alternatives.
AHF-Anti-Inhibitor Coagulation Complex		
All products require PA	Feiba®	**Feiba:** medication is being used for the treatment of acute bleeding episodes or routine prophylaxis in a patient with Hemophilia A or B with inhibitors.
Gene Therapy		
All products require PA	Hemgenix® (etranacogene dezaparvovec-drlb)	**Hemgenix:**

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA

		• Patient is ≥ 18 years of age AND
		• Patient has a diagnosis of severe congenital Factor IX deficiency, as evidenced by < 1% of normal circulating factor IX AND
		• Patient has the following:
		  ○ Current and continuous use of Factor IX prophylaxis therapy for the previous 6 months as evidence by claims history or clinical documentation, without breaks in adherence. (Continuous use is defined as routine prophylaxis with defined frequency, e.g. twice weekly, once every two weeks) AND
		  ○ Current or historical life-threatening hemorrhage despite use of preferred prophylaxis therapy OR Repeated, serious spontaneous bleeding episodes requiring hospitalization AND
		• Patient has been tested and found negative for Factor IX inhibitor titers (if test result is positive, re-test within approximately 2 weeks. If re-test is also positive, Hemgenix should not be administered) AND
		• Patient must have a baseline anti-AAV5 antibody titer of less than or equal to 1:678 measured by ELISA AND
		• Baseline liver function tests will be completed prior to start of therapy and continued weekly for 3 months following Hemgenix administration AND
		• Factor IX activity will be monitored weekly for 3 months AND Factor IX prophylaxis therapy will be discontinued when circulating factor IX levels reach 5%
		• Approval will be granted for a max one-time dose per lifetime and may not be renewed

HEPATITIS B AGENTS		
ENTECAVIR (compare to Baraclude®) VIREAD® (tenofovir disoproxil fumarate) tablet	Adefovir (compare to Hepsera®) Baraclude® (entecavir) tablet, solution Lamivudine HBV (compare to Epivir-HBV®) Vemlidy® (tenofovir alafenamide fumarate) Viread® (tenofovir disoproxil fumarate) powder	**Adefovir, Lamivudine HBV, Epivir-HBV:** The prescriber must provide a clinically compelling reason for the use of the requested medication including reasons why any of the preferred products would not be suitable alternatives **Note:** AASLD and WHO guidelines recommend these not be utilized first line due to potential for the development of resistance. **Baraclude tabs:** the patient has a documented intolerance to generic entecavir. **Baraclude suspension, Viread Powder:** the patient has a medical necessity for a non-solid oral dosage form. **Vemlidy:** the patient must have a diagnosis of osteoporosis, renal insufficiency (CrCl < 60ml/min), or other contraindication to Viread such as chronic steroid use.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
HEPATITIS C AGENTS		
Initial PA: 3 months; subsequent maximum 3 months		
RIBAVIRIN PRODUCTS RIBAVIRIN 200 mg tablets **PEGINTERFERON PRODUCTS** PEGASYS® (peginterferon alfa-2a) *QTY LIMIT:* 4 vials or syringes/28 days **DIRECT ACTING ANTIVIRALS** ***Preferred After Clinical Criteria Are Met*** MAVYRET™ (glecaprevir/pibrentasvir) SOFOSBUVIR/VELPATASVIR (compare to Epclusa®)	Ribavirin 200 mg capsules Epclusa® (sofosbuvir/velpatasvir) Harvoni® (ledipasvir/sofosbuvir) Ledipasvir/sofosbuvir (compare to Harvoni®) Sovaldi® (sofosbuvir) Vosevi® (sofosbuvir/velpatasvir/voxilaprevir) Zepatier® (elbasvir/grazoprevir)	**Non-preferred Ribavirin Brands/strengths:** The patient is unable to use generic ribavirin 200 mg tablets **Direct Acting Agents: Epclusa, Harvoni, Ledipasvir/sofosbuvir, Mavyret, Sofosbuvir/velpatasvir, Sovaldi, Vosevi, Zepatier:** • Hep C PA form must be completed, and clinical documentation supplied. • Combination therapy will be either approved or denied in its entirety. • Prescriber is, or has consulted with, a hepatologist, gastroenterologist or infectious disease specialist. Consult must be within the past year with documentation of recommended regimen. Specialist requirement will NOT apply for patients meeting all the following: treatment naïve, non-cirrhotic, HBV negative, HIV negative, no prior liver transplantation, and not pregnant. • See PA form for detailed requirements and for documentation required For approval of a non-preferred agent, the provider must submit clinical documentation detailing why the patient is not a candidate for a preferred direct acting agent regimen.
HEREDITARY ANGIOEDEMA MEDICATIONS		
TREATMENT		
Preferred After Clinical Criteria are Met BERINERT® (human C1 inhibitor) ICATIBANT (compare to Firazyr®) *QTY LIMIT:* 3 syringes (9 ml)/fill	Firazyr® (icatibant) *QTY LIMIT:* 3 syringes (9 ml)/fill Kalbitor® (escallantide) *QTY LIMIT:* 6 vials (2 packs) per fill Ruconest® (recombinant C1 esterase inhibitor) *QTY LIMIT:* 4 vials/fill	**Berinert, Firazyr, Icatibant:** The diagnosis or indication is treatment of an acute Hereditary Angioedema (HAE) attack AND for approval of Firazyr, the patient must have a documented intolerance to generic Icatibant. (Approval may be granted so that 2 doses may be kept on hand for Berinert and 3 doses for Icatibant/Firazyr). **Kalbitor, Ruconest:** The diagnosis or indication is treatment of an acute Hereditary Angioedema (HAE) attack AND the patient has a documented side effect, allergy, treatment failure or contraindication to a preferred agent

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		(Approval may be granted so that 2 doses may be kept on hand.)
PROPHYLACTIC		
Preferred After Clinical Criteria are Met CINRYZE® (human C1 inhibitor) *QTY LIMIT:* 20 vials/30days HAEGARDA® (human C1 inhibitor) ORLADEYO™ (berotralstat) QTY LIMIT: 1 capsule/day TAKHZYRO™ (lanadelumab-flyo) *QTY LIMIT:* 2 vials/28 days		**Cinryze, Haegarda, Orladeyo, Takhzyro:** The diagnosis or indication is prophylaxis of Hereditary Angioedema (HAE) attacks.
HIDRADENITIS SUPPURATIVA		
BIOLOGICS: Initial approval is 3 months; renewals are 1 year		
Preferred After Clinical Criteria Are Met **INJECTABLE** HUMIRA® (adalimumab) *QTY LIMIT:* 6 syringes/28 days for the first month (HS starter kit);4 syringes/28 days subsequently		• The patient has a diagnosis of moderate-severe hidradenitis suppurativa (Hurley Stage II-III) AND • The medication is being prescribed by, or in consultation with, a dermatologist AND • The patient has not responded to a 12-week course of standard antibiotic therapy with an oral tetracycline (e.g. Doxycycline) or clindamycin plus rifampin, unless contraindicated.
HYPERKALEMIA AGENTS		
Lokelma™ (sodium zirconium cyclosilicate) SPS® (sodium polystyrene sulfonate) suspension	Veltassa® (patiromer sorbitex calcium) powder packets *QTY LIMIT:* 1 packet/day	**Veltassa:** The patient requires therapy for the treatment of non-emergent hyperkalemia AND where clinically appropriate, medications known to cause hyperkalemia (e.g. ACE inhibitors, ARBs, aldosterone antagonists, NSAIDs) have been discontinued or reduced to the lowest effective dose AND where clinically appropriate, a loop or thiazide diuretic has failed for potassium removal, AND the patient has been counseled to follow a low potassium diet (≤ 3 grams/day).
HYPOTHYROID AGENTS		
ARMOUR THYROID tablet EUTHYROX® (levothyroxine) tablet	Cytomel® (liothyronine) tablet Ermeza™ (levothyroxine) oral solution	**Ermeza, Thyquidity, Tirosint-Sol:** The patient has a medical necessity for a non-solid oral dosage form and the medication cannot be administered by crushing

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
LEVOTHYROXINE tablet LEVOXYL® (levothyroxine) tablet LIOTHYRONINE (compare to Cytomel®) tablet NP THYROID® (thyroid) tablet UNITHROID® (levothyroxine) tablet	Levothyroxine capsule (compare to Tirosint®) Synthroid® (levothyroxine) tablet Thyquidity™ (levothyroxine) oral solution Tirosint® (levothyroxine) capsule Tirosint®-Sol (levothyroxine) oral solution	oral tablets AND for approval of Thyquidity, the patient must have a documented intolerance to Ermeza or Tirosint-Sol. **Levothyroxine capsule, Tirosint capsule:** patient has had a documented side effect, allergy, or treatment failure to 2 preferred hypothyroid agents. **Cytomel, Synthroid:** The patient has a documented intolerance to the generic equivalent.
IDIOPATHIC PULMONARY FIBROSIS (IPF)		
All products require PA	Esbriet® (pirfenidone) *QTY LIMIT:*267 mg tablets = 270 tabs/month, 801 mg tablets = 90 tabs/month Ofev® (nintedanib) *QTY LIMIT:* 60 tabs/month	**Clinical Criteria: Esbriet, Ofev** ○ Age ≥ 18 ○ Diagnosis of idiopathic pulmonary fibrosis (Esbriet and Ofev) OR chronic fibrosing interstitial lung disease or systemic sclerosis associated interstitial lung disease (Ofev Only) ○ May not be used in combination ○ The prescriber is a pulmonologist. ○ Clinical documentation that the member is a non-smoker or has not smoked in 6 weeks. ○ FVC≥ 50% of predicted **Reauthorization Criteria:** ○ Documentation the patient is receiving clinical benefit to Esbrit® or Ofev® therapy as evidenced by < 10% decline in percent predicted FVC or < 200mL decrease in FVC AND ○ There is clinical documentation that the member has remained tobacco-free.
IMMUNOLOGIC THERAPIES FOR ASTHMA		
Initial 6 months, Renewal 1 year		
Preferred After Clinical Criteria are Met DUPIXENT® (dupilumab) subcutaneous injection, pre-filled syringe, and auto-injector pen *QTY LIMIT*: 4 syringes/pens the first 28 days then 2 syringes/pens every 28 days thereafter NUCALA® (mepolizumab) subcutaneous injection, auto-injector pen *QTY LIMIT*: 1mL every 28 days XOLAIR® (omalizumab) subcutaneous injection	Cinqair® (reslizumab) Intravenous injection Fasenra® (benralizumab) subcutaneous injection, pre-filled syringe and auto-injector pen *QTY LIMIT:* 1 mL every 28 days for 3 doses then 1 mL every 56 days Nucala® (mepolizumab) subcutaneous injection, vial, pre-filled syringe *QTY LIMIT:* 1mL every 28 days Tezspire™ (tezepelumab-ekko) subcutaneous injection,	**Xolair:** *Diagnosis of moderate to severe persistent asthma:* • The patient must be 6 years of age or older AND • The patient has a history of uncontrolled asthma symptoms (symptoms occurring almost daily or waking at night with asthma at least once a week) or 2 or more exacerbations in the previous year despite regular use of medium-high dose ICS/LABA for a minimum of 3 consecutive months, with or without oral corticosteroids. Pharmacy claims will be evaluated to assess compliance with therapy. AND

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
vial, prefilled syringe *QTY LIMIT:* 900 mg every 28 days	pre-filled syringe and auto-injector pen *QTY LIMIT*: 1.91 mL every 28 days	• The prescriber is a pulmonologist, allergist, or immunologist AND • Patient has tested positive to at least one perennial aeroallergen by skin or blood test (i.e.: RAST, CAP, intracutaneous test) AND • Patient has an IgE level ≥ 30 and ≤ 700 IU/ml (ages 12 and older) OR IgE level ≥ 30 and ≤ 1300 IU/ml (ages 6-11) prior to beginning therapy with Xolair. • For continuation of therapy after the initial 6-month authorization, the patient must continue to receive therapy with an ICS/LABA AND have either a decreased frequency of exacerbations, decreased use of maintenance oral corticosteroids, reduction in the signs and symptoms of asthma, or an increase in predicted FEV1 from baseline. *Diagnosis of chronic idiopathic urticaria:* • The patient must be 12 years of age or older AND • The patient has a therapeutic failure or contraindication to an H1 antihistamine (e.g. cetirizine, fexofenadine) at double the daily dose • For continuation of therapy after the initial 6-month authorization, the patient must have documented clinical improvement in symptoms. *Diagnosis of Chronic Rhinosinusitis with Nasal Polyps:* • Patient is 18 years of age or older AND • Prescriber is an allergist or ENT specialist AND • Patient has had an inadequate response to at least a 3-month trial of 2 different nasal corticosteroids AND • Patient has had an inadequate response to at least a 10-14 day course of oral corticosteroids AND • Patient will use Xolair concurrently with an Intranasal corticosteroid. • For continuation of therapy after the initial 6-month authorization, the patient must continue to receive therapy with an intranasal corticosteroid AND there must be documented improvement in nasal symptoms. **Limitations:** Xolair use will not be approved if requested for prevention of peanut related allergic reaction or in patients with a diagnosis of moderate to severe persistent asthma who are currently smoking. **Fasenra, Nucala, Cinqair:** *Diagnosis of moderate to severe persistent asthma:* • The patient must be 6 years of age or older for Nucala, 12 years of age or older for Fasenra, or 18 years of age or older for Cinqair AND • The patient must have a diagnosis of severe persistent asthma with an eosinophilic phenotype as defined by pre-treatment blood eosinophil count of ≥ 150 cells per mcL within the previous 6 weeks or ≥ 300 cells per mcL within 12 months prior to initiation of therapy AND

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		• The patient has a history of uncontrolled asthma symptoms (symptoms occurring almost daily or waking at night with asthma at least once a week) or 2 or more exacerbations in the previous year despite regular use of medium-high dose ICS/LABA for a minimum of 3 consecutive months, with or without oral corticosteroids. Pharmacy claims will be evaluated to assess compliance with therapy. AND • The prescriber is an allergist, immunologist, or pulmonologist. AND • For approval of Cinqair or Fasenra, the patient must have a documented side effect, allergy, or treatment failure with Dupixent or Nucala. For approval of Nucala vial or prefilled syringe, the patient must be unable to use the auto-injector. • For continuation of therapy after the initial 6-month authorization, the patient must continue to receive therapy with an ICS/LABA AND have either a decreased frequency of exacerbations, decreased use of maintenance oral corticosteroids, reduction in the signs and symptoms of asthma, or an increase in predicted FEV_1 from baseline. *Diagnosis of hypereosinophilic syndrome (Nucala only):* • Patient must be 12 years of age or older AND • The patient must have a blood eosinophil count of ≥ 1,000 cells per mcl AND • The patient has had at least 2 HES flares within the past 12 months AND • The patient is on a stable dose of background HES therapy (chronic or episodic corticosteroids, immunosuppressive, or cytotoxic therapy) for at least 4 weeks prior to treatment initiation AND • The prescriber is an allergist, hematologist, immunologist, or pulmonologist • For continuation of therapy after the initial 6-month authorization, the patient must continue to receive background HED therapy AND there must be documented improvement in the number or frequency of HES flares. *Diagnosis of Chronic Rhinosinusitis with Nasal Polyps (Nucala Only):* • Patient is 18 years of age or older AND • Prescriber is an allergist or ENT specialist AND • Patient has had an inadequate response to at least a 3-month trial of 2 different nasal corticosteroids AND • Patient has had an inadequate response to at least a 10–14-day course of oral corticosteroids AND • Patient will use Nucala concurrently with an intranasal corticosteroid • For continuation of therapy after the initial 6-month authorization, the patient must continue to receive therapy with an intranasal

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		corticosteroid AND there must be documented improvement in nasal symptoms. **Dupixent:** *Diagnosis of moderate to severe persistent asthma:* • The patient must be 6 years of age or older AND • The patient must have an eosinophilic phenotype as defined by pre-treatment blood eosinophil count of ≥ 150 cells per mcL within the previous 6 weeks or ≥ 300 cells per mcL within 12 months prior to initiation of therapy OR the patient is dependent on oral corticosteroids. • The patient has a history of uncontrolled asthma symptoms (symptoms occurring almost daily or waking at night with asthma at least once a week) or 2 or more exacerbations in the previous year despite regular use of medium-high dose ICS/LABA for a minimum of 3 consecutive months, with or without oral corticosteroids. Pharmacy claims will be evaluated to assess compliance with therapy. AND • The prescriber is an allergist, immunologist, or pulmonologist AND • For continuation of therapy after the initial 6-month authorization, the patient must continue to receive therapy with an ICS/LABA AND have either a decreased frequency of exacerbations OR decreased use of maintenance oral corticosteroids OR reduction in the signs and symptoms of asthma OR an increase in predicted FEV1 from baseline. *Diagnosis of Chronic Rhinosinusitis with Nasal Polyps:* • Patient is 18 years of age or older AND • Prescriber is an allergist or ENT specialist AND • Patient has had an inadequate response to at least a 3-month trial of 2 different nasal corticosteroids AND • Patient has had an inadequate response to at least a 10–14-day course of oral corticosteroids AND • Patient will use Dupixent concurrently with an intranasal corticosteroid • For continuation of therapy after the initial 6-month authorization, the patient must continue to receive therapy with an intranasal corticosteroid AND there must be documented improvement in nasal symptoms. *Diagnosis of Eosinophilic Esophagitis:* • Patient is 12 years of age or older, weighing at least 40kg AND • Prescriber is an allergist or gastroenterologist AND • Diagnosis is confirmed by endoscopic esophageal biopsy showing ≥ 15 intraepithelial eosinophils per high-power field AND • Symptoms of esophageal dysfunction are present (e.g. pain while swallowing, sensation of food being stuck in the throat or chest) AND • The patient has had an inadequate response after a minimum trial of 8 weeks to at least one of the following: swallowed topical corticosteroids (e.g. Budesonide) or high-dose proton inhibitor.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		• For continuation of therapy after the initial 6-month authorization, there must be documented improvement in EoE symptoms. *Diagnosisis is Prurigo Nodularis:* • The patient must be 18 years of age or older AND • Diagnosis is confirmed based on the following: chronic pruritis lasting ≥ 6 weeks, history and/or signs of repeated scratching, and multiple localized or generalized pruriginous skin lesions (e.g. whitish or pink papules, nodules and/or plaques) AND • The patient has had a documented side effect, allergy, or treatment failure (defined as daily treatment for at least one month) with at least one moderate to high potency topical corticosteroid and one preferred topical calcineurin inhibitor within the last 6 months • For continuation of therapy after the initial 6-month authorization, there must be documented improvement in PN symptoms. **Limitations:** Dupixent®, Fasenra®, Nucala® and Cinqair® will not be considered in patients with a diagnosis of moderate to severe persistent asthma who are currently smoking or in combination with omalizumab or Tezepelumab. **Tezspire:** • The patient must be 12 years of age or older AND • The patient has a history of uncontrolled asthma symptoms (symptoms occurring almost daily or waking at night with asthma at least once a week) or 2 or more exacerbations in the previous year despite regular use of medium-high dose ICS/LABA for a minimum of 3 consecutive months, with or without oral corticosteroids. Pharmacy claims will be evaluated to assess compliance with therapy. AND • The prescriber is an allergist, immunologist, or pulmonologist AND • If the patient has an eosinophilic phenotype (as defined by pretreatment blood eosinophil count of ≥ 150 cells per mcL within the previous 6 weeks or ≥ 300 cells per mcL within 12 months prior to initiation of therapy), there must have been a documented side effect, allergy, or treatment failure with Dupixent or Nucala AND • For continuation of therapy after the initial 6-month authorization, the patient must continue to receive therapy with an ICS/LABA AND have either a decreased frequency of exacerbations OR decreased use of maintenance oral corticosteroids OR reduction in the signs and symptoms of asthma OR an increase in predicted FEV1 from baseline. **Limitations:** Tezspire will not be considered in patients who are currently smoking or in combination with anti-IgE, anti-IL4, or anti-IL5 monoclonal antibodies.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
IMMUNOSUPPRESANTS, ORAL		
AZATHIOPRINE tablet CYCLOSPORINE capsule CYCLOSPORINE MODIFIED MYCOPHENOLATE MOFETIL tablet, capsule, suspension MYCOPHENOLIC ACID delayed release tablet SIROLIMUS tablet TACROLIMUS capsule	Astagraf® XL (tacrolimus) capsule Azasan® (azathioprine) tablet Cellcept® (mycophenolate mofetil) tablet, capsule, suspension Envarsus® XR (tacrolimus) tablet Everolimus (compare to Zortress®) tablet Gengraf® (cyclosporine modified) capsule, solution Imuran® (azathioprine) tablet Lupkynis™ (voclosporin) capsule Myfortic® (mycophenolic acid) delayed release tablet Neoral® (cyclosporine modified) capsule, solution Prograf® (tacrolimus) capsule, granules for suspension Rapamune® (sirolimus) tablet, solution Rezurock™ (belumosudil) tablet Sandimmune® (cyclosporine) capsule, solution Zortress® (everolimus) tablet	**Criteria (except Lupkynis and Rezurock):** The patient has been started and stabilized on the requested product OR the patient has a documented side effect, allergy, or treatment failure to a preferred agent (if a product has and AB rated generic, there must be a trial of the generic formulation). **Lupkynis:** • The patient has a diagnosis of Systemic Lupus Erythematosus (SLE) AND • The patient has active Lupus Nephritis confirmed by urine/blood tests or kidney biopsy AND • The patient is ≥ 18 years of age AND • Medication is prescribed by, or in consultation with, a nephrologist or rheumatologist AND • The patient has clinical progression (e.g. worsening of proteinuria or serum creatinine) after 3 months of induction therapy with corticosteroids plus cyclophosphamide or mycophenolate mofetil OR failure to respond after 6 months of induction therapy with corticosteroids plus cyclophosphamide or mycophenolate mofetil AND • Medication will be used in combination with background immunosuppressive therapy (e.g. mycophenolate mofetil and systemic corticosteroids) AND • The patient has a documented intolerance or treatment failure with Benlysta **Rezurock:** • The patient is ≥ 12 years of age AND • The patient has a diagnosis of Chronic Graft-versus-host disease AND • The patient has had a treatment failure with at least 2 prior courses of systemic immunosuppressant therapy (e.g. Corticosteroids, rituximab) AND • The prescriber attests to monthly monitoring of liver function tests (total bilirubin, AST, and ALT)
CRYOPYRIN ASSOCIATED PERIODIC SYNDROMES (CAPS) AND PERIODIC FEVER SYNDROME (PFS)		
All Products Require PA	Arcalyst® (rilonacept) *QTY LIMIT:* 2 vials for loading dose, then 1 vial per Week Ilaris® (canakinumab)	**Ilaris:** The diagnosis is Cryopyrin-Associated Periodic Syndrome (CAPS) OR The diagnosis is Familial Cold Autoinflammatory Syndrome (FCAS), Familial Mediterranean Fever (FMF), Hyper-IgD periodic fever syndrome (HIDS), Muckle-Wells Syndrome (MWS), or Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS) AND The patient is > 4 years old

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		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 **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.
IRON CHELATING AGENTS		
DEFERASIROX tablet	Deferasirox dispersible tablet, granule pack Deferiprone tablet Exjade® (defarasirox) dispersible tablet Ferripirox® (deferiprone) tablet, solution Jadenu®(deferasirox) tablet, granule pack	**Deferasirox dispersible tablet, Exjade dispersible tablet:** The patient has a medical necessity for a non-solid oral dosage form AND for approval of Exjade, the patient has a documented intolerance to generic deferasirox dispersible tablets. **Deferiprone tablet, Ferriprox tablet, Jadenu tablet:** the patient has a documented intolerance to generic deferasirox tablets **Deferasirox granule pack, Ferripirox solution, Jadenu granule pack:** The patient has a medical necessity for a non-solid oral dosage form AND The patient has a documented intolerance to generic deferasirox dispersible tablets.
LIPOTROPICS		
BILE ACID SEQUESTRANTS		
CHOLESTYRAMINE powder (compare to Questran®) CHOLESTYRAMINE LIGHT powder (compare to Questran Light®) COLESTIPOL tablets (compare to Colestid®) WELCHOL® (colesevelam) tablets, powder packets	Colesevelam (compare to Welchol®) Colestid® tablets, granules (colestipol) Colestipol granules, packets Prevalite powder (cholestyramine light) Questran®powder (cholestyramine) Questran Light® powder (cholestyramine light)	**Colesevelam:** The patient has had a documented intolerance to the brand name equivalent. **Colestipol granules, packets:** The patient has a documented side effect, allery, or treatment failure with two preferred bile acid sequestrants. **Prevalite, Questran, Questran Light, Colestid:** The patient has had a documented intolerance to the preferred generic formulation.
FIBRIC ACID DERIVATIVES		
GEMFIBROZIL (compare to Lopid®) 600 mg FENOFIBRATE MICRONIZED CAPSULE (compare to Lofibra® capsules) 67 mg, 134 mg, 200 mg FENOFIBRATE NANOCRYSTALIZED (compare to	Antara® (fenofibrate micronized) 30 mg, 43 mg, 90 mg, 130 mg F Fenofibrate capsule (compare to (Lipofen®) 50 mg,	**Lopid:** The patient has had a documented intolerance to generic gemfibrozil. **All other non-preferred medications:** The patient has had a documented side effect, allergy, or treatment failure with two preferred fibric acid derivatives (If a product has an AB rated generic, there must have been a trial with the generic

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
Tricor®) 48 mg, 145 mg tablets FENOFIBRATE TABLETS (compare to Lofibra® tablets) 54 mg, 160 mg	150 mg Fenofibrate micronized (compare to Antara®) 43 mg, 130 mg Fenofibric acid (compare to Trilipix) 45 mg, 135 mg delayed release capsule Fenofibric acid 35 mg, 105 mg *QTY LIMIT:* 1 capsule/day Fenoglide® (fenofibrate MeltDose) 40 mg, 120 mg Lipofen® (fenofibrate) 50 mg, 150 mg Lopid® (gemfibrozil) 600 mg Tricor® (fenofibrate nanocrystallized) 48 mg, 145 mg Trilipix (fenofibric acid) 45 mg, 135 mg delayed release capsule	formulation.)
MISC. HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMA (HoFH) AGENTS		
All products require PA	Evkeeza™ (evinacumab-dgnb) intravenous solution Juxtapid® (lomitapide) Capsule *QTY LIMIT:* 5 and 10 mg caps = 1/day, 20 mg cap = 3/day Maximum day supply per fill is 28 days	**CRITERIA FOR APPROVAL:** • Total cholesterol levels > 290mg/dL or LDL-C > 190mg/dL (adults) OR Total cholesterol levels > 260mg/dL or LDL-C > 155mg/dL (children < 16 years) and TG within reference range or Confirmation of diagnosis by gene testing AND • Documented adherence to prescribed lipid lowering medications for the previous 90 days AND • Recommended or prescribed by a lipidologist or Cardiologist AND • Inability to reach goal LDL-C despite a trial of 2 or more maximum tolerated dose of statins (one of which must be atorvastatin or rosuvastatin), ezetimibe 10mg daily, and Repatha
NICOTINIC ACID DERIVATIVES		
NIACIN NIACIN extended release		
STATINS		
ATORVASTATIN (compare to Lipitor®) LOVASTATIN PRAVASTATIN ROSUVASTATIN (compare to Crestor®) SIMVASTATIN (compare to Zocor®) **Note:** All preferred agents have a quantity limit of	Altoprev® (lovastatin SR) Atorvaliq® (atorvastatin) oral suspension Crestor® (rosuvastatin) Ezallor ® (rosuvastatin) sprinkle capsule Fluvastatin Fluvastatin ER (compare to Lescol® XL) Lescol® XL (fluvastatin ER) Lipitor® (atorvastatin)	**Non-preferred agents (except as noted below):** The patient must have a documented side effect, allergy, or treatment failure to 3 preferred statins. If the product has an AB rated generic, one trial must be the generic formulation. **Atorvaliq, Ezallor:** medical necessity for a specialty dosage form has been provided. **Zypitamag:** The patient must have a documented side effect, allergy, or treatment

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
1 tablet/day except Lovastatin 40mg which has a quantity limit of 2 tablets/day	Livalo® (pitavastatin) Zocor® (simvastatin) Zypitamag™ (pitavastatin) **Note:** All non-preferred agents have a quantity limit of 1 tablet/day except fluvastatin IR which has a quantity limit of 2 tablets/day.	failure to 3 preferred statins AND clinical justification is provided documenting why the patient is unable to use Livalo. **LIMITATIONS: Simvastatin 80 mg:** initiation of simvastatin 80 mg or titration to 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		
Ezetimibe (compare to Zetia®) *QTY LIMIT:* 1 tab/day Omega-3-acid ethyl esters (compare to Lovaza®) Ezetimibe/simvastatin (compare to Vytorin®) 10/10 mg, 10/20mg, and 10/40mg *QTY LIMIT: 1 tab/day*	Amlodipine/atorvastatin (compare to Caduet®) *QTY LIMIT:* 1 tab/day Caduet® (atorvastatin/amlodipine) *QTY LIMIT:* 1 tab/day Ezetimibe/simvastatin (compare to Vytorin®) 10/80mg strength only Icosapent Ethyl (compare to Vascepa®) *QTY LIMIT:* 4 caps/day Lovaza® (omega-3-acid ethyl esters) Omega-3-acid ethyl esters (compare to Lovaza®) Nexletol® (bempedoic acid) *QTY LIMIT: 1 tab/day* Nexlizet® (bempedoic acid/ezetimibe) *QTY LIMIT: 1 tab/day* Vascepa® (icosapent ethyl) *QTY LIMIT:* 4 caps/day Vytorin® (ezetimibe/simvastatin) *QTY LIMIT:* 1 tab/day Zetia® (ezetimibe) *QTY LIMIT:* 1 tab/day	**Lovaza, Vytorin, Zetia:** patient must have a documented intolerance to the generic equivalent. **Icosapent Ethyl, Vascepa:** *Indication for use is severe hypertriglyceridemia:* • The patient has pre-treatment triglyceride levels > 500 mg/dL AND • The patient has a documented contraindication, side effect, allergy, or treatment failure to Omega-3-acid ethyl esters. *Indication for use is cardiovascular risk reduction:* • The patient has pre-treatment triglyceride levels > 150 mg/dL AND • The patient is receiving adjunct therapy with a maximally tolerated high intensity statin AND • For approval of icosapent ethyl, the patient has had a documented intolerance to brand Vascepa **Amlodipine/atorvastatin, Caduet:** The patient is unable to take the individual separate agents AND for approval of Caduet, the patient must have also had a documented intolerance to the generic equivalent. **Nexletol, Nexlizet:** The patient has had an inadequate response to a 3-month trial of atorvastatin or rosuvastatin OR Patient has demonstrated statin intolerability as defined by statin-related rhabdomyolysis or skeletal related muscle symptoms AND Patient (if eligible) will continue adjunct therapy with maximally tolerated high intensity statin. If patient is using simvastatin, dose should not exceed 20 mg/day; if patient is using pravastatin, dose should not exceed 40 mg/day **Ezetimibe/simvastatin (10/80):** the patient has been taking this dose for 12 or more months without evidence of muscle toxicity.
PCSK9 INHIBITORS		
Preferred After Clinical Criteria Are Met		**Criteria for approval:**

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
PRALUENT® (alirocumab) *QTY LIMIT:* 2ml (75 mg injection every 2 weeks or 300 mg every month)/28 days Max 28-day supply REPATHA® (evolocumab) Sureclick, prefilled syringe QTY LIMIT: 2ml (2 injections)/28 days Max 28-day supply REPATHA® (evolocumab) Pushtronix™ QTY LIMIT: 3.5ml (One single-use infusor and prefilled cartridge)/28 days, Max 28-day supply	Leqvio® (inclisiran) prefilled syringe	• The patient's age is FDA approved for the given indication AND • Concurrent use with statin therapy AND • Documented adherence to prescribed lipid lowering medications for the previous 90 days AND • Inability to reach goal LDL-C despite a trial of 2 or more maximum tolerated dose of statins (one of which must be atorvastatin or rosuvastatin) • For approval of Leqvio, the patient must have a documented side effect, allergy, or treatment failure (defined as inability to get within 10% of stated LDL-C goal, not to exceed guideline recognized goals) with a minimum 12-week trial of both Praluent and Repatha.
MISCELLANEOUS		
KUVAN® (sapropterin) 100mg, 500mg powder PYRIDOSTIGMINE BROMIDE (Compare to Mestinon) SAPROPTERIN 100mg powder TRANEXAMIC ACID (compare to Lysteda®) *QTY LIMIT:* 30 tablets/28 days FENSOLVI® (leuprolide acetate) subcutaneous injection *QTY LIMIT:* 1 vial every 6 months ***Preferred After Clinical Criteria Are Met*** CARGLUMIC ACID (compare to Carbaglu®) dispersible tablets CRYSVITA® (burosumab-twza) FABRAZYME (agalsidase beta) IV	Brineura™ (cerliponase alfa) *QTY LIMIT:* 1 package per 14 days (Brineura Injection, 2 vials of 150mg/5ml, and Intraventricular Electrolytes Injection, 1 vial of 5ml) Carbaglu® dispersible tablets (carglumic acid) Daybue™ (trofinetide) solution *QTY LIMIT:* 120 mL/day Elaprase® (idursulfase) *QTY LIMIT:* calculated dose/week Firdapse® (amifampridine) *QTY LIMIT:* 8 tablets/day Galafold™ (migalastat) *QTY LIMIT:* 14 caps/28 days Maximum day supply = 28 days Gamifant® (emapalumab-lzsg) Hyftor™ (sirolimus) topical gel Korsuva® (difelikefalin) Kuvan (sapropterin) tablets Hydroxyprogesterone caproate 250 mg/ml vial (intramuscular injection) Luxturna® (voretigine neparvovec-rzyl) suspension for subretinal injection *QTY LIMIT:* one injection per eye per lifetime Lysteda® tablets (tranexamic acid)	**Brineura:** • Patient is 3 years of age or older AND • The diagnosis or indication is late infantile neuronal ceroid lipofuscinosis type 2 (CLN2), confirmed by deficiency of the lysosomal enzyme tripeptidyl peptidase-1 (TPP1) (results of genetic testing must be submitted AND • The prescriber is a neurologist or other physician specializing in intraventricular administration **Note:** Bineura will be approved as a medical benefit ONLY and will NOT be approved if billed through pharmacy point of sale. Initial approval will be granted for 3 months. Renewal may be granted for up to 12 months. For therapy continuation, clinical documentation must be submitted documenting improvement or maintenance of motor ability OR slower progression of disease than would otherwise be expected AND a 12-lead ECG evaluation is performed every 6 months. **Carbaglu, Carglumic Acid:** The diagnosis or indication for the requested medication is hyperammonemia due to N-acetylglutamate synthetase (NAGS) deficiency, propionic acidemia, or methylmalonic acidemia AND The prescriber is a specialist in metabolic disorders (e.g., medical geneticist) or prescriber is in consultation with a specialist AND for approval of brand name Carbaglu, the patient has had a documented intolerance to the generic equivalent of the requested medication. **Crysvita:**

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	QTY LIMIT: 30 tablets/28 days Mestinon® Myalept® (metreleptin) vial for subcutaneous injection *QTY LIMIT:* one vial/day Maximum day supply per fill = 30 days Oxlumo™ (lumasiran) Palynziq™ (pegvaliase-pqpz) Ruzurgi® (amifampridine) *QTY LIMIT:* 10 tablets/day Sapropterin (compare to Kuvan®) tablets, 500mg powder Tepezza® (teprotumumab-trbw) vial for IV infusion Vyvgart® (efgartigimod alfa-fcab) IV solution Xatmep™ (methotrexate) oral solution Zinplava™ (Bezlotoxumab) injection Zokinvy® (lonafarnib) capsule	• Patient is ≥ 1 year of age AND • Patient has a diagnosis of X-linked hypophosphatemia AND • Medication is prescribed by or in consultation with an endocrinologist or nephrologist AND • Patient has not received oral phosphate or vitamin D analogs within 1 week prior to starting therapy AND • Baseline fasting serum phosphorous level is below the lower limit of the laboratory normal reference range AND • Patient does not have severe renal impairment, defined as a GFR of < 30mL/min AND • Dose does not exceed 90mg every 14 days (pediatrics) or 90mg every 28 days (adults) **Note:** Initial approval will be granted for 6 months. Renewal may be granted for up to 1 year. For therapy continuation, patient must have disease response as indicated by one of the following: • Increased serum phosphate levels, not exceeding the upper limit of the laboratory normal range. • A reduction in serum total alkaline phosphatase activity. • Improvement in symptoms (e.g. skeletal pain, linear growth, etc.). • Improvement in radiographic imaging of Rickets/osteomalacia. **Daybue:** • The patient is ≥ 2 years of age. • The prescription is initiated by or in consultation with a neurologist or other developmental specialist. • The patient has a diagnosis of typical Rett syndrome per the Rett Syndrome Diagnostic Criteria (must meet ALL): ○ Partial or complete loss of acquired purposeful hand skills. ○ Partial or complete loss of acquired spoken language. ○ Gait abnormalities: Impaired (dyspraxic) or absence of ability. ○ Stereotypic hand movements such as hand wringing/squeezing, clapping/tapping, mouthing, and washing/rubbing automatisms. • The patient does not have any of the Exclusion Criteria: ○ Brain injury secondary to trauma (peri- or postnatally), neurometabolic disease, or severe infection that causes neurological problems. ○ Grossly abnormal psychomotor development in first 6 months of life • The patient has a documented disease-causing mutation in the *MECP2* gene. • The patient is not using any insulin. • Detailed clinical baseline has been provided using an objective measure or tool (Rett Syndrome Behavior Questionnaire (RSBQ)). • Initial approval will be granted for 3 months. For reapproval, the patient

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		must have a documented clinical improvement in disease as evidenced by ≥ 10% reduction in the RSBQ questionnaire score. Patients with a baseline RSBQ score of ≤ 30 must have at least a ≥ 3-point reduction AND The patient has not experienced significant weight loss (>5% from baseline). **Elaprase (Hunter's Syndrome Injectable**): The diagnosis or indication for the requested medication is Hunter's Syndrome **Fabrazyme:** Diagnosis or indication is Fabry Disease. **Firdapse, Ruzurgi:** patient has a diagnosis of Lambert-Eaton myasthenic syndrome (LEMS) AND prescription is initiated by or in consultation with a neurologist AND patient does not have a history of seizures AND for approval of Firdapse, the patient must have a documented intolerance to Ruzurgi. Initial approval will be granted for 3 months with documentation of the patient's baseline clinical muscle strength assessment using a standardized rating scale. For re-approval after 3 months, the patient must have improved, or stable symptoms documented with the appropriate standardized rating scale **Galafold:** Patient is ≥ 18 years of age AND Diagnosis or indication is Fabry Disease with an amenable galactosidase alpha (GLA) gene variant for treatment (results must be submitted) AND enzyme replacement therapy is not a therapeutic option (e.g. due to allergy, hypersensitivity, or poor venous access). **Gamifant**: the patient has a diagnosis of primary hemophagocytic lymphohistiocytosis (HLH) with refractory, recurrent, or progressive disease or intolerance with conventional HLH therapy (e.g. etoposide + dexamethasone) AND the patient is a candidate for a stem cell transplant AND Gamifant will be administered in combination with dexamethasone **Hyftor:** The patient has 3 or more angiofibromas (≥ 2mm in diameter with redness in each) on the face, associated with tuberous sclerosis AND the patient has completed all ACIP recommended age-appropriate vaccinations prior to starting therapy. Initial approval will be granted for 3 months. For re-approval, there must be documented reduction in the size and redness of angiofibromas from baseline. **Korsuva:** The patient has a diagnosis of moderate-to-severe pruritis associated with chronic kidney disease AND the patient is receiving hemodialysis AND the patient has a documented side effect, allergy, or treatment failure with at least 1 topical and 1 systemic pruritis treatment (e.g. antihistamines, corticosteroids, gabapentin, pregabalin, capsaicin) **Kuvan tabs, Sapropterin tabs:** patient has a documented intolerance to the powder formulation.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		Luxturna: patient must have inherited retinal dystrophy due to mutations in both copies of the RPE65 gene (results of genetic testing must be submitted) AND patient has sufficient viable retinal cells as determined by the treating physician(s) AND Luxturna will be administered by a retinal specialist;/surgeon experienced in performing intraocular surgery and associated with an Ocular Gene Therapy Treatment Center. **Lysteda** the patient has had a documented intolerance to the generic product. **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: Insulin resistance (defined 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. 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. **Oxlumo:** The patient has a diagnosis of Primary Hyperoxaluria Type I (PH1) confirmed via genetic testing (identification of alanine: glyoxylate aminotransferase gene (AGXT) mutation) AND urinary oxalate excretion > 0.5mmol/1.73 m^2 or urinary oxalate: creatinine ratio is above the upper limit of normal for age AND medication is being prescribed by, or in consultation, with a nephrologist or urologist AND patient has not previously received a liver transplant **Palynziq:** Patient is 18 years of age or older AND has a diagnosis of phenylketonuria AND has uncontrolled blood phenylalanine (PHE) concentrations (> 600 micromol/L) on existing management, including restricting dietary phenylalanine and protein intake and treatment with sapropterin. For re-approval, the patient must have achieved at least a 20% reduction in PHE concentration from pre-treatment baseline or a PHE ≤ 600 micromol/L after 16 weeks of continuous treatment with the maximum dosage of 40mg daily. **Note:** Palynziq has a black box warning for anaphylaxis which can occur at any time during treatment. Patients, pharmacies, and physicians must be enrolled in the Palynziq REMS program AND concurrent auto-injectable epinephrine must be prescribed. **Note:** Initial approval will be granted for 4 loading doses (the first 3 loading doses should be administered at 14-day intervals; the 4th loading dose should be administered 30 days after the 3rd dose). Renewal may be granted for up to 12 months with a maximum of 3 doses approved per year (12mg(5ml) every 4 months). For therapy continuation, clinical documentation must be

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		submitted documenting improvement or maintenance of motor ability OR slower progression of disease than would otherwise be expected. **Sapropterin 500mg powder:** patient has a documented intolerance to brand Kuvan **Tepezza:** • Patient has a diagnosis of Thyroid Eye Disease (TED) related to Graves' Disease AND • Patient has a baseline Clinical Activity Score (CAS) ≥ 4 in the most severely affected eye AND • Patient has active TED associated with at least one of the following: o Lid retraction ≥ 2 mm o Moderate or severe soft tissue involvement o Exophthalmos ≥ 3 mm above normal for race and gender o Diplopia (double vision) • Patient is euthyroid, defined as free triiodothyronine (T3) and thyroxine (T4) levels within the normal limits, OR Patient has free T3 and T4 levels less than 50% above or below the normal limits and is undergoing treatment to correct the hypo- or hyperthyroidism to maintain a euthyroid state AND • Patient has had an inadequate response or contraindication to high-dose intravenous glucocorticoid therapy. **Vyvgart:** • Patient is ≥ 18 years of age AND • Patient has a diagnosis of generalized Myasthenia Gravis with Myasthenia Gravis Foundation of America (MGFA) clinical classification class II to IV AND • Patient is anti-acetylcholine receptor (AChR) positive AND • MG-Activities of Daily Living (MG-ADL) total score of ≥5 at baseline AND • Patient has IgG levels of at least 6g/L AND • Patient has had an inadequate response with at least 2 immunosuppressive therapies (e.g. corticosteroids, azathioprine, cyclosporine, mycophenolate) over the course of at least 12 months AND • Dose does not exceed 10mg/kg weekly; maximum of four doses per 50 days For re-approval, the patient must have had a positive response to therapy as evidenced by a 2-point reduction in the MG-ADL score. **Xatmep:** The patient has a diagnosis of polyarticular juvenile idiopathic arthritis or acute lymphoblastic leukemia (ALL) AND patient has a requirement for an oral liquid dosage form (i.e. swallowing disorder, inability to take oral medications) **Zinplava:**

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		• The patient is 18 years of age or older AND • The patient has a diagnosis of *Clostridium difficile* infection (CDI) confirmed by a positive stool test collected within the past 7 days AND • The patient is or will receive concomitant Standard of Care antibacterial therapy for CDI (e.g. metronidazole, vancomycin, or fidaxomicin) AND • The patient is at high risk for recurrence based on at least one of the following: o Age ≥ 65 years o Two or more episodes of CDI within the past 6 months o The patient is immunocompromised o The patient has clinically severe CDI (e.g. fever, abdominal tenderness, WBC ≥ 15,000 cells/mm^3, albumin <30g/L, or renal failure) **Zokinvy:** The patient meets FDA approved age and BSA AND the patient has a diagnosis of Hutchinson-Gilford Progeria Syndrome (HGPS) OR the patient has a diagnosis of processing-deficient Progeroid Laminopathies with documentation of either Heterozygous LMNA mutation with progerin-like protein accumulation or Homozygous or compound heterozygous ZMPSTE24 mutations. **Note:** A single-dose of 10mg/kg will be approved per active CDI. A repeat dose will not be approved for recurrence of the same active infection.
AMYOTROPHIC LATERAL SCLEROSIS (ALS)		
RILUZOLE (Compare to Rilutek®)	Exservan™ (riluzole) film Radicava® (edaravone) IV injection Relyvrio™ (sodium phenylbutyrate/taurursodiol) powder for suspension *QTY LIMIT*: 2 packets/day Rilutek® (riluzole) Tiglutik™ (riluzole) suspension	**Exservan, Tiglutik**: patient must be unable to take whole or crushed Riluzole tablets **Radicava:** • The diagnosis is amyotrophic lateral sclerosis (ALS) AND • Disease duration is ≤ 2 years AND • Patient has functionally retained most activities of daily living AND • Patient has normal respiratory function (defined as a % predicted forced vital capacity of ≥ 80%) AND • Patient does not have a sulfite allergy AND • Initial approval will be granted for 14 doses/28 days and all subsequent approvals will be for 10 doses/28 days **Relyvrio:** • The diagnosis is amyotrophic lateral sclerosis (ALS) • AND Disease duration is ≤ 18 months AND • The patient has a slow vital capacity (SVC) spirometry test of greater than

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		60% of predicted at screening AND • Baseline ALS Functional Rating Scale-Revised (ALSFRS-R) total score has been completed AND • Initial approval will be granted for 6 months. For reapproval, clinical notes must indicate there has been improved or maintained baseline functional ability as measured by ALSFRS-R scale. **Rilutek:** patient must have a documented intolerance with riluzole.
COMPLEMENT INHIBITORS		
All products require PA	Enjaymo™ (sutimlimab-jome) Empaveli™ (pegcetacoplan) subcutaneous solution *QTY LIMIT: 8 vials/28 days* Soliris® (eculizumab) vial Ultomiris® (ravulizumab-cwvz)	**Enjaymo:** The patient has a diagnosis of cold agglutinin syndrome (CAD) AND the patient does not have an active chronic systemic infection (e.g. Hepatitis B, Hepatitis C, HIV) AND the medication is prescribed by, or in consultation with, a hematologist AND the patient has had at least one blood transfusion in the 6 months prior to starting Enjaymo AND the patient has received the pneumococcal, Haemophilus influenzae, and meningococcal vaccines 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 (e.g. stabilization of hemoglobin levels, reductions in transfusions, improvement in hemolysis, etc.) **Empaveli:** 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. Authorization for continued use shall be reviewed to confirm that the patient has experienced an objective response to the therapy (e.g. stabilization of hemoglobin levels, reductions in transfusions, improvement in hemolysis, etc.). **Note:** For patients switching from eculizumab, an additional 4 weeks of eculizumab will be approved before continuing monotherapy with Empaveli. For patients switching from ravulizumab, Empaveli will be initiated no more than 4 weeks after the last dose of ravulizumab. Ongoing combination therapy of complement inhibitors will not be approved. **Soliris:** *Indication for use is Atypical Hemolytic Uremic Syndrome:* Dose requested must be within the FDA parameters for loading and maintenance dose *Indication for use is paroxysmal nocturnal hemoglobinuria (PNH):* Diagnosis is documented by flow cytometry 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 (e.g. stabilization of hemoglobin levels, reductions in transfusions, improvement in hemolysis, etc.)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		Indication for use is Myasthenia Gravis: The patient is anti-aceytlcholine receptor (AchR) antibody positive AND the patient has a documented side effect, allergy, or treatment failure with at least 2 immunosuppressive therapies (e.g. corticosteroids, azathioprine, cyclosporine, mycophenolate, etc.). **Ultomiris**: The patient has a diagnosis of Atypical Hemolytic Uremic Syndrome or 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. Authorization for continued use shall be reviewed to confirm that the patient has experienced an objective response to the therapy (e.g. stabilization of hemoglobin levels, reductions in transfusions, improvement in hemolysis, etc.) **Note:** Dose requested must be within the weight-based parameters for loading and maintenance dose
GLYCOPYRROLATE		
GLYCOPYRROLATE 1 mg, 2 mg tablets (compare to Robinul®, Robinul Forte®)	Cuvposa® oral solution (glycopyrrolate) Maximum days supply per fill is 30 days Dartisla ODT™ (glycopyrrolate) *QTY LIMIT* = 4 tabs/day Glycopyrrolate 1mg/5ml oral solution (compare to Cuvposa) Robinul® (glycopyrrolate) 1mg Robinul® Forte (glycopyrrolate) 2mg	**Cuvposa, Glycopyrrolate oral solution:** The patient has medical necessity for a non-solid oral dosage form OR the dose cannot be obtained from the tablet formulation. **Dartisla ODT:** The patient has been established on the 2mg dosage strength of another form of glycopyrrolate AND the patient has a documented intolerance to glycopyrrolate tablets and solution. **Robinul, Robinul Forte:** The patient has a documented intolerance to glycopyrrolate tablets.
INJECTABLE METHOTREXATE		
METHOTREXATE 25 MG/ML solution for injection	Otrexup® or Rasuvo® Single-dose auto-injector for subcutaneous use (methotrexate) QTY LIMIT: 4 syringes/28 days RediTrex® Prefilled syringe for subcutaneous use (methotrexate) QTY LIMIT: 4 syringes/28 days	**Otrexup, Rasuvo, Reditrex:** 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 preferred form of injectable methotrexate (includes difficulty with manual dexterity)
Immunoglobulin A Nephropathy (IgAN) Agents		
All products require PA	Filspari™ (sparsentan) tablet *QTY LIMIT:* 1 tablet/day Tarpeyo™ (budesonide) delayed release capsule	**Filspari, Tarpeyo:** • The patient has a diagnosis of Immunoglobulin A Nephropathy (IgAN) confirmed by biopsy AND • eGFR ≥ is 35ml/min/1.73m2 AND • The patient meets one of the following: Proteinuria ≥ 1g/day or Urine protein-to-creatinine ratio (UPCR) ≥ 1.5 g/g AND • The patient is on a stable dose of maximally tolerated ACE-I or ARB therapy for a minimum of 3 months AND • The patient's kidney function has continued to decline despite treatment with a preferred oral corticosteroid AND • Duration of therapy does not exceed 9 months (Tarpeyo only) • The presciber, patient, and pharmacy are enrolled in the REMS program (Filspari only)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
MINERALOCORTICOID RECEPTOR ANTAGONISTS		
EPLERENONE SPIRONOLACTONE	Aldactone® (spironolactone) CaroSpir® (spironolactone) oral suspension Inspra® (eplerenone) Kerendia® (finerenone)	**Aldactone, Inspra:** The patient has a documented intolerance to the generic formulation **Carospir:** patient has a medical necessity for a specialty dosage form (i.e. dysphagia, swallowing disorder). **Kerendia:** The patient has a diagnosis of chronic kidney disease (CKD) associated with Type II Diabetes AND the estimated glomerular filtration rate at baseline is ≥ 25 mL/min/1.73m2 AND the urine albumin-to-creatinine ratio is ≥ 30mg/g AND the patient is currently receiving, or has a contraindication to, an ACE inhibitor or angiotensin receptor blocker (ARB)
NEUROMYELITIS OPTICA SPECTRUM DISORDERS (NMOSD)		
All Products Require PA	Enspryng® (satralizumab-mwge) prefilled syringe QTY LIMIT = 3/28 days for the first month then 1/28 days thereafter Soliris® (eculizumab) vial Uplizna® (inebilizumab-cdon) vial QTY LIMIT = 300mg x 2 doses for the first 2 weeks then 300mg every 6 months thereafter	**Enspryng, Soliris, Uplizna:** • The patient is ≥ 18 years AND • Diagnosis or indication is the treatment of neuromyelitis optica spectrum disorder (NMOSD) AND • Patient is anti aquaporin-4 (AQP4) antibody positive AND • Patient has a history of one or more relapses that required rescue therapy within the year prior to screening, or 2 or more relapses that required rescue therapy in 2 years prior to screening AND • Patient must have a documented side effect, allergy, treatment failure, or contraindication to rituximab. • Initial approval will be granted for 6 months. Renewal requires documentation of improvement or stabilization of neurologic symptoms such as a decrease in acute relapses, reduced hospitalization, or reduction in plasma exchange treatments. **Soliris, Uplizna additional criteria:** The patient must have a documented side effect, allergy, treatment failure or contraindication to Enspryng.
SOMATOSTATIN ANALOGS		
OCTREOTIDE ACETATE solution for injection SANDOSTATIN® (octreotide acetate) LAR Depot	Bynfezia® (octreotide) pen Mycapssa® (octreotide) capsule QTY LIMIT: 4 caps/day Sandostatin® (octreotide) solution for injection Somatuline® Depot Injection (lanreotide) *QTY LIMIT:* 60 mg syringe = 0.2 ml/28 days, 90 mg syringe = 0.3 ml/28 days, 120 mg = 0.5 ml/28 days	**Bynfezia, Sandostatin:** the patient has a documented intolerance to Octreotide injection. **Mycapssa:** the diagnosis or indication is long-term maintenance treatment of acromegaly AND the patient has already responded to and tolerated treatement with an injectable somatostatin alalog AND there is a clinically valid reason why the patient is unable to use Sandostatin LAR Depot. **Somatuline:** the patient has a documented side effect, allergy, treatment failure, or contraindication to Sandostatin LAR Depot.
SPINAL MUSCULAR ATROPHY		
Preferred After Clinical Criteria Are Met ZOLGENSMA® (onasemnogene abeparvovec-xioi) intravenous suspension	Evrysdi® (risdiplam) oral solution Spinraza (nusinersen) injection 12mg/5ml single-dose vial	**Evrysdi:** • The diagnosis is spinal muscular atrophy (SMA) AND • Patient is 2 months of age or older AND • Medication is prescribed per the dosing guidelines in the package insert AND

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		• A negative pregnancy test is obtained for females of reproductive potential prior to initiating therapy and patient has been advised to use effective contraception during treatment and for at least 1 month after her last dose AND • A patient who has been started on Spinraza will not be approved for Evrysdi until at least 3 months after the fifth dose (i.e. nine months after the first loading dose, three months after the fifth dose). Concurrent use will not be approved. **Note:** For therapy continuation, clinical documentation must be submitted documenting improvement or maintenance of motor ability OR slower disease progression than would otherwise be expected. **Spinraza:** • The diagnosis is spinal muscular atrophy (SMA) type 1,2, or 3 (results of genetic testing must be submitted) AND • The patient has at least 2 copies of the SMN2 gene AND • The need for invasive or noninvasive ventilation (if applicable) does not exceed more than 16 hours per 24 hour period AND • Baseline motor ability has been established using one of the following exams: o Hammersmith Infant Neurological Exam (HINE) o Hammersmith Functional Motor Scale Expanded (HFMSE) o Upper Limb Module Test (non-ambulatory) o Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND) AND • Prior to starting therapy, and prior to each dose, the following laboratory tests will be conducted: Platelet count, prothrombin time (PT), activated partial thromboplastin time (aPTT), and quantitative spot urine protein • Concurrent use with Evrysdi will not be approved. **Note:** Initial approval will be granted for 4 loading doses (the first 3 loading doses should be administered at 14-day intervals; the 4th loading dose should be administered 30 days after the 3rd dose). Renewal may be granted for up to 12 months with a maximum of 3 doses approved per year (12mg(5ml) every 4 months). For therapy continuation, clinical documentation must be submitted documenting improvement or maintenance of motor ability OR slower progression of disease than would otherwise be expected. **Zolgensma:** • The patient is less than 2 years of age AND • The diagnosis is spinal muscular atrophy (SMA) AND • The patient has bi-allelic mutations of the SMN1 gene AND • The patient does not have advanced SMA (e.g. complete paralysis of limbs or permanent ventilator dependence) AND • Medication is prescribed per the dosing guidelines in the package insert (recommended dose is 1.1×10^{4} vector genomes per kilogram) AND • Baseline anti-AAV9 antibodies are less than 1:50 AND • Prior to starting therapy and periodically for at least 3 months, the following laboratory tests will be conducted: Liver function (AST, ALT,

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		total bilirubin, prothrombin time), platelet counts, and troponin-I **Note:** The safety and effectiveness of repeat administration has not been evaluated. Approval is limited to a single intravenous infusion.
SYSTEMIC LUPUS ERYTHEMATOSUS (SLE)		
	Benlysta® (belimumab) Maximum days supply per fill = 28 days Saphnelo™ (anifrolumab-fnia)	**Benlysta:** *Indication for use is Systemic Lupus Erythematosus (SLE):* • 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, corticosteroids, azathioprine, methotrexate, mycophenolate mofetil AND • Initial approval will be granted for 3 months. For therapy continuation, clinical documentation must be submitted documenting stable disease activity OR reduction in disease activity or corticosteroid dose. **Note:** The efficacy of Benlysta® has not been evaluated in patients with 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. *Indication for use is Active Lupus Nephritis:* • Diagnosis has been confirmed by urine/blood tests or kidney biopsy AND • The patient is ≥ 18 years of age AND • Medication is prescribed by, or in consultation with, a nephrologist or rheumatologist AND • The patient has clinical progression (e.g. worsening of proteinuria or serum creatinine) after 3 months of induction therapy with corticosteroids plus cyclophosphamide or mycophenolate mofetil OR failure to respond after 6 months of induction therapy with corticosteroids plus cyclophosphamide or mycophenolate mofetil AND • Medication will be used in combination with background immunosuppressive therapy (e.g. mycophenolate mofetil and systemic corticosteroids) AND • Initial approval will be granted for 3 months. For therapy continuation, clinical documentation must be submitted documenting stable disease activity OR reduction in disease activity. **Saphnelo:** • The patient has a diagnosis of moderate-severe Systemic Lupus Erythematosus AND • The patient is ≥ 18 years of age AND • Medication is prescribed by, or in consultation with, a nephrologist or rheumatologist AND • The patient has had a documented inadequate response or intolerance to

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		at least TWO of the following agents: hydroxychloroquine, corticosteroids, azathioprine, methotrexate, mycophenolate mofetil AND • The patient has had a documented intolerance or treatment failure with Benlysta • Initial approval will be granted for 3 months. For therapy continuation, clinical documentation must be submitted documenting stable disease activity OR reduction in disease activity or corticosteroid dose. **Note:** The efficacy of Saphnelo has not been evaluated in patients with severe active lupus nephritis or severe active central nervous system lupus. Saphnelo has not been studied in combination with other biologics or intravenous cyclophosphamide. Use of Saphnelo is not recommended in these situations.
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

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
MOVEMENT DISORDERS		
Preferred After Clinical Criteria Are Met AUSTEDO® (deutetrabenazine) tablets *QTY LIMIT*: 48 mg/day Maximum 1-month supply per fill AUSTEDO XR® (deutetrabenazine) extended release tablets *QTY LIMIT:* 6 mg and 12 mg = 1 tablet/day; 24 mg = 2 tablets/day; Starter pack = 42 tablets/28 days Maximum 1-month supply per fill INGREZZA® (valbenazine tosylate) capsules *QTY LIMIT*: 80 mg/day Maximum 1-month supply per fill TETRABENAZINE (compare to Xenazine®) *QTY LIMIT:* 50 mg/day at initial approval (12.5 mg tablets ONLY), up to 100 mg/day at subsequent approvals (12.5 mg or 25 mg tablets) Maximum 1-month supply per fill	Xenazine® (tetrabenazine) tablets *QTY LIMIT:* 50 mg/day at initial approval (12.5 mg tablets ONLY), up to 100 mg/day at subsequent approvals (12.5 mg or 25 mg tablets) Maximum 1-month supply per fill	**Austedo, Austedo XR, Ingrezza:** The diagnosis or indication for the requested medication is Huntington's Disease (HD) with chorea or Tardive Dyskinesia (TD) AND the results of an Abnormal Involuntary Movement Scale (AIMS) exam have been submitted AND the patient is ≥18 years of age. For re-approval, there must be documented clinical improvement. **Tetrabenazine, Xenazine:** The diagnosis or indication for use is Tourette Syndrome OR the diagnosis or indication for use is Huntington's Disease (HD) with Chorea or Tardive Dyskinesia (TD) AND the patient is ≥18 years of age AND for approval of Xenazine, the patient must have a documented intolerance to tetrabenazine. **Note:** Austedo, Tetrabenazine, and Xenazine are contraindicated in patients with Huntington's Disease who are suicidal or with untreated/inadequately treated depression.
MULTIPLE SCLEROSIS MEDICATIONS		
INJECTABLES **INTERFERONS** AVONEX® (interferon B-1a) BETASERON® (interferon B-1b) REBIF® (interferon B-1a) REBIF® REBIDOSE (interferon B-1a) **OTHER** COPAXONE® 20 mg (glatiramer acetate) *QTY LIMIT:* 1 kit/30 days ***Preferred After Clinical Criteria are Met***	Briumvi™ (ublituximab-xiiy) Extavia® (interferon beta-1b) Copaxone® 40 mg (glatiramer) *QTY LIMIT:* 12 syringes (12 ml)/28 days Glatiramer Acetate (compare to Copaxone®)20 mg *QTY LIMIT:* 1 kit/30days Glatiramer Acetate (compare to Copaxone®) 40 mg *QTY LIMIT:* 12 syringes (12 ml)/28 days Glatopa® 20 mg (glatiramer acetate) *QTY LIMIT:* 1 carton (30 syringes/30 days	**Ampyra, Aubagio, Gilenya, Tecfidera:** patient must have a documented intolerance to the generic equivalent. **Bafiertam, Vumerity:** Patient is ≥ 18 years AND has a diagnosis of relapsing forms of Multiple Sclerosis AND the patient has a documented side effect, allergy, treatment failure, or contraindication to at least two preferred drugs, one of which must be Dimethyl fumarate. **Copaxone 40 mg Syringe:** 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. **Glatiramer, Glatopa:** Patient is ≥ 18 years AND diagnosis of relapsing forms of Multiple Sclerosis AND the provider provides a clinical reason why

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
TYSABRI® (natalizumab)	Glatopa® 40 mg (glatiramer) *QTY LIMIT:* 12 syringes (12 ml)/28 days Kesimpta® (ofatumumab) Lemtrada® (alemtuzumab) intravenous Ocrevus® (ocrelizumab) *QTY LIMIT:* 300 mg X 2 doses, then 600 mg every 6 months thereafter Plegridy® (peginterferon beta-1a)	Copaxone cannot be prescribed. **Mavenclad:** Patient is ≥ 18 years AND has a diagnosis of relapsing-remitting MS (RRMS) or active secondary progressive MS (SPMS) AND Documentation is provided showing ≥ 1 relapse within the past year AND baseline CBC w/ diff (including lymphocyte count), liver function tests, and MRI (within the past 3 months) have been completed AND the patient is negative for HIV, Hepatitis B, and Hepatitis C infections AND the patient is not pregnant AND patient has a documented side effect, allergy, treatment failure or contraindication to at least three preferred drugs AND dosing does not exceed any of the following: 2 tablets per day, 10 tablets per cycle, 2 treatment cycles per course, 1 course per year. Following the administration of 2 treatment courses, Mavenclad may not be administered during the next 2 years. **Mayzent, Ponvory, Zeposia:** *Diagnosis of relapsing-remitting MS, Clinical Isolated Syndrome, or Active Secondary Progressive MS (SPMS):* • Patient is ≥ 18 years AND • Patient CYP2C9 variant status has been tested to determine genotyping (Mayzent only; required for dosing; therapy is contraindicated in CYP2C9*3/*3) AND • Baseline CBC, electrocardiogram (ECG), and ophthalmic evaluation have been completed AND • Patient has a documented side effect, allergy, treatment failure or contraindication to at least two preferred drugs, one of which must be Fingolimod. **Briumvi, Kesimpta, Lemtrada, Ocrevus:** Patient is ≥18 years AND has a diagnosis of relapsing multiple sclerosis AND has a documented side effect, allergy, treatment failure or contraindication to at least two preferred drugs, one of which must be Tysabri, unless contraindicated. OR Patient is ≥18 years AND has a diagnosis of primary progressive multiple sclerosis (Ocrevus only). **Plegridy:** Patient is ≥ 18 years AND has a diagnosis of relapsing form of Multiple Sclerosis AND has a documented side effect, allergy, treatment failure or contraindication to at least three preferred drugs including at least one preferred form of interferon. **Tascenso ODT**: patient has a medical necessity for a non-solid oral dosage form. **Tysabri:** Patient is ≥ 18 years AND has a diagnosis of relapsing multiple sclerosis (including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease).
ORAL DALFAMPRIDINE ER tablet (compare to Ampyra®) *QTY LIMIT:* 2 tablets/day *M*aximum 30-day supply per fill DIMETHYL FUMARATE QTY LIMIT: 2 capsules/day Maximum 30-day supply per fill FINGOLIMOD capsule (compare to Gilenya®) *QTY LIMIT:* 1 capsule/day Maximum 30-day supply per fill TERIFLUNOMIDE (compare to Aubagio®) tablet *QTY LIMIT:* 1 tablet/day Maximum 30-day supply per fill	Ampyra® (dalfampridine ER) tablet *QTY LIMIT:* 2 tablets/day Maximum 30-day supply per fill Aubagio® (teriflunamide) tablet *QTY LIMIT:* 1 tablet/day Maximum 30-day supply per fill Bafiertam® (monomethyl fumarate) capsule QTY LIMIT: 4 capsules/day Maximum 30-day supply per fill Gilenya® (fingolimod) capsule *QTY LIMIT:* 1 capsule/day Maximum 30-day supply per fill Mavenclad® (cladribine) tablet Mayzent® (siponimod) tablet Ponvory™ (ponesimod) tablet *QTY LIMIT:* 1 tablet/day Maximum 30-day supply per fill Tascenso ODT® (fingolimod) *QTY LIMIT:* 1 capsule/day Maximum 30-day supply per fill Tecfidera® (dimethyl fumarate) *QTY LIMIT:* 2 capsules/day Maximum 30-day supply per fill Vumerity® (diroximel fumarate) capsule *QTY LIMIT:* 4 capsules/day Zeposia® (ozanimod) capsule *QTY LIMIT:* 1 capsule/day	

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
MUSCLE RELAXANTS, SKELETAL		
MUSCULOSKELETAL AGENTS **SINGLE AGENTS** CYCLOBENZAPRINE 5 mg, 10 mg tablets (compare to Flexeril®) *QTY LIMIT:* 5 mg = 6 tablets/day, 10 mg = 3 tablets/day METHOCARBAMOL tablets (compare to Robaxin®) *QTY LIMIT:* 8 tablets/day ORPHENADRINE CITRATE ER 100 mg tablet *QTY LIMIT:* 2 tablets/day **COMBINATION PRODUCT** All products require PA *ASA = aspirin* **ANTISPASTICITY AGENTS** BACLOFEN tablets DANTROLENE (compare to Dantrium®) TIZANIDINE (compare to Zanaflex®) tablets	Amrix® (cyclobenzaprine sustained-release) capsule *QTY LIMIT:* 1 capsule/day Carisoprodol tablets *QTY LIMIT:* 8 tablets/day Chlorzoxazone tablets *QTY LIMIT:* 4 tablets/day Cyclobenzaprine 7.5 mg tab (compare to Fexmid®) *QTY LIMIT:* 3 tablets/day Fexmid® (cyclobenzaprine) 7.5 mg tablet *QTY LIMIT:* 3 tablets/day Lorzone® (chlorzoxazone) tablets *QTY LIMIT:* 4 tablets/day Metaxalone (compare to Skelaxin®) tablets *QTY LIMIT:* 4 tablets/day Skelaxin® (metaxalone) tablets *QTY LIMIT:* 4 tablets/day Soma® (carisoprodol) tablets *QTY LIMIT:* 4 tablets/day *C*arisoprodol, ASA, codeine *QTY LIMIT:* 4 tablets/day Baclofen oral solution Dantrium® (dantrolene) Fleqsuvy™ (baclofen) oral suspension Lyvispah™ (baclofen) oral granule packet Tizanidine (compare to Zanaflex®) capsules Zanaflex® (tizanidine) capsules Zanaflex® (tizanidine) tablets	**Amrix, Cyclobenzaprine 7.5 mg, Fexmid**: The prescriber must provide a clinically valid reason why a preferred generic cyclobenzaprine 5mg or 10mg cannot be used. For approval of Fexmid, the patient must also have a documented intolerance to the generic equivalent. **Baclofen oral solution Fleqsuvy**: Patient has a medical necessity for a non-solid oral dosage form AND the patient has a documented intolerance to Lyvispah. **Carisoprodol, Carisoprodol/ASA/codeine, Chlorzoxazone, Lorzone, Soma, Metaxalone, 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. **Dantrium, Zanaflex tablets:** The patient must have a documented intolerance with the AB rated generic product. **Lyvispah:** Patient has a meical necessity for the non-solid oral dosage form. **Tizanidine 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 generic tizanidine capsules
MUSCULAR DYSTROPHY AGENTS		
All products require PA	Amondys®45 (casimersen)	**Emflaza:**

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Emflaza™ (deflazacort) Maximum 30-day supply per fill Exondys 51™ (eteplirsen) Viltepso® (viltorsen) Vyondys 53™ (golodirsen)	• The patient must be ≥ 2 years of age AND • The patient must have a diagnosis of Duchenne Muscular Dystrophy AND • There is documented improvement in muscle function or strength with use of prednisone, but the patient has experienced weight gain >10% of body weight within 3 months or >25% within 1 year. **Amondys, Exondys, Viltepso, Vyondys:** • The patient must have a diagnosis of Duchenne Muscular Dystrophy with a confirmed mutation of the DMD gene that is amenable to exon 45 skipping (for Amondys) or exon 51 skipping (for Exondys) or exon 53 skipping (for Viltepso, Vyondys) (results of genetic testing must be submitted) AND • The prescriber is, or has consulted with, a neuromuscular disorder specialist AND • The dose does not exceed 30mg/kg once weekly (for Amondys, Exondys, Vyondys) or 80mg/kg once weekly (for Viltepso) AND • The patient is currently on a stable corticosteroid dose for at least 6 months. AND • Baseline documentation of the members voluntary motor and cardiac function has been provided and results have shown member retains meaningful voluntary motor function: Optional • 6-minute walk test (6MWT) or other timed fuctions tests (e.g time to stand [TTSTAND], tiem to run/walk 10 meters [TTRW], time to climb 4 stairs [TTCLIMB]) • Brooks Upper Extremity Test • North Star Ambulatory Assessment (NSAA) Required • Forced Vital Capacity (FVC) percent predicted • Ejection Fraction Percentage **Note:** Initial approval will be granted for 6 months. For re-approval after 6 months, the patient must demonstrate a response to therapy compared to baseline as evidenced by stable, improved, or slowed rate of either motor function or cardiac function degradation. Evidence may include one or more of the following (not all-inclusive): • 6MWT or other timed function tests (e.g., time to stand [TTSTAND], time to run/walk 10 meters [TTRW], time to climb 4 stairs [TTCLIMB]) • Brooks Upper Extremity Test • North Star Ambulatory Assessment (NSAA)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		• Forced Vital Capacity (FVC) percent predicted • Ejection Fraction Percentage • Improvement in quality of life.
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 **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
NEUROPATHIC PAIN & FIBROMYALGIA AGENTS		
Oral		
DULOXETINE (compare to Cymbalta®) *QTY LIMIT:* 2 capsules/day PREGABALIN (compare to Lyrica®) capsules *QTY LIMIT:* 3 capsules/day SAVELLA® (milnacipran) tablet, titration pack *QTY LIMIT:* 2 tablets/day	Cymbalta® (duloxetine) *QTY LIMIT:* 2 capsules/day Gralise® (gabapentin) tablet, starter pack *QTY LIMIT:* 3 tablets/day Maximum 30-day supply per fill Horizant® (gabapentin enacarbil) ER Tablet FDA maximum recommended dose = 1200 mg/day Lyrica® (pregabalin) capsules *QTY LIMIT:* 3 capsules/day Lyrica® CR (pregabalin, extended release)	**Cymbalta, Lyrica:** the patient has had a documented intolerance with the generic equivalent. **Gralise, Horizant:** 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. **Pregabalin ER, Lyrica CR:** The patient has a diagnosis of post-herpetic neuralgia (PHN) or diabetic peripheral neuropathy (DPN) AND patient has not been able to be adherent to a twice daily dosing schedule of pregabalin immediate release

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	FDA maximum recommended dose = 330 mg/day (DPN), 660 MG/day (PHN) Lyrica® (pregabalin) solution Pregabalin (compare to Lyrica®) solution Pregabalin extended release (compare to Lyrica® CR) FDA maximum recommended dose = 330 mg/day (DPN), 660 mg/day (PHN)	resulting in a significant clinical impact AND for approval of pregabalin ER, the patient has a documented intolerance to brand Lyrica CR. **Note:** The efficacy of Lyrica® CR has not been established for the management of fibromyalgia or as adjunctive therapy for adult patients with partial onset seizures. **Pregabalin solution, Lyrica solution:** the patient is unable to use Lyrica capsules (e.g. Swallowing disorder) AND for approval of brand Lyrica oral solution, the patient must have a documented intolerance to the generic equivalent.
NUTRITIONALS, LIQUID ORAL SUPPLEMENTS		
All products require PA	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, Cerebral Palsy, Cystic Fibrosis, Dementia resulting in loss of motor skills, Neuromuscular Disease, 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 OR Involuntary loss of > 5% of body weight within 1 month OR Loss of > 2% of body weight within one week OR BMI of < 18.5 kg/m2 **Elderly:** (>65): Involuntary loss of > 10 % of body weight within 6 months OR Involuntary loss of > 5 % of body weight within 3 months OR Loss of > 2 % of body weight within one month OR BMI of < 18.5 kg/m2 **Children:** Anatomic causes for malnutrition have been evaluated and treated AND clinical diagnosis and documentation supports the need for enteral nutrition (See Below) • Members weight is below the 5th percentile for sex and corrected age AND weight-to-length ratio is below the 10th percentile OR • Sustained decrease in growth velocity as demonstrated by weight-for-

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		age or weight-for-length fall by two major percentiles (percentile markers 95, 90, 75, 50, 25, 10, and 5) over time (defined by the WHO for children less than 2 years of age and the CDC for children greater than 2 years of age) **Limitations:** Approvals will be based on medical necessity for supplemental nutrition. Approval will NOT be granted for individuals whose need is nutritional rather than medical, including an unwillingness to consume solid or pureed foods. For nonmedical needs contact WIC at 800-464-4343
ONCOLOGY: DRUGS (select)		
		Clinical Criteria: Medication is being used for an FDA approved indication AND age, dose, duration, required concurrent therapy, and past treatment failures (if applicable) are consistent with prescribing information AND the patient does not have any contraindications prohibiting use of the medication OR medication is being used in accordance with the National Comprehensive Cancer Network® (NCCN®) Clinical Practice Guidelines. Requests outside of these parameters require medical director review. This includes all cell and gene therapies, including CAR-T therapies, regardless of site of administration. For physician-administered drugs, please refer to the Fee Schedule for which codes require a PA: http://vtmedicaid.com/#/feeSchedule/hcpcs
OPHTHALMICS		
ANTIBIOTICS		
QUINOLONES BESIVANCE® (besifloxacin) suspension CILOXAN® ointment CIPROFLOXACIN HCL (compare to Ciloxan®) solution MOXIFLOXACIN 0.5% solution (compare to Vigamox®) **MACROLIDES** ERYTHROMYCIN ointment	Ciloxan® (ciprofloxacin) solution Gatifloxacin 0.5% solution (compare to Zymaxid®) Levofloxacin 0.5 % solution Moxifloxacin 0.5% (compare to Moxeza®) (preservative free) solution Ocuflox®(ofloxacin) solution Ofloxacin (compare to Ocuflox®) solution Vigamox® (moxifloxacin 0.5%) (preservative free) solution Zymaxid® (gatifloxacin 0.5%) solution	**Criteria for All Non-Preferred:** The patient has had a documented side effect, allergy or treatment failure with at least TWO preferred ophthalmic antibiotics or ophthalmic antibiotic combination agents, one of which must be in the same therapeutic class. (If a product has an AB rated generic, there must have also been a trial of the generic formulation.)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
AMINOGLYCOSIDES **SINGLE AGENT** AK-TOB (tobramycin) solution GENTAMICIN solution TOBRAMYCIN solution (compare to Tobrex®) **COMBINATION** TOBRAMYCIN W/DEXAMETHASONE suspension ZYLET® (tobramycin/loteprednol) suspension	Azasite®(azithromycin) solution All other brands Tobrex® ointment, solution (tobramycin) Tobradex ST®(tobramycin/dexamethasone) suspension	
MISCELLANEOUS **SINGLE AGENT** All products require PA **Combination** BACITRACIN ZINC W/POLYMYXIN B ointment NEOMYCIN/BACITRACIN/POLYMYXIN ointment NEOMYCIN/POLYMYXIN W/DEXAMETHASONE (compare to Maxitrol®) ointment, suspension NEOMYCIN/POLYMYXIN/BACITRACIN/ HYDROCORTISONE ointment POLYMYXIN B W/TRIMETHOPRIM (compare to Polytrim®) solution SULFACETAMIDE W/PREDNISOLONE SOD PHOSPHATE solution	Bacitracin ointment Bleph-10® (sulfacetamide) solution Sulfacetamide sodium (compare to Bleph-10®) solution Sulfacetamide sodium ointment Blephamide® (sulfacetamide/prednisolone acetate) suspension Blephamide® S.O.P. (sulfacetamide/prednisolone acetate) ointment Maxitrol® (neomycin/polymyxin/dexamethasone) suspension, ointment Neomycin/Polymyxin W/Gramicidin solution Neomycin/Polymyxin w/Hydrocortisone ointment, suspension Polytrim® (polymyxin B/trimethoprim) soln	
ANTIHISTAMINES		
AZELASTINE *QTY LIMIT*: 1 bottle/month KETOTIFEN 0.025 % *QTY LIMIT*: 1 bottle/month OLOPATADINE 0.1%, 0.2% *QTY LIMIT*: 1 bottle/month	Bepotastine (compare to Bepreve®) Bepreve® (bepotastine besilate) Epinastine *QTY LIMIT*: 1 bottle/month Lastacaft® (alcaftadine) *QTY LIMIT*: 1 bottle/month	**Bepotastine, Bepreve, Epinastine:** The patient has had a documented side effect, allergy, or treatment failure to a preferred ophthalmic antihistamine AND for approval of Bepotastine, the patient must have a documented intolerance to brand Bepreve. **Lastacaft:** The patient is pregnant, and the diagnosis is allergic conjunctivitis

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Zerviate® (cetirizine 0.24%) *QTY LIMIT*:60 vials/30 days	OR The patient has had a documented side effect, allergy, or treatment failure to a preferred ophthalmic antihistamine. **Zerviate:** The patient has had a documented side effect, allergy, or treatment failure to TWO preferred ophthalmic antihistamines.
CORTICOSTEROIDS: TOPICAL		
ALREX® (loteprednol) 0.2% suspension DEXAMETHASONE sodium phosphate 0.1% solution DUREZOL® (difluprednate) 0.05% emulsion FLAREX® (fluorometholone acetate) 0.1% suspension FML Forte® (fluorometholone) 0.25% suspension FLUOROMETHOLONE 0.1% suspension FML® (fluorometholone) 0.1% ointment LOTEMAX® (loteprednol) 0.5% suspension, ointment MAXIDEX® (dexamethasone) suspension PRED MILD® (prednisolone acetate) 0.12% suspension PREDNISOLONE ACETATE 1% suspension PREDNISOLONE SODIUM PHOSPHATE 1% solution	Difluprednate (compare to Durezol®) FML Liquifilm® (fluorometholone) 0.1% suspension Inveltys™ (loteprednol) suspension Lotemax® (loteprednol) 0.5% gel Lotemax SM (loteprednol) 0.038% gel drops Loteprednol suspension Pred Forte® (prednisolone acetate) 1% suspension All other brands	**Non-preferred agents:** The patient has had a documented side effect, allergy, or treatment failure with TWO preferred ophthalmic corticosteroids. (If a product has an AB rated generic, there must have been a trial of the generic formulation)
CYSTEAMINE		
All products require PA	Cystadrops® (cysteamine) 0.37% ophthalmic solution QTY LIMIT: 4 bottles (20 ml)/28 days Maximum day supply/Rx = 28 days Cystaran® (cysteamine) 0.44% ophthalmic solution *QTY LIMIT:* 4 bottles (60 ml)/ 28 days Maximum day supply/RX = 28 days	**Cystadrops, Cystaran:** The indication for use is corneal cystine accumulation in patients with cystinosis.
DRY EYE SYNDROME		
OCULAR LUBRICANTS Please refer to the DVHA website for covered OTC ocular lubricants https://dvha.vermont.gov/sites/dvha/files/documents/providers/Pharmacy/OTCWebList.pdf **IMMUNOMODULATORS**	Cequa™ (cyclosporine ophthalmic solution) 0.09% Cyclosporin ophthalmic emulsion 0.05% droperette (compare to Restasis®) QTY LIMIT: 180 vials per 90 days Eysuvis® (loteprednol etabonate ophthalmic suspension) 0.25%	**Cequa:** The patient has a diagnosis of Dry Eye Disease AND has a documented side effect, allergy, or treatment failure to two ophthalmic immunomodulators, one of which must be Restasis. **Cyclosporin emulsion, Tyrvaya, Xiidra:** The patient has a diagnosis of Dry Eye Disease AND has a documented side effect, allergy or treatment failure to Restasis. **Eysuvis**: The patient has a diagnosis of Dry Eye Disease AND has failed at least a

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
RESTASIS® (cyclosporine ophthalmic emulsion) 0.05% droperette (NDC 00023916330 and 00023916360 are the only preferred NDC's) *QTY LIMIT:* 180 vials per 90 days	Restasis® (cyclosporine ophthalmic emulsion) 0.05% multidose bottle *QTY LIMIT:* 1 bottle (5.5ml) per 25 days Tyrvaya™ (varenicline) nasal spray QTY LIMIT: 2 bottles (8.4 ml) per 30 days Verkazia® (cyclosporine ophthalmic emulsion) 0.1% single dose vials Xiidra® (lifitegrast) solution *QTY LIMIT:* 60 vials per 30 days	14-day course of a preferred OTC ocular lubricant AND has a documented side effect, allergy, or treatment failure with 2 preferred ophthalmic corticosteroids, one of which must be a formulation of loteprednol. **Restasis Multidose:** Both package sizes of the droperettes must be on a long-term backorder and unavailable from the manufacturer. **Verkazia:** The patient has a diagnosis of vernal keratoconjunctivitis (VKC) AND the patient has had a documented side effect, allergy, or treatment failure with a mast cell stabilizer (e.g. cromolyn sodium) or a dual acting antihistamine/mast cell stabilizer (e.g. olopatadine, azelastine)
GLAUCOMA AGENTS/MIOTICS		
ALPHA-2 ADRENERGIC **SINGLE AGENT** ALPHAGAN P® 0.1 %, 0.15 % (brimonidine tartrate) BRIMONIDINE TARTRATE 0.2 % **COMBINATION** COMBIGAN® (brimonidine tartrate/timolol maleate) SIMBRINZA® (brinzolamide 1% and brimonidine 0.2%) Suspension **BETA BLOCKER** CARTEOLOL HCL LEVOBUNOLOL HCL TIMOLOL MALEATE (compare to Timoptic®) **PROSTAGLANDIN INHIBITORS** LATANOPROST (compare to Xalatan®) LUMIGAN®(bimatoprost) TRAVATAN Z® (travoprost) (BAK free) **RHO KINASE INHIBITORS** **SINGLE AGENT** RHOPRESSA® (netarsudil)	Apraclonidine (compare to Iopidine®) Brimonidine tartrate 0.15 % (compare to Alphagan P®) Iopidine® (apraclonidine) Brimonidine tartrate/timolol maleate (compare to Combigan®) Betaxolol HCl solution Betoptic S® (betaxolol suspension) Istalol® (timolol) Timoptic® (timolol maleate) Timoptic XE® (timolol maleate gel) Timolol maleate gel (compare to Timotic XE®) Bimatoprost 0.03% (Lumigan®) Durysta® (bimatoprost) 10 mcg implant Travoprost BAK Free (compare to Travatan Z®) Vyzulta® (latanoprostene bunod) Xelpros® (latanoprost) (BAK free) Zioptan® (tafluprost)	**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 P 0.15%. **Brimonidine/timolol:** the patient must have a documented intolerance to brand Combigan. **BETA BLOCKERS:** The patient has had a documented side effect, allergy or treatment failure with at least one preferred ophthalmic beta blocker. **PROSTAGLANDIN INHIBITORS** **Bimatoprost, Travoprost, Vyzulta, Xalatan, Xelpros, Zioptan:** The patient has had a documented side effect, allergy or treatment failure with at least 2 preferred prostaglandin inhibitors. **Durysta:** The patient has had a documented side effect, allergy, or treatment failure with at least 2 preferred prostaglandin inhibitors OR the patient is not a candidate for topical drop therapy AND the patient does not have any of the following contraindications: • History of prior corneal transplantation or endothelial cell transplants (e.g. Descemet's Stripping Automated Endothelial Keratoplasty) • Diagnosis of corneal endothelial dystrophy (e.g. Fuchs' Dystrophy) • Absent or ruptured posterior lens capsule Approval will be limited to a single implant per eye without retreatment. **CARBONIC ANHYDRASE INHIBITORS** **Trusopt:** 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

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
COMBINATION ROCKLATAN® (netarsudil/latanoprost) **CARBONIC ANHYDRASE INHIBITOR SINGLE AGENT** AZOPT® (brinzolamide 1%) DORZOLAMIDE 2 % (compare to Trusopt®) **COMBINATION** DORZOLAMIDE w/TIMOLOL (compare to Cosopt®) **MISCELLANEOUS** ISOPTO® CARPINE (pilocarpine) PILOCARPINE HCL PHOSPHOLINE IODIDE® (echothiophate)	Trusopt® (dorzolamide 2 %) Cosopt PF® (dorzolamide w/timolol) (pres-free) Miochol-E® (acetylcholine)	the generic combination product. **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		
CROMOLYN SODIUM	Alocril® (nedocromil sodium) Alomide® (lodoxamide)	**Criteria for Approval:** The patient has had a documented side effect, allergy, or treatment failure with generic cromolyn sodium
NEUROTROPHIC KERATITIS		
All products require PA	Oxervate™ (cenegermin-bkbj) ophthalmic solution 0.002% *QTY LIMIT:* 1 vial (1mL) per eye per day Maximum of 8 weeks therapy	**Oxervate:** Medication is being prescribed by, or in consultation with, an ophthalmologist AND Patient has a diagnosis of Stage 2 or 3 neurotrophic keratitis (in one or both eyes) as evidenced by persistent epithelial defect or corneal ulceration AND patient has evidence of decreased corneal sensitivity in at least one corneal quadrant AND patient has failed one or more conventional non-surgical treatments such as artificial tears, gels, or ointments.
NON-STEROIDAL ANTI-INFLAMMATORY DRUGS (NSAIDs)		
DICLOFENAC 0.1% ophthalmic solution KETOROLAC 0.4 % ophthalmic solution (compare to Acular LS®) KETOROLAC 0.5 % ophthalmic solution (compare to Acular®) NEVANAC® ophthalmic suspension (nepafenac 0.1%)	Acular® (ketorolac 0.5% ophthalmic solution) Acular LS ® (ketorolac 0.4% ophthalmic solution) Acuvail (ketorolac 0.45 %) Ophthalmic Solution *QTY LIMIT:* 30-unit dose packets/15 days Bromfenac 0.09 % ophthalmic solution BromSite™ (bromfenac 0.075%) solution Flurbiprofen 0.03% ophthalmic solution Ilevro® ophthalmic suspension (nepafenac 0.3%)	**Acuvail:** The patient has had a documented side effect, allergy, or treatment failure to Acular OR ketorolac 0.5% OR The patient has a documented hypersensitivity to the preservative benzalkonium chloride. **All other non-preferred agents:** The patient has had a documented side effect, allergy, or treatment failure to TWO preferred agents. In addition, if a product has an AB rated generic, there must have also been a trial of the generic formulation.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Prolensa® ophthalmic solution (bromfenac 0.07%)	
PRESBYOPIA AGENTS		
All products require PA	Vuity™ (pilocarpine) 1.25% solution	**Vuity:** The patient has a diagnosis of presbyopia AND the patient is between the ages of 40-55 at the time of therapy initiation AND the medication is being prescribed by or in consultation with an optometrist or ophthalmologist AND the patient has failed corrective eyeglasses or contact lenses, unless contraindicated.
OTIC ANTI-INFECTIVES/ANTI-INFLAMMATORIES		
ANTI-INFECTIVE SINGLE AGENT OFLOXACIN 0.3% Otic solution	Ciprofloxacin 0.2% otic solution *QTY LIMIT*: 14-unit dose packages/ 7 days	**Anti-infective single and combination agents:** The patient has had a documented side effect, allergy, or treatment failure to two preferred products. **DermOtic, Flac Oil:** the patient has a documented intolerance to generic fluocinolone oil.
ANTI-INFECTIVE/CORTICOSTEROID COMBINATION CIPRO-HC® (ciprofloxacin 0.2%/hydrocortisone 1%) Otic suspension	Cortisporin-TC® (neomycin/colistin/thonzium/hydrocortisone)	
NEOMYCIN/POLYMYXIN B SULFATE/ HYDROCORTISONE SOLUTION, SUSPENSION	Ciprofloxacin/Dexamethasone (formerly Ciprodex®) otic suspension	
CORTICOSTEROID FLUOCINOLONE OIL 0.01%	Ciprofloxacin/Fluocinolone otic solution *QTY LIMIT*: 28-units dose packages/7days	
MISCELLANEOUS AGENTS ACETIC ACID Otic solution	DermOtic® Oil (fluocinolone acetonide) 0.01% Flac® Oil (fluocinolone acetonide) 0.01%	
	Acetic Acid/Hydrocortisone Otic Solution	
OVER THE COUNTER (OTC) MEDICATIONS		
Please refer to the DVHA website for covered OTC categories not already managed on the PDL. Many categories limited to generics ONLY and other categories not covered. No PA process for non-covered OTCs.		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
https://dvha.vermont.gov/sites/dvha/files/documents/providers/Pharmacy/OTCWebList.pdf		
PANCREATIC ENZYME PRODUCTS		
CREON® DR Capsule ZENPEP® DR Capsule	Pertzye® DR Capsule Viokace® DR Capsule	**Pertzye, Viokace:** 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.
PARATHYROID AGENTS		
CALCITRIOL (compare to Rocaltrol®) CINACALCET (compare to Sensipar®) ERGOCALCIFEROL (compare to Drisdol®) PARICALCITOL (compare to Zemplar®)	Doxercalciferol (compare to Hectoral®) Drisdol® (ergocalciferol) Hectoral® (doxercalciferol) Natpara® (parathyroid hormone) *QTY LIMIT:* 2 cartridges per 28 days Parsabiv™ (etelcalcetide) Rayaldee® (calcifediol ER) Rocaltrol® (calcitriol) Sensipar® (cinacalcet) Zemplar® (paricalcitol)	**Doxercalciferol, Drisdol, Hectoral, Rayaldee, Rocaltrol, Zemplar:** The patient must have a documented side effect, allergy, or treatment failure to two preferred agents. If a product has an AB rated generic, one trial must be the generic formulation. **Natpara:** ▪ Natpara: diagnosis of hypocalcemia secondary to hypoparathyroidism (but NOT acute post-surgical hypoparathyroidism within 6 months of surgery) **AND** ▪ Natpara PA form must be completed and clinical and lab documentation supplied **AND** ▪ Must be prescribed by an endocrinologist **AND** ▪ Must be documented by **ALL** of the following: ○History of hypoparathyroidism >18 months **AND** ○Biochemical evidence of hypocalcemia **AND** ○Concomitant serum intact parathyroid hormone (PTH) concentrations below the lower limit of the normal laboratory reference range on 2 test dates at least 21 days apart within the past 12 months **AND** ▪ No history of the following: ○mutation in CaSR gene **OR** ○pseudohypoparathyroidism **OR** ○a condition with an increased risk of osteosarcoma **AND** ▪ Hypocalcemia is not corrected by calcium supplements and preferred active forms of vitamin D alone **AND** ▪ Patients must be taking vitamin D metabolite/analog therapy with calcitriol ≥0.25 µg per day OR equivalent **AND** ▪ Must be taking supplemental oral calcium treatment ≥ 1000 mg per day over and above normal dietary calcium intake **AND** ▪ Serum calcium must be ≥ 7.5 mg/dl prior to starting Natpara **AND** ▪ Serum thyroid function tests and serum magnesium levels must be within normal limits **AND** ▪ Documentation of creatinine clearance > 30 mL/min on two separate

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		measurements **OR** creatinine clearance > 60 mL/min AND serum creatinine < 1.5 mg/dL **Parsabiv:** indication is for the treatment of secondary hyperparathyroidism in a patient with Chronic Kidney Disease (CKD) receiving hemodialysis AND the patient has a documented side effect, allergy, or treatment failure with Sensipar. Note: treatment failure is defined as < 30% reduction from baseline in mean pre-dialysis PTH concentrations. **Sensipar:** the patient has a documented intolerance to the generic equivalent.
PARKINSON'S MEDICATIONS		
DOPAMINE PRECURSOR CARBIDOPA/LEVODOPA (compare to Sinemet®) CARBIDOPA/LEVODOPA ER (compare to Sinemet® CR) CARBIDOPA/LEVODOPA ODT **DOPAMINE AGONISTS (ORAL)** BROMOCRIPTINE (compare to Parlodel®) PRAMIPEXOLE (compare to Mirapex®) ROPINIROLE (compare to Requip®) **DOPAMINE AGONISTS (TRANSDERMAL)** All products require PA **COMT INHIBITORS** ENTACAPONE (compare to Comtan®) **MAO-B INHIBITORS** SELEGILINE	Inbrija® (levodopa capsule for inhalation) *QTY LIMIT:* 10 caps/day Rytary® (carbidopa/levodopa ER caps) Sinemet® (carbidopa/levodopa) Mirapex ER® (pramipexole ER) *QTY LIMIT:* 1 tab/day Pramipexole ER (compare to Mirapex ER®) *QTY LIMIT:* 1 tab/day Ropinirole XL *QTY LIMIT:* 12 mg = 2 tabs/day, All other strengths = 1 tab/day Neupro® (rotigotine) transdermal patch *QTY LIMIT:* 2, 4, 6, and 8 mg = 1 patch/day Comtan® (entacapone) Ongentys® (opicapone) Tasmar® (tolcapone) Tolcapone (compare to Tasmar®) Azilect® (rasagiline) *QTY LIMIT:* 1 mg/day Rasagiline (compare to Azilect®) *QTY LIMIT:* 1 mg/day Xadago® (safinamide) *QTY LIMIT:* 1 tab/day	**Inbrija:** The patient has a diagnosis of Parkinson's disease with intermittent presence of OFF episodes AND the patient is currently taking Carbidopa/Levodopa AND the patient has had a documented side effect, allergy, or treatment failure with Apokyn® **Comtan, Sinemet, Parlodel, Stalevo:** The patient has had a documented intolerance to the generic product. **Ongentys:** The diagnosis or indication is Parkinson's disease AND the patient has had a documented side effect, allergy, or treatment failure with entacapone. **Rytary:** The patient has a diagnosis of Parkinson's disease, post-encephalitic parkinsonism, or parkinsonism following intoxication from carbon monoxide or manganese AND the prescriber is a neurologist AND the patient is having breakthrough symptoms despite a combination of concurrent IR and ER formulations of carbidopa/levodopa **Azilect, Rasagiline:** 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 **Gocovri**: diagnosis or indication is for the treatment of dyskinesia in a patient with Parkinson's Disease AND the patient is currently receiving levodopa-based therapy (with or without concomitant dopaminergic medications) AND the patient has a documented side effect, allergy, or treatment failure with immediate release amantadine. **Note:** treatment failure is defined by a decrease in effectiveness despite attempts to increase dosage to 300mg/day or by temporarily discontinuing amantadine for several weeks and restarting therapy. **Kynmobi:** The patient has a diagnosis of Parkinson's disease with intermittent presence of OFF episodes AND the patient is receiving concomitant levodopa which has been at a stable dose for a minimum of 4 weeks AND the patient is not taking a 5HT3 antagonist (e.g ondansetron, alosetron) concurrently AND the patient has had a documented side effect, allergy or

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ANTICHOLINERGICS BENZTROPINE TRIHEXYPHENIDYL **ADENSOSINE RECEPTOR AGONIST** All products require PA **OTHER** APOKYN® (apomorphine) AMANTADINE syrup AMANTADINE capsules, tablets (PA required for ≤ 10-day supply) CARBIDOPA/LEVODOPA/ENTACAPONE (compare to Stalevo®)	Zelapar® (selegiline ODT) *QTY LIMIT:* 2.5 mg/day Nourianz (istradefylline) *QTY LIMIT:* 1 tab/day Gocovri™ (amantadine extended release) *QTY LIMIT:* 2 tabs/day Kynmobi® (apomorphine) sublingual film Osmolex® ER (amantadine extended-release) *QTY LIMIT:* 1 tablet/strength/day Stalevo® (carbidopa/levodopa/entacapone)	treatment failure with Apokyn. **Mirapex ER, Pramipexole ER, Ropinirole XL:** 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 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. **Neupro:** The patient has a medical necessity for a specialty dosage form. **Nourianz:** The patient has a diagnosis of Parkinson's disease with intermittent presence of OFF episodes AND the patient is currently taking Carbidopa/Levodopa AND the patient has had a documented side effect, allergy, or treatment failure with TWO preferred medications being used as adjunct therapy. **Osmolex ER:** patient has not been able to be adherent to the dosing schedule of amantadine immediate release resulting in a significant clinical impact. **Tasmar, Tolcapone:** The diagnosis or indication is Parkinson's disease. AND The patient has had a documented side effect, allergy, or treatment failure with entacapone AND patient has provided written acknowledgement of risks per the package insert. For approval of brand Tasmar, the patient must have documented intolerance to the generic equivalent. **Xadago:** The diagnosis or indication is Parkinson's disease AND The patient is on current therapy with levodopa/carbidopa AND The patient has had a documented side effect, allergy, or treatment failure with selegiline. Note: Xadago will not be approved for monotherapy. **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 exceed 2.5 mg/day **Limitations:** To prevent the use of amantadine in influenza treatment/prophylaxis, days supply < 10 days will require PA.
PLATELET INHIBITORS		
AGGREGATION INHIBITORS BRILINTA® (ticagrelor) Tablet	Effient® (prasugrel) Tablet	**Agrylin, Effient, Plavix:** The patient has had a documented intolerance to the generic formulation of the medication.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
QTY LIMIT: 2 tablets/day CILOSTAZOL CLOPIDOGREL 75 mg (compare to Plavix®) PRASUGREL (compare to Effient®) **OTHER** ANAGRELIDE (compare to Agrylin®) ASPIRIN DIPYRIDAMOLE DIPYRIDAMOLE/ASPIRIN	*QTY LIMIT:* 1 tablet/day Plavix® 75 mg (clopidogrel bisulfate) Zontivity® (vorapaxar) Tablet *QTY LIMIT:* 1 tablet/day Agrylin® (anagrelide)	**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 300 mg is not an outpatient dose and is not covered in the pharmacy benefit.
PLATELET STIMULATING AGENTS		
Preferred After Clinical Criteria Are Met PROMACTA® (eltrombopag)	Doptelet® (avatrombopag) Mulpleta® (lusutrombopag) Nplate® (romiplostim) Tavalisse™ (fostamatinib disodium hexahydrate)	**Doptelet:** *Indication for use is chronic immune (idiopathic) thrombocytopenic purpura (ITP):* The patient's platelet count is less than 30,000/µL (< 30 x 10^9/L) or the patient is actively bleeding AND The patient has an insufficient response or documented intolerance to corticosteroids, immunoglobulins, or splenectomy AND Promacta. *Indication for use is thrombocytopenia in a patient with chronic liver disease scheduled to undergo an elective surgical or dental procedure:* The patient is at least 18 years of age AND the patient's platelet count is less than 50,000/µL (< 50 x 10^9/L) AND approval will be limited to a maximum of 5 days' supply per procedure **Mulpleta:** The patient is at least 18 years of age AND the diagnosis is thrombocytopenia in a patient with chronic liver disease scheduled to undergo an elective surgical or dental procedure AND the patient's platelet count is less than 50,000/µL (< 50 x 10^9/L) AND approval will be limited to a maximum of 7 days' supply per procedure. AND patient has had a documented side effect, allergy, contraindication, or treatment failure to Doptelet. **Nplate:** 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 10^9/L) or the patient is actively bleeding. AND The patient has an insufficient response or documented intolerance to corticosteroids, immunoglobulins, or splenectomy AND Promacta. **Promacta:** *Indication for use is chronic immune thrombocytopenia (ITP):* The patient's platelet count is less than 30,000/µL (< 30 x 10^9/L) or the patient is actively bleeding, AND the patient has had an insufficient response or documented intolerance to corticosteroids, immunoglobulins, or splenectomy. *Indication for use is chronic Hepatitis-C associated thrombocytopenia:* The patient is at least 18 years of age AND medication is used to initiate or maintain interferon-based therapy.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		Indication for use is Severe Aplastic Anemia: patient has had an inadequate response to standard immunosuppressive therapy (e.g. cyclosporine). **Tavalisse:** The patient is at least 18 years of age AND The diagnosis is chronic immune thrombocytopenia (ITP) AND The patient's platelet count is less than < 30 x 10^9/L AND The patient has had a documented side effect, allergy, treatment failure or a contraindication to therapy with corticosteroids AND the patient has failed at least one of the following additional treatments: immunoglobulins, rituximab, splenectomy, or a thrombopoietin receptor agonist (e.g. eltrombopag, romiplostim, etc.). **Note:** Initial approval will be granted for 12 weeks. For therapy continuation, the patient must have achieved and maintained a platelet count of at least 50 x 10^9/L and/or have a documented decrease in rescue treatment(s) with platelet transfusions.
PSEUDOBULBAR AFFECT AGENTS		
All products require PA	Nuedexta® capsules (dextromethorphan/quinidine) *QTY LIMIT:* 2 capsules/day	**Nuedexta:** The patient must have a diagnosis of pseudobulbar affect (PBA) secondary to a neurological condition AND the patient has had a trial and therapy failure at a therapeutic dose with a tricyclic antidepressant (TCA) or an SSRI AND the patient has documentation of a current EKG (within the past 3 months) without QT prolongation AND initial authorizations will be approved for 6 months with a baseline Center for Neurologic Studies Lability Scale (CNS-LS) questionnaire AND subsequent prior authorizations will be considered at 6 month intervals with documented efficacy as seen in an improvement in the CNS-LS questionnaire
PSORIASIS		
BIOLOGICS: Initial approval is 3 months, renewals are 1 year		
Preferred After Clinical Criteria Are Met **INJECTABLE** AVSOLA® (infliximab-axxq) biosimilar to Remicade® ENBREL® (etanercept) *QTY LIMIT:* 50 mg = 8 syringes/28 days for the first 3 months; then 4 syringes/28 days 25 mg = 8 syringes/28 days subsequently HUMIRA® (adalimumab) *QTY LIMIT:* 4 syringes/28 days for one month; 2 syringes/28 days subsequently	Cimzia® (certolizumab pegol) *QTY LIMIT:* 1 kit/28 days (starter X 1, then regular) Cosentyx® (secukinumab) Ilumya™ (tildrakizumab-asmn) *QTY LIMIT:* 2 ml (2 syringes) for the first month then 1 ml (1 syringe)/84 days subsequently Remicade® (infliximab) Renflexis™ (infliximab-abda) biosimilar to Remicade® Siliq™ (brodalumab) injection *QTY LIMIT:* 6 ml (4 syringes) for the first month then	**Clinical Criteria:** **For all drugs (except Spevigo):** The prescription must be written by a dermatologist or rheumatologist AND The patient has a documented diagnosis of moderate to severe plaque psoriasis and has already been stabilized on the drug being requested OR The prescription must be written by a dermatologist or rheumatologist 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,

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
INFLECTRA® (infliximab-dyyb) biosimilar to Remicade® TALTZ® (ixekizumab) *QTY LIMIT:* 3 syringes/28 days for the first month, 2 syringes/28 days months 2 and 3 and 1 syringe/28 days subsequently **ORAL** OTEZLA® tablet (apremilast) *QTY LIMIT:* Starter Pack = 55 tablets/28 days, 30 mg = 2 tablets/day	3 ml (2 syringes)/28 days subsequently Skyrizi™ (risankizumab-rzaa) *QTY LIMIT:* 150 mg/28 days for the first month and 150mg/84 days thereafter Spevigo® (spesolimab-sbzo) *QTY LIMIT:* 900 mg (15 ml) per dose Stelara® (ustekinumab) *QTY LIMIT:* 45 mg (0.5 ml) or 90 mg (1 ml) per dose (90mg dose only permitted if patient weight > 100kg) One dose/28 days for the first month and one dose/84 days thereafter Tremfya® (guselkumab) *QTY LIMIT:* 2 syringes/28 days for the first month, then 1 syringe every 56 days thereafter Sotyktu® (deucravacitinib) *QTY LIMIT:* 1 tablet/day	(unless otherwise contraindicated)] from the following categories: Topical agents: emollients, keratolytics, corticosteroids, calcipotriene, tazarotene, etc. Systemic agents: methotrexate, sulfasalazine, azathioprine, cyclosporine, tacrolimus, mycophenolate mofetil, etc. Phototherapy: ultraviolet A and topical psoralens (topical PUVA), ultraviolet A and oral psoralens (systemic PUVA, narrow band ultraviolet B (NUVA), etc. **Additional Criteria for Taltz:** The prescriber must provide evidence of a trial and failure or contraindication to a preferred TNF Inhibitor. **Additional Criteria for Cimzia, Cosentyx, Ilumya, Siliq, Skyrizi, Sotyktu, Stelara, Tremfya:** The prescriber must provide a clinically valid reason why both a preferred TNF Inhibitor and Taltz® cannot be used. **Note:** Cosentyx approvals for 300mg dose(s) must use "300DOSE" package (containing 2x150mg pens or syringes) Approval will not be granted for 2 separate 150mg packages. **Additional Criteria for Remicade, Renflexis:** The prescriber must provide a clinically valid reason why Humira®, Taltz®, and Avsola/Inflectra cannot be used. **Spevigo:** • The patient is experiencing a moderate-to-severe intensity flare of generalized pustular psoriasis (GPP) as defined by: o A Generalized Pustular Psoriasis Physician Global Assessment (GPPPGA) total score of at least 3 (moderate) or greater AND o The presence of fresh pustules (new appearance or worsening of pustules) AND At least 5% of body surface area (BSA) covered with erythema and the presence of pustules AND • The patient will not use concomitantly with other systemic immunosuppressants or topical agents AND Approval will be granted for a maximum of two 900mg doses, given 7 days apart.
NON-BIOLOGICS		
ORAL ACITRETIN capsules CYCLOSPORINE (generic) METHOTREXATE (generic) **TOPICAL** CALCIPOTRIENE Cream, Ointment, Solution	Methoxsalen (compare to Oxsoralen-Ultra®) Oxsoralen-Ultra® (methoxsalen) Calcitriol (compare to Vectical®) Ointment *QTY LIMIT:* 200 g (2 tubes)/week Calcipotriene Foam (compare to Sorilux®) Calcipotriene/betamethasone ointment (compare to Taclonex®)	**Duobrii lotion:** the patient has had an inadequate response to at least 2 different preferred high or very high potency corticosteroids AND tazarotene cream. **Enstilar, Taclonex or Calcipotriene/betamethasone dipropionate Ointment or Scalp Suspension:** The patient has had an inadequate response to a trial (defined as daily treatment for at least one month) of a betamethasone dipropionate product and Dovonex (or generic calcipotriene), simultaneously. **Calcipotriene Foam, Calcitriol Ointment, Sorilux, Tazarotene, Vtama, Zoryve:** The patient has a diagnosis of mild-to-moderate plaque psoriasis AND The patient has demonstrated inadequate response, (defined as daily treatment for

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	QTY LIMIT: Initial fill = 60 grams Duobrii™ (halobetasol propionate/tazarotene) lotion Enstilar® (calcipotriene/betamethasone) foam Sorilux® (calcipotriene) foam Taclonex® (calcipotriene/betamethasone ointment/scalp suspension) *QTY LIMIT:* Initial fill = 60 grams Tazarotene Cream, Gel Vtama® (tapinarof) cream Zoryve® (roflumilast) Cream	at least one month), adverse reaction, or contraindication to a preferred formulation of calcipotriene. **Methoxsalen, Oxsoralen Ultra:** The patient has a documented diagnosis of moderate to severe 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 topical agents and at least 1 oral systemic agent, unless otherwise contraindicated. **Limitations:** Kits with non-drug or combinations of 2 drug products are not covered.
PULMONARY AGENTS		
ANTICOLINERGICS: INHALED		
SHORT-ACTING BRONCHODILATORS ATROVENT HFA® (ipratropium) COMBIVENT® RESPIMAT (ipratropium/albuterol) *QTY LIMIT:* 3 inhalers (12 grams)/90 days IPRATROPIUM NEBULIZER SOLN IPRATROPIUM/ALBUTEROL NEBULIZER SOLN		**Tudorza:** The patient has had documented side effect, allergy or treatment failure with a preferred LAMA. **Bevespi Aerosphere, Duaklir Pressiar:** The patient has a documented side effect, allergy, or treatment failure to TWO preferred LAMA/LABA combinations. **Yupelri:** patient has a diagnosis of COPD (not FDA approved for asthma) AND has a failure of nebulized ipratropium solution AND at least 3 inhaled LAMAs. **Breztri:** patient has a diagnosis of COPD (not FDA approved for asthma) AND patient has a treatment failure of at least 2 different combinations of a preferred Inhaled Corticosteroid, LABA, and LAMA used in combination for a minimum of 30 consecutive days AND patient has a documented side effect, allergy, treatment failure, or contraindication with Trelegy Ellipta. **Trelegy Ellipta:** patient has a treatment failure of at least 2 different combinations of a preferred Inhaled Corticosteroid, LABA, and LAMA used in combination for a minimum of 30 consecutive days.
LONG-ACTING BRONCHODILATORS (LAMA) INCRUSE ELLIPTA® (umeclidinium bromide) *QTY LIMIT:* 3 inhalers/90 days SPIRIVA® HANDIHALER (tiotropium) *QTY LIMIT*: 1 capsule/day SPIRIVA® RESPIMAT (tiotropium) *QTY LIMIT:* 3 inhalers/90 days	Tudorza® Pressair® (aclidinium bromide) *QTY LIMIT*: 3 inhalers/90 days Yupelri™ (revefenacin) inhalation solution *QTY LIMIT:* 300 vials/30 days	
COMBINATION LONG-ACTING BRONCHODILATORS (LAMA & LABA) ANORO® ELLIPTA (umeclidinium/vilanterol) *QTY LIMIT:* 3 inhalers (180 blisters)/90 days STIOLTO® RESPIMAT (tiotropium/olodaterol) QTY LIMIT: 3 inhalers/90 days	Bevespi Aerosphere® (glycopyrrolate/formoterol) *QTY LIMIT:* 3 inhalers/90 days Duaklir® Pressair (aclidinium bromide/ formoterol fumarate) QTY LIMIT: 3 inhalers/90 days Breztri® Aerosphere (budesonide/glycopyrrolate/formoterol fumarate)	

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
LAMA/LABA/ICS COMBINATION All products require PA	QTY LIMIT: 1 inhaler (120 blisters)/30 days Trelegy® Ellipta (fluticasone/umeclidinium/vilanterol) *QTY LIMIT:* 1 inhaler (60 blisters)/30 days	
ANTIHISTAMINES: INTRANASAL		
SINGLE AGENT AZELASTINE 0.1% Nasal Spray *QTY LIMIT:* 1 bottle (30 ml)/25 days **COMBO WITH CORTICOSTEROID** DYMISTA® (azelastine/fluticasone) Nasal Spray *QTY LIMIT:* 1 bottle (23 gm)/30 days	Azelastine 0.15 % Nasal Spray *QTY LIMIT:* 1 bottle (30 ml)/25 days Olopatadine 0.6% (compare to Patanase®) Nasal Spray *QTY LIMIT:* 1 bottle (31 gm)/30 days Patanase® (olopatadine 0.6%) Nasal Spray *QTY LIMIT:* 1 bottle (31 gm)/30 days Azelastine/fluticasone (compare to Dymista®) Nasal Spray *QTY LIMIT:* 1 bottle (23 gm)/30 days Ryaltris® (olopatadine/mometasone) *QTY LIMIT:* 1 bottle (29 gm)/30days	**Azelastine 0.15%, Olopatadine, Patanase:** The patient has a documented side effect, allergy, or treatment failure to Azelastine 0.1% **Azelastine/Fluticasone, Ryaltris:** The patient has a documented side effect, allergy, or treatment failure to azelastine 0.1% AND The patient has a documented side effect, allergy, or treatment failure to a preferred nasal corticosteroid OR the patient has a documented intolerance to Dymista.
ANTIHISTAMINES:		
Please refer to the DVHA website for covered OTC antihistamines https://dvha.vermont.gov/sites/dvha/files/doc_library/OTCWebList_12.pdf	Clarinex® (desloratadine) 5 mg tablet Clarinex-D® 12 hr (desloratadine/pseudoephedrine 2.5 mg/120 mg) Desloratadine (compare to Clarinex®) 5 mg tablet Desloratadine ODT (compare to Clarinex Reditabs®) 2.5 mg, 5 mg Fexofenadine (compare to Allegra®) suspension Levocetirizine Solution	**LIMITATIONS:** Over-the-counter antihistamines are not covered for Members Age 21 and Older. **Clarinex tablets, Desloratadine tablets:** The patient is ≤ 20 years of age AND The patient has had a documented side effect, allergy, or treatment failure to 2 second generation antihistamines, at least one of which must be loratadine AND If the request is for Clarinex, the patient must also have a documented intolerance to the generic equivalent tablets. **Desloratadine ODT:** The patient is ≤ 20 years of age AND The patient has had a documented side effect, allergy, or treatment failure to cetirizine oral solution and one of the following loratadine formulations: chewable tablet, rapidly disintegrating tablet, or oral solution. **Fexofenadine suspension, Levocetirizine solution:** The patient is ≤ 20 years of age AND the patient has had a documented side effect, allergy, or treatment failure to loratadine syrup AND cetirizine syrup. **Clarinex-D:** The patient has had a documented side effect, allergy, or treatment failure to loratadine-D and cetirizine-D.
BETA-ADRENERGIC AGENTS		
METERED-DOSE INHALERS (SHORT-ACTING) ALBUTEROL HFA (Teva labeler code 00093 is	Albuterol HFA (all other labelers)	**Albuterol HFA, ProAir Digihaler:** The patient has a documented side effect, allergy, or treatment failure to two preferred short acting metered dose inhalers.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
the only preferred form) PROAIR® Respiclick (albuterol) VENTOLIN® HFA (albuterol) XOPENEX® HFA (levalbuterol)	Levalbuterol Aerosol (compare to Xopenex ® HFA) ProAir® Digihaler (albuterol)	**Levalbuterol HFA:** The patient has a documented intolerance to brand Xopenex HFA. **Serevent**: The patient has a diagnosis of asthma and is prescribed an inhaled corticosteroid (pharmacy claims will be evaluated to assess compliance with long term controller therapy) OR the patient has a diagnosis of COPD. **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 Serevent. **Levalbuterol nebulizer solution (age > 12 years):** The patient must have had a documented side effect, allergy, or treatment failure to albuterol nebulizer.
METERED-DOSE INHALERS (LONG-ACTING) ***Preferred After Clinical Criteria Are Met*** SEREVENT® DISKUS (salmeterol xinafoate) *QTY LIMIT:* 3 inhalers (180 blisters)/90 days	Striverdi Respimat® (olodaterol)	**Arformoterol, Brovana, Formoterol, 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 (Serevent or Spiriva) due to a physical limitation AND for approval of Brovana, Formoterol, or Perforomist, the patient must also have a documented intolerance or treatment failure with arformoterol. **Terbutaline tablets:** The medication is not being prescribed for the prevention/treatment of preterm labor.
NEBULIZER SOLUTIONS (SHORT-ACTING) ALBUTEROL neb solution (all strengths) LEVALBUTEROL neb solution (age ≤ 12 years)	Levalbuterol neb solution (compare to Xopenex®) (age > 12 years)	
NEBULIZER SOLUTIONS (LONG-ACTING) All products require PA	Arformoterol (compare to Brovana®) *QTY LIMIT*: 2 vials/day Brovana® (arformoterol) *QTY LIMIT*: 2 vials/day Formoterol (compare to Perforomist®) *QTY LIMIT*: 2 vials/day Perforomist® (formoterol) *QTY LIMIT:* 2 vials/day	
TABLETS/SYRUP (SHORT-ACTING) ALBUTEROL tablets/syrup	Terbutaline tablets	
CORTICOSTEROIDS/COMBINATIONS: INHALED		
METERED DOSE INHALERS (SINGLE AGENT) ARNUITY ELLIPTA (fluticasone furoate) *QTY LIMIT*: 90 blisters/90 days ASMANEX® (mometasone furoate)	Armonair® Digihaler (fluticasone propionate) *QTY LIMIT* = 3 inhalers/90 days Alvesco® (ciclesonide)	**Metered-dose inhalers (single agent):** The patient has had a documented side effect, allergy, or treatment failure to at least two preferred agents AND for approval of Asmanex HFA, there must be a clinically compelling reason the patient is unable to use Asmanex. **Advair HFA (age < 12 years):** The patient has had a documented side effect,

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
QTY LIMIT: 3 inhalers/90 days FLOVENT® DISKUS (fluticasone propionate) QTY LIMIT: 3 inhalers/90 days FLOVENT® HFA (fluticasone propionate) QTY LIMIT: 3 inhalers (36 gm)/90 days PULMICORT FLEXHALER® (budesonide) *QTY LIMIT:* 6 inhalers/90 days QVAR REDIHALER® (beclomethasone dipropionate) 40mcg/inh *QTY LIMIT:* 2 inhalers (21.2 gm)/90 days QVAR REDIHALER® 80mcg/inh *QTY LIMIT:* 3 inhalers (31.8 gm)/90 days	*QTY LIMIT:* 80 mcg = 3 inhalers/90 days Asmanex® (mometasone furoate) HFA *QTY LIMIT:* 3 inhalers (39 gm)/90 days Fluticasone propionate HFA (compare to Flovent® HFA) *QTY LIMIT:* 3 inhalers (36 gm)/90 days	allergy, or treatment failure to Dulera or Symbicort. **AirDuo Digihaler, Breo Ellipta, Fluticasone Furoate/Vilanterol, Fluticasone/Salmeterol (non-authorized generics):** The patient has had a documented side effect, allergy, or treatment failure to any 2 of the following: Advair HFA, Advair Diskus, Airduo Respiclick, Dulera, or Symbicort AND for approval of Fluticasone Furoate/Vilanterol, the patient must also have a documented intolerance to Breo Ellipta. **Budesonide/formoterol:** the patient has a documented intolerance to brand Symbicort. **Budesonide Inh Suspension:** Medical necessity for the use of a nebulized solution has been provided AND if the dose is 1mg, the patient must be unable to use two 0.5 mg vials **Fluticasone/salmeterol powder (authorized generic), Wixela Inhub:** A clinically compelling reason must be provided detailing why the patient is unable to use Advair HFA or Advair Diskus. **Pulmicort Respules:** medical necessity for the use of a nebulized solution has been provided AND if the dose is 1 mg, the patient must be unable to use two 0.5 mg vials AND the patient has a documented intolerance to the generic.
METERED DOSE INHALERS (COMBINATION PRODUCT) ADVAIR® DISKUS (fluticasone/salmeterol) (Age ≥ 4 years) *QTY LIMIT:* 3 inhalers/90 days ADVAIR® HFA (fluticasone/salmeterol) (Age ≥ 12 years) *QTY LIMIT:* 3 inhalers (36 gm)/90 days AIRDUO RESPICLICK® (fluticasone/salmeterol) *QTY LIMIT:* 3 inhalers/90 days DULERA® (mometasone/formoterol) *QTY LIMIT:* 9 inhalers (39 gm)/90 days SYMBICORT® (budesonide/formoterol) *QTY LIMIT:* 9 inhalers (91.8gm)/90 days	AirDuo® Digihaler (fluticasone/salmeterol) *QTY LIMIT:* 3 inhalers/90 days Breo Ellipta® (fluticasone furoate/vilanterol) *QTY LIMIT:* 3 inhalers (180 blisters)/ 90 days Budesonide/formoterol (compare to Symbicort®) *QTY LIMIT:* 9 inhalers (91.8gm)/90 days Fluticasone furoate/vilanterol (compare to Breo Ellipta®) *QTY LIMIT*: 3 inhalers (180 blisters)/90 days Fluticasone/salmeterol (compare to AirDuo Respiclick®) *QTY LIMIT:* 3 inhalers/90 days Fluticasone/salmeterol inhalation Powder (compare to Advair® Diskus) *QTY LIMIT:* 3 inhalers/90 days Wixela™ Inhub™ (fluticasone/salmeterol inhalation powder) (compare to Advair® Diskus) *QTY LIMIT:* 3 inhalers/90 days	
NEBULIZER SOLUTIONS BUDESONIDE INH SUSPENSION 0.25mg, 0.5mg (Age ≤ 12 yrs)	Budesonide Inh Suspension 1mg (all ages), 0.25mg and 0.5mg (age >12 years) Pulmicort Respules® (budesonide)	
CORTICOSTEROIDS: INTRANASAL		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
BUDESONIDE *QTY LIMIT:* 1 inhaler (8.43 ml)/30 days FLUTICASONE PROPIONATE *QTY LIMIT:* 1 inhaler (16 gm)/30 days OMNARIS® (ciclesonide) *QTY LIMIT:* 1 inhaler (12.5 gm)/30 days TRIAMCINOLONE *QTY LIMIT:* 1 inhaler (16.9 ml)/30 days ZETONNA® (ciclesonide) *QTY LIMIT:* 1 inhaler (6.1 gm)/30 days	Beconase AQ® (beclomethasone) *QTY LIMIT:* 2 inhalers (50 gm)/30 days Flunisolide 25 mcg/spray *QTY LIMIT:* 2 inhalers (50 ml)/30 days Mometasone (compare to Nasonex®) *QTY LIMIT:* 1 inhaler (17 gm)/30 days QNASL® (beclomethasone dipropionate) *QTY LIMIT:* 1 inhaler (10.6 gm)/30 days Xhance™ (fluticasone propionate) *QTY LIMIT:* 1 inhaler (16 ml)/30 days	**Beconase AQ, Flunisolide 25 mcg/spray, Mometasone, QNASL:** The patient has had a documented side effect, allergy, or treatment failure of two preferred nasal glucocorticoids. If a product has an AB rated generic, one trial must be the generic. **Xhance:** The patient has had a documented side effect, allergy, or treatment failure of three preferred nasal glucocorticoids, one of which must be fluticasone. **Limitations:** Nasacort Allergy OTC and Flonase are not covered as no Federal Rebate is offered.
LEUKOTRIENE MODIFIERS		
Preferred After Age Criteria Are Met MONTELUKAST SODIUM (compare to Singulair®) tablets, 10mg for ages ≥ 15 MONTELUKAST SODIUM (compare to Singulair®) chews, 4 mg for ages 2-5, 5 mg for age 6-14 MONTELUKAST SODIUM (compare to Singulair®) granules, ages 6 months-23 months	Accolate® (zafirlukast) *QTY LIMIT:* 2 tablets/day Singulair® (montelukast sodium) tablets, chew tabs, granules *QTY LIMIT:* 1 tablet or packet per day Zafirlukast (compare to Accolate®) Zileuton ER (compare to Zyflo CR®) *QTY LIMIT:* 4 tablets/day Zyflo (zileuton) *QTY LIMIT:* 4 tablets/day	**Montelukast:** Clinical rationale must be provided for prescribing a dose and formulation that differs from age recommendations AND If the request is for brand Singulair, 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. **Zileuton ER, Zyflo:** 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/Zafirlukast or Singulair/Montelukast
PHOSPHODIESTERASE-4 (PDE-4) INHIBITORS		
All products require PA	Daliresp® tablet (roflumilast) *QTY LIMIT:* 1 tablet/day Roflumilast (compare to Daliresp) tablet *QTY LIMIT:* 1 tablet/day *** Maximum days' supply per fill = 30 ***	**Daliresp, Roflumilast:** 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 at least one inhaled corticosteroid AND for approval of brand name Daliresp, the patient has had a documented intolerance to the generic equivalent.
SYNAGIS		
	SYNAGIS® (palivizumab) *QTY LIMIT:* 50 mg = 1 vial/month, 100 mg = 2 vials/month	**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

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		(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). • 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). • The prescriber must confirm the member has not already received Beyfortus™ for the current RSV season. Concomitant use with Beyfortus™ will not be approved. **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

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		therapy. • Breakthrough hospitalization for RSV disease (Synagis therapy should be discontinued for the season once hospitalization for RSV has occurred). • Infants and children with Down syndrome unless other indications above are present. • Infants and children with cystic fibrosis unless other specific conditions are present
PULMONARY ARTERIAL HYPERTENSION MEDICATIONS		
ENDOTHELIN RECEPTOR ANTAGONISTS AMBRISENTAN (compare to Letairis®) *QTY LIMIT*: 1 tablet/day BOSENTAN (compare to Tracleer) *QTY LIMIT:* 2 tablets/day **PROSTACYCLIN AGONISTS INJECTION** EPOPROSTENOL (compare to Flolan®) REMODULIN® (treprostinil sodium injection) VELETRI® (epoprostinil) **INHALATION** All products require PA **ORAL** ORENITRAM® (treprostinil) ER Tablet **sGC STIMULATOR** All products require PA ****Maximum days supply for all drugs is 30 days****	Letairis® (ambrisentan) Tablet *QTY LIMIT*: 1 tablet/day Opsumit® (macitentan) Tablet *QTY LIMIT*: 1 tablet/day Tracleer® tablets for oral suspension (32 mg) Tracleer® (bosentan) tablet (62.5 mg, 125 mg) *QTY LIMIT*: 2 tablets/day Flolan® (epoprostenol) Treprostinil sodium injection (compare to Remodulin®) Tyvaso® (Treprostinil) inhalation solution Tyvaso® DPI (treprostinil) powder for inhalation Ventavis® (iloprost) inhalation solution Uptravi® (selexipag) tablets *QTY LIMIT:* 200 mcg = 140 tablets/30 days for the first 2 months, then 2 tablets/day thereafter All other strengths = 2 tablets/day Adempas® (riociguat) Tablets *QTY LIMIT:* 3 tablets/day	**Adempas:** The patient has a diagnosis of pulmonary arterial hypertension (PAH) 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, Letairis, Tracleer:** patient has a documented intolerance to the generic equivalent. **Tracleer tablets for oral suspension:** Patient has a diagnosis of PAH with NYHA Functional Class II or III AND patient is ≤ 12 years of age and <40kg. **Opsumit:** Patient has a diagnosis of PAH with NYHA Functional Class II or III AND Patient is not pregnant AND Female patients have been enrolled in the REMS Program AND the patient has a documented side effect, allergy, or treatment failure with Tracleer or Letairis. **Treprostinil:** Patient has a diagnosis of pulmonary arterial hypertension AND The patient has had a documented intolerance to the brand Remodulin. **Tyvaso, Ventavis:** The patient has a diagnosis of pulmonary arterial hypertension (PAH) with New York Heart Association (NYHA) Functional Class II or III heart failure AND the patient is unable to tolerate or has failed 2 different preferred medications. **Uptravi:** The patient has a diagnosis of pulmonary arterial hypertension (PAH)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		with New York Heart Association (NYHA) Functional Class II or III heart failure AND the patient is unable to tolerate or has failed 2 different preferred medications, one of which must be Orenitram
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.**		
Preferred After Clinical Criteria Are Met SILDENAFIL CITRATE (compare to Revatio®) tablet *QTY LIMIT:* 3 tablets/day TADALAFIL (compare to Adcirca®) *QTY LIMIT:* 2 tablets/day	Adcirca® (tadalafil) *QTY LIMIT:* 2 tablets/day Revatio® (sildenafil) tabs *QTY LIMIT:* 3 tablets/day Revatio® (sildenafil citrate) suspension Revatio® (sildenafil citrate) vial *QTY LIMIT:* 3 vials/day Maximum 14-day supply per fill Sildenafil (compare to Revatio ®) suspension Sildenafil (compare to Revatio®) vial Tadliq® (tadalafil) suspension	**Sildenafil, Tadalafil:** Clinical Diagnosis of Pulmonary Hypertension **Adcirca (tadalafil) 20 mg, Revatio (sildenafil citrate) 20 mg:** Clinical diagnosis of pulmonary hypertension AND No concomitant use of organic nitrate-containing products AND patient has a documented intolerance to the generic equivalent. **Revatio Suspension, Sildenafil Suspension:** Clinical diagnosis of pulmonary hypertension AND medical necessity for a liquid formulation is provided OR the patient is unable to tolerate a 20 mg dose AND for approval of Revatio, the patient must have a documented intolerance to the generic equivalent. **Revatio IV, Sildenafil 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. **Tadliq:** Clinical diagnosis of pulmonary hypertension AND medical necessity for a liquid formulation is provided AND the patient has a documented side effect, allergy, or treatment failure with sildenafil suspension.
RENAL DISEASE: PHOSPHATE BINDERS		
CALCIUM ACETATE capsule CALCIUM ACETATE tablet SEVELAMER CARBONATE (compare to Renvela®) tablets **ORAL SOLUTIONS** PHOSLYRA® (calcium acetate) oral solution	Auryxia® (ferric citrate) *QTY LIMIT:* 12/day Fosrenol® (lanthanum carbonate) Lanthanum carbonate (compare to Fosrenol) Renagel® (sevelamer) Renvela® (sevelamer carbonate) Oral Suspension Packet *QTY LIMIT:* 0.8 g = 2 packs/day Renvela® (sevelamer carbonate) tablets Sevelamer carbonate Oral Suspension Packet (compare to Renvela®)	**Renvela Oral Suspension Packet, Sevelamer Packet:** The patient has a requirement for a liquid dosage form. **Auryxia, lanthanum carbonate, Renagel, Renvela tablets, sevelamer hydrochloride tablets, Velphoro Chew Tablet:** The patient must have a documented side effect, allergy, or inadequate response to one preferred phosphate binder.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	QTY LIMIT: 0.8 g = 2 packs/day Sevelamer hydrochloride (compare to Renagel®) Velphoro® (sucroferric oxyhydroxide) Chew Tablet	
RESTLESS LEG SYNDROME MEDICATIONS		
DOPAMINE AGONISTS (ORAL) PRAMIPEXOLE (compare to Mirapex®) ROPINIROLE (compare to Requip®) **DOPAMINE AGONISTS (TRANSDERMAL)** All products require PA **GAMMA-AMINOBUTYRIC ACID ANALOG** GABAPENTIN IR	Mirapex® (pramipexole) Neupro® (rotigotine) transdermal patch *QTY LIMIT:* 1, 2, and 3 mg ONLY = 1 patch/day Horizant® (gabapentin enacarbil) ER Tablet *QTY LIMIT:* 1 tablet/day	**Mirapex:** The patient has had a documented intolerance to the generic product. **Neupro:** The patient has a medical necessity for a specialty dosage form. **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 two preferred dopamine agonists AND gabapentin IR. **Limitations:** Requests for Mirapex ER and Requip XL will not be approved for Restless Leg Syndrome (RLS).
RHEUMATOID, JUVENILE & PSORIATIC ARTHRITIS: IMMUNOMODULATORS		
Preferred After Clinical Criteria Are Met **INJECTABLE** AVSOLA® (infliximab-axxq) biosimilar to Remicade® ENBREL® (etanercept) *QTY LIMIT:* 50 mg = 4 syringes/28 days, 25 mg = 8 syringes/28 days INFLECTRA® (infliximab-dyyb) biosimilar to Remicade® KINERET® (anakinra) *QTY LIMIT:* 1 syringe/day HUMIRA® (adalimumab) *QTY LIMIT:* 4 syringes/28 days TALTZ® (ixekizumab) *QTY LIMIT*: 80 mg prefilled syringe or autoinjector = 2/28 days for the first month and 1/28 days subsequently	Actemra® (tocilizumab) Intravenous Infusion *QTY LIMIT:* 80 mg vial = 4 vials/28 days, 200 mg vial = 3 vials/28 days, 400 mg vial = 2 vials/28 days Actemra® (tocilizumab) Subcutaneous Prefilled Syringe *QTY LIMIT:* 4 prefilled syringes (3.6ml)/28 days Actemra® (tocilizumab) ACTPen *QTY LIMIT:* 4 pens (3.6ml)/28 days Cimzia® (certolizumab pegol) *QTY LIMIT:* 1 kit/28 days Cosentyx® (secukinumab) Kevzara® (sarilumab) *QTY LIMIT:* 2 syringes/28 days Ilaris® (canakinumab) Orencia® (abatacept) Subcutaneous Injection *QTY LIMIT:* 4 syringes/28 days Orencia® (abatacept) Intravenous Infusion Remicade® (infliximab) Renflexis™ (Infliximab-abda) biosimilar to Remicade® Simponi® (golimumab) Subcutaneous *QTY LIMIT:* 50 mg = 1 prefilled syringe or autoinjector/28 days	**Clinical Criteria for all drugs:** Patient has a diagnosis of rheumatoid arthritis (RA), juvenile idiopathic arthritis* or psoriatic arthritis and has already been stabilized on the drug being requested 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 therapy. Other DMARDs include leflunomide, sulfasalazine, gold, antimalarials, minocycline, D-penicillamine, azathioprine, cyclophosphamide and cyclosporine **Taltz, Xeljanz, Xeljanz XR additional criteria:** patient must be ≥ 18 years of age AND the prescriber must provide evidence of a trial and failure or contraindication to a preferred TNF Inhibitor. **Note:** Xeljanz 10mg BID and XR 22mg are NOT recommended for Rheumatoid Arthritis or Psoriatic Arthritis. Please refer to Gastrointestinal: Inflammatory Bowel Disease Biologics for Ulcerative Colitis criteria. **Actemra, Cimzia, Cosentyx, Kevzara, Orencia, Simponi (subcutaneous), Skyrizi, Stelara, and Tremfya additional criteria:** The prescriber must provide clinically valid reason why at least 2 preferred agents cannot be used. **Ilaris:** The diagnosis is systemic juvenile idiopathic arthritis (sJIA) with active systemic features and varying degrees of synovitis with continued disease

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ORAL OTEZLA® tablet (apremilast) *QTY LIMIT*: Starter Pack = 55 tablets/28 days, 30 mg = 2 tablets/day Maximum 30 days supply XELJANZ® (tofacitinib) 5 mg tablet *QTY LIMIT*: 2 tablets/day Maximum 30 days supply XELJANZ® XR (tofacitinib) tablet *QTY LIMIT*: 1 tablet/day	Simponi Aria® (golimumab) 50 mg/4 ml Vial for Intravenous Infusion Skyrizi™ (risankizumab-rzaa) *QTY LIMIT:* 150 mg/28 days for the first month and 150mg/84 days thereafter Stelara® (ustekinumab) *QTY LIMIT*: 45 mg (0.5 ml) or 90 mg (1 ml) per dose (90 mg dose only permitted for pt weight > 100 kg) One dose/28 days for the first month and one dose/84 days thereafter Tremfya® (guselkumab) *QTY LIMIT:* 1 syringe/28 days for the first month, then 1 syringe every 56 days thereafter Olumiant® (baricitinib) tablets *QTY LIMIT*: 1 tablet/day Maximum 30 days supply Rinvoq ® (upadactinib) extended release tablet *QTY LIMIT: 1 tablet/day* Maximum 30 days supply	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. **Remicade, Renflexis additional criteria:** The prescriber must provide a clinically valid reason why at least 2 preferred agents cannot be used AND the patient must be unable to use Avsola or Inflectra. **Simponi Aria additional criteria:** The patient has not responded adequately to Simponi subcutaneous. AND The prescriber must provide a clinically valid reason why at least 2 preferred agents cannot be used. **Olumiant, Rinvoq additional criteria:** The patient must be ≥ 18 years of age AND The prescriber must provide a clinically valid reason why at least two preferred agents cannot be used, one of which must be Xeljanz or Xeljanz XR. **Note:** 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 the case of a contraindication to methotrexate is not required. * 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 and a DMARD trial are required (unless otherwise contraindicated).
SICKLE CELL DISEASE THERAPIES		
DROXIA® (hydroxyurea) 200 mg, 300 mg, 400 mg cap HYDROXYUREA (compare to Hydrea®) 500 mg cap	Adakveo® (crizanlizumab-tmca) Endari (L-glutamine powder for oral solution) *QTY LIMIT*: maximum of 30-day supply Hydrea® (hydroxyurea) 500 mg cap Oxbryta® (voxelotor) 500 mg tablet *QTY LIMIT:* 3 tablets/day Oxbryta® 300mg tablets for oral suspension Siklos® (hydroxyurea) 100 mg, 1000 mg tablet	**Adakveo:** Patient has a diagnosis of Sickle Cell Disease AND patient is at least 16 years of age or older AND patient has had an inadequate response to a 6-month trial of hydroxyurea dosed at 15-35 mg/kg/day, unless contraindicated AND patient has experienced at least 2 vaso-occlusive crises in the previous 12 months despite compliance with hydroxyurea. Initial approval will be granted for 6 months. For re-approval, the patient must have a decrease in the frequency or severity of VOC compared to baseline. **Note:** Adakveo will not be approved in conjunction with Oxbryta. **Endari:** Indication for use is to reduce the acute complications of Sickle Cell Anemia AND medication will be approved with quantity limits based on patient weight (<30kg = 2 packets/day, 30-65kg = 4 packets/day, > 65kg = 6 packets/day). **Hydrea:** Patient has had a documented intolerance to the generic equivalent. **Oxbryta:** Patient has a diagnosis of Sickle Cell Disease AND patient is at least 4 years of age or older AND patient has a baseline hemoglobin (Hb) ≤10.5 g/dL

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		AND patient has had an inadequate response to a 6-month trial of hydroxyurea dosed at 15-35 mg/kg/day, unless contraindicated AND patient has experienced at least 2 vaso-occlusive crises in the previous 12 months despite compliance with hydroxyurea. Initial approval will be granted for 6 months. For re-approval, the patient must have a decrease in the frequency or severity of VOC compared to baseline. **Note:** Oxbryta will not be approved in conjunction with Adakveo. **Siklos:** Patient has a diagnosis of Sickle Cell Anemia with recurrent moderate to severe pain crises AND the required dose is < 200mg OR Patient has a diagnosis of Sickle Cell Anemia with recurrent moderate to severe pain crises AND has a documented intolerance to a preferred hydroxyurea formulation. For re-approval, the patient must have a documented decrease in vaso-occlusive episodes, acute chest syndrome, SCD related hospitalizations, or blood transfusions.
SEDATIVE/HYPNOTICS		
BENZODIAZEPINE		
TEMAZEPAM 7.5mg, 15 mg, 30 mg (compare to Restoril®)	Estazolam Flurazepam Halcion® (triazolam) Restoril® (temazepam) Temazepam 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 Temazepam. If a product has an AB rated generic, one trial must be the generic.
NON BENZODIAZEPINE, NON BARBITURATE		
ESZOPICLONE (compare to Lunesta) *QTY LIMIT:* 1 tab/day ZALEPLON *QTY LIMIT:* 5 mg = 1 cap/day, 10 mg = 2 caps/day ZOLPIDEM (compare to Ambien®) *QTY LIMIT:* 1 tab/day ZOLPIDEM CR (compare to Ambien CR®) *QTY LIMIT:* 1 tab/day	Ambien® (zolpidem) *QTY LIMIT:* 1 tab/day Ambien CR® (zolpidem) *QTY LIMIT:* 1 tab/day Belsomra® (suvorexant) *QTY LIMIT:* 1 tab/day Dayvigo® (lemborexant) tablet *QTY LIMIT:* 1 tab/day Doxepin 3mg tablets (compare to Silenor) *QTY LIMIT:* 1 tab/day Edluar® (zolpidem) sublingual tablet *QTY LIMIT:* 1 tab/day Hetlioz® (tasimelteon) 20 mg oral capsule *QTY LIMIT:* 1 capsule/day Maximum days supply per fill is 30 days	**Ambien, Ambien CR, Lunesta:** The patient has had a documented intolerance to the generic equivalent. **Belsomra:** The patient has had a documented side effect, allergy, or treatment failure to one preferred sedative/hypnotic. **Dayvigo, Quviviq:** The patient has had a documented side effect, allergy, or treatment failure to two preferred sedative/hypnotics and Belsomra. **Edluar, Zolpidem sublingual:** The patient has a medical necessity for a disintegrating tablet formulation (i.e. swallowing disorder). **Hetlioz:** Patient has documentation of Non-24-Hour Sleep-Wake Disorder (Non24) or Insomnia due to Smith-Magenis Syndrome AND Patient has had a documented side effect, allergy or treatment failure with Rozerem and at least one OTC melatonin product. **Ramelteon, Rozerem:** The patient has had a documented side effect, allergy, contraindication, or treatment failure to one preferred sedative/hypnotic OR

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Lunesta® (eszopiclone) *QTY LIMIT:* 1 tab/day Quviviq™ (daridorexant) *QTY LIMIT*: 1 tab/day Ramelteon (compare to Rozerem®) *QTY LIMIT:* 1 tab/day Rozerem® (ramelteon) *QTY LIMIT:* 1 tab/day Silenor® (doxepin) *QTY LIMIT:* 1 tab/day Zolpidem sublingual tablet *QTY LIMIT:* 1 tab/day	the patient has had a treatment failure after a minimum 2-week trial of melatonin. OR There is a question of substance abuse with the patient or family of the patient. If the request is for Ramelteon, there must also have been a documented intolerance to brand Rozerem. **Silenor:** The patient has had a documented side effect, allergy, contraindication, or treatment failure to two preferred sedative/hypnotics AND The patient has had a documented intolerance with a preferred generic doxepin formulation.
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 LOZENGE NICOTINE PATCH OTC NICOTROL® (nicotine) NASAL SPRAY **ORAL THERAPY** BUPROPION SR (compare to Zyban®) CHANTIX® (varenicline) (Limited to 18 years and older) *QTY LIMIT:* 2 tabs/day Max duration 24 weeks (2x12 weeks)/365 days) VARENICLINE (Limited to 18 years and older) *QTY LIMIT:* 2 tabs/day Max duration 24 weeks (2x12 weeks)/365 days)	Nicotrol Inhaler®	**Nicotrol Inhaler:** The patient has had a documented treatment failure with nicotine patch used in combination with nicotine gum or lozenge. *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) https://802quits.org/ **GETQUIT™** Support Plan available free to all Chantix® patients 1-877-CHANTIX (242-6849) https://www.get-quit.com/

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
SUBSTANCE USE DISORDER TREATMENTS		
ALCOHOL USE DISORDER		
ACAMPROSATE DISULFIRAM NALTREXONE VIVITROL® (naltrexone for extended-release injectable suspension) *QTY LIMIT:* 1 injection (380 mg) per 28 days		
OPIOID USE DISORDER		
Oral NALTREXONE tablet BUPRENORPHINE/NALOXONE TABLET *QTY LIMIT:* 8 mg = 3 tablets/day, 2mg N/A (Maximum Daily Dose = 24 mg/day, PA required for over 24 mg) SUBOXONE® sublingual FILM (buprenorphine/naloxone) *QTY LIMIT:* 4mg = 1 film per day, 8 mg = 3 films per day, 12mg = 2 films per day, 2mg N/A (Maximum daily Dose = 24 mg/day, PA required for over 24 mg) ***Maximum days supply for Suboxone Films, Buprenorphine/naloxone tablets is 30 days*** **Injectable** BRIXADI® (buprenorphine extended-release) injection WEEKLY *QTY LIMIT:* 1 syringe per week; maximum days' supply 28 days (Note: Two 8 mg syringes may be approved for initial titration purposes in patients not currently receiving buprenorphine) BRIXADI® (buprenorphine extended-release) injection MONTHLY *QTY LIMIT:* 1 syringe per 28 days SUBLOCADE® (buprenorphine extended-release) injection *QTY LIMIT:* 300mg 1 injection per 28 days for a maximum of 2 months, then 100mg 1 injection per	Buprenorphine sublingual tablet *QTY LIMIT:* 2 mg N/A, 8 mg = 3 tablets/day Maximum Daily Dose = 24 mg/day Buprenorphine/naloxone (compare to Suboxone®) sublingual film *QTY LIMIT:* 4mg = 1 film per day, 8 mg = 3 films per day, 12mg = 2 films per day, 2mg N/A Maximum daily Dose = 24 mg/day Zubsolv® (buprenorphine/naloxone) sublingual tablet *QTY LIMIT:* 1 tablet per day of all strengths ****Maximum days supply for oral buprenorphine/naloxone films or buprenorphine is 30 days****	**CLINICAL CONSIDERATIONS:** These products are not FDA approved for alleviation of pain. For this indication, please refer to the Opioid Analgesics PDL category. **Note:** As of 1/1/23, a completed Buprenorphine safety checklist (page 2 of the buprenorphine Spoke (OBOT) prior authorization form) must be submitted with all PA requests. **Buprenorphine/naloxone films, Zubsolv, Buprenorphine tablets:** The patient has experienced a current or past intolerance to the preferred products that cannot be resolved or mitigated through alternative efforts AND the Buprenorphine Safety Checklist has been completed (see PA form for detailed requirements). **Requests to exceed quantity limits or maximum daily dose:** Documentation must be submitted explaining medical necessity for requested dosage regimen AND the Buprenorphine Safety Checklist has been completed (see PA form for detailed requirements). **Requests for treatment of pain AND opioid use disorder:** The Buprenorphine Safety Checklist has been completed (see PA form for detailed requirements and for documentation required) AND other non-opioid medications and pain management modalities have been trialed prior to increasing the buprenorphine dose for pain AND split dosing (multiple daily administrations) on current dose have been trialed for pain control as recommended in the ASAM 2020 practice guidelines AND clinical rationale has been provided if the request is for a dose increase > 25% the current daily dose. **Sublocade (to exceed quantity limits):** A maintenance dose increase to 300mg will be considered for those patients who are able to tolerate the 100mg dose but do not demonstrate a satisfactory clinical response (including supplemental oral buprenorphine dosing, documentation of self-reported illicit opioid use, or urine drug screens positive for illicit opioid use). Once the patient is established on a maintenance dose, concurrent use of Sublocade and supplemental oral buprenorphine dosing will not be permitted. Sublocade must be dispensed

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
28 days thereafter VIVITROL® (naltrexone for extended-release injectable suspension) *QTY LIMIT:* 1 injection (380 mg) per 28 days **Note:** Methadone for opioid use disorder can only be prescribed through a Methadone Maintenance Clinic		directly to a healthcare provider and will not be approved for dispensing to the patient.
OPIOID WITHDRAWAL TREATMENT		
Central Alpha Agonists CLONIDINE IR tablets (compare to Catapres®) **Note:** Methadone for opiate dependency or withdrawal can only be prescribed through a Methadone Maintenance Clinic	Lucemyra® (lofexidine) Maximum length of therapy = 14 days	**Lucemyra:** Indication for use is the mitigation of opioid withdrawal symptoms to facilitate abrupt opioid discontinuation AND the patient is ≥ 18 years of age AND the patient is unable to tolerate clonidine due to significant side effects.
OVERDOSE TREATMENT		
KLOXXADO™ (naloxone HCl) 8mg Nasal Spray *QTY LIMIT:* 4 single-use sprays/28days NALOXONE HCl OTC 4 mg Nasal Spray *QTY LIMIT*: 4 single-use sprays/28days NALOXONE HCL Prefilled luer-lock needleless syringe plus intranasal mucosal atomizing device (Rescue kit) NARCAN® OTC (naloxone hcl) 4mg Nasal Spray *QTY LIMIT:* 4 single-use sprays/28days	Naloxone HCl RX (compare to Narcan® 4 mg Nasal Spray) *QTY LIMIT:* 4 single-use sprays/28days Zimhi™ (naloxone HCl) 5mg Prefilled Syringe	**Naloxone Nasal Spray (RX version):** Narcan or OTC Naloxone nasal spray must be on a backorder and unavailable from the manufacturer. **Zimhi:** The prescriber must provide a clinically compelling reason why the preferred agents would not be suitable alternatives.
TESTOSTERONE REPLACEMENT THERAPY		
TOPICAL		
ANDRODERM® Transdermal 2 mg, 4 mg (testosterone patch) *QTY LIMIT*: 1 patch/day/strength TESTOSTERONE 1.62% Gel Packets *QTY LIMIT:* 1.25 gm packet (1.62%) = 1 packet/day, 2.5 gm packet (1.62%) = 2 packets/day TESTOSTERONE 1.62% Gel Pump (compare to Androgel®)	Androgel® pump 1.62% (testosterone pump bottles) *QTY LIMIT:* 2 bottles/30 days Fortesta® (testosterone 2 % Gel) 60 gm Pump Bottle *QTY LIMIT:* 2 bottles/30 days Testim® Gel 5 gm (testosterone 1% gel tube) *QTY LIMIT:* 2 tubes/day Testosterone 1% gel tube (compare to Testim® Gel 5 gm,	**Non-preferred agents:** The patient has a documented side effect, allergy, or treatment failure to at least two preferred topical products.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
QTY LIMIT: 2 bottles/30 days TESTOSTERONE 1% Gel Packets (compare to Androgel®,Vogelxo®) *QTY LIMIT:* 2.5 gm packet = 1 packet/day, 5 gm packet = 2 packets/day TESTOSTERONE 2% solution 90ml Pump Bottle	Vogelxo®, Androgel®) *QTY LIMIT:* 2 tubes/day Testosterone 1% Gel Pump (compare to Vogelxo®) *QTY LIMIT:* 4 bottles/30 days Testosterone 2% gel 60 gm pump bottle (compare to Fortesta®) *QTY LIMIT:* 2 bottles/30 days Vogelxo® 1% (testosterone 1%) gel, pump *QTY LIMIT:* 2 tubes/day (5 gm gel tubes), 4 bottles/30 days (gel pump bottle)	
NASAL		
All products require PA	Natesto® (testosterone) nasal gel *QTY LIMIT:* 3 bottles/30 days	**Natesto:** The patient has had a documented side effect, allergy, or treatment failure to TWO preferred testosterone products (topical and/or injectable formulations)
ORAL		
All products require PA	Methitest (methyltesterone) tablet 10 mg Methyltestosterone capsule 10 mg Tlando (testosterone undecanoate) capsule *Maximum day supply all products is 30 days*	**Oral non-preferred agents:** The patient has had a documented side effect, allergy, or treatment failure to TWO preferred testosterone products (topical and/or injectable formulations) AND if the request is for Methitest or methyltestosterone, the patient has had a documented side effect, allergy, or treatment failure with Tlando.
INJECTABLE		
TESTOSTERONE CYPIONATE IM (compare to Depo®-Testosterone) TESTOSTERONE ENANTHATE IM	Aveed® (testosterone undecanote) IM Depo®-Testosterone (testosterone cypionate) IM Testopel® (testosterone) implant pellets Xyosted™ (testosterone enanthate) SC	**Depo-Testosterone:** The patient has a documented intolerance to generic testosterone cypionate. **Aveed, Testopel, Xyosted:** The patient has had a documented side effect, allergy, or treatment failure to TWO preferred testosterone products, one of which must be an injectable formulation. Treatment failure is defined as inability to achieve testosterone values in the 300-1,000ng/dL range despite adjustments to dose and frequency of injection.
URINARY ANTISPASMODICS		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
SHORT-ACTING AGENTS OXYBUTYNIN **LONG-ACTING AGENTS** OXYBUTYNIN XL (compare to Ditropan® XL) *QTY LIMIT:* 1/day SOLIFENACIN (compare to Vesicare®) *QTY LIMIT:* 1/day TOVIAZ® (fesoterodine) *QTY LIMIT:* 1/day **TRANSDERMAL/TOPICAL** All products require PA **BETA-3 ADRENERGIC AGONISTS** MYRBETRIQ® (mirabegron) ER Tablet *QTY LIMIT*: 1 tablet/day	Detrol® (tolterodine) Flavoxate Tolterodine (compare to Detrol®) Trospium Darifenacin ER (compare to Enablex®) Ditropan XL® (oxybutynin XL) Tolterodine SR (compare to Detrol LA®) Trospium ER Vesicare® (solifenacin) Vesicare LS™ (solifenacin) oral suspension Gelnique 10%® (oxybutynin topical gel) *QTY LIMIT:* 1 sachet/day Oxytrol® (oxybutinin transdermal) *QTY LIMIT:* 8 patches/28 days Gemtesa® (vibegron) tablet *QTY LIMIT:* 1 tablet/day Myrbetriq® ER Granules for Suspension	**Darifenacin, Detrol, Ditropan XL, tolterodine (generic), tolterodine SR (generic), trospium (generic), trospium ER (generic), Vesicare:** The patient has had a documented side effect, allergy, or treatment failure with two preferred long-acting agents. If a medication has an AB rated generic, there must have also been a trial of the generic formulation. **Gelnique 10%, Oxytrol:** The patient is unable to swallow a solid oral formulation (e.g. patients with dysphagia) OR The patient is unable to be compliant with solid oral dosage forms. **Gemtesa:** The patient has had a documented side effect, allergy, treatment failure, or contraindication with one preferred long-acting urinary antimuscarinic agent and Myrbetriq. **Myrbetriq Granules, Vesicare LS:** The patient has a diagnosis of neurogenic detrusor overactivity AND the patient has a documented side effect, allergy, or treatment failure with oxybutynin or Toviaz AND for patients ≥ 18 years of age, medical necessity has been provided for a liquid formulation. **Limitations:** Oxytrol (for Women) OTC not covered. Oxytrol RX is available but subject to prior authorization.
VAGINAL ANTI-INFECTIVES		
CLEOCIN® Vaginal Ovules (clindamycin vaginal suppositories) CLINDAMYCIN VAGINAL (clindamycin vaginal cream 2%) CLINDESSE® (clindamycin vaginal cream 2%) CLOTRIMAZOLE Vaginal cream MICONAZOLE Nitrate Vaginal cream, suppositories MICONAZOLE 1 Vaginal Kit MICONAZOLE 3 Vaginal Kit, cream MICONAZOLE 7 Vaginal cream, suppositories METRONIDAZOLE VAGINAL GEL 0.75%	Cleocin® (clindamycin vaginal cream 2%) Gynazole-1® (butoconazole vaginal cream 2%) Nuvessa™ (metronidazole 1.3% Vaginal Gel) Solosec™ (secnidazole) oral granules packet Terconazole (compare to Terazol®) vaginal cream 0.4%, 0.8%, vaginal suppositories 80 mg Vandazole (metronidazole vaginal 0.75%) Xaciato™ (clindamycin vaginal gel 2%)	**Cleocin, Xaciato:** The patient has had a documented side effect, allergy, or treatment failure to a preferred clindamycin vaginal cream. **Nuvessa, Vandazole:** The patient has had a documented side effect, allergy, or treatment failure to preferred metronidazole vaginal gel. **Solosec:** The patient has had a documented side effect, allergy, or treatment failure to a preferred topical anti-infective and oral metronidazole. **Gynazole, Terconazole:** The patient has a documented side effect, allergy, or treatment failure to a preferred miconazole or clotrimazole formulation.
VASOPRESSIN RECEPTOR ANTAGONIST		
	Jynarque® tablets (tolvaptan) *QTY LIMIT:* 56 tablets/28 days	**Jynarque:** The patient must be ≥ 18 years of age AND the patient is at risk of rapidly progressing Autosomal Polycystic Kidney Disease (ADPKD) AND the

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Samsca® tablets (tolvaptan) *QTY LIMIT*: 15 mg = 1 tablet/day, 30 mg 2 tablets/day	patient has normal serum sodium concentrations before starting the medication (results must be submitted) AND the patient and provider are enrolled in the Jynarque® REMS program **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
VITAMINS: PRENATAL MULTIVITAMINS		
C-NATE DHA M-NATAL PLUS NIVA-PLUS PRENATAL PLUS IRON PRENATAL VITAMINS PLUS SE-NATAL CHEW WESTAB PLUS	All others	**All 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.