



**EFFECTIVE**  
**Version**  
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## 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.

<p><b>GHS/Change Healthcare          PRESCRIBER Call Center:</b>          PA Requests          Tel: 1-844-679-5363; Fax: 1-844-679-5366          Note: Fax requests are responded to within 24 hrs.</p>	<p><b>Change Healthcare          PHARMACY Call Center:</b>          PA Requests          Tel: 1-844-679-5362          Available for assistance with claims processing</p>	<p><b>GHS/Change Healthcare Sr. Account Manager:</b>          Michael Ouellette, RPh          Tel: 802-922-9614          Fax:          E-Mail: <a href="mailto:mouellette@changehealthcare.com">mouellette@changehealthcare.com</a></p>
	<p><b>DVHA Pharmacy Unit Staff:</b>          Stacey Baker          Tel: 802-241-0140          Fax: 802-879-5651          E-Mail: <a href="mailto:stacey.baker@vermont.gov">stacey.baker@vermont.gov</a></p>	<p><b>DVHA Pharmacy Administration:</b>  <i>Director of Pharmacy Services</i>          Nancy Hogue, Pharm. D.          Tel: 802-241-0143          Fax: 802-879-5651          E-mail: <a href="mailto:nancy.hogue@vermont.gov">nancy.hogue@vermont.gov</a></p>

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

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PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<b>ACNE AGENTS</b>		
<b>ORAL AGENTS</b>		
ISOTRETINOIN CAP (AMNESTEEM, CLARAVIS, MYORISAN, ZENATANE)	Absorica® (isotretinoin) capsules	<b>Absorica:</b> patient has had a documented side effect, allergy, or treatment failure with at least two isotretinoin preferred products.
<b>TOPICAL AGENTS</b>		
<p><b><u>BENZOYL PEROXIDE PRODUCTS</u></b> BENZOYL PEROXIDE 2.5%, 5%, 10%G; 3%, 5%, 10% CL; 5.3%, 9.8% F PANOXYL; 4%, 10% CL,</p> <p><b><u>CLINDAMYCIN PRODUCTS</u></b> CLINDAMYCIN 1% S, G, L, P,</p> <p><b><u>ERYTHROMYCIN PRODUCTS</u></b> ERYTHROMYCIN 2% S, G</p> <p><b><u>MINOCYCLINE PRODUCTS</u></b> All Products Require PA</p> <p><b><u>SODIUM SULFACETAMIDE PRODUCTS</u></b> All Products Require PA</p> <p><b><u>COMBINATION PRODUCTS</u></b> ERYTHROMYCIN / BENZOYL PEROXIDE CLINDAMYCIN/BENZOYL PEROXIDE (compare to Benzaclin®) G</p> <p><b><u>OTHER</u></b> C=cream, CL=cleanser, E=emulsion, F=foam, G=gel, L=lotion, O=ointment, P=pads, S=solution, W=wash, B=bar</p>	<p>Benzol Peroxide 6%CL; 5%, 10%L</p> <p>Clindamycin 1%F Cleocin-T® (clindamycin) 1% S, P, L, G</p> <p>Erygel® (erythromycin 2% G)</p> <p>Amzeeq® (minocycline) 4% foam</p> <p>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)</p> <p>Benzaclin® (clindamycin/benzoyl peroxide) Benzamycin® (erythromycin/benzoyl peroxide) Clindamycin/Benzoyl Peroxide Pump Onexton® (clindamycin/benzoyl peroxide)</p> <p>Aczone® (dapsons 5% G) Azelex® (azelaic acid 20% C) Dapsone (compare to Aczone) 5% G</p> <p>All other brands any topical acne anti-infective medication</p>	<p><b>Single ingredient products:</b> 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.</p> <p><b>Combination products:</b> patient has had a documented side effect, allergy, or treatment failure with generic erythromycin/benzoyl peroxide or clindamycin/benzoyl peroxide. (If a product has an AB rated generic, there must have been a trial of the generic.) AND patient has had a documented side effect or treatment failure on combination therapy with the separate generic ingredients of the requested combination product, if applicable.</p> <p><b>Azelex:</b> the diagnosis or indication is acne AND patient has had a documented side effect, allergy, or treatment failure with two generic topical anti-infective agents (benzoyl peroxide, clindamycin, erythromycin, erythromycin/benzoyl peroxide).</p> <p><b>Clindamycin/Benzoyl peroxide pump:</b> there must be a clinically compelling reason why clindamycin/benzoyl peroxide gel cannot be used.</p> <p><b>Limitations:</b> Kits with non-drug products are not covered</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<b>TOPICAL - RETINOIDS</b>		
<p>AVITA<sup>®</sup> (tretinoin) DIFFERIN<sup>®</sup> (adapalene) 0.1% C, G; L 0.3% G RETIN-A<sup>®</sup> (tretinoin) 0.025%, 0.05%, 0.1% C; 0.01%, 0.025% G</p> <p>C= cream, G=gel, L=lotion</p>	<p>Adapalene (compare to Differin<sup>®</sup>) 0.1% C, G, 0.3% G <b>Adapalene/Benzoyl Peroxide (compare to Epiduo) 0.1-2.5% G</b> Aklief<sup>®</sup> (trifarotene) 0.005% C Altreno<sup>™</sup> (tretinoin) 0.05% L Arazlo<sup>®</sup> (tazarotene) 0.045% L Atralin<sup>®</sup> (tretinoin) 0.05% G Clindamycin/tretinoin 1.2-0.025% G <b>Epiduo Forte (adapalene/benzoyl peroxide) 0.3-2.5% G</b> Fabiator<sup>®</sup> (tazarotene) 0.1% F Plixda<sup>®</sup> (adapalene) 0.1% swabs Retin-A Micro<sup>®</sup> (tretinoin microsphere) 0.04%, 0.06%, 0.08%, 0.1% G Tazarotene (compare to Tazorac<sup>®</sup>) 0.1% C Tretinoin (compare to Retin-A<sup>®</sup>) 0.025%, 0.05%, 0.1% C; 0.01%, 0.025% G Tretinoin microsphere (compare to Retin-A Micro<sup>®</sup>) 0.1%, 0.04%</p>	<p><b>Altreno, Atralin, Retin-A Micro, tretinoin, tretinoin microsphere:</b> 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<sup>®</sup>).</p> <p><b>Adapalene:</b> patient has had a documented side effect, allergy, or treatment failure with the brand name equivalent.</p> <p><b>Aklief, Arazlo, Fabior, Tazarotene:</b> patient has had a documented side effect or treatment failure with a preferred topical tretinoin product and Differin.</p> <p><b>Adapalene/benzoyl peroxide gel, Clindamycin/tretinoin gel, Epiduo Forte:</b> patient has had a documented side effect or treatment failure on combination therapy with the separate ingredients of the combination product</p> <p><b>Plixda:</b> patient has had a documented side effect, allergy, or treatment failure with brand Differin AND a generic adapalene product.</p> <p><b>Limitations:</b> Coverage of topical retinoid products will not be approved for cosmetic use (wrinkles age spots, etc.) (i.e. Avage, Renova, Tri-Luma).</p>
<b>TOPICAL - ROSACEA</b>		
<p>FINACEA<sup>®</sup> (azelaic acid) 15% G, F METRONIDAZOLE 0.75% C, G, L</p> <p>C=cream, F=foam, G=gel, L=lotion</p>	<p>All brand metronidazole products (MetroCream<sup>®</sup> 0.75% C, Metrogel<sup>®</sup> 1% G, MetroLotion<sup>®</sup> 0.75% L, Noritate<sup>®</sup> 1% C etc.) Metronidazole 1% G Soolantra<sup>®</sup> (ivermectin) Zilxi<sup>®</sup> (minocycline) 1.5% F</p>	<p><b>Brand name metronidazole products, metronidazole 1% gel (generic), and Soolantra:</b> 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.</p> <p><b>Zilxi:</b> 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.</p> <p><b>Limitations:</b> 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.</p>
<b>ADHD AND NARCOLEPSY CATAPLEXY MEDICATIONS</b>		
<b>SHORT/INTERMEDIATE ACTING STIMULANTS</b>		
<p>AMPHETAMINE/DETROAMPHETAMINE (compare to Adderall<sup>®</sup>)</p>	<p>Amphetamine Sulfate (compare to Evekeo) Dextroamphetamine IR (Zenzedi 5 or 10 mg, formerly</p>	<p><b>Clinical Criteria for ALL non-preferred drugs:</b> 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</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<p>DEXMETHYLPHENIDATE (compare to Focalin®) METHYLIN® (compare to Ritalin®) solution METHYLPHENIDATE (compare to Ritalin®) tablets, solution METHYLPHENIDATE SR (compare to Ritalin® SR)</p>	<p>Dexedrine® Evekeo® (amphetamine sulfate) Evekeo® ODT (amphetamine sulfate) Focalin® (dexamethylphenidate) Ritalin® (methylphenidate) Adderall® (amphetamine/dextroamphetamine) Desoxyn® (methamphetamine) Dextroamphetamine sulfate 1 mg/ml oral solution Methamphetamine (compare to Desoxyn®) Methylphenidate (compare to Ritalin®) chewable tablets Procentra® (dextroamphetamine sulfate) 1 mg/ml oral solution Zenedi® (dextroamphetamine IR) 2.5 mg, 7.5 mg, 15 mg, 20 mg, 30 mg tablets</p>	<p>for stabilization.) OR patient meets additional clinical criteria outlined below. <b>Focalin, Adderall, Ritalin:</b> the patient must have had a documented intolerance to the preferred generic equivalent. <b>Methamphetamine and Desoxyn:</b> 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. <b>Methylphenidate chewable tablets:</b> patient has a documented intolerance to methylphenidate tablets and Methylin solution. <b>Evekeo ODT, Procentra, Dextroamphetamine oral solution:</b> patient has a medical necessity for a non solid oral dosage form. (e.g. swallowing disorder). AND if the request is for Evekeo ODT or Procentra, the patient has a documented intolerance to generic dextroamphetamine oral solution. <b>Amphetamine Sulfate, Dextroamphetamine IR, Zenedi, Evekeo:</b> 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.)</p>
<b>LONG ACTING STIMULANTS</b>		
<b><u>METHYLPHENIDATE PRODUCTS</u></b>		
<b><u>ORAL</u></b>		
<p>APTENSIO®XR (methylphenidate DR 24HR IR/.ER, 40:60%) CONCERTA® (methylphenidate SA OSM IR/ER, 22:78%) FOCALIN® XR (dexamethylphenidate SR 24 HR IR/ER, 50:50%) QUILLICHEW ER™ (methylphenidate IR/ER, 30:70%) chewable tablets</p>	<p>Adhansia® XR (methylphenidate IR/ER 20:80%) <i>QTY LIMIT:</i> 1 capsule/day Cotempla® XR (methylphenidate IR/ER 25:75%) ODT Dexamethylphenidate SR 24 HR IR/ER, 50:50% (compare to Focalin XR®) Jornay PM™ (methylphenidate ER) capsules <i>QTY LIMIT:</i> 1 capsule/day Methylphenidate CR, IR/ER, 30:70% (compare to Metadate CD®) Methylphenidate SA OSM IR/ER, 22:78% (compare to Concerta®) Methylphenidate SR 24 HR, IR/ER, 50:50% (compare to Ritalin LA®) Ritalin LA® (methylphenidate SR 24 HR, IR/ER, 50:50%)</p>	<p><b>Clinical criterial for ALL non-preferred drugs:</b> 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. <b>Ritalin LA, and Methylphenidate CR, Methylphenidate SR 24 HR:</b> patient has had a documented side-effect, allergy, or treatment failure on one preferred long-acting Methylphenidate product AND for approval of Ritalin LA, the patient must have a documented intolerance to the generic equivalent. <b>Dexamethylphenidate SR 24 HR ER (generic):</b> patient must have a documented intolerance to the brand name equivalent. <b>Adhasia XR, Cotempla XR ODT, Jornay PM:</b> patient has had a documented side- effect, allergy, or treatment failure on 3 preferred long-acting Methylphenidate products. <b>Methylphenidate SA OSM:</b> the patient must have a documented intolerance to brand Concerta.</p>
<b><u>ORAL SUSPENSION</u></b>		
<p>QUILLIVANT XR® (methylphenidate IR/ER, 20:80%) <i>QTY LIMIT:</i> 1 bottle (60ml, 120ml, 150ml)/30days 2 bottles (180ml)/30days</p>		
<b><u>TRANSDERMAL</u></b>		
<p>All products require PA</p>	<p>Daytrana® (methylphenidate patch) <i>QTY LIMIT:</i> 1 patch/day</p>	<p><b>Daytrana patch:</b> patient has a documented medical necessity for a specialty non- oral dosage form.</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<p><b><u>AMPHETAMINE PRODUCTS</u></b> <b><u>ORAL</u></b> 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, chewable tablet <i>QTY LIMIT:</i> 1 cap or tab/day</p>	<p>Adzenys XR® ODT (amphetamine SR 24 HR, IR/ER, 50:50%) <i>QTY LIMIT:</i> 1 cap/day Adzenys ER™ suspension (amphetamine SR 24 HR, IR/ER, 50:50%) Dyanavel™ suspension (amphetamine/dextroamphetamine SR) <i>QTY LIMIT:</i> 240ml/30days Dexedrine CR® (dextroamphetamine 24 HR SR) Dextroamphetamine 24 HR SR (compare to Dexedrine CR®) Mydayis® (mixed amphetamine salts) extended-release capsules</p>	<p><b>Adzenys XR ODT, Adzenys ER suspension:</b> patient has had a documented side-effect, allergy, or treatment failure to Vyvanse chewable. <b>Dexedrine CR, dextroamphetamine SR, Dyanavel, Mydayis:</b> 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.</p>
<b>MISCELLANEOUS</b>		
<p>ARMODAFINIL (compare to Nuvigil®) <i>QTY LIMIT:</i> 50 mg = 2 tabs/day 150 mg/200 mg/250 mg = 1 tab/day, Max days supply = 30 days ATOMOXETINE (compare to Strattera®) <i>QTY LIMIT:</i> 10, 18, 25 and 40 mg = 2 capsules/day 60, 80 and 100 mg = 1 capsule/day FDA maximum recommended dose = 100 mg/day GUANFACINE ER (Intuniv®) MODAFINIL (compare to Provigil®) <i>QTY LIMIT:</i> 100 mg = 1.5 tablets/day; 200 mg = 2 tablets/day Maximum Daily Dose = 400 mg, Max day supply = 30 days</p>	<p>Clonidine ER (compare to Kapvay®) <i>QTY LIMIT:</i> 4 tabs/day Intuniv® (guanfacine extended release) Tablet <i>QTY LIMIT:</i> 1 tablet/day Nuvigil® (armodafinil) <i>QTY LIMIT:</i> 50 mg = 2 tablets/day; 150 mg/200 mg/250 mg = 1 tablet/day, Max days supply = 30 days Provigil® (modafinil) <i>QTY LIMIT:</i> 100 mg = 1.5 tablets/day; 200 mg = 2 tablets/day Maximum Daily Dose = 400 mg, Max day supply = 30 days Strattera® (atomoxetine) <i>QTY LIMIT:</i> 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 <i>QTY LIMIT:</i> 1 tablet/day FDA maximum recommended dose = 150 mg/day Wakix® (pitolisant) tablet <i>QTY LIMIT:</i> 2 tablets/day FDA maximum recommended dose = 35.6 mg/day Xyrem® (sodium oxybate) oral solution <i>QTY LIMIT:</i> 540 ml/30 days Xywav™ (calcium, magnesium, potassium, and sodium</p>	<p><b>Clonidine ER:</b> patient has had a documented side effect, allergy, or treatment failure to guanfacine ER. <b>Intuniv, Nuvigil, Provigil, Strattera:</b> patient must have a documented intolerance to the generic equivalent. <b>Sunosi:</b> indication for use is the treatment of excessive daytime sleepiness in narcolepsy or obstructive sleep apnea (OSA) AND patient has had a documented side effect, allergy, or treatment failure to 2 preferred agents (may be stimulant or non-stimulant) <b>Wakix:</b> indication for use is the treatment of excessive daytime sleepiness in narcolepsy 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) 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. <b>Xyrem, Xywav:</b> indication for use is the treatment of cataplexy or excessive daytime sleepiness in narcolepsy AND 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.</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	oxybates) solution QTY LIMIT: 9 g (18 mL)/day	

## ALLERGEN IMMUNOTHERAPY

	<p>Oralair®  <i>QTY LIMIT:</i> 1 tablet/day            Palforzia® (peanut allergen powder-dnfp)</p>	<p><b>Oralair:</b></p> <ul style="list-style-type: none"> <li>• Patient age <math>\geq 10</math> years and <math>\leq 65</math> years</li> <li>• Prescriber must provide the testing to show that the patient is allergic to the components in the prescribed therapy and must provide a clinically valid rationale why single agent sublingual therapy is being chosen over subcutaneous therapy</li> <li>• 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</li> <li>• Have an auto-injectable epinephrine on-hand</li> </ul> <p><b>Palforzia:</b></p> <ul style="list-style-type: none"> <li>• Patient age <math>\geq 4</math> years and <math>\leq 17</math> years for initial dose escalation or <math>\geq 4</math> years for up-dosing and maintenance</li> <li>• The prescriber is an allergist or immunologist</li> <li>• Prescriber must provide the testing to show that the patient is allergic to peanuts</li> <li>• Patient must not have a recent history of uncontrolled asthma, eosinophilic esophagitis, or other eosinophilic GI disease.</li> <li>• Prescriber, pharmacy, and patient must be registered with the REMS program</li> <li>• Patient must have an auto-injectable epinephrine on-hand</li> <li>• Initial approval will be granted for 6 months and includes approval for initial dose escalation and Up Dosing. Approval for Up Dosing may be extended if the patient was unable to tolerate all the dose levels at 2-week intervals.</li> <li>• 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).</li> </ul>
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PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
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### ALPHA1-PROTEINASE INHIBITORS

	<p>Aralast NP<sup>®</sup>  Glassia<sup>®</sup>  Prolastin-C<sup>®</sup>  Zemaira<sup>®</sup>  **Maximum days supply per fill for all drugs is 14 days**</p>	<p><b>Criteria for Approval:</b> 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 &lt; 80 mg per dl [or &lt; 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 &gt; 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.</p>
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### ALZHEIMER'S MEDICATIONS

#### CHOLINESTERASE INHIBITORS

<p>DONEPEZIL (compare to Aricept<sup>®</sup>) tablet 5 mg and 10 mg  <i>QTY LIMIT:</i> 1 tablet/day</p> <p><b><u>SOLUTION</u></b>  All products require PA</p> <p><b><u>TRANSDERMAL</u></b>  All products require PA</p>	<p>Aricept<sup>®</sup> (donepezil) Tablet  <i>QTY LIMIT:</i> 1 tablet/day  Donepezil (compare to Aricept<sup>®</sup>) Tablet 23 mg  Donepezil ODT (compare to Aricept<sup>®</sup> ODT)  <i>QTY LIMIT:</i> 1 tablet/day  Galantamine tablet (compare to Razadyne<sup>®</sup> Tablet)  Galantamine ER capsule (compare to Razadyne<sup>®</sup> ER)  Razadyne<sup>®</sup> (galantamine) Tablet  Razadyne ER<sup>®</sup> (galantamine) capsule  Rivastigmine (compare to Exelon<sup>®</sup>) capsule  <i>QTY LIMIT:</i> 2 capsules/day</p> <p>Galantamine (compare to Razadyne<sup>®</sup>) Oral Solution</p> <p>Exelon<sup>®</sup> (rivastigmine transdermal) Patch  <i>QTY LIMIT:</i> 1 patch/day  Rivastigmine (compare to Exelon<sup>®</sup>) patch  <i>QTY LIMIT:</i> 1 patch/day</p>	<p><b>Donepezil 23mg Tablet, Galantamine Tablet, Galantamine ER Capsule, Razadyne Tablet, Razadyne ER Capsule, Rivastigmine capsule:</b> diagnosis or indication for the requested medication is Alzheimer's disease. AND patient has been started and stabilized on the requested medication (Note: samples are not considered adequate justification for stabilization) OR patient had a documented side effect, allergy or treatment failure to a preferred donepezil product AND if the product has an AB rated generic, the patient has a documented intolerance to the generic.</p> <p><b>Aricept:</b> diagnosis or indication for the requested medication is Alzheimer's disease. AND the patient has a documented intolerance to the generic product.</p> <p><b>Exelon Patch, Donepezil ODT, Galantamine Oral Solution, Rivastigmine patch:</b> diagnosis or indication for the requested medication is Alzheimer's disease AND medical necessity for a specialty dosage form has been provided. AND for approval of Exelon patch the patient has a documented intolerance to the generic formulation.</p>
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#### NMDA RECEPTOR ANTAGONIST

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
MEMANTINE Tablets	Memantine oral solution Memantine XR (compare to Namenda® XR) Oral capsule <i>QTY LIMIT: 1 capsule/day</i> Namenda® (memantine) tablet Namenda® XR (memantine ER) Oral Capsule <i>QTY LIMIT: 1 capsule/day</i>	<b>Namenda:</b> Patient has a documented intolerance to the generic. <b>Memantine XR, Namenda XR:</b> Patient has not been able to tolerate twice daily dosing of immediate release memantine, resulting in significant clinical impact. <b>Memantine Oral Solution:</b> medical necessity for a specialty dosage form has been provided.
<b>CHOLINESTERASE INHIBITOR/NMDA COMBINATION</b>		
	Namzaric® (donepezil/memantine) Capsule <i>QTY LIMIT: 1 capsule/day</i>	<b>Namzaric:</b> Clinically compelling reason why the individual ingredients of donepezil and memantine cannot be used.
<b>ANALGESICS</b>		
<b>MISCELLANEOUS: TOPICAL AND TRANSDERMAL PATCH</b>		
LIDOCAINE 3% Cream LIDOCAINE 4% OTC Patch LIDOCAINE 4% cream LIDODERM® Patch (lidocaine 5%) <i>QTY LIMIT: 3 patches/day</i> LIDOCAINE 5% Ointment, Cream LIDOCAINE/PRILOCAINE 2.5-2.5% Cream SYNERA® (lidocaine/tetracaine) Patch	Lidocaine 5% patch (compare to Lidoderm®) <i>QTY LIMIT: 3 patches/day</i> Qutenza® Patch (capsaicin 8%) <i>QTY LIMIT: 4 patches/90 days</i> Ztlido™ Patch (lidocaine 1.8%) <i>QTY LIMIT: 3 patches/day</i>  (Note: Please refer to Analgesics: COX IIs and NSAIDs for topical NSAIDS)	<b>Lidocaine 5% patch:</b> the patient has had a documented intolerance to brand Lidoderm. <b>Qutenza, Ztlido:</b> 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 Lidoderm 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 Lidoderm patch.
<b>OPIOIDS: SHORT ACTING</b>		
ACETAMINOPHEN W/CODEINE (compare to Tylenol® w/codeine) BUTALBITAL COMP. W/CODEINE (compare to Fiorinal® w/codeine) CODEINE SULFATE ENDOCET® (oxycodone w/ acetaminophen) HYDROCODONE (plain, w/acetaminophen, or w/ibuprofen) (some exceptions apply) <i>QTY LIMIT: Hydrocodone/APAP = 12 tablets/day</i> HYDROMORPHONE tablets (compare to Dilaudid®)	Acetaminophen w/hydrocodone: <i>all branded products</i> <i>QTY LIMIT: = 12 tablets/day</i> Acetaminophen w/oxycodone: <i>all branded products</i> <i>QTY LIMIT: = 12 tablets/day</i> Actiq® (fentanyl lozenge on a stick: 200 mcg, 400 mcg, 600 mcg, 800 mcg, 1200 mcg, 1600 mcg) Apadaz® (benzhydrocodone/APAP) <i>QTY LIMIT: 12 tablets/day</i> Benzhydrocodone/APAP <i>QTY LIMIT: 12 tablets/day</i> Butorphanol Nasal Spray <i>QTY LIMIT: 2 bottles/month</i>	<b>Note:</b> 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. <b>Butorphanol Nasal Spray:</b> 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. <b>Actiq, Fentanyl transmucosal, Fentora:</b> 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

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<p>MORPHINE SULFATE            OXYCODONE (plain)            OXYCODONE (w/acetaminophen, w/aspirin or w/ibuprofen)  <b>QTY LIMIT: Oxycodone/APAP = 12 tablets/day</b></p> <p>TRAMADOL (compare to Ultram<sup>®</sup>)  <b>QTY LIMIT: 8 tablets/day (Age ≥ 16)</b></p> <p>TRAMADOL/APAP (compare to Ultracet<sup>®</sup>)  <b>QTY LIMIT: 8 tablets/day (Age ≥ 18)</b></p> <p><b>**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 opiates)**</b></p>	<p>Demerol (meperidine)            Dilaudid<sup>®</sup> (hydromorphone) tablets            Dilaudid-5<sup>®</sup> (hydromorphone) oral solution            Fentanyl citrate transmucosal (compare to Actiq<sup>®</sup>)            Fentora<sup>®</sup> (fentanyl citrate buccal tablets)            Hydrocodone-Acetaminophen solution 10-325 Mg/15ml            Hydromorphone oral solution (compare to Dilaudid-5<sup>®</sup>)            Meperidine  <b>QTY LIMIT: 30 tablets/5-day supply per 30 days</b></p> <p>Nucynta<sup>®</sup> (tapentadol)            Oxycodone (plain) capsules            Oxymorphone (compare to Opana<sup>®</sup>)            Pentazocine w/acetaminophen            Pentazocine w/naloxone            Ultracet<sup>®</sup> (tramadol w/ acetaminophen)  <b>QTY LIMIT: 8 tablets/day</b></p>	<p>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.</p> <p><b>Dilaudid - 5 Oral Solution, Hydromorphone Oral Solution:</b> 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.</p> <p><b>Oxycodone (generic) Capsules:</b> member has a documented intolerance to generic oxycodone tablets.</p> <p><b>Ultracet:</b> member has a documented intolerance to the generic formulation</p> <p><b>Other Short acting Opioids:</b> 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.)</p> <p><b>PA requests to exceed daily cumulative MME limits:</b></p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• Vermont Prescription Monitoring System (VPMS) has been queried.</li> <li>• Patient education and informed consent have been obtained, and a Controlled Substance Treatment Agreement is included in the patient's medical record.</li> <li>• 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.</li> <li>• Patient has a valid prescription for or states they are in possession of naloxone.</li> <li>• 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.</li> </ul> <p><b>Limitations:</b> APAP containing products: daily doses that result in &gt; 4 grams of acetaminophen/day will reject for PA; Meperidine 75 mg/ml injection no longer available – 25 mg/ml, 50 mg/ml and 100 mg/ml available. Brand name Demerol 75 mg/ml and 100 mg/2ml not covered - no generic equivalents.</p>
<b>OPIOIDS: LONG ACTING</b>		
<p><b><u>TRANSDERMAL</u></b>            BUTRANS (buprenorphine) TRANSDERMAL SYSTEM  <b>QTY LIMIT: 4 patches/28 days (Maximum 28-day fill)</b></p> <p>FENTANYL PATCH (compare to Duragesic<sup>®</sup>)  <b>QTY LIMIT: 12 mcg/hr, 25 mcg/hr, 50 mcg/hr = 15</b></p>	<p>Buprenorphine patch (compare to Butrans<sup>®</sup>)  <b>QTY LIMIT: 4 patches/28 days (Maximum 28-day Fill)</b>            Fentanyl patch 37.5 mcg/hr, 62.5 mcg/hr, 87.5 mcg/hr</p>	<p><b>CLINICAL CONSIDERATIONS:</b> 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-</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<p>patches/30 days, 75 mcg/hr, 100 mcg/hr = 30 patches/30 days</p> <p><b><u>BUCCAL</u></b> All products require PA</p> <p><b><u>ORAL</u></b> MORPHINE SULFATE CR 12 hr tablet (compare to MS Contin<sup>®</sup>) <i>QTY LIMIT: 90 tablets/strength/30 days</i></p>	<p>Belbuca<sup>®</sup> (buprenorphine hcl buccal film) <i>QTY LIMIT: 56 films/28 days (Maximum 28-day fill)</i></p> <p>Conzip<sup>®</sup> (tramadol ER biphasic release) capsule <i>QTY LIMIT: 1 capsule/day</i></p> <p>Hydromorphone XR tablet <i>QTY LIMIT: 30 tablets/30 days (8 mg, 12 mg, 16 mg tabs)</i></p> <p>Methadone 5 mg, 10 mg tablets Methadone oral solution (no PA required for patient less than 1 year old) Methadone oral concentrate 10 mg/ml</p> <p>Morphine sulfate SR 24hr capsule (compare to Kadian<sup>®</sup>) <i>QTY LIMIT: 60 capsules/strength/30 days</i></p> <p>Morphine sulfate SR beads 24hr capsule <i>QTY LIMIT: 30 capsules/strength/30 days</i></p> <p>MS Contin<sup>®</sup> (morphine sulfate CR 12 hr) tablets <i>QTY LIMIT: 90 tablets/strength/30 days</i></p> <p>Oxymorphone ER <i>QTY LIMIT: 60 tablets/strength/30 days</i></p> <p>Nucynta ER<sup>®</sup> (tapentadol ER) <i>QTY LIMIT: 2 tablets/day</i></p> <p>Tramadol SR (compare to Ultram ER<sup>®</sup>) <i>QTY LIMIT: 1 tablet/day</i></p> <p>Tramadol ER biphasic-release<sup>®</sup> capsule <i>QTY LIMIT: 150 mg = 1 capsule/day</i></p> <p>Tramadol ER biphasic-release tablet (formerly Ryzolt<sup>®</sup>) <i>QTY LIMIT: 1 tablet/day</i></p> <p>Zohydro ER<sup>®</sup> (hydrocodone bitartrate)</p>	<p>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 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.</p> <p><b>Belbuca Films, Buprenorphine Patch:</b> the patient has had a documented intolerance to Butrans patches</p> <p><b>Fentanyl patches 37.5mcg/hr, 62.5mcg/hr, 87.5mcg/hr:</b> provider must submit clinical rationale detailing why the patient is unable to use a combination of the preferred strengths.</p> <p><b>Methadone Tablet:</b> 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.)</p> <p><b>Methadone Liquid:</b> 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.)</p> <p><b>Conzip, Tramadol ER biphasic-release Capsule, Tramadol ER biphasic-release Tablet, Tramadol ER/SR:</b> 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.</p> <p><b>Oral Non-Preferred (except methadone &amp; tramadol containing products):</b> 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.</p> <p><b>Hysingla ER/Zohydro ER:</b> Available with PA for those unable to tolerate any preferred medications. All requests will go to the DVHA Medical Director for approval.</p> <p><b>PA requests to exceed daily cumulative MME limits:</b></p> <ul style="list-style-type: none"> <li>• Non-Opioid alternatives (up to a maximum dose recommended by the FDA) and Non-Pharmacological Treatments have been considered, and</li> </ul>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<p><b><u>ORAL, ABUSE-DETERRENT FORMULATIONS</u></b>            XTAMPZA ER® (oxycodone ER)  <i>QTY LIMIT: 60 caps/strength/30days</i></p> <p><b>**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 opiates)**</b></p>	<p>Hysingla ER® (hydrocodone bitartrate)  <i>QTY LIMIT: 1 tablet/ day</i></p> <p>Oxycodone ER (compare to OxyContin®)  <i>QTY LIMIT: 90 tablets/strength/30 days</i></p> <p>OxyContin® (Oxycodone ER)  <i>QTY LIMIT: 90 tablets/strength/30 days</i></p>	<p>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.</p> <ul style="list-style-type: none"> <li>• Vermont Prescription Monitoring System (VPMS) has been queried.</li> <li>• Patient education and informed consent have been obtained, and a Controlled Substance Treatment Agreement is included in the patient's medical record.</li> <li>• 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.</li> <li>• Patient has a valid prescription for or states they are in possession of naloxone.</li> <li>• 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.</li> </ul> <p><b>Limitations:</b> Methadone 40mg dispersible tablet not approved for retail dispensing.</p>
<b>NSAIDS</b>		
<p><b><u>ORAL SINGLE AGENT</u></b>            DICLOFENAC POTASSIUM            DICLOFENAC SODIUM (compare to Voltaren®)            ETODOLAC (formerly Lodine®)            FLURBIPROFEN            IBUPROFEN (compare to Motrin®)            INDOMETHACIN (formerly Indocin®, Indocin SR®)            INDOMETHACIN ER            KETOPROFEN            KETOROLAC (formerly Toradol®)  <i>QTY LIMIT: 20 doses/5 day supply every 90 day</i>            MECLOFENAMATE SODIUM            MELOXICAM tabs (compare to Mobic®)            NABUMETONE            NAPROXEN (compare to Naprosyn®) 250 mg, 375 mg, 500 mg            NAPROXEN ENTERIC COATED (compare to EC-Naprosyn®) 375 mg, 500 mg            NAPROXEN SODIUM OTC 220 mg            OXAPROZIN (compare to Daypro®)</p>	<p>Cambia® (diclofenac potassium) packet for oral solution  <i>QTY LIMIT: 9 packets/month</i></p> <p>Daypro® (oxaprozin)</p> <p>EC-Naprosyn® (naproxen sodium enteric coated)</p> <p>Etodolac ER</p> <p>Feldene® (piroxicam)</p> <p>Fenoprofen 400 mg cap            Fenoprofen 600 mg tab</p> <p>Indocin® (indomethacin) suspension, suppository            Ketoprofen ER</p> <p>Mefenamic acid capsules (compare to Ponstel®)</p> <p>Mobic® (meloxicam) tablets</p> <p>Nalfon® (fenoprofen) 400 mg capsules</p> <p>Naprelan® (naproxen sodium ER)            Naproxen oral suspension            Naproxen Sodium 275 mg and 550 mg (compare to Anaprox, Anaprox DS®)</p> <p>Naproxen sodium ER            Qmiiz (meloxicam) ODT™            Relafen® DS (nabumetone)</p>	<p><b>Arthrotec, diclofenac/misoprostol, Duexis:</b> 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 patient is unable to take the individual components separately AND if the request is for brand Arthrotec, the patient has a documented intolerance to the generic equivalent.</p> <p><b>Cambia:</b> 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.</p> <p><b>Celebrex:</b> patient has had a documented intolerance to generic celecoxib.</p> <p><b>Pennsaid:</b> patient has had a documented side effect or inadequate response to Diclofenac gel or topical solution.</p> <p><b>Diclofenac Patch, Licart:</b> 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.</p> <p><b>Sprix:</b> 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</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<p>PIROXICAM (compare to Feldene®) SULINDAC</p> <p><b><u>ORAL</u></b> <b><u>COX-II Selective</u></b> CELECOXIB <i>QTY LIMIT: 2 caps/day</i></p> <p><b><u>INJECTABLE</u></b> KETOROLAC Injection (formerly Toradol®) <i>QTY LIMIT: 1 dose per fill</i></p> <p><b><u>NASAL SPRAY</u></b> All products require PA</p> <p><b><u>TOPICAL</u></b> DICLOFENAC (compare to Voltaren®) gel 1% DICLOFENAC 1.5 % Topical Solution</p> <p><b><u>TRANSDERMAL</u></b> Flector® (diclofenac) 1.3 % Patch <i>QTY LIMIT: 2 patches/day</i></p> <p><b><u>NSAID/ANTI-ULCER</u></b> All products require PA</p> <p>Note: Please refer to “Dermatological: Actinic Keratosis Therapy” for Solaraze® or Diclofenac 3% Gel</p>	<p>Tivorbex (indomethacin) capsules <i>QTY LIMIT: 3 caps/day</i> Vivlodex® (meloxicam) capsules Zipsor® (diclofenac potassium) Zorvolex® (diclofenac) Capsules <i>QTY LIMIT: 3 capsules/day</i></p> <p>Sprix® (ketorolac) Nasal Spray <i>QTY LIMIT: 5 bottles/5 days – once every 90 days</i></p> <p>Pennsaid® (diclofenac) 2% Topical Solution</p> <p>Diclofenac (compare to Flector®) 1.3% Patch <i>QTY LIMIT: 2 patches/day</i> Licart® (diclofenac epolamine) 1.3% Patch <i>QTY LIMIT: 1 patch/day</i></p> <p>Arthrotec® (diclofenac sodium w/misoprostol) Diclofenac sodium w/misoprostol (compare to Arthrotec®) Duexis® (ibuprofen/famotidine) <i>QTY LIMIT: 3 tablets/day</i> Vimovo® (naproxen/esomeprazole) <i>QTY LIMIT: 2 tablets/day</i></p>	<p>form (i.e. inability to take medication orally (NPO)).</p> <p><b>Relafen DS:</b> patient has had a documented side effect, allergy, or treatment failure to 4 or more preferred generic NSAIDs, including generic nabumetone.</p> <p><b>Tivorbex:</b> patient has had a documented side effect, allergy, or treatment failure to 4 or more preferred generic NSAIDs, including generic indomethacin.</p> <p><b>Qmiiz, Vivlodex:</b> patient has had a documented side effect, allergy, or treatment failure to 4 or more preferred generic NSAIDs, including generic meloxicam.</p> <p><b>Vimovo:</b> patient has had 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 NSAIDs due to one of the following: Patient is 60 years of age or older, Patient has a history of GI bleed, Patient is currently taking an oral corticosteroid, Patient is currently taking methotrexate AND patient is unable to take naproxen and a preferred proton pump inhibitor, separately.</p> <p><b>Zipsor, Zorvolex:</b> patient has had a documented intolerance to diclofenac tablets. AND patient has had a documented side effect, allergy, or treatment failure to 4 or more preferred generic NSAIDs.</p> <p><b>All other PA requiring NSAIDs:</b> 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.</p>

### ANKYLOSING SPONDYLITIS: INJECTABLES

**Length of Authorization:** Initial PA 3 months; 12 months thereafter

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<p><b><u>Preferred After Clinical Criteria Are Met</u></b></p> <p>ENBREL<sup>®</sup> (etanercept)  <i>QTY LIMIT:</i> 50 mg = 4 syringes/28 days,  25 mg = 8 syringes/28 days</p> <p>HUMIRA<sup>®</sup> (adalimumab)  <i>QTY LIMIT:</i> 2 syringes/28 days</p> <p>TALTZ<sup>®</sup> (ixekizumab)  <i>QTY LIMIT:</i> 80 mg prefilled syringe or  autoinjector = 2/28 days for the first month  and 1/28 days subsequently</p>	<p>Avsola<sup>®</sup> (infliximab-axxq) biosimilar to Remicade<sup>®</sup>  Cimzia<sup>®</sup> (certolizumab pegol)  <i>QTY LIMIT:</i> 1 kit/28 days (starter X 1, then regular)  Cosentyx<sup>®</sup> (secukinumab) Subcutaneous</p> <p>Inflectra<sup>®</sup> (infliximab-dyyb) biosimilar to Remicade<sup>®</sup>  Remicade<sup>®</sup> (infliximab)  Renflexis<sup>™</sup> (infliximab-abda) biosimilar to Remicade<sup>®</sup>  Simponi<sup>®</sup> (golimumab) Subcutaneous  <i>QTY LIMIT:</i> 50 mg prefilled syringe or autoinjector  = 1/28 days</p>	<p><b>Clinical Criteria:</b>  <b>For all drugs:</b> 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.</p> <p><b>Additional criteria for Taltz:</b> the patient had a trial and failure or contraindication to Humira.</p> <p><b>Additional criteria for Cimzia, Remicade, Renflexis, Simponi:</b> the prescriber must provide a clinically valid reason why at least 2 preferred agents cannot be used. <b>Note:</b> Patient must be ≥ 18 years of age for Simponi approval as safety and efficacy has not been established in pediatric patients.</p> <p><b>Additional criteria for Avsola, Inflectra:</b> 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 Remicade or Renflexis.</p> <p>* 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).</p>

## ANTI-ANXIETY: ANXIOLYTICS

### BENZODIAZEPINE

<p>CHLORDIAZEPOXIDE (formerly Librium<sup>®</sup>)</p> <p>CLONAZEPAM (compare to Klonopin<sup>®</sup>)  <i>QTY LIMIT:</i> 4 tabs/day except 2 mg.  2 mg = 3 tabs/day</p> <p>CLONAZEPAM ODT (formerly Klonopin Wafers<sup>®</sup>)  <i>QTY LIMIT:</i> 4 tabs/day except 2 mg.  2 mg = 3 tabs/day</p> <p>DIAZEPAM (compare to Valium<sup>®</sup>)</p> <p>LORAZEPAM (compare to Ativan<sup>®</sup>)  <i>QTY LIMIT:</i> 4 tablets/day</p> <p>OXAZEPAM (formerly Serax<sup>®</sup>)</p>	<p>Alprazolam (compare to Xanax<sup>®</sup>)  <i>QTY LIMIT:</i> 4 tablets/day</p> <p>Alprazolam ER, alprazolam XR<sup>®</sup> (compare to Xanax XR<sup>®</sup>)  <i>QTY LIMIT:</i> 2 tablets/day</p> <p>Alprazolam ODT (compare to Niravam<sup>®</sup>)  <i>QTY LIMIT:</i> 3 tablets/day</p> <p>Alprazolam Intensol<sup>®</sup> (alprazolam concentrate)</p> <p>Ativan<sup>®</sup> (lorazepam)  <i>QTY LIMIT:</i> 4 tablets/day</p> <p>Clorazepate tabs (compare to Tranxene T<sup>®</sup>)</p> <p>Diazepam Intensol<sup>®</sup> (diazepam concentrate)</p> <p>Klonopin<sup>®</sup> (clonazepam)  <i>QTY LIMIT:</i> 4 tabs/day except 2 mg.  2 mg = 3 tabs/day</p> <p>Lorazepam Intensol<sup>®</sup> (lorazepam concentrate)</p>	<p><b>Non-preferred Benzodiazepines (except for alprazolam ODT, Klonopin Wafers, Niravam &amp; Intensol Products):</b> 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.)</p> <p><b>Alprazolam ODT and Niravam:</b> 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.</p> <p><b>Alprazolam Intensol, Diazepam Intensol, and Lorazepam Intensol:</b> patient has a medical necessity for the specialty dosage form (i.e. swallowing disorder). AND the medication cannot be administered by crushing oral tablets.</p>
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PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Niravam <sup>®</sup> (alprazolam ODT) <i>QTY LIMIT: 3 tablets/day</i> Tranxene T <sup>®</sup> (clorazepate tablets) Valium <sup>®</sup> (diazepam) Xanax <sup>®</sup> (alprazolam) <i>QTY LIMIT: 4 tablets/day</i> Xanax XR <sup>®</sup> (alprazolam XR) <i>QTY LIMIT: 2 tablets/day</i>	
<b>NON-BENZODIAZEPINE</b>		
BUSPIRONE (formerly Buspar <sup>®</sup> ) HYDROXYZINE HYDROCHLORIDE (formerly Atarax <sup>®</sup> ) HYDROXYZINE PAMOATE (compare to Vistaril <sup>®</sup> ) (all strengths except 100 mg) MEPROBAMATE	Hydroxyzine Pamoate (100 mg strength ONLY) (compare to Vistaril <sup>®</sup> ) Vistaril <sup>®</sup> (hydroxyzine pamoate)	<b>Hydroxyzine Pamote 100mg strength ONLY:</b> patient is unable to use generic 50 mg capsules. <b>Vistaril:</b> patient has a documented intolerance to the generic formulation.
<b>ANTICOAGULANTS</b>		
<b>ORAL</b>		
<u><b>VITAMIN K ANTAGONIST</b></u> WARFARIN (compare to Coumadin <sup>®</sup> )  <u><b>DIRECT THROMBIN INHIBITOR</b></u> PRADAXA <sup>®</sup> (dabigatran etexilate) <i>QTY LIMIT: 2 capsules/day</i>  <u><b>FACTOR XA INHIBITOR</b></u> ELIQUIS <sup>®</sup> (apixaban) <i>QTY LIMIT: 2 tablets/day</i> <i>QTY LIMIT: 5mg = 4 tablets/day for 7 days if indication is treatment of DVT or PE) (followed by 5 mg twice daily)</i> XARELTO <sup>®</sup> (rivaroxaban) <i>QTY LIMIT: 10 mg = 1 tablet/day, maximum 30 day supply to complete total 35 days/every 180 days</i> <i>QTY LIMIT: 15 mg and 20 mg = 1 tablet/day</i> <i>QTY LIMIT: 15 mg = 2 tablets/day for 21 days if indication is treatment of DVT or PE) (followed by 20mg once daily)</i>	Coumadin <sup>®</sup> (warfarin)          Savaysa <sup>®</sup> (edoxaban) <i>QTY LIMIT: 1 tablet/daily</i>	<b>Coumadin:</b> patient has been started and stabilized on the requested medication OR patient has had a documented intolerance to generic warfarin.          <b>Savaysa:</b> Diagnosis or indication is nonvalvular atrial fibrillation or the indication is treatment of DVT or PE following 5-10 days of parenteral anticoagulation or the indication is reduction of risk of recurrent DVT or PE following initial therapy AND 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

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<p><i>QTY LIMIT:</i> Starter Pack (15 mg/20 mg) = 51 tablets/30days</p> <p><b><u>Preferred After Clinical Criteria Are Met</u></b> XARELTO® (rivaroxaban) 2.5 mg <i>QTY LIMIT:</i> 2 tablets/day)</p>		<p><b>Xarelto 2.5 mg:</b> Patient has a diagnosis of chronic coronary artery disease (CAD) or peripheral artery disease (PAD) AND medication is being used concurrently with aspirin.</p>
<b>INJECTABLE</b>		
<p><b><u>UNFRACTIONATED HEPARIN INJECTABLE</u></b> HEPARIN</p> <p><b><u>LOW MOLECULAR WEIGHT HEPARINS</u></b> <b><u>INJECTABLE</u></b> ENOXAPARIN (compare to Lovenox®) <i>QTY LIMIT:</i> 2 syringes/day calculated in ml volume</p> <p><b><u>SELECTIVE FACTOR XA INHIBITON</u></b> <b><u>INJECTABLE</u></b> All products require PA</p>	<p>Fragmin® (dalteparin) Lovenox® (enoxaparin) <i>QTY LIMIT:</i> 2 syringes/day calculated in ml volume</p> <p>Arixtra® (fondaparinux) Fondaparinux (compare to Arixtra®)</p>	<p><b>Arixtra, Fondaparinux, Lovenox and Fragmin:</b> 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.</p>
<b>ANTICONVULSANTS</b>		
<b>ORAL</b>		
<p>CARBAMAZEPINE tablets (compare to Tegretol®) CARBAMAZEPINE capsules (compare to Carbatrol®) CARBAMAZEPINE extended release (compare to Tegretol XR®)</p> <p>CELONTIN® (methsuxamide) CLOBAZAM (compare to Onfi®) <i>QTY LIMIT:</i> 10 mg = 3 tabs/day, 20 mg = 2 tabs/day</p> <p>CLONAZEPAM (compare to Klonopin®) <i>QTY LIMIT:</i> 4 tablets/day</p> <p>CLONAZEPAM ODT (formerly Klonopin Wafers®) <i>QTY LIMIT:</i> 4 tablets/day</p> <p>DIAZEPAM (compare to Valium®) DILVALPROEX SODIUM capsules (compare to Depakote Sprinkles®)</p>	<p>Aptiom® (eslicarbazepine acetate) <i>QTY LIMIT:</i> 200, 400, and 800 mg = 1 tab/day 600 mg = 2 tabs/day</p> <p>Banzel® (rufinamide) <i>QTY LIMIT:</i> 400 mg = 8 tabs/day, 200 mg = 16 tabs/day</p> <p>Banzel® (rufinamide) oral suspension <i>QTY LIMIT:</i> 80 ml/day (3,200 mg/day)</p> <p>Briviact® (brivaracetam) tablets, oral suspension Carbatrol® (carbamazepine) capsules Clorazepate (compare to Tranxene-T®) tablets</p> <p>Depakote® (divalproex sodium) Depakote ER® (divalproex sodium) Depakote Sprinkles® (divalproex sodium caps) Diacomit® (stiripentol)</p>	<p><b>Criteria for approval of ALL non-preferred drugs:</b> 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.</p> <p><b>Aptiom:</b> 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.</p> <p><b>Banzel:</b> diagnosis or indication is treatment of Lennox-Gastaut Syndrome. AND patient has had a documented side effect, allergy, treatment failure/inadequate response or a contraindication to at least TWO preferred anticonvulsants used for the treatment of Lennox-Gastaut syndrome (topiramate, lamotrigine, valproic acid) AND for approval of the oral suspension, patient must be unable to use Banzel tabs (i.e. swallowing disorder).</p> <p><b>Briviact:</b> 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 levetiracetam.</p> <p><b>Carbatrol, Depakote, Depakote ER, Depakote Sprinkles, Dilantin, Kepra</b></p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<p>DIVALPROEX SODIUM (compare to Depakote<sup>®</sup>)  DIVALPROEX SODIUM ER (compare to Depakote ER<sup>®</sup>)  EPITOL (carbamazepine)  ETHOSUXAMIDE (compare to Zaronin<sup>®</sup>)  GABAPENTIN 100 mg, 300 mg, 400 mg capsules, 600 mg, 800 mg tablets, 250 mg/5 ml oral solution (compare to Neurontin<sup>®</sup>)  GABITRIL<sup>®</sup> (tiagabine)  LAMOTRIGINE chew tabs (compare to Lamictal<sup>®</sup> chew tabs)  LAMOTRIGINE tabs (compare to Lamictal<sup>®</sup> tabs)  LEVETIRACETAM tabs (compare to Keppra<sup>®</sup> tabs)  LEVETIRACETAM oral solution (compare to Keppra<sup>®</sup> oral solution)  OXCARBAZEPINE tablets (compare to Trileptal<sup>®</sup>)  OXCARBAZEPINE oral suspension (compare to Trileptal<sup>®</sup>)  PEGANONE<sup>®</sup> (ethotoin)  PHENYTOIN (compare to Dilantin<sup>®</sup>)  PHENYTOIN EX cap (compare to Phenytek<sup>®</sup>)  PREGABALIN capsules (compare to Lyrica)  <i>QTY LIMIT:</i> 3 capsules/day  PRIMIDONE (compare to Mysoline<sup>®</sup>)  TEGRETOL<sup>®</sup> (carbamazepine) suspension  TEGRETOL XR<sup>®</sup> (carbamazepine) 100 mg ONLY  TOPIRAMATE ER  TOPIRAMATE tabs (compare to Topamax<sup>®</sup> tabs)  TOPIRAMATE sprinkle caps (compare to Topamax<sup>®</sup> Sprinkles)  VALPROIC ACID  ZONISAMIDE</p>	<p>Dilantin<sup>®</sup> (phenytoin) chewable tablets, capsules, suspension  Epidiolex<sup>®</sup> (cannabidiol) oral solution  <i>QTY LIMIT:</i> 20 mg/kg/day  Felbamate (compare to Felbatol<sup>®</sup>)  Fintepla<sup>®</sup> (fenfluramine) oral solution  Felbatol<sup>®</sup> (felbamate)  Fycompa<sup>®</sup> (perampanel) tablets  <i>QTY LIMIT:</i> 1 tablet/day  Keppra<sup>®*</sup> (levetiracetam) tablets, oral solution  Keppra XR<sup>®</sup> (levetiracetam extended release)  Klonopin<sup>®</sup> (clonazepam)  <i>QTY LIMIT:</i> 4 tablets/day  Lamictal<sup>®</sup> tabs (lamotrigine tabs)  Lamictal<sup>®</sup> chew tabs (lamotrigine chew tabs)  Lamictal ODT<sup>®</sup> (lamotrigine orally disintegrating tablets)  Lamictal XR<sup>®</sup> tablets (lamotrigine extended release)  Lamotrigine ER (compare to Lamictal XR<sup>®</sup>)  Lamotrigine ODT (compare to Lamictal ODT<sup>®</sup>)  Levetiracetam ER (compare to Keppra XR<sup>®</sup>)  Lyrica<sup>®</sup> (pregabalin) capsules  <i>QTY LIMIT:</i> 3 capsules/day  Lyrica<sup>®</sup> (pregabalin) oral solution  Mysoline<sup>®</sup> (primidone)  Neurontin<sup>®</sup> (gabapentin) capsules, tablets and solution  Onfi<sup>®</sup> (clobazam) Oral Suspension 2.5 mg/ml  <i>QTY LIMIT:</i> 16 ml/day  Onfi<sup>®</sup> (clobazam) Tablets  <i>QTY LIMIT:</i> 10 mg = 3 tabs/day, 20 mg = 2 tabs/day  Oxtellar<sup>®</sup> XR (oxcarbazapine ER) tablet  Pregabalin oral solution (compare to Lyrica<sup>®</sup>)  Qudexy<sup>®</sup> XR (topiramate) capsules  Sabril<sup>®</sup> (vigabatrin)  Spritam<sup>®</sup> (levetiracetam) tablets for oral suspension  Sympazan<sup>®</sup> (clobazam) films  Tegretol<sup>®</sup> (carbamazepine) tablets  Tegretol XR<sup>®</sup> (carbamazepine) (200 and 400 mg strengths)</p>	<p><b>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 &amp; 400 mg), Topamax tabs, Topamax sprinkles, Trileptal tablets, Trileptal oral suspension, Zaronin:</b> patient has had a documented intolerance to the generic equivalent of the requested medication.</p> <p><b>Clorazepate, Fycompa, Tranxene-T:</b> 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.</p> <p><b>Diacomit:</b> 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. <b>Note:</b> There are no clinical data to support the use of Diacomit as monotherapy.</p> <p><b>Epidiolex:</b>  <i>Diagnosis or indication is treatment of Lennox-Gastaut Syndrome:</i> Serum transaminases (AST and ALT) and total bilirubin levels have been obtained prior to starting therapy and are monitored periodically thereafter 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 AND either rufinamide or clobazam.  <i>Diagnosis or indication is treatment of Dravet Syndrome:</i> serum transaminases (AST and ALT) and total bilirubin levels have been obtained prior to starting therapy and are monitored periodically thereafter AND patient has had a documented side effect, allergy, treatment failure/inadequate response or a contraindication to at least one preferred anticonvulsant and clobazam</p> <p><b>Felbamate, Felbatol:</b> 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.</p> <p><b>Fintepla:</b> Diagnosis or indication is treatment of Dravet 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.</p> <p><b>Keppra XR, Lamictal XR, Lamotrigine ER, Levetiracetam ER, Oxtellar XR:</b> patient has been unable to be compliant with or tolerate twice daily dosing of</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	<p>Tiagabine (compare to Gabitril®)</p> <p>Topamax® (topiramate) tablets</p> <p>Topamax® (topiramate) Sprinkle Capsules</p> <p>Tranxene-T® (clorazepate) tablets</p> <p>Trileptal® tablets (oxcarbazepine)</p> <p>Trileptal® oral suspension (oxcarbazepine)</p> <p>Trokendi XR® (topiramate SR 24hr) capsules <i>QTY LIMIT:</i> 200 mg = 2 caps/day, all other strengths = 1 cap/day</p> <p>Vigabatrin (compare to Sabril®)</p> <p>Vimpat® (lacosamide) tablets, oral solution</p> <p>Xcopri® (cenobamate) tablets <i>QTY LIMIT:</i> 200 mg = 2 tabs/day, all other strengths = 1 tab/day</p> <p>Zarontin® (ethosuximide)</p>	<p>the immediate release product. Additionally, if brand Keppra XR or Lamictal XR is requested, the patient has a documented intolerance to the generic product.</p> <p><b>Lamictal ODT, Lamotrigine ODT:</b> 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.</p> <p><b>Lyrica oral solution, Pregabalin oral solution:</b> 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.</p> <p><b>Qudexy XR, Trokendi XR:</b> patient has failed treatment with topiramate ER.</p> <p><b>Spritam:</b> medical necessity for a specialty dosage form has been provided AND patient must have a documented intolerance to levetiracetam oral solution.</p> <p><b>Sympazan:</b> 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</p> <p><b>Tiagabine generic:</b> patient has had a documented intolerance to the brand name product.</p> <p><b>Sabril, Vigabatrin:</b> prescriber and patient are registered with the REMS program AND diagnosis is infantile spasms OR patient is &gt; 16 years old and the indication is adjunctive therapy in refractory complex partial seizures and failure of THREE other preferred anticonvulsants.</p> <p><b>Vimpat:</b> diagnosis is monotherapy or adjunctive therapy of partial-onset seizures and the patient has had a documented side effect, allergy, treatment failure/inadequate response or a contraindication to at least TWO preferred anticonvulsants AND if the request is for the oral solution, the patient is unable to use Vimpat tables (e.g. swallowing disorder).</p> <p><b>Xcopri:</b> the 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.</p> <p><b>PA Requests to Exceed QTY LIMIT for clonazepam/clonazepam ODT or Klonopin:</b> 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.</p>
<b>NASAL</b>		
<p>NAYZILAM® (midazolam) nasal spray (age ≥ 12 years) <i>QTY LIMIT:</i> 10 units/30 days</p> <p>VALTOCO® (diazepam) nasal spray (age ≥ 6 years)</p>		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<i>QTY LIMIT:</i> 20 units/30 days		
<b>RECTAL</b>		
DIAZEPAM (compare to Diastat®) rectal gel	Diastat® (diazepam) rectal gel	<b>Diastat:</b> patient has had a documented intolerance to the generic equivalent
<b>ANTIDEPRESSANTS</b>		
<b>MAO INHIBITORS – Length of Authorization: Duration of Need for Mental Health Indications</b>		
PHENELZINE SULFATE (compare to Nardil®) FDA maximum recommended dose = 90 mg/day TRANYLCPYROMINE (compare to Parnate®) FDA maximum recommended dose = 60 mg/day	Emsam® (selegiline) <i>QTY LIMIT:</i> 1 patch/day Marplan® (isocarboxazid) Nardil® (phenylzine) FDA maximum recommended dose = 90 mg/day	<b>Marplan:</b> 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. <b>Nardil:</b> patient has had a documented intolerance to generic equivalent product. <b>Emsam:</b> 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.
<b>MISCELLANEOUS - Length of Authorization: Duration of Need for Mental Health Indications, 1 Year for Other Indications</b>		
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 (compare to Wellbutrin®) 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 <i>QTY LIMIT:</i> 1 tablet/day Trintellix® (vortioxetine) Tablet <i>QTY LIMIT:</i> 1 tablet/day Bupropion XL 450mg (compare to Forfivo XL®) <i>QTY LIMIT:</i> 1 tablet/day FDA maximum recommended dose = 450 mg/day Forfivo XL® (bupropion SR 24hr) 450 mg tablet <i>QTY LIMIT:</i> 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 <i>QTY LIMIT:</i> not to exceed FDA recommended dose and frequency for corresponding timeframe Viibryd® (vilazodone) Tablet <i>QTY LIMIT:</i> 1 tablet/day	<b>Criteria for approval for ALL non-preferred drugs:</b> 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. <b>Aplenzin:</b> The patient has had a documented side effect, allergy, or in adequate 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 XL. <b>Bupropion XL 450mg, Forfivo XL:</b> 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. <b>Nefazodone:</b> 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) <b>Remeron, Remeron SolTab, Wellbutrin SR, and Wellbutrin XL:</b> The patient has had a documented intolerance to the generic formulation of the requested medication. <b>Spravato:</b> the patient has a diagnosis of treatment resistant depression AND 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 nonpreferred) AND the healthcare site and patient are enrolled in the

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	<p>Wellbutrin SR<sup>®</sup> (bupropion SR)  FDA maximum recommended dose = 400 mg/day</p> <p>Wellbutrin XL<sup>®</sup> (bupropion XL)  FDA maximum recommended dose = 450 mg/day</p> <p>Zulresso<sup>™</sup> (brexanolone) intravenous solution</p>	<p>Spravato<sup>®</sup> REMS program. Initial approval will be granted for 3 months. For re-approval after 3 months, the patient must have documented improvement in symptoms. <b>Note:</b> Spravato<sup>®</sup> will be approved as a medical benefit ONLY and will NOT be approved if billed through pharmacy point of sale.</p> <p><b>Trintellix, Viibryd:</b> The diagnosis or indication is MDD AND The patient has had a documented side effect, allergy, or inadequate response (defined by at least 4 weeks of therapy) to at least 2 different antidepressants from the SSRI, SNRI, and/or Miscellaneous Antidepressant categories (may be preferred or non-preferred).</p> <p><b>Zulresso:</b> Patient is <math>\geq 18</math> years of age and <math>\leq 6</math> 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<sup>™</sup> will be approved as a medical benefit ONLY and will NOT be approved if billed through pharmacy point of sale.</p> <p><b>Note:</b> 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.</p>
<b>SNRI - Length of Authorization: Duration of Need for Mental Health Indications, 1 Year for Other Indications</b>		
<p>DULOXETINE (compare to Cymbalta<sup>®</sup>) capsule  <i>QTY LIMIT:</i> 2 capsules/day  FDA maximum recommended dose = 120 mg/day (MDD and GAD), 60 mg/day all others</p> <p>VENLAFAXINE ER capsule (compare to Effexor XR<sup>®</sup>)  <i>QTY LIMIT:</i> 37.5 mg and 75 mg = 1 capsule/day  FDA maximum recommended dose = 225 mg/day</p> <p>VENLAFAXINE IR tablet  FDA maximum recommended dose = 225 mg/day</p>	<p>Cymbalta<sup>®</sup> (duloxetine) capsule  <i>QTY LIMIT:</i> 2 capsules/day  FDA maximum recommended dose = 120 mg/day (MDD and GAD), 60 mg/day all others</p> <p>Desvenlafaxine base SR (compare to Khedezla<sup>®</sup>)  <i>QTY LIMIT:</i> 50 mg tablet only = 1 tablet/day  FDA maximum recommended dose = 400 mg/day</p> <p>Desvenlafaxine succinate ER (compare to Pristiq<sup>®</sup>)  <i>QTY LIMIT:</i> 50 mg tablet only = 1 tablet/day  FDA maximum recommended dose = 400 mg/day</p> <p>Drizalma<sup>®</sup> (duloxetine) sprinkle capsule  <i>QTY LIMIT:</i> 2 capsules/day  FDA maximum recommended dose = 120 mg/day (MDD and GAD), 60 mg/day all others</p> <p>Effexor XR<sup>®</sup> (venlafaxine XR) capsule  <i>QTY LIMIT:</i> 37.5 mg and 75 mg = 1 capsule/day  FDA maximum recommended dose = 225 mg/day</p>	<p><b>Criteria for approval of ALL non-preferred drugs:</b> 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.</p> <p><b>Venlafaxine ER tablet (generic), Effexor XR Capsule (brand), Desvenlafaxine ER succinate, Pristiq:</b> 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.</p> <p><b>Desvenlafaxine SR (base), Fetzima, Khedezla:</b> 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.</p> <p><b>Cymbalta, Drizalma:</b> There must be a clinically compelling reason why the dosing needs cannot be accomplished with generic duloxetine.</p> <p><b>Note:</b> 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.</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	<p>Fetzima® (levomilnacipran ER) capsule <i>QTY LIMIT:</i> 1 capsule/day FDA maximum recommended dose = 120 mg/day</p> <p>Fetzima® (levomilnacipran ER) capsule titration pack <i>QTY LIMIT:</i> 1 pack per lifetime FDA maximum recommended dose = 120 mg/day</p> <p>Khedezla® (desvenlafaxine base SR) <i>QTY LIMIT:</i> 50 mg tablet only = 1 tablet/day FDA maximum recommended dose = 400 mg/day</p> <p>Pristiq® (desvenlafaxine succinate SR) <i>QTY LIMIT:</i> 50 mg tablet only = 1 tablet/day FDA maximum recommended dose = 400 mg/day</p> <p>Venlafaxine ER® tablet <i>QTY LIMIT:</i> 37.5 mg and 75 mg = 1 tablet/day FDA maximum recommended dose = 225 mg/day</p>	
<b>SSRIs – Length of Authorization: Duration of Need for Mental Health Indications, 1 Year for Other Indications</b>		
<p>CITALOPRAM (compare to Celexa®) FDA maximum recommended dose = 40 mg/day</p> <p>ESCITALOPRAM (compare to Lexapro®) tablets <i>QTY LIMIT:</i> 5 mg and 10 mg tablets = 1.5 tabs/day FDA maximum recommended dose = 20mg/day</p> <p>FLUOXETINE (compare to Prozac®) capsules, solution FDA maximum recommended dose = 80 mg/day</p> <p>FLUVOXAMINE FDA maximum recommended dose = 300 mg/day</p> <p>PAROXETINE tablet (compare to Paxil®) FDA maximum recommended dose = 60 mg/day</p> <p>SERTRALINE (compare to Zoloft®) <i>QTY LIMIT:</i> 25 mg and 50 mg tablets = 1.5 tabs/day FDA maximum recommended dose = 200 mg/day,</p>	<p>Brisdelle® (paroxetine) <i>QTY LIMIT:</i> 1 capsule/day</p> <p>Celexa® (citalopram) FDA maximum recommended dose = 40 mg/day</p> <p>escitalopram solution FDA maximum recommended dose = 20 mg/day</p> <p>Fluoxetine® Tablets FDA maximum recommended dose = 80 mg/day</p> <p>Fluoxetine 90 mg (compare to Prozac Weekly®) FDA maximum recommended dose = 90 mg/week</p> <p>Lexapro® (escitalopram) <i>QTY LIMIT:</i> 5 mg and 10 mg tablets = 1.5 tabs/day FDA maximum recommended dose = 20mg/day</p> <p>Fluvoxamine CR <i>QTY LIMIT:</i> 2 capsules/day FDA maximum recommended dose = 300 mg/day</p> <p>Paroxetine suspension (compare to Paxil® suspension) FDA maximum recommended dose = 60 mg/day</p> <p>Paroxetine CR (compare to Paxil CR®) FDA maximum recommended dose = 75 mg/day</p> <p>Paxil® (paroxetine) FDA maximum recommended dose = 60 mg/day</p> <p>Paxil® suspension (paroxetine) FDA maximum recommended dose = 60 mg/day</p>	<p><b>Celexa, fluvoxamine CR, Lexapro, Paxil tablet, Pexva, Paroxetine CR, Paxil CR, Prozac, Sarafem, Zoloft:</b> 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.</p> <p><b>Brisdelle:</b> The indication for use is moderate to severe vasomotor symptoms (VMS) associated with menopause. AND The patient has tried and failed generic paroxetine.</p> <p><b>Paroxetine suspension, Paxil suspension, Escitalopram solution:</b> The patient has a requirement for an oral liquid dosage form. AND The patient had a documented side effect, allergy, or treatment failure with 2 preferred SSRIs. If the request is for the brand product, the patient also has a documented intolerance to the generic equivalent.</p> <p><b>Fluoxetine tablet:</b> Prescriber must provide a clinically compelling reason why the patient is unable to use capsules</p> <p><b>Fluoxetine 90mg:</b> 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.</p> <p><b>Note:</b> 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.</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Paxil CR <sup>®</sup> (paroxetine CR) FDA maximum recommended dose = 75 mg/day Pexeva <sup>®</sup> (paroxetine) FDA maximum recommended dose = 60 mg/day Prozac <sup>®</sup> (fluoxetine) FDA maximum recommended dose = 80 mg/day Sarafem <sup>®</sup> (fluoxetine pmdd) FDA maximum recommended dose = 80 mg/day Zoloft <sup>®</sup> (sertraline) <i>QTY LIMIT</i> : 25 mg and 50 mg tablets = 1.5 tabs/day FDA maximum recommended dose = 200 mg/day	
<b>TRICYCLICS – Length of Authorization: Duration of Need for Mental Health Information, 1 Year for Other Indications</b>		
AMITRIPTYLINE FDA maximum recommended dose = 300 mg/day AMOXAPINE DOXEPIN (formerly Sinequan <sup>®</sup> ) IMIPRAMINE (compare to Tofranil <sup>®</sup> ) FDA maximum recommended dose = 300 mg/day NORTRIPTYLINE (compare to Pamelor <sup>®</sup> ) NORTRIPTYLINE Oral Solution	Anafranil <sup>®</sup> (clomipramine) Clomipramine (compare to Anafranil <sup>®</sup> ) Imipramine Pamoate capsules Desipramine (compare to Norpramin <sup>®</sup> ) Norpramin <sup>®</sup> (desipramine) Pamelor <sup>®</sup> (nortriptyline) Protriptyline Trimipramine (compare to Surmontil <sup>®</sup> ) Tofranil <sup>®</sup> (imipramine) FDA maximum recommended dose = 300 mg/day	<p><b>Criteria for approval of ALL non-preferred drugs:</b> 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.</p> <p><b>Imipramine Pamoate:</b> The patient has had a documented side effect, allergy, or treatment failure to 3 preferred TCAs, one of which must be imipramine tablets.</p> <p><b>Desipramine:</b> The patient has had a documented side effect, allergy, or treatment failure to nortriptyline.</p> <p><b>Clomipramine:</b> 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.</p> <p><b>All other non-preferred agents:</b> 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</p> <p><b>Limitation:</b> Chlordiazepoxide/amitriptyline and amitriptyline/perphenazine combinations are not covered. Generic agents may be prescribed separately.</p>
<b>ANTI-DIABETICS</b>		
<b>ALPHA-GLUCOSIDASE INHIBITORS</b>		
ACARBOSE (compare to Precose <sup>®</sup> ) GLYSET <sup>®</sup> (miglitol)	Precose <sup>®</sup> (acarbose)	<p><b>Precose:</b> patient must have a documented intolerance to generic acarbose</p>
<b>BIGUANIDES &amp; COMBINATIONS</b>		
<b><u>SINGLE AGENT</u></b>		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<p>METFORMIN (compare to Glucophage®) METFORMIN XR (compare to Glucophage XR®)</p> <p><b>COMBINATION</b></p> <p>GLIPIZIDE/METFORMIN (compare to Metaglip®) GLYBURIDE/METFORMIN (compare to Glucovance®)</p>	<p>Fortamet® (metformin ER Osmotic) Glucophage® (metformin) Glucophage XR® (metformin XR) Glumetza® (metformin ER)</p> <p>Metformin ER Osmotic (compare to Fortamet®) Riomet® (metformin oral solution)</p>	<p><b>Fortamet, Glucophage XR, Glumetza, Metformin ER osmotic:</b> 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)</p> <p><b>Glucophage:</b> patient has had a documented side effect, allergy OR treatment failure with at least one preferred biguanide OR biguanide combination product (if a product has an AB rated generic, the trial must be the generic.)</p> <p><b>Riomet:</b> prescriber provides documentation of medical necessity for the specialty dosage form (i.e. inability to swallow tablets, dysphagia)</p>
<b>DIPEPTIDYL PEPTIDASE (DPP-4) INHIBITORS</b>		
<p><u><i>Preferred After Clinical Criteria Are Met</i></u> <b>SINGLE AGENT</b></p> <p>JANUVIA® (sitagliptin) <i>QTY LIMIT:</i> 1 tab/day</p> <p>TRADJENTA® (<i>linagliptin</i>) <i>QTY LIMIT:</i> 1 tab/day</p> <p><b>COMBINATION</b></p> <p>JANUMET® (sitagliptin/metformin) <i>QTY LIMIT:</i> 2 tabs/day</p> <p>JANUMET XR® (sitagliptin/metformin ER) <i>QTY LIMIT:</i> 50/500 and 100/1000 mg = 1 tab/day, 50/1000 mg = 2 tabs/day</p> <p>JENTADUETO® (linagliptin/metformin) <i>QTY LIMIT:</i> 2 tabs/day</p>	<p><u><i>Non-Preferred After Clinical Criteria Are Met</i></u></p> <p>Alogliptan (compare to Nesina®) <i>QTY LIMIT:</i> 1 tab/day</p> <p>Nesina® (alogliptin) <i>QTY LIMIT:</i> 1 tab/day</p> <p>Onglyza® (saxagliptin) <i>QTY LIMIT:</i> 1 tab/day</p> <p>Jentaducto XR (linagliptan/metformin ER) <i>QTY LIMIT:</i> 1 tab/day</p> <p>Kazano® (alogliptin/metformin) <i>QTY LIMIT:</i> 1 tab/day</p> <p>Kombiglyze XR® (saxagliptin/metformin ER) <i>QTY LIMIT:</i> 1 tab/day</p> <p>Oseni® (alogliptin/pioglitazone) <i>QTY LIMIT:</i> 1 tab/day</p>	<p><b>Januvia, Tradjenta:</b> patient has had a documented side effect, allergy, contraindication OR treatment failure with metformin</p> <p><b>Alogliptan, Nesina, Onglyza:</b> patient has had a documented side effect, allergy, contraindication OR treatment failure with metformin AND patient has had a documented side effect, allergy OR treatment failure with at least one preferred DPP-4 agent.</p> <p><b>Janumet, Janumet XR:</b> patient has had an inadequate response with Januvia OR Metformin/Metformin XR monotherapy OR patient has been started and stabilized on Januvia and Metformin/Metformin XR combination therapy.</p> <p><b>Kazano, Kombiglyze XR:</b> patient has had a documented side effect, allergy OR treatment failure with at least one preferred DPP-4 combination agent.</p> <p><b>Jentaducto XR:</b> patient is unable to take Tradjenta in combination with Metformin XR as the individual separate agents.</p> <p><b>Jentaducto:</b> patient has had an inadequate response with Tradjenta OR Metformin monotherapy OR patient has been started and stabilized on Tradjenta and Metformin combination therapy</p> <p><b>Oseni:</b> patient is unable to take Nesina and Actos (pioglitazone) as the individual separate agents (after meeting clinical criteria for each individual agent)</p>
<b>GLUCAGON</b>		
<p>GLUCAGEN® HYPOKIT® (glucagon for injection) 1mg GLUCAGON EMERGENCY KIT (glucagon for injection) 1mg (Lilly labeler code 00002 is the only preferred form)</p>	<p>Baqsimi® (glucagon nasal powder) 3mg Gvoke™ (glucagon SC injection) prefilled syringe, auto-injector 0.5mg, 1mg</p>	<p><b>Baqsimi, Gvoke:</b> the patient must be ≥ 4 years of age for Baqsimi or ≥ 2 years of age for Gvoke AND Patient has recurrent episodes of symptomatic or severe hypoglycemia (&lt;55 mg/dL) requiring the assistance of another individual AND caregiver(s) is unable to reconstitute and administer IM glucagon (e.g. difficulty with manual dexterity). Convenience is not adequate justification for inability to use Glucagon IM.</p>
<b>INSULINS</b>		
<p><b>RAPID-ACTING INJECTABLE</b></p> <p>HUMALOG® (insulin lispro)</p>	<p>Admelog® (insulin lispro)</p>	<p><b>Admelog, Fiasp, Insulin Lispro:</b> Both Humalog and Novolog must be on a long-term backorder and unavailable from the manufacturer.</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<p>NOVOLOG® (Aspart)</p> <p><b><u>SHORT-ACTING INJECTABLE</u></b> HUMULIN R® U-500</p> <p><b><u>INTERMEDIATE-ACTING INJECTABLE</u></b> All products require PA</p> <p><b><u>LONG-ACTING ANALOGS INJECTABLE</u></b> LANTUS® (insulin glargine) LEVEMIR® (insulin detemir)</p> <p><b><u>MIXED INSULINS INJECTABLE</u></b> NOVOLOG MIX 70/30® (Protamine/Aspart) HUMALOG MIX 50/50® (Protamine/Lispro) HUMALOG MIX 75/25® (Protamine/Lispro)</p>	<p>Afrezza® Inhaled (insulin human) Apidra® (insulin glulisine) Fiasp® (insulin aspart) Insulin Lispro (compare to Humalog®)</p> <p>Humulin R® (Regular) U-100 Novolin R® (Regular) U-100 Humulin N® (NPH) Novolin N® (NPH)</p> <p>Toujeo® (insulin glargine) Toujeo® Max (insulin glargine) Tresiba® Flextouch (insulin degludec) Basaglar® (insulin glargine)</p> <p>Humulin 70/30® (NPH/Regular) Novolin 70/30® (NPH/Regular)</p>	<p><b>Apidra, Humulin R (U-100), Novolin R:</b> 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 Novolog or Humalog.</p> <p><b>Humulin N, Novolin N:</b> patient has a documented treatment failure to at least one preferred long-acting agent (Lantus or Levemir).</p> <p><b>Humulin 70/30, Novolin 70/30:</b> 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 Novolog Mix or Humalog Mix.</p> <p><b>Tresiba, Toujeo:</b> Patient has had a documented treatment failure of at least one preferred long-acting agent (Lantus or Levemir) OR each Lantus or Levemir dose exceeds 80 units. <b>Note:</b> Pharmacy claims will be evaluated to assess compliance with insulin glargine or detemir U100 therapy prior to approval. Initial approval will be granted for 6 months. For re-approval after 6 months, the patient must have a documented improvement in hemoglobin A1c of <math>\geq 0.5\%</math> or decreased incidence of hypoglycemic events.</p> <p><b>Toujeo Max:</b> The patient is currently using insulin glargine 300 units/mL AND the dose exceeds 160 units.</p> <p><b>Basaglar:</b> Diagnosis of diabetes mellitus AND Lantus must be on a long-term backorder and unavailable from the manufacturer.</p> <p><b>AFREZZA INHALED INSULIN:</b></p> <ul style="list-style-type: none"> <li>• Baseline PFT with FEV1 <math>\geq 70\%</math> predicted</li> <li>• Patient does not have underlying lung disease (Asthma, COPD)</li> <li>• Patient is a non-smoker or has stopped smoking more than six months prior to starting Afrezza</li> <li>• Patient is currently using a long-acting insulin</li> <li>• Patient has failed to achieve HbA1c goal (defined as <math>\leq 7\%</math>) on a short-acting insulin in combination with a long-acting insulin</li> <li>• Initial approval is for 3 months and improved glycemic control must be documented for further approvals</li> </ul>
<b>MEGLITINIDES</b>		
<p><b><u>SINGLE AGENT</u></b> NATEGLINIDE (compare to Starlix®) REPAGLINIDE (compare to Prandin®)</p> <p><b><u>COMBINATION</u></b> All products require PA</p>	<p>Prandin® (replaglinide) Starlix® (nateglinide)</p> <p>Repaglinide/metformin</p>	<p><b>Prandin, Starlix:</b> patient has had a documented intolerance to generic equivalent.</p> <p><b>Repaglinide/metformin:</b> patient is unable to take repaglinide and metformin as the individual separate agents.</p>
<b>PEPTIDE HORMONES: GLP-1 RECEPTOR AGONISTS</b>		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<p><b><u>SINGLE AGENTS</u></b>            TRULICITY® (dulaglutide)  <i>QTY LIMIT: 12 pens/84 days</i>            VICTOZA® (liraglutide)  <i>QTY LIMIT: 9 pens/90 days</i></p> <p><b><u>COMBINATION AGENTS</u></b>            All products require PA</p> <p><b><u>AMYLINOMIMETICS</u></b>            All products require PA</p>	<p>Adlyxin® (lixisenatide)            Bydureon® (exenatide extended-release)  <i>QTY LIMIT: 12 vials/84 days</i>            Bydureon® BCise™ (exenatide extended-release)  <i>QTY LIMIT: 12 pens/84 days</i>            Byetta® (exenatide)  <i>QTY LIMIT: 3 pens/90 days</i>            Ozempic® (semaglutide)            Rybelsus® (semaglutide) tablets  <i>QTY LIMIT: 1 tablet/day</i></p> <p>Soliqua® (insulin glargine/lixisenatide)  <i>QTY LIMIT: 3 pens/25 days</i>            Xultophy® (insulin degludec/liraglutide)</p> <p>Symlin® (pramlintide)</p>	<p><b>Adlyxin/Bydureon/Byetta/Bydureon BCise/Ozempic:</b> patient has a documented side effect, allergy, contraindication, or treatment failure with at least one preferred GLP-1 Receptor Agonist.</p> <p><b>Rybelsus:</b> patient has a diagnosis of type 2 diabetes AND patient is at least 18 years of age AND patient has had a documented side effect, allergy, contraindication or treatment failure with metformin AND patient has a documented side effect, allergy, contraindication, or treatment failure with and one preferred SGLT2 inhibitor AND patient has a documented side effect, allergy, contraindication, or treatment failure with at least one preferred GLP-1 Receptor Agonist or has a clinically valid reason for being unable to administer an injection (e.g. visual impairment, impaired dexterity).</p> <p><b>Soliqua/Xultophy:</b> patient has a diagnosis of type 2 diabetes AND patient is at least 18 years of age AND patient has had a documented side effect, allergy, contraindication or treatment failure with metformin AND patient cannot achieve glycemic control (defined as hemoglobin A1c ≤ 7%) with a preferred GLP-1 receptor agonist used in combination with Lantus or Levemir.</p> <p><b>Symlin:</b> patient has a diagnosis of diabetes mellitus. AND patient is at least 18 years of age. AND patient is on insulin.</p>
<b>SODIUM-GLUCOSE CO-TRANSPORTER 2 (SGLT2) INHIBITORS AND COMBINATIONS</b>		
<p><b><u>SINGLE AGENTS</u></b>            FARXIGA® (dapagliflozin)  <i>QTY LIMIT: 1 tab/day</i>            INVOKANA® (canagliflozin)  <i>QTY LIMIT: 1 tab/day</i>            JARDIANCE (empagliflozin)  <i>QTY LIMIT: 1 tab/day</i></p> <p><b><u>COMBINATIONS AGENTS</u></b>            INVOKAMET® (canagliflozin/metformin)  <i>QTY LIMIT: 1 tab/day</i>            SYNJARDY® (empagliflozin/metformin)  <i>QTY LIMIT: 2 tabs/day</i>            XIGDUO XR® (dapagliflozin &amp; metformin ER)  <i>QTY LIMIT: 5/1000 mg = 2/day, all other strengths = 1/day</i></p>	<p>Steglatro® (ertugliflozin)  <i>QTY LIMIT: 1 tab/day</i></p> <p>Glyxambi® (empagliflozin/ linagliptin)  <i>QTY LIMIT: 1 tab/day</i>            Invokamet® XR (canagliflozin/metformin ER)            Qtern® (dapagliflozin/saxagliptin)            Segluromet® (ertugliflozin/metformin)  <i>QTY LIMIT: 2 tabs/day</i>            Steglujan® (ertugliflozin/sitagliptin)  <i>QTY LIMIT: 1 tab/day</i>            Synjardy® XR (empagliflozin/metformin ER)  <i>QTY LIMIT: 1 tab/day</i>            Trijardy® XR (empagliflozin/linagliptin/metformin ER)</p>	<p><b>Steglatro:</b> Patient has a documented side effect, allergy, or contraindication to two preferred SGLT2 inhibitors.</p> <p><b>Invokamet XR/Segluromet/ Synjardy XR additional criteria:</b> The patient has documentation of a failure of therapy with a preferred SGLT2 inhibitor used in combination with metformin/metformin XR.</p> <p><b>Glyxambi/Qtern/Steglujan additional criteria:</b> The patient has documentation of a failure of therapy with the combination of a preferred SGLT2 inhibitor plus a preferred DPP-4 inhibitor</p> <p><b>Trijardy XR:</b> patient has documentation of a failure of therapy with a preferred SGLT2 inhibitor, a preferred DPP-4 inhibitor and metformin/metformin XR used in combination.</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<b>SULFONYLUREAS 2<sup>ND</sup> GENERATION</b>		
GLIMEPIRIDE (compare to Amaryl <sup>®</sup> ) GLIPIZIDE (compare to Glucotrol <sup>®</sup> ) GLIPIZIDE ER (compare to Glucotrol XL <sup>®</sup> ) GLYBURIDE GLYBURIDE MICRONIZED	Amaryl <sup>®</sup> (glimepiride) Glucotrol <sup>®</sup> (glipizide) Glucotrol XL <sup>®</sup> (glipizide ER) Glynase <sup>®</sup> (glyburide micronized)	<b>Criteria for Approval:</b> 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.
<b>THIAZOLIDINEDIONES &amp; COMBINATIONS</b>		
<p><u><i>Preferred After Clinical Criteria Are Met</i></u></p> PIOGLITAZONE (compare to Actos <sup>®</sup> )	Actos <sup>®</sup> (pioglitazone) Avandia <sup>®</sup> (rosiglitazone)  Actoplus Met <sup>®</sup> (pioglitazone/metformin) Duetact <sup>®</sup> (pioglitazone/glimepiride) <i>QTY LIMIT:</i> 1 tablet/day Pioglitazone/Glimepiride (compare to Duetact <sup>®</sup> ) <i>QTY LIMIT:</i> 1 tablet/day Pioglitazone/Metformin (Compare to Actoplus Met)	<p><b>Actos, Pioglitazone:</b> Patient has been started and stabilized on the requested medication OR patient has had a documented side effect, allergy, contraindication OR treatment failure with metformin AND for approval of Actos, the patient has a documented intolerance to the generic equivalent.</p> <p><b>Avandia:</b> patient has been started and stabilized on the requested medication and appears to be benefiting from it and the patient acknowledges that they understand the risks OR patient is unable to achieve glycemic control using other medications (including a documented side effect, allergy, contraindication or treatment failure with metformin).</p> <p><b>Actoplus Met, Duetact, Pioglitazone/Metformin, Pioglitazone/Glimepiride:</b> 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.</p>
<b>ANTI-EMETICS</b>		
<b>5HT3 ANTAGONISTS:</b> Length of Authorization: 6 months for chemotherapy or radiotherapy; 3 months for hyperemesis gravidarum, 1 time for prevention of post-op nausea/vomiting: see clinical criteria. Monthly quantity limits apply, PA required to exceed.		
ONDANSETRON injection (vial and premix) ONDANSETRON tablet <i>QTY LIMIT:</i> 3 tabs/day, maximum of 30 days per fill ONDANSETRON ODT <i>QTY LIMIT:</i> 3 tabs/day, maximum of 30 days per fill	Akynzeo <sup>®</sup> (nutupitant/palonosetron) Anzemet <sup>®</sup> (dolansetron) 50 mg <i>QTY LIMIT:</i> 4 tabs/28 days Anzemet <sup>®</sup> (dolansetron) 100 mg <i>QTY LIMIT:</i> 2 tabs/28 days Granisetron 1 mg <i>QTY LIMIT:</i> 6 tabs/28 days Granisetron injectable Ondansetron (generic) oral solution 4 mg/5 ml Sancuso <sup>®</sup> 3.1 mg/24 hr transdermal patch (granisetron) <i>QTY LIMIT:</i> 4 patches/28 days	<p><b>Akynzeo:</b> 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</p> <p><b>Anzemet, Granisetron:</b> has a diagnosis of nausea and vomiting associated with cancer chemotherapy. AND patient has had a documented side effect, allergy, or treatment failure to generic ondansetron.</p> <p><b>Zofran:</b> patient must have a documented intolerance to the corresponding generic ondansetron product (tablets, orally disintegrating tablets (ODT), oral solution or injection). If the request is for oral solution, the patient must be unable to use ondansetron ODT or ondansetron tablets.</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	<p>Sustol® (granisetron) injection 10 mg/0.4ml <i>QTY LIMIT:</i> 4 injections/28 days</p> <p>Zofran® (ondansetron) injection</p> <p>Zofran® (ondansetron) oral tablets and ODT <i>QTY LIMIT:</i> 4 mg = 12 tabs/28 days, 8 mg = 6 tabs/28 days</p> <p>Zofran® (ondansetron) oral solution 4 mg/5 ml</p> <p>Zuplenz® (ondansetron) oral soluble film <i>QTY LIMIT:</i> 4 mg = 12 films/28 days, 8 mg = 6 films/28 days</p>	<p><b>Ondansetron Oral Sol:</b> patient is unable to use ondansetron ODT or ondansetron tablets.</p> <p><b>Sancuso:</b> 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.</p> <p><b>Sustol:</b> 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.</p> <p><b>Zuplenz:</b> 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 a clinical rationale as to why ondansetron ODT is not a suitable option for the patient.</p> <p><b>CRITERIA FOR APPROVAL to Exceed QTY LIMIT:</b></p> <p><b>Zuplenz:</b> For nausea and vomiting associated with chemotherapy or radiation therapy, 3 tablets for each day of chemotherapy/radiation and 3 tablets for each day for 2 days after completion of chemotherapy/radiation may be approved.</p> <p><b>Anzemet:</b> For nausea and vomiting associated with chemotherapy, 1 tablet for each day of chemotherapy and 1 tablet for 2 days after completion of chemotherapy may be approved.</p> <p><b>Granisetron:</b> 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.</p> <p><b>Sancuso:</b> For nausea and vomiting associated with chemotherapy, 1 patch for each chemotherapy cycle may be approved.</p> <p><b>Limitations:</b> Aloxi is not considered an outpatient medication and is not covered in the pharmacy benefit.</p>
<b>MISCELLANEOUS (PREGNANCY)</b>		
	<p>Bonjesta® (20 mg doxylamine succinate and 20 mg pyridoxine hydrochloride ER tablet) <i>QTY LIMIT:</i> 2 tablets/day</p> <p>Diclegis® (10 mg doxylamine succinate and 10 mg pyridoxine hydrochloride) DR tablet <i>QTY LIMIT:</i> 4 tablets/day</p> <p>Doxylamine succinate/pyridoxine hydrochloride DR tablet (compare to Diclegis®)</p>	<p><b>Bonjesta:</b> Patient has a diagnosis of nausea and vomiting of pregnancy AND Patient has tried and had an inadequate response to conservative management (i.e. change in dietary habits, ginger, or acupressure), generic doxylamine and generic pyridoxine (Vitamin B6) used in combination, ondansetron, and Diclegis.</p> <p><b>Diclegis, Doxylamine/Pyridoxine DR tablet:</b> Patient has a diagnosis of nausea and vomiting of pregnancy AND Patient has tried and had an inadequate response to conservative management (i.e. change in dietary habits, ginger, or acupressure) AND Patient has tried and had an inadequate response to generic doxylamine and generic pyridoxine (Vitamin B6) AND Patient has tried and had an inadequate response to generic ondansetron.</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<b>NK1 ANTAGONISTS</b>		
<p>Cinvanti® (aprepitant) injection Emend® (fosaprepitant) injection</p> <p><b><u>Preferred After Clinical Criteria Are Met</u></b></p> <p>EMEND® (aprepitant) 40 mg <i>QTY LIMIT: 1 cap/28 days</i></p> <p>EMEND® (aprepitant) 80 mg <i>QTY LIMIT: 2 caps/28 days</i></p> <p>EMEND® (aprepitant) 125 mg <i>QTY LIMIT: 1 cap/28 days</i></p> <p>EMEND® (aprepitant) Tri-fold Pack <i>QTY LIMIT: 1 pack/28 days</i></p>	<p>Aprepitant (compare to Emend®) 40 mg <i>QTY LIMIT: 1 cap/28 days</i></p> <p>Aprepitant (compare to Emend®) 80 mg <i>QTY LIMIT: 2 caps/28 days</i></p> <p>Aprepitant (compare to Emend®) 125 mg <i>QTY LIMIT: 1 cap/28 days</i></p> <p>Emend® (aprepitant) oral suspension Varubi® (rolapitant) <i>QTY LIMIT: 4 tabs/28 days</i></p>	<p><b>Aprepitant, Emend (aprepitant) 80 mg, 125 mg, and Tri-Fold pack:</b> 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.</p> <p><b>Emend 40mg:</b> patient requires prevention of postoperative nausea and vomiting. AND The requested quantity does not exceed one 40 mg capsule per surgery or course of anesthesia. Patients with multiple surgeries or courses of anesthesia in a 28-day period will be approved quantities sufficient for the number of surgeries or courses of anesthesia.</p> <p><b>Emend oral suspension:</b> 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)</p> <p><b>Varubi:</b> 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 4 tablets per 28 days AND the patient has had a documented side effect, allergy, or treatment failure with Emend®.</p>
<b>THC DERIVATIVES</b>		
<p>All products require PA</p>	<p>Dronabinol (compare to Marinol®) Marinol® (dronabinol) Cesamet® (nabilone)</p>	<p><b>Pharmacology:</b> Marinol® is a schedule III cannabinoid agent containing the same active ingredient, tetrahydrocannabinol, as marijuana. While its exact mechanism of action is unknown, it is speculated to inhibit medullary activity as well as suppress prostaglandin and endorphin synthesis. Cesamet® is a schedule II synthetic cannabinoid that acts by activating the endocannabinoid receptors, CB1 and CB2, which are involved in nausea/vomiting regulation. Both Marinol® and Cesamet® are FDA-approved for use in chemotherapy associated nausea and vomiting refractory to conventional antiemetics. In addition, Marinol® is indicated for patients with HIV/AIDS-related anorexia or wasting syndrome.</p> <p><b>Dronabinol/Marinol:</b> 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 meggestrol</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		<p>acetate. If the request is for Marinol, the patient must additionally have a documented intolerance to generic dronabinol.</p> <p><b>Cesamet:</b> 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.</p>
<b>ANTI-HYPERTENSIVES</b>		
<b>ACE INHIBITORS</b>		
<p>BENAZEPRIL (compare to Lotensin<sup>®</sup>)</p> <p>ENALAPRIL (compare to Vasotec<sup>®</sup>)</p> <p>EPANED<sup>®</sup> (enalapril) oral solution (age &lt; 12 years old)</p> <p>FOSINOPRIL</p> <p>LISINOPRIL (compare to Zestril<sup>®</sup>, Prinivil<sup>®</sup>)</p> <p>QUINAPRIL (compare to Accupril<sup>®</sup>)</p> <p>RAMIPRIL (compare to Altace<sup>®</sup>)</p> <p>TRANDOLAPRIL</p>	<p>Accupril<sup>®</sup> (quinapril)</p> <p>Altace<sup>®</sup> (Ramipril)</p> <p>Captopril</p> <p>Epaned<sup>®</sup> (enalapril) oral solution (age ≥ 12 years old)</p> <p>Lotensin<sup>®</sup> (benazepril)</p> <p>Moexepil</p> <p>Perindopril</p> <p>Prinivil<sup>®</sup> (lisinopril)</p> <p>Qbrelis<sup>®</sup> (Lisinopril) 1mg/ml solution</p> <p>Vasotec<sup>®</sup> (enalapril)</p> <p>Zestril<sup>®</sup> (lisinopril)</p>	<p><b>Epaned Oral Solution (Patients &gt; 12 years old):</b> patient has a requirement for an oral liquid dosage form (i.e. swallowing disorder, inability to take oral medications).</p> <p><b>Qbrelis Oral Solution:</b> 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.</p> <p><b>Other ACE Inhibitors:</b> 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.</p>
<b>ACE INHIBITOR W/ HYDROCHLOROTHIAZIDE</b>		
<p>BENAZEPRIL/HYDROCHLOROTHIAZIDE (compare to Lotensin HCT<sup>®</sup>)</p> <p>CAPTOPRIL/HYDROCHLOROTHIAZIDE</p> <p>ENALAPRIL/HYDROCHLOROTHIAZIDE (compare to Vaseretic<sup>®</sup>)</p> <p>FOSINOPRIL/HYDROCHLOROTHIAZIDE</p> <p>LISINOPRIL/HYDROCHLOROTHIAZIDE (compare to Zestoretic<sup>®</sup>)</p> <p>QUINAPRIL/HYDROCHLOROTHIAZIDE (compare to Accuretic<sup>®</sup>)</p>	<p>Accuretic<sup>®</sup> (quinapril/HCTZ)</p> <p>Lotensin HCT<sup>®</sup> (benazepril/HCTZ)</p> <p>Vaseretic<sup>®</sup> (enalapril/HCTZ)</p> <p>Zestoretic<sup>®</sup> (lisinopril/HCTZ)</p>	<p><b>ACE Inhibitor/Hydrochlorothiazide combinations:</b> 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.</p>
<b>ACE INHIBITOR W/CALCIUM CHANNEL BLOCKER</b>		
<p>AMLODIPINE/BENAZEPRIL (compare to Lotrel<sup>®</sup>)</p>	<p>Lotrel<sup>®</sup> amlodipine/(benazepril)</p>	<p><b>Lotrel:</b> The patient has had a documented side effect, allergy, or treatment failure to the generic formulation.</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Tarka <sup>®</sup> (trandolopril/verapamil) Trandolapril/Verapamil ER (compare to Tarka <sup>®</sup> )	<b>Tarka, Trandolapril/Verapamil ER:</b> 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.
<b>ANGIOTENSIN RECEPTOR BLOCKERS (ARBs)</b>		
IRBESARTAN (compare to Avapro <sup>®</sup> ) LOSARTAN (compare to Cozaar <sup>®</sup> ) MICARDIS <sup>®</sup> (telmisartan) OLMESARTAN (compare to Benicar <sup>®</sup> ) VALSARTAN (compare to Diovan <sup>®</sup> )	Avapro <sup>®</sup> (irbesartan) Benicar <sup>®</sup> (olmesartan) Candesartan Cozaar <sup>®</sup> (losartan) Diovan <sup>®</sup> (valsartan) Edarbi <sup>®</sup> (azilsartan) Tablet <i>QTY LIMIT:</i> 1 tablet/day Telmisartan (compare to Micardis <sup>®</sup> )	<b>Avapro, Benicar, Candesartan, Cozaar, Diovan, Edarbi, and Telmisartan:</b> 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.
<b>ANGIOTENSIN RECEPTOR BLOCKER/DIURETIC COMBINATIONS</b>		
IRBESARTAN/HYDROCHLOROTHIAZIDE (compare to Avalide <sup>®</sup> ) LOSARTAN/HYDROCHLOROTHIAZIDE (compare to Hyzaar <sup>®</sup> ) OLMESARTAN/HYDOCHLOROTHIAZIDE (compare to Benicar HCT <sup>®</sup> ) VALSARTAN/HYDROCHLOROTHIAZIDE (compare to Diovan HCT <sup>®</sup> )	Avalide <sup>®</sup> (irbesartan/hydrochlorothiazide) Benicar HCT <sup>®</sup> (olmesartan/hydrochlorothiazide) Candesartan/hydrochlorothiazide Diovan HCT <sup>®</sup> (valsartan/hydrochlorothiazide) Edarbyclor <sup>®</sup> (azilsartan/chlorthalidone) Tablet <i>QTY LIMIT:</i> 1 tablet/day Hyzaar <sup>®</sup> (losartan/hydrochlorothiazide) Micardis HCT <sup>®</sup> (telmisartan/hydrochlorothiazide) Telmisartan/hydrochlorothiazide (compare to Micardis HCT <sup>®</sup> )	<b>Avalide, Benicar HCT, Candesartan/HCTZ, Diovan HCT, Edarbyclor, Hyzaar, Micardis HCT and Telmisartan/HCTZ:</b> patient has had a 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.
<b>ANGIOTENSIN RECEPTOR BLOCKER/CALCIUM CHANNEL BLOCK COMBINATIONS</b>		
VALSARTAN/AMLODIPINE (compare to Exforge <sup>®</sup> ) <i>QTY LIMIT:</i> 1 tablet/day	Azor <sup>®</sup> (olmesartan/amlodipine) <i>QTY LIMIT:</i> 1 tablet/day Amlodipine/telmisartan (compare to Twynsta <sup>®</sup> ) <i>QTY LIMIT:</i> 1 tablet/day Exforge <sup>®</sup> (valsartan/amlodipine) <i>QTY LIMIT:</i> 1 tablet/day Olmesartan/amlodipine (compare to Azor <sup>®</sup> )	<b>Azor, Amlodipine/Telmisartan, Exforge, Olmesartan/amlodipine:</b> The patient has had a documented side effect, allergy, or treatment failure to Valsartan/amlodipine.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<b>ANGIOTENSIN RECEPTOR BLOCKER/CALCIUM CHANNEL BLOCKER/HCTZ COMBO</b>		
<p>VALSARTAN/AMLODIPINE/HCTZ (compare to Exforge HCT<sup>®</sup>) <i>QTY LIMIT:</i> 1 tablet/day</p>	<p>Exforge HCT<sup>®</sup> (amlodipine/valsartan/hydrochlorothiazide) <i>QTY LIMIT:</i> 1 tablet/day</p> <p>Olmесartan/amlodipine/hydrochlorothiazide (compare to Tribenzor<sup>®</sup>) <i>QTY LIMIT:</i> 1 tablet/day</p> <p>Tribenzor<sup>®</sup> (amlodipine/olmesartan/hydrochlorothiazide) <i>QTY LIMIT:</i> 1 tablet/day</p>	<p><b>Exforge HCT, Olmesartan/amlodipine/HCTZ, Tribenzor:</b> patient has had a documented side effect, allergy, or treatment failure to Valsartan/amlodipine/HCTZ.</p>
<b>BETA BLOCKERS</b>		
<p><b><u>SINGLE AGENT</u></b> ACEBUTOLOL ATENOLOL (compare to Tenormin<sup>®</sup>) BISOPROLOL FUMARATE CARVEDILOL (compare to Coreg<sup>®</sup>) LABETALOL METOPROLOL TARTRATE (compare to Lopressor<sup>®</sup>) METOPROLOL SUCCINATE XL (compare to Toprol XL<sup>®</sup>) NADOLOL PINDOLOL PROPRANOLOL PROPRANOLOL ER (compare to Inderal LA<sup>®</sup>) SOTALOL (compare to Betapace<sup>®</sup>, Betapace AF<sup>®</sup>)</p> <p><b><u>Preferred After Clinical Criteria Are Met</u></b> HEMANGEOL<sup>®</sup> oral solution (propranolol)</p> <p><b><u>BETA-BLOCKER/DIURETIC COMBINATION</u></b> ATENOLOL/CHLORTHALIDONE (compare to Tenoretic<sup>®</sup>)</p>	<p>Betapace<sup>®</sup> (sotalol) Betapace AF<sup>®</sup> (sotalol) Betaxolol Bystolic<sup>®</sup> (nebivolol) <i>QTY LIMIT:</i> 2.5, 5, and 10 mg = 1 tablet/day, 20 mg = 2 tablets/day</p> <p>Carvedilol CR (compare to Coreg<sup>®</sup>) <i>QTY LIMIT:</i> 1 tablet/day</p> <p>Coreg<sup>®</sup> (carvedilol) Coreg CR<sup>®</sup> (carvedilol CR) <i>QTY LIMIT:</i> 1 tablet/day</p> <p>Corgard<sup>®</sup> (nadolol) Inderal LA<sup>®</sup> (propranolol ER) Inderal XL<sup>®</sup> (propranolol SR) Innopran XL<sup>®</sup> (propranolol SR) Kapsargo Sprinkle™ (metoprolol succinate XL) Lopressor<sup>®</sup> (metoprolol tartrate) Sorine<sup>®</sup> (sotalol) Tenormin<sup>®</sup> (atenolol) Timolol Toprol XL<sup>®</sup> (metoprolol succinate XL)</p> <p>Nadolol/bendroflumethiazide Propranolol/HCTZ</p>	<p><b>Non-preferred drugs (except as noted below)</b> 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.)</p> <p><b>Carvedilol CR, Coreg CR:</b> <i>Indication: Heart Failure:</i> 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. <i>Indication: Hypertension:</i> 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.</p> <p><b>Hemangeol:</b> indication for use is the treatment of proliferating infantile hemangioma</p> <p><b>Kapsargo:</b> patient is unable to take a solid oral dosage form and has a treatment failure with an immediate release oral solution or crushed tablets.</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
BISOPROLOL/HYDROCHLOROTHIAZIDE (compare to Ziac <sup>®</sup> ) METOPROLOL/HYDROCHLOROTHIAZIDE	Tenoretic <sup>®</sup> (atenolol/chlorthalidone) Ziac <sup>®</sup> (bisoprolol/HCTZ)	
<b>CALCIUM CHANNEL BLOCKERS</b>		
<p><b><u>SINGLE AGENT</u></b>  <b><u>DIHYDROPYRIDINES</u></b>            AMLODIPINE (compare to Norvasc<sup>®</sup>)            FELODIPINE ER            NIFEDIPINE IR (compare to Procardia<sup>®</sup>)            NIFEDIPINE SR osmotic (compare to Procardia<sup>®</sup> XL)            NIFEDIPINE SR (compare to Adalat<sup>®</sup> CC)</p> <p><b><u>MISCELLANEOUS</u></b>            CARTIA<sup>®</sup> XT (diltiazem SR, compare to Cardizem<sup>®</sup> CD)            DILT-XR<sup>®</sup> (diltiazem SR)            DILTIAZEM (compare to Cardizem<sup>®</sup>)            DILTIAZEM ER 24-hour capsules (compare to Tiazac<sup>®</sup>)            DILTIAZEM SR 24-hour capsules (compare to Cardizem<sup>®</sup> CD)            DILTIAZEM SR 24-hour tablets            TAZTIA<sup>®</sup> XT (diltiazem ER, compare to Tiazac<sup>®</sup>)            VERAPAMIL (compare to Calan<sup>®</sup>)            VERAPAMIL CR (compare to Calan SR<sup>®</sup>)            VERAPAMIL SR 120 mg, 180 mg, 240 mg, and 360 mg (compare to Verelan<sup>®</sup>)            VERAPAMIL SR 100 mg, 200 mg, 300mg (compare to Verelan PM<sup>®</sup>)</p> <p><b>Note:</b> Please refer to the Anti-Hypertensives: Angiotensin Receptor Blockers (ARBs) PDL category for ARB/CCB combination therapies</p>	Isradipine Katerzia <sup>®</sup> (amlodipine) oral suspension Nicardipine Nimodipine Nisoldipine ER (compare to Sular <sup>®</sup> ) Norvasc <sup>®</sup> (amlodipine) Nymalize <sup>®</sup> (nimodipine) Oral Solution Procardia <sup>®</sup> (nifedipine IR) Procardia XL <sup>®</sup> (nifedipine SR osmotic) Sular <sup>®</sup> (nisoldipine)  Calan <sup>®</sup> SR (verapamil CR) Cardizem <sup>®</sup> (diltiazem) Cardizem <sup>®</sup> CD (diltiazem SR) Cardizem <sup>®</sup> LA (diltiazem SR) Diltiazem ER 12-hour capsules Diltiazem ER/Matzin LA (compare to Cardizem <sup>®</sup> LA) Tiazac <sup>®</sup> (diltiazem ER) Verelan <sup>®</sup> (verapamil SR 120 mg, 180 mg, 240 mg and 360 mg) Verelan <sup>®</sup> PM (100 mg, 200 mg and 300 mg)	<p><b>Criteria for approval (except as noted below):</b> 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.)</p> <p><b>Katerzia, Nymalize</b> patient has a medical necessity for a specialty dosage form (i.e. dysphagia, swallowing disorder).</p>
<b>CENTRAL ALPHA AGONISTS</b>		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<p><b><u>ORAL TABLETS</u></b>            CLONIDINE IR Tablets (compare to Catapres®)            GUANFACINE IR Tablets (compare to Tenex®)            METHYLDOPA Tablets</p> <p><b><u>TRANSDERMAL</u></b>            CATAPRES-TTS® (clonidine) Transdermal Patch  <i>QTY LIMIT: 1 patch/7 days</i></p>	<p>Catapres® (clonidine) tablet</p> <p>Clonidine (compare to Catapres-TTS) Transdermal Patch  <i>QTY LIMIT: 1 patch/7 days</i></p>	<p><b>Catapres tablets:</b> Patient has a documented intolerance to the generic product.  <b>Clonidine Patches (generic):</b> patient has a documented intolerance to brand Catapres-TTS patches</p>
<b>GANGLIONIC BLOCKERS</b>		
<p>All products require PA</p>	<p>Vecamyl® (mecamylamine) tablet</p>	<p><b>Vecamyl tabs:</b> 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.</p>
<b>RENIN INHIBITOR</b>		
	<p><b><u>SINGLE AGENT</u></b>            Aliskiren (compare to Tekturna®)  <i>QTY LIMIT: 1 tablet/day</i>            Tekturna® (aliskiren)  <i>QTY LIMIT: 1 tablet/day</i></p> <p><b><u>COMBINATIONS</u></b>            Tekturna HCT® (aliskiren/hydrochlorothiazide)  <i>QTY LIMIT: 1 tablet/day</i></p>	<p><b>Aliskiren, Tekturna:</b> 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).  <b>Tekturna HCT:</b> the patient must meet criteria as listed above for Tekturna and is unable to use the individual separate agents.</p>
<b>ANTI-INFECTIVES ANTIBIOTICS</b>		
<b>AMINOGLYCOSIDES</b>		
<p>NEOMYCIN SULFATE            PAROMYCIN</p>	<p>Arikayce® (amikacin inhalation suspension)  <i>QTY LIMIT: 28 vials (235.2 mL)/28 days</i></p>	<p><b>Arikayce:</b> Patient is ≥ 18 years of age AND indication for use is treatment of <i>Mycobacterium avium complex</i> (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, &amp; ethambutol) within the past 12 months. <b>Note:</b> 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.</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<b>CEPHALOSPORINS 1<sup>ST</sup> GENERATION</b>		
<p><b><u>CAPSULES/TABLETS</u></b>            CEFADROXIL capsules            CEPHALEXIN capsules (compare to Keflex<sup>®</sup>)</p> <p><b><u>SUSPENSION</u></b>            CEFADROXIL suspension            CEPHALEXIN suspension</p> <p>IV drugs are not managed at this time</p>	<p>Cefadroxil tablets            Cephalexin<sup>®</sup> tablets            Keflex<sup>®</sup>* (cephalexin) capsules</p>	<p><b>Cephadroxil tabs:</b> patient has had a documented intolerance to cefadroxil generic capsules.</p> <p><b>Cephalexin Tabs:</b> patient has had a documented intolerance to cephalexin generic capsules.</p> <p><b>Keflex:</b> patient has had a documented side effect, allergy, or treatment failure to generic cefadroxil and cephalexin.</p>
<b>CEPHALOSPORINS 2<sup>ND</sup> GENERATION</b>		
<p><b><u>CAPSULES/TABLETS</u></b>            CEFACLOR capsule            CEFPROZIL tablet            CEFUROXIME tablet</p> <p><b><u>SUSPENSION</u></b>            CEFPROZIL suspension</p> <p>IV drugs are not managed at this time</p>	<p>Cefaclor<sup>®</sup> ER tablet</p> <p>Cefaclor suspension</p>	<p><b>Cefaclor ER Tabs:</b> patient has had a documented intolerance to cefaclor capsules.</p> <p><b>Cefaclor Suspension:</b> patient has a documented side effect, allergy, or treatment failure to Cefprozil suspension.</p>
<b>CEPHALOSPORINS 3<sup>RD</sup> GENERATION</b>		
<p><b><u>CAPSULES/TABLETS</u></b>            CEFDINIR CAPSULE            CEFPODOXIME TABLET</p> <p><b><u>SUSPENSION</u></b>            CEFDINIR suspension</p> <p>IV drugs are not managed at this time</p>	<p>Suprax<sup>®</sup> (cefixime) capsule            Suprax<sup>®</sup> (cefixime) chewable tablets</p> <p>Cefixime suspension            Cefpodoxime proxetil suspension            Suprax<sup>®</sup> (cefixime) suspension</p>	<p><b>Suprax capsule, chewable tablet:</b> 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.</p> <p><b>Cefpodoxime Proxetil Susp, Cefixime Susp, Suprax Susp:</b> 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.</p>
<b>CLINDAMYCIN DERIVATIVES</b>		
<p>CLINDAMYCIN (compare to Cleocin<sup>®</sup>) capsules            CLINDAMYCIN (compare to Cleocin<sup>®</sup>) oral solution</p>	<p>Cleocin (clindamycin) Capsules            Cleocin<sup>®</sup> Ped (clindamycin) oral solution</p>	<p><b>Cleocin:</b> the patient has a documented intolerance to the generic equivalent.</p>
<b>MACROLIDES</b>		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<p>AZITHROMYCIN tabs, liquid (≤ 5-day supply) (compare to Zithromax®) Maximum 10 days therapy/30 days</p> <p>CLARITHROMYCIN (compare to Biaxin®) tablets</p> <p>IV drugs are not managed at this time</p>	<p>Azithromycin tablets and liquid (if &gt; 5-day supply) (compare to Zithromax®) Azithromycin packet (compare to Zithromax®) <i>QTY LIMIT: 2 grams/fill</i></p> <p>Zithromax® (azithromycin) tablets and liquid <i>QTY LIMIT: 5 days supply/RX, maximum 10 days, therapy/30 days</i></p> <p>Zithromax® (azithromycin) packet <i>QTY LIMIT: 2 grams/fill</i></p> <p>Clarithromycin SR (compare to Biaxin® XL) Clarithromycin suspension</p> <p>E.E.S.® (erythromycin ethylsuccinate) ERY-TAB® (erythromycin base, delayed release) ERYTHROMYCIN BASE Erythromycin base, delayed release (compare to Ery-tab®) ERYTHROMYCIN ETHYLSUCCINATE (compare to E.E.S.®) Eryped® (erythromycin ethylsuccinate) Erythrocin (erythromycin stearate) Dificid® (fidaxomicin) tablet <i>QTY LIMIT: 2 tablets per day, 10-day supply per 30 days</i></p>	<p><b>Non-preferred agents (except as below):</b> 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.</p> <p><b>Azithromycin/Zithromax packets:</b> A clinically valid reason why the dose cannot be obtained using generic azithromycin tablets AND If the request is for brand Zithromax, the patient has a documented intolerance to the generic product.</p> <p><b>Azithromycin &gt; 5-day supply (criteria for approval based on indication):</b> <i>Lyme Disease:</i> 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</p> <p><i>Cystic Fibrosis:</i> length of authorization up to 6 months <i>HIV/immunocompromised status:</i> azithromycin is being used for MAC or Toxoplasmosis treatment or prevention. (length of authorization up to 6 months)</p> <p><i>Bacterial Sinusitis:</i> 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)</p> <p><i>Severe Bronchiectasis or COPD with frequent exacerbations:</i> length of authorization up to 6 months</p> <p><i>Babesiosis:</i> 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)</p> <p><b>Dificid:</b> 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.</p>
<b>NITROFURANTOIN DERIVATIVES</b>		
<p>NITROFURANTOIN MACROCRYSTALLINE capsules (compare to Macrochantin®)</p> <p>NITROFURANTOIN MONOHYDRATE MACROCRYSTALLINE capsules (compare to Macrobid®)</p> <p>NITROFURANTOIN SUSPENSION (age ≤ 12 yrs)</p>	<p>Macrobid® (nitrofurantoin monohydrate macrocrystalline) capsules</p> <p>Macrochantin® (nitrofurantoin macrocrystalline) capsules</p>	<p><b>Macrobid, Macrochantin:</b> the patient has a documented intolerance to the generic equivalent.</p> <p><b>Nitrofurantoin susp (age &gt; 12 yrs):</b> patient must have medical necessity for a liquid formulation (i.e. swallowing disorder)</p>
<b>OXAZOLIDINONES</b>		
	<p>Linezolid (compare to Zyvox®)</p>	<p><b>Criteria for Approval:</b> patient has been started on intravenous or oral linezolid or</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<p>IV form of this medication not managed at this time</p>	<p><i>QTY LIMIT:</i> 56 tablets per 28 days Linezolid (compare to Zyvox®) suspension <i>QTY LIMIT:</i> 60 ml/day, maximum 28 days supply Sivextro® (tedizolid) <i>QTY LIMIT:</i> 1 tab/day Zyvox® (linezolid) <i>QTY LIMIT:</i> 56 tablets per 28 days Zyvox® (linezolid) suspension <i>QTY LIMIT:</i> 60 ml/day, maximum 28 days supply</p>	<p>tedizolid in the hospital and will be finishing the course of therapy in an outpatient setting OR patient has a documented blood, tissue, sputum, or urine culture that is positive for Vancomycin-Resistant Enterococcus (VRE) species. OR patient has a documented blood or sputum culture that is positive for Methicillin-Resistant Staphylococcus species OR patient has a documented tissue or urine culture that is positive for Methicillin-Resistant Staphylococcus AND patient has had a documented treatment failure with trimethoprim/sulfamethoxazole, 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 brand Zyvox the patient has an intolerance to generic linezolid.</p>
<b>PLEUROMUTILINS</b>		
<p>All products require PA</p> <p>IV form of this medication not managed at this time</p>	<p>Xenleta® (lefamulin acetate) <i>QTY LIMIT:</i> 2 tabs/day</p>	<p><b>Xenleta:</b> 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&amp;S) report shows isolated pathogen is a susceptible to lefamulin (If obtaining a C&amp;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.</p>
<b>PENICILLINS (ORAL)</b>		
<p><b><u>SINGLE ENTITY AGENTS</u></b> <b><u>NATURAL PENICILLINS</u></b> PENICILLIN V POTASSIUM tablets, oral solution</p> <p><b><u>PENICILLINASE-RESISTANT PENICILLINS</u></b> DICLOXACILLIN Capsules</p> <p><b><u>AMINOPENICILLINS</u></b> AMOXICILLIN capsules, tablets, chewable tablets, suspension AMPICILLIN capsules, suspension</p> <p><b><u>COMBINATION PRODUCTS</u></b></p>		<p><b>Augmentin:</b> patient has had a documented intolerance to the generic formulation of the requested medication. OR patient is &lt; 12 weeks of age and requires the 125 mg/5 mL strength of Augmentin.</p> <p><b>Amoxicillin/Clavulanate ER, Augmentin XR:</b> prescriber must provide a clinically valid reason for the use of the requested medication. Additionally, for approval of brand Augmentin XR, the patient must have a documented intolerance to generic Amoxicillin/Clavulanate ER</p> <p><b>Limitations:</b> Brand Augmentin® tablets and Chewable tablets do not offer Federal Rebate and therefore cannot be provided.</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<p>AMOXICILLIN/CLAVULANATE (compare to Augmentin<sup>®</sup>) tablets, chewable tablets, suspension</p>	<p>Amoxicillin/clavulanate ER (compare to Augmentin XR<sup>®</sup>) tablets            Augmentin<sup>®</sup> (amoxicillin/clavulanate) suspension            Augmentin XR<sup>®</sup> (amoxicillin/clavulanate) tablets</p> <p>PA will be granted for 125 mg/5 mL strength for patients &lt; 12 weeks of age</p>	
<b>QUINOLONES</b>		
<p>CIPROFLOXACIN (compare to Cipro<sup>®</sup>) tabs, oral suspension            CIPRO<sup>®</sup> (ciprofloxacin) oral suspension            LEVOFLOXACIN (compare to Levaquin<sup>®</sup>) tabs, solution            MOXIFLOXACIN tabs</p> <p>IV drugs are not managed at this time</p>	<p>Baxdela<sup>™</sup> (delafloxacin)            Cipro<sup>®</sup> (ciprofloxacin) tabs            Levaquin<sup>®</sup> (levofloxacin) tabs, solution            Ofloxacin</p>	<p><b>Cipro, Levaquin:</b> the patient has had a documented intolerance to the generic equivalent.</p> <p><b>Baxdela:</b> 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&amp;S) report shows isolated pathogen is a gram-positive or gram-negative organism susceptible to delafloxacin (If obtaining a C&amp;S report is not feasible, provider must submit documentation.) AND member has a documented treatment failure, intolerance or contraindication to 2 preferred antibiotics, one of which must be a fluoroquinolone AND duration of therapy does not exceed 14 days.</p> <p><b>Ofloxacin:</b> patient has had a documented side effect, allergy, or treatment failure with two preferred fluoroquinolones</p>
<b>RIFAMYCINS</b>		
<p>All products require PA</p>	<p>Xifaxan<sup>®</sup> (rifaximin) 200 mg tablets  <i>QTY LIMIT:</i> depends on indication            Xifaxan<sup>®</sup> (rifaximin) 550 mg tablets  <i>QTY LIMIT:</i> depends on indication</p>	<p><b>Critical for Approval: Based on Indication:</b></p> <p><b>Hepatic Encephalopathy (Xifaxan 550 mg Tablets Only):</b> 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).</p> <p><b>Traveler’s Diarrhea (Xifaxan 200 mg Tablets Only):</b> 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. AND Quantity limit is 9 tablets/RX (200 mg tablets only).</p> <p><b>Small Intestinal Bacterial Overgrowth (Xifaxan 550 mg or 200 mg Tablets):</b> patient has a diagnosis of SIBO AND Quantity limit is 1,200 mg to 1,650mg/day, maximum of 14 days.</p> <p><b>Irritable Bowel Syndrome (Xifaxan 550 mg or 200 mg Tablets):</b> patient has a diagnosis of irritable bowel syndrome without constipation or with symptoms</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		<p>of bloating. AND Patient has attempted dietary modification and has had a documented side effect, allergy, treatment failure or contraindication to two of the following classes (one of which must be an antibiotic): • Antibiotics (alone or in combination: amoxicillin-clavulanate, cephalosporin, metronidazole, fluoroquinolone, tetracycline, trimethoprim-sulfamethoxazole) • SSRIs • TCAs • Antispasmodics • Antidiarrheals • Cholestyramine resin AND Quantity limit is 1,200 mg to 1,650 mg/day.</p> <p><b>Inflammatory Bowel Disease: Crohn’s Disease (Xifaxan 550 mg or 200 mg Tablets):</b> patient has a diagnosis of Crohn’s Disease. AND Patient has had a documented side effect, allergy, treatment failure or contraindication to two of the following: 6-mercaptopurine, aminosalicylates, azathioprine, corticosteroids, fluoroquinolone and/or metronidazole. AND Quantity limit is 600 mg to 1,600 mg/day.</p> <p><b>Clostridium difficile Diarrhea (Xifaxan 200 mg Tablets):</b> 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.</p>
<b>TETRACYCLINES</b>		
<p>DOXYCYCLINE MONOHYDRATE 50 MG, 100 MG capsules, tablets</p> <p>DOXYCYCLINE HYCLATE 100 MG capsules, tablets</p> <p>DOXYCYCLINE HYCLATE 50MG capsules</p> <p>DOXYCYCLINE MONOHYDRATE suspension 25 MG/5ML</p> <p>MINOCYCLINE 50 MG, 100 MG capsules</p>	<p>Adoxa® (doxycycline monohydrate) 150 mg tab</p> <p>Demeclocycline 150mg, 300mg tabs</p> <p>Doryx (doxycycline hyclate) delayed release tabs</p> <p>Doxycycline hyclate delayed release tabs</p> <p>Doxycycline 75mg, 150mg caps, tabs</p> <p>Minolira® ER (minocycline extended release) tablet</p> <p>QTY LIMIT: 1 tablet/day</p> <p>Oracea® (doxycycline monohydrate) 40mg cap</p> <p>Vibramycin® (doxycycline hyclate) cap, suspension</p> <p>Vibramycin® (doxycycline calcium) syrup</p> <p>Minocycline 50 mg, 75 mg, 100 mg tabs</p> <p>Nuzyra® (omadacycline) tabs</p> <p>QTY LIMIT: Max 14-day supply</p> <p>Solodyn®(minocycline) tabs ER</p> <p>Tetracycline 250 mg, 500 mg cap</p> <p>Ximino® (minocycline) caps ER</p> <p>All other brands</p>	<p><b>Non-preferred doxycycline/minocycline products (except as listed below):</b> patient has had a documented side effect, allergy, or treatment failure with a preferred doxycycline/minocycline. If a product has an AB rated generic, the trial must be the generic formulation.</p> <p><b>Nuzyra:</b> 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.</p> <p><b>Oracea:</b> 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.</p> <p><b>Minolira ER/Solodyn/Ximino:</b> patient is <math>\geq 12</math> 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. <b>Note:</b> no effect has been demonstrated on non-inflammatory acne lesions.</p> <p><b>Vibramycin Suspension, Syrup:</b> patient has a medical necessity for a liquid dosage form AND a documented failure of preferred doxycycline suspension.</p> <p><b>Tetracycline:</b> 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 and the patient has a contraindication or treatment failure to</p>

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		clarithromycin.
<b>VANCOMYCIN</b>		
<p>All products require PA</p> <p>IV vancomycin products are not managed at this time</p>	<p>Firvanq™ (vancomycin HCl) powder for oral solution <i>QTY LIMIT:</i> 1 bottle (150ml) per course of therapy. If more than 150ml is required, use of 300ml bottle is required.</p> <p>Vancocin® (vancomycin) capsules Vancomycin (compare to Vancocin®) capsules</p>	<p><b>Criteria for Approval:</b> patient's diagnosis or indication is Clostridium difficile associated diarrhea (CDAD) AND For approval of brand Vancocin, the patient must meet the above criteria and have a documented intolerance to the generic.</p>
<b>ANTI-INFECTIVES ANTIFUNGAL</b>		
<b>ALLYLAMINES</b>		
<p>TERBINAFINE tabs (compare to Lamisil®) <i>QTY LIMIT:</i> 30 tablets/month (therapy limit of 90 days)</p> <p>GRISEOFULVIN MICROSIZED Suspension</p>	<p>Griseofulvin Microsize Tablets Griseofulvin Ultramicrosize Tablets</p>	<p><b>Griseofulvin Microsize Tabs/Griseofulvin Ultramicrosize:</b> patient has had a documented side effect, allergy, or treatment failure with terbinafine tablets and a preferred formulation of griseofulvin.</p>
<b>AZOLES</b>		
<p>FLUCONAZOLE (compare to Diflucan®) tabs, suspension CLOTTRIMAZOLE Troche (compare to Mycelex®)</p> <p>IV drugs are not managed at this time.</p>	<p>Cresemba® (isavuconazonium) caps Diflucan® (fluconazole) tabs, suspension Itraconazole (compare to Sporanox®) caps, solution Ketoconazole tabs Noxafil® (posaconazole) oral suspension</p> <p>Noxafil® (posaconazole) DR Tablets <i>QTY LIMIT:</i> 93 tablets/30 days</p> <p>Onmel® (itraconazole) 200 mg tablet <i>QTY LIMIT:</i> 1 tab/day</p> <p>Oravig® (miconazole) 50 mg buccal tablet Posaconazole DR Tablets (compare to Noxafil®) <i>QTY LIMIT:</i> 93 tablets/30 days</p> <p>Sporanox® (itraconazole) caps, solution Tolsura® (itraconazole) caps <i>QTY LIMIT:</i> 4 caps/day</p> <p>VFend® (voriconazole) tabs, suspension Voriconazole (compare to VFend®) tabs, suspension</p>	<p><b>Cresemba:</b></p> <ul style="list-style-type: none"> <li>• Diagnosis of either invasive aspergillosis or mucormycosis</li> <li>• Age ≥18 years old</li> <li>• Documented side effect, allergy, contraindication or treatment failure with voriconazole</li> <li>• Completion of regimen started by hospital</li> </ul> <p><b>Ketoconazole/Itraconazole 100mg cap/Itraconazole Solution/Sporanox</b> 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.</p> <p><b>Tolsura:</b> 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</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		<p>capsules and solution.</p> <p><b>Onmel 200 mg:</b> patient has a diagnosis of a toenail onychomycosis infection (confirmed with a positive KOH stain, PAS stain, fungal culture or physician clinical judgment) AND has a documented side-effect, allergy, contraindication, or treatment failure to oral terbinafine AND there is a clinical reason that itraconazole 100 mg generic capsules cannot be used AND meets at least 1 of the following criteria: Pain to affected area that limits normal activity, Diabetes Mellitus, Patient has significant vascular compromise</p> <p><b>Limitations:</b> Coverage of Onychomycosis agents will NOT be approved solely for cosmetic purposes.</p> <p><b>Voriconazole/Vfend:</b> 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.</p> <p><b>Noxafil, posaconazole:</b> 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. OR For Oral Suspension ONLY the patient has a documented side-effect, allergy, or treatment failure to one of the preferred medications and itraconazole AND the patient is being treated for oropharyngeal candidiasis.</p> <p><b>Diflucan (brand):</b> For approval of Diflucan brand name product, the patient must have a documented intolerance to generic fluconazole.</p> <p><b>Oravig:</b> 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.</p>
<b>ANTI-INFECTIVES ANTIMALARIALS</b>		
ATOVAQUONE/PROGUANIL (compare to Malarone®) CHLOROQUINE COARTEM® (artemether/lumefantrine) DARAPRIM® (pyrimethamine) HYDROXYCHLOROQUINE SULFATE MEFLOQUINE	Malarone® (atovaquone/proguanil) Pyrimethamine (compare to Daraprim®) Quinine Sulfate (compare to Qualquin®) Qualaquin® (quinine sulfate)	<p><b>Krintafel:</b> the patient is ≥ 16 years of age AND is receiving concurrent antimalarial therapy</p> <p><b>Malarone:</b> patient has a documented intolerance to the generic equivalent</p> <p><b>Pyrimethamine:</b> patient has a documented intolerance to brand Daraprim</p> <p><b>Quinine sulfate, Qualaquin:</b> 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.</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
PRIMAQUINE QUINIDINE SULFATE  <u><i>Preferred After Clinical Criteria Are Met</i></u> KRINTAFEL® (tafenoquine succinate)		
<b>ANTI-PARASITICS</b>		
ALBENDAZOLE (compare to Albenza®) BILTRICIDE® (praziquantel) IVERMECTIN (compare to Stromectol®)	Albenza® (albendazole) Benznidazole Emverm® (mebendazole) Lampit (nifurtimox) Stromectol® (ivermectin)	<b>Benznidazole, Lampit:</b> 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. <b>Emverm:</b> patient has a documented side effect, allergy, treatment failure, or contraindication to albendazole OR indication for use is hookworm infection (e.g. ancylostomiasis, necatoriasis, uninariasis). <b>Albenza, Stromectol:</b> patient has a documented intolerance to the generic product.
<b>ANTI-INFECTIVES ANTI-VIRALS</b>		
<b>HERPES SIMPLEX VIRUS MEDICATIONS (ORAL)</b>		
ACYCLOVIR (compare to Zovirax®) tablets, capsules ACYCLOVIR suspension (age ≤ 12 yrs) VALACYCLOVIR (compare to Valtrex®)	Famciclovir (compare to Famvir®) Sitavig® (acyclovir) Buccal Tablet <i>QTY LIMIT:</i> 2 tablets/30 days Valtrex® (valacyclovir) Zovirax® (acyclovir) tablets, capsules, suspension	<b>Acyclovir suspension (age &gt; 12 yrs), Zovirax suspension:</b> 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. <b>Famciclovir, Zovirax (tabs, caps):</b> patient has a documented side effect or allergy, treatment failure (at least one course of ten or more days) with acyclovir or valacyclovir. <b>Sitavig:</b> patient has a diagnosis of recurrent herpes labialis (cold sores). AND patient is immunocompetent AND patient has a documented side effect or treatment failure with acyclovir AND valacyclovir. <b>Valtrex:</b> patient has a documented intolerance to generic valacyclovir
<b>INFLUENZA MEDICATIONS</b>		
OSELTAMIVIR (compare to Tamiflu®) <i>QTY LIMIT:</i> 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) <i>QTY LIMIT:</i> 20 blisters/30 days	Tamiflu® (oseltamivir) <i>QTY LIMIT:</i> 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) <i>QTY LIMIT:</i> 2 tablets/30 days	<b>Tamiflu:</b> Patient has a documented intolerance to generic Oseltamivir <b>Xofluza:</b> Patient is ≥ 12 years of age AND there is a clinical, patient-specific reason the patient cannot use a preferred agent. <b>Note:</b> 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 (2 x 40mg tablets)

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		<p>for patients weighing at least 80kg.</p> <p><b>Limitations:</b> 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”.</p>
<b>CYTOMEGALOVIRUS (CMV) INFECTION MEDICATIONS</b>		
VALGANCICLOVIR (compare to Valcyte®) tablet	Prevmis® (letermovir) Valcyte® tablets, solution Valganciclovir (compare to Valcyte®) solution	<p><b>Prevmis:</b> 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.</p> <p><b>Valcyte:</b> 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.</p> <p><b>Valganciclovir solution:</b> the patient has a medical necessity for a non-solid oral dosage form.</p>
<b>INFLUENZA VACCINES</b>		
<p><b><u>SEASONAL INFLUENZA VACCINE INJECTION</u></b></p> <p><b><u>INACTIVATED INFLUENZA VACCINE, QUADRIVALENT (IIV4), STANDARD DOSE (EGG BASED)</u></b>            AFLURIA® QUADRIVALENT Injection            FLUARIX® QUADRIVALENT Injection            FLULAVAL® QUADRIVALENT Injection            FLUZONE® QUADRIVALENT Injection</p>	<p><b><u>ADJUVANTED INACTIVATED INFLUENZA VACCINE, QUADRIVALENT (IIV4), STANDARD DOSE (EGG BASED)</u></b>            Fluad™ Injection</p> <p><b><u>INACTIVATED INFLUENZA VACCINE, QUADRIVALENT (IIV4), HIGH DOSE (EGG BASED)</u></b>            Fluzone High-Dose® Injection</p> <p><b><u>RECOMBINANT INFLUENZA VACCINE, QUADRIVALENT (RIV4) (EGG FREE)</u></b>            Flublok® Injection</p> <p><b><u>INACTIVATED INFLUENZA VACCINE, QUADRIVALENT (ccIIV4), STANDARD DOSE</u></b></p>	<p><b>Flucelvax Quadrivalent:</b> Prescriber provides clinical rationale why one of the preferred influenza vaccines cannot be used.</p> <p><b>Flublok:</b> Patient must have a documented severe reaction to egg based influenza vaccine.</p> <p><b>Flumist:</b> 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.</p> <p><b>Fluzone High Dose, Fluad:</b> Vaccine is being requested for influenza prophylaxis during flu season AND patient is ≥ 65 years old AND 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.</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	<p><b><u>(CELL CULTURE BASED) (NOT EGG FREE)</u></b> Flucelvax Quadrivalent® Injection</p> <p><b><u>LIVE ATTENUATED INFLUENZA VACCINE, QUADRIVALENT (LAIV4) (EGG BASED)</u></b> Flumist® Quadrivalent Intranasal</p>	
<b>VACCINES - OTHER</b>		
<p><b><u>Preferred After Age Limit Is Met</u></b> GARDASIL SHINGRIX ZOSTAVAX</p>		<p><b>Gardasil:</b> Covered for 19 years old to 45 years old (those under 19 should be referred to their pediatrician or PCP for state-supplied vaccine)</p> <p><b>Shingrix:</b> Covered if ≥ 50 years of age</p> <p><b>Zostavax:</b> Covered if ≥ 60 years of age</p> <p>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.</p> <ul style="list-style-type: none"> <li>• 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 <a href="http://healthvermont.gov/hc/imm/provider.aspx">http://healthvermont.gov/hc/imm/provider.aspx</a></li> <li>• Vaccines not on the recommended list may require Prior Authorization.</li> </ul>
<b>MIGRAINE THERAPY: PREVENTATIVE TREATMENTS</b>		
<b>Calcitonin gene-related peptide (CGRP) Inhibitors:</b> Initial approval is 6 months; renewals are 1 year		
<p><b><u>Preferred After Clinical Criteria Are Met</u></b> AJOVY® (fremanezumab-vfrm) <i>QTY LIMIT:</i> 225 mg (1 injection) per 30 days or 675 mg (3 injections) every 90 days EMGALITY® (galcanezumab-gnlm) 120 mg/mL <i>QTY LIMIT:</i> 240 mg (2 injections) for the first 30 days followed by 120 mg (1 injection) per 30 days)</p>	<p>Aimovig™ (erenumab-aoee) <i>QTY LIMIT:</i> 1 injection (1mL) per 30 days Emgality® (galcanezumab-gnlm) 100 mg/mL <i>QTY LIMIT:</i> 300 mg (3 injections) per 30 days, maximum of 6 months per year approved Vyepti® (eptinezumab-jjmr)</p>	<p><b>Aimovig, Ajovy, Emgality 120mg/mL, Vyepti:</b> 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 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</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<p><i>Note:</i> Please refer to “Botulinum Toxins” for Botox</p>		<p>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</p> <p><b>Aimovig, Vyepti additional criteria:</b> The patient must have a documented side effect, allergy, or treatment failure to Emgality and Ajovy.</p> <p><b>Emgality 100mg/mL:</b></p> <ul style="list-style-type: none"> <li>• Patient is 18 years of age or older AND</li> <li>• Patient has a diagnosis of episodic cluster headache as defined by the following: <ul style="list-style-type: none"> <li>○ Severe to very severe unilateral pain felt in the orbital, supraorbital, and/or temporal regions lasting 15-180 minutes (when untreated)</li> <li>○ Pain is accompanied by a sense of restlessness or agitation OR at least one of the following signs or symptoms, ipsilateral to the headache: <ul style="list-style-type: none"> <li>▪ Conjunctival injection and/or lacrimation</li> <li>▪ Eyelid edema</li> <li>▪ Miosis and/or ptosis</li> <li>▪ Nasal congestion and/or rhinorrhea</li> <li>▪ Forehead and facial sweating</li> </ul> </li> </ul> </li> <li>• Patient has <math>\geq 2</math> active cluster periods lasting 7 days to 1 year, separated by remission for periods lasting <math>\geq 3</math> months AND</li> <li>• Patient has not achieved satisfactory response to adequate doses of corticosteroids (<math>\geq 30</math>mg prednisone or <math>\geq 16</math>mg 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</li> <li>• 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 dosed verapamil) <b>Note:</b> this requirement will be waived if the patient’s 2 most recent active cluster periods were less than 3 weeks in duration.</li> </ul>

### MIGRAINE THERAPY: ACUTE TREATMENTS

#### GEPANTS

*Preferred After Clinical Criteria Are Met*

NURTEC® ODT (rimegepant)  
*QTY LIMIT:* 16 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 AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		preferred triptans, unless contraindicated AND patient has a documented side effect, allergy, or treatment failure with Nurtec ODT.
<b>DITANS</b>		
All products require PA	Reyvow® (lasmiditan) <i>QTY LIMIT</i> : 8 tablets/30 days	<b>Reyvow</b> : 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
<b>TRIPTANS</b>		
<p><b><u>SINGLE AGENT</u></b> <b><u>ORAL</u></b></p> <p>SUMATRIPTAN (compare to Imitrex®) <i>QTY LIMIT</i>: 25 mg = 18 tablets/30 days, 50 and 100 mg = 9 tablets/30 days</p> <p>RELPAx® (eletriptan) 20 mg, 40 mg <i>QTY LIMIT</i>: 12 tablets/30 days</p> <p>RIZATRIPTAN (compare to Maxalt®) <i>QTY LIMIT</i>: 12 tablets/30 days</p> <p>RIZATRIPTAN ODT (compare to Maxalt-MLT®) <i>QTY LIMIT</i>: 12 tablets/30 days</p>	<p>Almotriptan 6.25 mg, 12.5 mg <i>QTY LIMIT</i>: 12 tablets/30 days</p> <p>Amerge® (naratriptan) 1 mg, 2.5 mg <i>QTY LIMIT</i>: 9 tablets/30 days</p> <p>Eletriptan (compare to Relpax®) <i>QTY LIMIT</i>: 12 tablets/30 days</p> <p>Frova® (frovatriptan) 2.5 mg <i>QTY LIMIT</i>: 9 tablets/30 days</p> <p>Frovatriptan (compare to Frova®) 2.5 mg <i>QTY LIMIT</i>: 9 tablets/30 days</p> <p>Imitrex® (sumatriptan) <i>QTY LIMIT</i>: 25 mg = 18 tablets/30 days, 50 and 100 mg = 9 tablets/30 days</p> <p>Maxalt® (rizatriptan) 5 mg, 10 mg tablet <i>QTY LIMIT</i>: 12 tablets/30 days</p> <p>Maxalt-MLT® (rizatriptan ODT) <i>QTY LIMIT</i>: 12 tablets/30 days</p> <p>Naratriptan (compare to Amerge®) <i>QTY LIMIT</i>: 9 tablets/30 days</p> <p>Zomig® (zolmitriptan) tablets <i>QTY LIMIT</i>: 2.5 mg = 12 tablets/30 days, 5 mg = 6 tablets/30 days</p> <p>Zomig® ZMT (zolmitriptan ODT) <i>QTY LIMIT</i>: 2.5 mg = 12 tablets/30 days, 5 mg = 6 tablets/30 days</p> <p>Zolmitriptan (compare to Zomig®) tablets <i>QTY LIMIT</i>: 2.5 mg = 12 tablets/30 days, 5 mg = 6 tablets/30 days</p> <p>Zolmitriptan ODT (compare to Zomig® ZMT)</p>	<p><b>Almotriptan, Amerge, Eletriptan, Frova, Frovatriptan, Imitrex, Maxalt, Maxalt MLT, Naratriptan, Zomig, Zomig ZMT, Zolmitriptan, Zolmitriptan ODT</b>: patient has had a documented side effect, allergy, or treatment failure to Sumatriptan, Relpax, and Rizatriptan or Rizatriptan ODT. If the request is for brand Frova, Maxalt, Zomig, or Zomig ZMT, the patient must also have a documented intolerance to the generic product.</p> <p><b>Sumatriptan/naproxen, Treximet</b>: 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.</p> <p><b>Zomig Nasal Spray, Imitrex Nasal Spray, Onzetra Xsail, Tosymra</b>: patient has had a documented side effect, allergy or treatment failure with Sumatriptan Nasal Spray</p> <p><b>Imitrex, Zembrace</b>: patient has had a documented intolerance to generic sumatriptan injection.</p> <p><b>To exceed quantity limits</b>: patient is taking a medication for migraine prophylaxis.</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<p><b><u>NASAL SPRAY</u></b> SUMATRIPTAN (compare to Imitrex®) <i>QTY LIMIT:</i> 5 mg nasal spray = 12 units/30 days, 20 mg nasal spray = 6 units/ 30 days</p> <p><b><u>NASAL POWDER</u></b> All products require PA</p> <p><b><u>INJECTABLE</u></b> SUMATRIPTAN (compare to Imitrex®) <i>QTY LIMIT:</i> 4 and 6 mg injection = 8 injections (4ml)/30 days</p> <p><b><u>COMBINATION PRODUCT</u></b> <b><u>ORAL</u></b></p>	<p><i>QTY LIMIT:</i> 2.5 mg = 12 tablets/30 days, 5 mg = 6 tablets/30 days</p> <p>Imitrex® (sumatriptan) <i>QTY LIMIT:</i> 5 mg nasal spray = 12 units/30 days, 20 mg nasal spray = 6 units/ 30 days</p> <p>Tosymra® (sumatriptan) <i>QTY LIMIT:</i> 6 units/30 days</p> <p>Zomig® (zolmitriptan) <i>QTY LIMIT:</i> 2.5 and 5 mg nasal spray = 12 units/30 days</p> <p>Onzetra Xsail® (sumatriptan succinate) <i>QTY LIMIT:</i> 8 doses/30 days</p> <p>Imitrex® (sumatriptan) <i>QTY LIMIT:</i> 4 and 6 mg injection = 8 injections (4ml)/30 days</p> <p>Zembrace® SymTouch (sumatriptan) 3 mg/5ml <i>QTY LIMIT:</i> 4 injections/ 30 days</p> <p>Sumatriptan/Naproxen (compare to Treximet®) <i>QTY LIMIT:</i> 9 tablets/30 days</p> <p>Treximet® (sumatriptan/naproxen) <i>QTY LIMIT:</i> 9 tablets/ 30 days</p>	

### ANTI-PSYCHOTIC ATYPICAL & COMBINATIONS (CHILDREN < 18 YEARS OLD)

<p><b><u>Preferred After Clinical Criteria Are Met</u></b> <b><u>TABLETS/CAPSULES</u></b> ARIPRAZOLE (compare to Abilify®) <i>QTY LIMIT:</i> 5, 10, and 15 mg = 1.5 tabs/day FDA maximum recommended dose = 30 mg/day</p> <p>OLANZAPINE (compare to Zyprexa®) <i>QTY LIMIT:</i> 2.5, 5, 7.5, and 10 mg = 1.5 tabs/day FDA maximum recommended dose = 20 mg/day</p> <p>RISPERIDONE (compare to Risperdal®) FDA maximum recommended dose = 16 mg/day</p>	<p>Abilify® (aripiprazole) <i>QTY LIMIT:</i> 5, 10, and 15 mg = 1.5 tabs/day FDA maximum recommended dose = 30 mg/day</p> <p>Clozapine (compare to Clozaril®) FDA maximum recommended dose = 900 mg/day</p> <p>Clozaril® (clozapine) FDA maximum recommended dose = 900 mg/day</p> <p>Geodon® (ziprasidone)</p>	<p><b>Target symptoms or Diagnosis that will be accepted for approval:</b> 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.</p> <p><b>Criteria for approval of ALL drugs:</b> Medication is being requested for one of the target symptoms or diagnoses listed above AND the patient is started and</p>
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PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<p>QUETIAPINE (compare to Seroquel®) FDA maximum recommended dose = 800 mg/day</p> <p>ZIPRASIDONE (compare to Geodon®) FDA maximum recommended dose = 160 mg/day</p> <p><u><b>Preferred After Clinical Criteria Are Met</b></u></p> <p><u><b>ORAL SOLUTIONS</b></u></p> <p>RISPERIDONE (compare to Risperdal®) oral solution FDA maximum recommended dose = 16 mg/day</p>	<p>FDA maximum recommended dose = 160 mg/day</p> <p>Invega® (paliperidone) <i>QTY LIMIT:</i> 3 and 9 mg = 1 tab/day, 6 mg = 2 tabs/day FDA maximum recommended dose = 12 mg/day</p> <p>Latuda® (lurasidone) <i>QTY LIMIT:</i> 1 tab/day FDA maximum recommended dose = 80 mg/day</p> <p>Paliperidone (compare to Invega®) <i>QTY LIMIT:</i> 3 and 9 mg = 1 tab/day, 6 mg = 2 tabs/day FDA maximum recommended dose = 12 mg/day</p> <p>Quetiapine ER (compare to Seroquel® XR) <i>QTY LIMIT:</i> 150 and 200 mg = 1 tab/day, 50 mg = 2 tabs/day FDA maximum recommended dose = 800 mg/day</p> <p>Risperdal® (risperidone) FDA maximum recommended dose = 16 mg/day</p> <p>Seroquel® (quetiapine) FDA maximum recommended dose = 800 mg/day</p> <p>Saphris® (asenapine) <i>QTY LIMIT:</i> 2 tabs/day FDA maximum recommended dose = 20 mg/day</p> <p>Seroquel XR® (quetiapine XR) <i>QTY LIMIT:</i> 150 and 200 mg = 1 tab/day, 50 mg = 2 tabs/day FDA maximum recommended dose = 800 mg/day</p> <p>Zyprexa® (olanzapine) <i>QTY LIMIT:</i> 2.5, 5, 7.5, and 10 mg = 1.5 tabs/day FDA maximum recommended dose = 20 mg/day</p>	<p>stabilized on the requested medication (Note: samples are not considered adequate justification for stabilization) OR patient meets additional criteria outlined below. Note: all requests for patients &lt; 5 years will be reviewed by the DVHA medical director.</p> <p><b>Invega, Paliperidone, Saphris:</b> patient had had a documented side effect, allergy or treatment failure with at least two preferred products (typical or atypical antipsychotics) one of which is risperidone.</p> <p><b>Abilify, Clozaril, Geodon, Risperdal, Seroquel, Zyprexa:</b> patient has a documented intolerance to the generic equivalent.</p> <p><b>Clozapine:</b> 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.</p> <p><b>Latuda:</b> <i>Indication for use is schizophrenia:</i> patient is ≥13 years of age or older AND patient has had a documented side effect, allergy or treatment failure with at least two preferred products (typical or atypical antipsychotics); the patient would not be required to have 2 preferred trials if pregnant. <i>Indication for use is Bipolar 1 depression:</i> patient is ≥ 10 years of age or older AND patient has had a documented side effect, allergy or treatment failure with at least two preferred products (typical or atypical antipsychotics) OR the prescriber feels that quetiapine or olanzapine/fluoxetine combination would not be appropriate alternatives for the patient because of pre-existing conditions such as obesity or diabetes; the patient would not be required to have 2 preferred trials if pregnant.</p> <p><b>Quetiapine XR, Seroquel XR:</b> patient has not been able to be adherent to a twice daily dosing schedule of quetiapine immediate release resulting in a significant clinical impact.</p> <p><b>Abilify Oral Solution:</b> 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.</p> <p><b>Versacloz Oral Solution:</b> patient has had a documented side effect, allergy or treatment failure with at least three other antipsychotic medications (typical or atypical antipsychotics). AND patient is unable to use clozapine orally disintegrating tablets.</p>
<p><u><b>ORALLY DISINTEGRATING TABLETS</b></u> All products require PA</p>	<p>Abilify® (aripiprazole) oral solution FDA maximum recommended dose = 25 mg/day</p> <p>Risperdal® (risperidone) oral solution FDA maximum recommended dose = 16 mg/day</p> <p>Versacloz® (clozapine) Oral Suspension <i>QTY LIMIT:</i> 18ml/day FDA maximum recommended dose = 900 mg/day</p> <p>Abilify® Discmelt (aripiprazole)</p>	<p><b>Olanzapine ODT, Risperdal M-Tabs, Risperidone ODT, Zyprexa Zydis:</b> patient meets clinical criteria for non-orally disintegrating oral dosage forms of the same medication AND Medical necessity for a specialty dosage form has been provided AND if the request is for Risperdal M-tabs or Zyprexa Zydis, the patient has a documented intolerance to the generic equivalent.</p> <p><b>Clozapine ODT:</b> Medical necessity for a specialty dosage form has been provided AND patient has had a documented side effect, allergy or treatment</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	<p><i>QTY LIMIT:</i> 10 and 15 mg = 2 tabs/day            FDA maximum recommended dose = 30 mg/day            Clozapine orally disintegrating tablets (Compare to FazaClo<sup>®</sup>)            FDA maximum recommended dose = 900 mg/day            Olanzapine orally disintegrating tablets (compare to Zyprexa Zydis<sup>®</sup>)  <i>QTY LIMIT:</i> 5 and 10 mg = 1.5 tabs/day            FDA maximum recommended dose = 20 mg/day            Risperdal<sup>®</sup> M-Tab (risperidone orally disintegrating tablets)            FDA maximum recommended dose = 16 mg/day            Risperidone ODT (compare to Risperdal<sup>®</sup> M-Tab)            FDA maximum recommended dose = 16 mg/day            Zyprexa Zydis<sup>®</sup> (olanzapine orally disintegrating tablets)  <i>QTY LIMIT:</i> 5 and 10 mg = 1.5 tabs/day            FDA maximum recommended dose = 20 mg/day</p>	<p>failure with at least three other antipsychotic medications (typical or atypical antipsychotics)  <b>Abilify Discmelt</b> Medical necessity for a specialty dosage form has been provided AND patient has had a documented side effect, allergy or treatment failure with Risperdal M-tab OR prescriber feels that risperidone would not be an appropriate alternative for the patient because of pre-existing medical conditions such as obesity or diabetes</p>

### ANTI-PSYCHOTIC ATYPICAL & COMBINATIONS (ADULTS ≥ 18 YEARS OLD)

<u>TABLETS/CAPSULES</u>		
<p><b>ARIPIPRAZOLE</b> (compare to Abilify<sup>®</sup>)  <i>QTY LIMIT:</i> 5, 10, and 15 mg = 1.5 tabs/day            FDA maximum recommended dose = 30 mg/day  <b>CLOZAPINE</b> (compare to Clozaril<sup>®</sup>)            FDA maximum recommended dose = 900 mg/day  <b>OLANZAPINE</b> (compare to Zyprexa<sup>®</sup>)  <i>QTY LIMIT:</i> 2.5, 5, 7.5, and 10 mg = 1.5 tabs/day            FDA maximum recommended dose = 20 mg/day  <b>RISPERIDONE</b> (compare to Risperdal<sup>®</sup>)            FDA maximum recommended dose = 16 mg/day  <b>QUETIAPINE</b> (compare to Seroquel<sup>®</sup>) &gt; 50 mg/day            FDA maximum recommended dose = 800 mg/day  <b>ZIPRASIDONE</b> (compare to Geodon<sup>®</sup>)            FDA maximum recommended dose = 160 mg/day</p>	<p>Abilify<sup>®</sup> (aripiprazole)  <i>QTY LIMIT:</i> 5, 10, and 15 mg = 1.5 tabs/day            FDA maximum recommended dose = 30 mg/day            Abilify<sup>®</sup> Mycite (aripiprazole tablets with sensor)  <i>QTY LIMIT:</i> 1 tab/day            FDA maximum recommended dose=30mg/day            Clozaril<sup>®</sup> (clozapine)            FDA maximum recommended dose = 900 mg/day            Caplyta<sup>®</sup> (lumateperone)  <i>QTY LIMIT:</i> 1 capsule/day            FDA maximum recommended dose = 42 mg/day            Fanapt<sup>®</sup> (iloperidone)  <i>QTY LIMIT:</i> 2 tablets/day            FDA maximum recommended dose = 24 mg/day            Geodon<sup>®</sup> (ziprasidone)            FDA maximum recommended dose = 160 mg/day            Invega<sup>®</sup> (paliperidone)  <i>QTY LIMIT:</i> 3 and 9 mg = 1 tab/day, 6 mg = 2 tabs/day            FDA maximum recommended dose = 12 mg</p>	<p><b>Criteria for approval of ALL non-preferred drugs:</b> 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. <b>Note:</b> Trazodone dosed at &lt; 150mg/day will not be considered as a trial for adjunct treatment of MDD or any anxiety disorder. Bupropion will not be considered as a trial for adjunct treatment of any anxiety disorder.  <b>Caplyta:</b> The indication for use is the treatment of schizophrenia AND The patient has had a documented side effect, allergy or treatment failure with at least three preferred products (typical or atypical antipsychotics).  <b>Fanapt:</b> 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).  <b>Invega, Paliperidone, Saphris:</b> The indication for use is the treatment of schizophrenia/schizoaffective disorder AND The patient has had a documented side effect, allergy or treatment failure with at least three preferred products (typical or atypical antipsychotics), one of which is risperidone.  <b>Note:</b> Prior therapy with injectable Invega Sustenna<sup>®</sup> is not considered to be started and stabilized for oral Invega. Patients transferring to oral therapy from Invega Sustenna<sup>®</sup> should transition to oral risperidone (unless patient</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<p><b><u>ORAL SOLUTIONS</u></b></p> <p>RISPERIDONE (compare to Risperdal®) oral solution FDA maximum recommended dose = 16 mg/day</p>	<p>Latuda® (lurasidone) QTY LIMIT: 80 mg = 2 tablets/day All other strengths = 1 tablet/day FDA maximum recommended dose = 160 mg/day</p> <p>Nuplazid™ (primavaserin) QTY LIMIT: 2 tablets/day FDA maximum recommended dose = 34 mg</p> <p>Paliperidone (compare to Invega®) QTY LIMIT: 3 and 9 mg = 1 tab/day, 6 mg = 2 tabs/day FDA maximum recommended dose = 12 mg</p> <p>Quetiapine (compare to Seroquel®) ≤ 50mg/day (adults &gt;18 years old)</p> <p>Quetiapine ER (compare to Seroquel® XR)</p> <p>Rexulti® (brexpiprazole) FDA maximum recommended dose = 3 mg (adjunct of MDD) or 5 mg (schizophrenia)</p> <p>Risperdal® (risperidone) FDA maximum recommended dose = 16 mg/day</p> <p>Saphris® (asenapine) sublingual tablet FDA maximum recommended dose = 20 mg/day</p> <p>Seroquel® (quetiapine) FDA maximum recommended dose = 800 mg/day</p> <p>Seroquel XR® (quetiapine XR) QTY LIMIT: 150 and 200 mg = 1 tab/day, 50 mg = 2 tabs/day FDA maximum recommended dose = 800 mg/day</p> <p>Vraylar® (cariprazine) QTY LIMIT: 1 capsule/day FDA maximum recommended dose = 6 mg/day</p> <p>Zyprexa® (olanzapine) QTY LIMIT: 2.5, 5, 7.5, and 10 mg = 1.5 tabs/day FDA maximum recommended dose = 20 mg/day</p> <p>Abilify® (aripiprazole) oral solution FDA maximum recommended dose = 25 mg/day</p> <p>Risperdal® (risperidone) oral solution FDA maximum recommended dose = 16 mg/day</p> <p>Versacloz® (clozapine) Oral Suspension QTY LIMIT: 18ml/day FDA maximum recommended dose = 900 mg/day</p>	<p>previously failed such treatment).</p> <p><b>Abilify, Clozaril, Geodon, Risperdal, and Zyprexa:</b> patient has a documented intolerance to the generic equivalent.</p> <p><b>Abilify Mycite:</b> 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.</p> <p><b>Vraylar:</b> <i>Indication for use is schizophrenia/schizoaffective disorder:</i> the patient has had a documented side effect, allergy or treatment failure with three preferred products (typical or atypical antipsychotics) OR <i>Indication for use is Bipolar I depression:</i> the patient has had a documented side effect, allergy or treatment failure with two preferred products (typical or atypical antipsychotics) OR 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.</p> <p><b>Latuda:</b> <i>Indication for use is schizophrenia/schizoaffective disorder or Bipolar I depression:</i> The patient is pregnant OR <i>Indication for use is schizophrenia/schizoaffective disorder:</i> the patient has had a documented side effect, allergy or treatment failure with two preferred products (typical or atypical antipsychotics) OR <i>Indication for use is Bipolar I depression:</i> the patient has had a documented side effect, allergy or treatment failure with two preferred products (typical or atypical antipsychotics) OR 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.</p> <p><b>Nuplazid:</b> The diagnosis or indication is the treatment of hallucinations/delusions associated with Parkinson's Disease psychosis.</p> <p><b>Rexulti:</b> <i>Indication for use is schizophrenia:</i> 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 <i>Indication for use is adjunct treatment of Major Depressive Disorder (MDD):</i> 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</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<p><b><u>SHORT-ACTING INJECTABLE PRODUCTS</u></b>            GEODON® IM (ziprasidone intramuscular injection)            FDA maximum recommended dose = 40 mg/day</p> <p><b><u>LONG-ACTING INJECTABLE PRODUCTS</u></b>            ABILIFY MAINTENA® (aripiprazole monohydrate)            FDA maximum recommended dose = 400 mg/month  <i>QTY LIMIT:</i> 1 vial/28 days            ARISTADA® (aripiprazole lauroxil)  <i>QTY LIMIT:</i> 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)  <i>QTY LIMIT:</i> 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)  <i>QTY LIMIT:</i> 405 mg = 1 vial/month, 210 and 300 mg = 2 vials/month            FDA maximum recommended dose = 600 mg/month</p> <p><b><u>Preferred After Clinical Criteria Are Met</u></b>            INVEGA TRINZA® (paliperidone palmitate)            FDA maximum recommended dose = 819 mg/3 months</p> <p><b><u>ORALLY DISINTEGRATING TABLETS</u></b>            All products require PA</p>	<p>Olanzapine intramuscular injection (compare to Zyprexa® IM)            FDA maximum recommended dose = 30 mg/day            Zyprexa® IM (olanzapine intramuscular injection)            FDA maximum recommended dose = 30 mg/day</p> <p>Abilify® Discmelt (aripiprazole)</p>	<p>antipsychotic products being used as adjunctive therapy, one of which must be aripiprazole</p> <p><b>Quetiapine/Seroquel &lt; or = 50mg/day:</b> The patient is being prescribed &gt; 50 mg/day with combinations of tablet strengths. OR Indication for use is a mental health indication (other than the two below indications or a sleep disorder) OR</p> <p><i>Indication for use is Adjunct treatment of Major Depressive Disorder (MDD):</i> the patient has had a documented inadequate response to at least 3 different antidepressants from 2 different classes OR</p> <p><i>Indication for use is Adjunct treatment of any anxiety disorder (panic, agoraphobia, social phobia, obsessive-compulsive disorder, PTSD, Acute Stress Disorder, Generalized Anxiety Disorder):</i> the patient has had a documented inadequate response to at least 3 different antidepressants from 2 different classes If the request is for brand Seroquel, the patient has a documented intolerance to generic quetiapine.</p> <p><b>NOTE:</b> Quetiapine in doses of ≤ 50 mg/day will not be approved for indications of insomnia, for sleep or as a hypnotic.</p> <p><b>Quetiapine ER, Seroquel XR:</b> The patient has not been able to be adherent to a twice daily dosing schedule of quetiapine immediate release resulting in a significant clinical impact</p> <p><b>Abilify Oral Solutions:</b> the patient has had a documented side effect, allergy or treatment failure with preferred risperidone oral solution.</p> <p><b>Risperdal Oral Solution:</b> The patient has a documented intolerance to the generic product risperidone.</p> <p><b>Versacloz Oral Solution:</b> The patient has a medical necessity for a non-solid oral dosage form and is unable to use clozapine orally disintegrating tablets.</p> <p><b>NON-PREFERRED SHORT-ACTING INJECTABLE PRODUCTS:</b> Medical necessity for a specialty dosage form has been provided. AND The patient has had a documented side effect, allergy, or treatment failure with Geodon IM. In addition, for approval of Zyprexa® IM, the patient must have had a documented intolerance to generic olanzapine IM.</p> <p><b>Invega Trinza:</b> The patient is started and stabilized on the medication OR tolerability has been established with Invega Sustenna for at least 4 months.  <b>Note:</b> This is processed via automated (electronic) step therapy.</p> <p><b>ORALLY DISINTEGRATING TABLETS:</b> Medical necessity for a specialty dosage form has been provided. AND If the request is for FazaClo, Risperdal M-Tab or Zyprexa Zydis, the patient has a documented intolerance to the generic equivalent.</p> <p><b>COMBINATION PRODUCTS:</b> The patient has had a documented side effect, allergy or treatment failure with two preferred products OR The prescriber</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<p><b><u>COMBINATION PRODUCTS</u></b> All products require PA</p> <p><b><u>TRANSDERMAL PRODUCTS</u></b> All products require PA</p>	<p><i>QTY LIMIT:</i> 10 and 15 mg = 2 tabs/day FDA maximum recommended dose = 30 mg/day Clozapine orally disintegrating tablets (Compare to FazaClo<sup>®</sup>) FDA maximum recommended dose = 900 mg/day FazaClo<sup>®</sup> (clozapine orally disintegrating tablets) FDA maximum recommended dose = 900 mg/day Olanzapine orally disintegrating tablets (compare to Zyprexa Zydis<sup>®</sup>) <i>QTY LIMIT:</i> 5 and 10 mg = 1.5 tabs/day FDA maximum recommended dose = 20 mg/day Risperdal<sup>®</sup> M-Tab (risperidone orally disintegrating tablets) FDA maximum recommended dose = 16 mg/day Risperidone ODT (compare to Risperdal<sup>®</sup> M-Tab) FDA maximum recommended dose = 16 mg/day Zyprexa Zydis<sup>®</sup> (olanzapine orally disintegrating tablets) <i>QTY LIMIT:</i> 5 and 10 mg = 1.5 tabs/day FDA maximum recommended dose = 20 mg/day</p> <p>Olanzapine/fluoxetine FDA maximum recommended dose = 18 mg/75 mg (per day)</p> <p>Secuado (asenapine) transdermal patch <i>QTY LIMIT:</i> 1 patch/day FDA maximum recommended dose = 7.6 mg/day</p>	<p>provides a clinically valid reason for the use of the requested medication.</p> <p><b>Secuado:</b> 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.</p>
<b>ANTI-PSYCHOTIC: TYPICALS</b>		
<p><b><u>ORAL</u></b> HALOPERIDOL LOXAPINE PERPHENAZINE PIMOZIDE TRIFLUOPERAZINE</p> <p><b><u>LONG ACTING INJECTABLE PRODUCTS</u></b> FLUPHENAZINE DECANOATE HALOPERIDOL DECANOATE (compare to Haldol<sup>®</sup> decanoate)</p>	<p>Chlorpromazine Fluphenazine Molindone Thioridazine Thiothixene</p> <p>Haldol<sup>®</sup> decanoate (haloperidol decanoate)</p>	<p><b>Chlorpromazine:</b> 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).</p> <p><b>Fluphenazine Oral Solution:</b> patient has a requirement for an oral liquid dosage form (i.e. swallowing disorder, inability to take oral medications)</p> <p><b>Fluphenazine tablets:</b> 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).</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		<p><b>All other oral medications:</b> 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.</p> <p><b>Long Acting Injectable Products:</b> for approval of Haldol decanoate, the patient has a documented intolerance to the generic product.</p>

## ANTIRETROVIRAL THERAPY HUMAN IMMUNODEFICIENCY VIRUS (HIV)

### SINGLE TABLET REGIMENS (STRs)

<p>ATRIPLA® (efavirenz/emtricitabine/tenofovir)            BIKTARVY® (bictegravir/emtricitabine/tenofovir AF)            COMPLERA® (emtricitabine/rilpivirine/tenofovir)            DELSTRIGO® (doravirine/lamivudine/tenofovir)            DOVATO® (dolutegravir/lamivudine)            GENVOYA® (elvitegravir/cobicistat/emtricitabine/tenofovir AF)            JULUCA® (dolutegravir/rilpivirine)            ODEFSEY® (emtricitabine/rilpivirine/tenofovir AF)            SYMFI™ (efavirenz/lamivudine/tenofovir)            SYMFI™ LO (efavirenz/lamivudine/tenofovir)            TRIUMEQ® (abacavir/lamivudine/dolutegravir)</p>	<p>Stribild® (elvitegravir/cobicistat/emtricitabine/tenofovir)            Symtuza® (darunavir/cobicistat/emtricitabine/tenofovir AF)</p>	<p><b>Stribild:</b></p> <ul style="list-style-type: none"> <li>The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR</li> <li>Genotype testing supporting resistance to other regimens OR</li> <li>Intolerance or contraindication to preferred combination of drugs AND</li> <li>Medical reasoning beyond convenience or enhanced compliance over preferred agents AND</li> <li>CrCl &gt; 70mL/min to initiate therapy OR CrCl &gt; 50mL/min to continue therapy</li> </ul> <p><b>Symtuza:</b> The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR Medical reasoning beyond convenience or enhanced compliance over preferred agents (Prezcobix &amp; Descovy)</p>
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### COMBINATION PRODUCTS - NRTIs

<p>ABACA VIR/LAMIVUDINE (compare to Epzicom®)            ABACA VIR/LAMIVUDINE/ZIDOVUDINE (compare to Trizivir®)            LAMIVUDINE/ZIDOVUDINE (compare to Combivir®)</p>	<p>Combivir® (lamivudine/zidovudine)            Epzicom® (abacavir/lamivudine)            Trizivir® (abacavir/lamivudine/zidovudine)</p>	<p><b>Combivir, Epzicom:</b> patient must have a documented intolerance to the generic equivalent</p> <p><b>Trizivir:</b> 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</p>
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### COMBINATION PRODUCTS – NUCLEOSIDE & NUCLEOTIDE ANALOG RTIs

<p>CIMDUO™ (lamivudine/tenofovir)            DESCOVY® (emtricitabine/tenofovir AF)            TRUVADA® (emtricitabine/tenofovir)</p>		
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### COMBINATION PRODUCTS – PROTEASE INHIBITORS

<p>KALETRA® (lopinavir/ritonavir)</p>	<p>Lopinavir/ritonavir (compare to Kaletra®)</p>	<p><b>Lopinavir/ritonavir:</b> patient must have a documented intolerance to brand Kaletra</p>
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PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<b>IMMUNOLOGIC THERAPIES</b>		
<p><u><i>Preferred After Clinical Criteria Are Met</i></u>  TROGARZO™ (ibalizumab-uiyk)  <i>QTY LIMIT</i>: 10 vials (2000 mg) x 1 dose then 4 vials (800 mg) every 14 days thereafter</p>		<p><b>Rukobia, Trogarzo:</b> The patient must meet ALL of the following criteria:</p> <ul style="list-style-type: none"> <li>• ≥ 18 years of age</li> <li>• Prescription is written by or in consultation with an infectious disease specialist</li> <li>• Viral Load is ≥ 1,000 copies/mL (results must be submitted)</li> <li>• Patient has been compliant but has had an inadequate response to at least 6 months of treatment with anti-retroviral therapy (ART), including recent failure within the last 8 weeks</li> <li>• Patient has multi-drug resistant HIV-1 infection including documented resistance to at least one medication from each of the following classes: <ul style="list-style-type: none"> <li>○ Protease Inhibitor (PI)</li> <li>○ Nucleoside Reverse Transcriptase Inhibitor (NRTI)</li> <li>○ Non-nucleoside Reverse Transcriptase Inhibitor (NNRTI)</li> </ul> </li> <li>• Medication will be used in combination with ART that includes at least one drug to which the individual’s virus is susceptible</li> <li>• 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.</li> </ul>
<b>GP120 DIRECTED ATTACHMENT INHIBITOR</b>		
<p><u><i>Preferred After Clinical Criteria Are Met</i></u>  RUKOBIA® (fostemsavir)  <i>QTY LIMIT</i> = 2 tablets per day</p>		
<b>INTEGRASE STRAND TRANSFER INHIBITORS</b>		
<p>ISENTRESS® (raltegravir potassium)  ISENTRESS HD (raltegravir potassium)  TIVICAY® (dolutegravir sodium)  TIVICAY® PD (dolutegravir sodium)</p>		
<b>NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTI)</b>		
<p>ABACA VIR SULFATE (compare to Ziagen®)  EMTRIVA® (emtricitabine)  LAMIVUDINE (compare to Epivir®)  TENOFIVIR DISOPROXIL FUMARATE (compare to Viread®) 300mg  VIREAD® (tenofovir disoproxil fumarate) 150mg, 200mg, 250mg tablet, 40mg/gm powder  ZIAGEN® (abacavir sulfate)  ZIDOVUDINE (compare to Retrovir®)</p>	<p>Didanosine DR  Epivir® (lamivudine)  Retrovir® (zidovudine)  Stavudine (compare to ZERIT®)  Videx EC (didanosine)  Videx® (didanosene) Solution  Viread® (tenofovir disoproxil fumarate) 300mg tablet  Ziagen® (abacavir sulfate) tablet</p>	<p><b>Epivir, Retrovir, Viread 300mg, Ziagen:</b> patient must have a documented intolerance to the generic equivalent  <b>Didanosine, Stavudine, Videx:</b> 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.</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<b>NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NNRTI)</b>		
EDURANT® (rilpivirine) EFAVIRENZ (compare to Sustiva®) INTELENCE® (etravirine) PIFELTRO (doravirine)	Nevirapine (compare to Viramune®) Nevirapine ER (compare to Viramune® ER) Sustiva® (efavirenz) Viramune® ER (nevirapine ER)	<b>Sustiva:</b> patient must have a documented intolerance to the generic equivalent <b>Nevirapine. Nevirapine ER, Viramune ER:</b> 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.
<b>PHARMACOENHANCER-CYTOCHROME P450 INHIBITOR</b>		
	TYBOST® (cobicistat)	<b>Tybost:</b> 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
<b>PROTEASE INHIBITORS (PEPTICIC)</b>		
ATAZANAVIR (compare to Reyataz®) EVOTAZ® (atazanavir/cobicistat) NORVIR® (ritonavir)	Fosemprenavir (compare to Lexiva®) Invirase® (saquinavir mesylate) Lexiva® (fosemprenavir) Reyataz® (atazanavir) Ritonavir (compare to Norvir®) Viracept® (nelfinavir)	<b>Fosemprenavir, Invirase, Lexiva, Viracept:</b> 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. <b>Reyataz:</b> patient must have a documented intolerance to the generic equivalent <b>Ritonavir:</b> patient must have a documented intolerance to brand Norvir
<b>PROTEASE INHIBITORS (NON-PEPTIDIC)</b>		
PREZCOBIX® (darunavir/cobicistat) PREZISTA® (darunavir ethanolate)	Aptivus® (tipranavir)	<b>Aptivus:</b> 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.
<b>ENTRY INHIBITORS-CCR5 CO-RECEPTOR ANTAGONISTS</b>		
	Selzentry® (maraviroc)	<b>Selzentry:</b> 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.
<b>ENTRY INHIBITORS-FUSION INHIBITORS</b>		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Fuzeon® (enfuvirtide)	<b>Fuzeon:</b> 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.

## BILE SALTS AND BILIARY AGENTS

URSODIOL capsules	Actigall® (ursodiol) Chenodal® (chenidiol) Cholbam® (cholic acid) Ocaliva® (obeticholic acid) Urso® (Urosiol) Ursodiol tablets Urso® Forte (ursodiol)	<p><b>Chenodal:</b> 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.</p> <p><b>Cholbam:</b> 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.</p> <p><b>Ocaliva:</b> 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.</p> <p><b>Urso, Ursodiol tablets, Urso Forte, Actigall:</b> The patient must have a documented treatment limiting side effect to generic ursodiol capsules.</p>
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## BONE RESORPTION INHIBITORS

<p><b><u>ORAL BISPHOSPHONATES</u></b> <b><u>TABLETS/CAPSULES</u></b> ALENDRONATE (compare to Fosamax®) tablets</p>	<p>Actonel® (risedronate) Alendronate oral solution Atelvia (risedronate) Delayed Release Tablet <i>QTY LIMIT:</i>4 tablets/28 days Binosto® (alendronate) 70mg effervescent tablet <i>QTY LIMIT:</i>4 tablets/28 days Boniva® (ibandronate)</p>	<p><b>Actonel, Atelvia, Boniva (oral), Ibandronate (oral), Risedronate</b> patient has had a documented side effect, allergy, or treatment failure (at least a six-month trial) to generic alendronate tablets AND if the request is for brand, the patient has also had a documented intolerance to generic equivalent.</p> <p><b>Alendronate Oral Solution, Binosto:</b> prescriber provides documentation of medical necessity for the specialty dosage form (i.e. inability to swallow tablets, dysphagia).</p> <p><b>Evista, Fosamax:</b> patient has a documented intolerance to the generic formulation</p>
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PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<p><b><u>INJECTABLE BISPHOSPHONATES</u></b> All products require PA</p> <p><b><u>ESTROGEN AGONIST/ANTAGONIST</u></b> RALOXIFENE (compare to Evista®) Tablet <i>QTY LIMIT:</i> 1 tablet/day</p> <p><b><u>INJECTABLE RANKL INHIBITOR</u></b> All products require PA</p> <p><b><u>INJECTABLE SCLEROSTIN INHIBITOR</u></b> All products require PA</p> <p><b><u>CALCITONIN NASAL SPRAY</u></b> All products require PA</p> <p><b><u>CALCITONIN INJECTION</u></b> All products require PA</p> <p><b><u>PARATHYROID HORMONE INJECTION</u></b></p>	<p><i>QTY LIMIT:</i> 150 mg = 1 tablet/28 days Etidronate Fosamax® (alendronate) Fosamax Plus D® (alendronate/vitamin D) Ibandronate (compare to Boniva®) <i>QTY LIMIT:</i> 150 mg = 1 tablet/28 days Risedronate (compare to Actonel®)</p> <p>Boniva® Injection (ibandronate) <i>QTY LIMIT:</i> 3 mg/3 months (four doses)/year Ibandronate Injection (compare to Boniva®) <i>QTY LIMIT:</i> 3 mg/3 months (four doses)/year</p> <p>Reclast® Injection (zoledronic acid) <i>QTY LIMIT:</i> 5 mg (one dose)/year Zoledronic Acid Injection (compare to Reclast®) 5 mg /100ml <i>QTY LIMIT:</i> 5 mg (one dose)/year</p> <p>Evista® (raloxifene) Tablet <i>QTY LIMIT:</i> 1 tablet/day</p> <p>Prolia® Injection (denosumab) <i>QTY LIMIT:</i> 60 mg/6 months (two doses)/year Xgeva® (denosumab) <i>QTY LIMIT:</i> 120 mg/28 days</p> <p>Evenity® (romosozumab-aqqg) injection <i>QTY LIMIT:</i> 210 mg (2 syringes)/month (Lifetime max duration = 12 months)</p> <p>Calcitonin Nasal Spray (compare to Miacalcin®)</p> <p>Miacalcin® (calcitonin) Injection</p>	<p><b>Calcitonin Nasal:</b> patient is started and stabilized on the requested medication. Note: Calcitonin Nasal Spray (brand and generic) no longer recommended for osteoporosis.</p> <p><b>Miacalcin Injection:</b> patient has a diagnosis/indication of Paget's Disease</p> <p><b>Fosamax Plus D:</b> there is a clinical reason why the patient is unable to take generic alendronate tablets and vitamin D separately.</p> <p><b>Etidronate:</b> patient has a diagnosis/indication of Paget's Disease AND patient has had a documented side effect, allergy, treatment failure (at least a six-month trial) to generic alendronate and risedronate tablets</p> <p><b>Forteo:</b> patient has a diagnosis/indication of postmenopausal osteoporosis in females, primary or hypogonadal osteoporosis in males or glucocorticoid induced osteoporosis AND patient has had a documented side effect, allergy, or treatment failure** to an oral bisphosphonate. AND prescriber has verified that the patient has been counseled about osteosarcoma risk</p> <p><b>Tymlos:</b> patient has a diagnosis/indication of postmenopausal osteoporosis in females AND patient has had a documented side effect, allergy, or treatment failure ** to an oral bisphosphonate and Forteo AND prescriber has verified that the patient has been counseled about osteosarcoma risk.</p> <p><b>Boniva Injection, Ibandronate Injection:</b> patient has a diagnosis/indication of postmenopausal osteoporosis AND patient has had a documented side effect or treatment failure** to a preferred bisphosphonate. <b>Prolia Injection:</b> diagnosis or indication is osteopenia in men at high risk for fracture receiving androgen deprivation therapy for nonmetastatic prostate cancer OR diagnosis or indication is osteopenia in women at high risk for fracture receiving adjuvant aromatase inhibitor therapy for breast cancer OR patient has a diagnosis/indication of postmenopausal osteoporosis AND patient has had a documented side effect, allergy, or treatment failure** to a preferred bisphosphonate..</p> <p><b>Reclast Injection, Zoledronic Acid Injection (5mg):</b> patient has a diagnosis/indication of Paget's disease of bone OR patient has a diagnosis/indication of postmenopausal osteoporosis OR patient is male with a diagnosis of osteoporosis OR patient has a diagnosis of glucocorticoid induced osteoporosis AND patient has had a documented side effect or treatment failure** to a preferred bisphosphonate. AND if the request is for Reclast, the patient has a documented intolerance to generic zoledronic acid injection.</p> <p><b>Zoledronic Acid Injection (4mg):</b> Diagnosis or indication is bone metastases from solid tumors, multiple myeloma, osteopenia or treatment of hypercalcemia of malignancy</p> <p><b>Xgeva Injection:</b> diagnosis or indication is bone metastases from solid tumors</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
All products require PA	Forteo <sup>®</sup> (teriparatide) <i>QTY LIMIT:</i> 1 pen (2.4ml/30 days) (Lifetime max duration of treatment = 2 years) Tymlos <sup>™</sup> (abaloparatide) injection <i>QTY LIMIT:</i> 1 pen (1.56ml)/30 days (Lifetime max duration of treatment = 2 years)	(e.g. prostate, breast, thyroid, non-small lung cancer), multiple myeloma, hypercalcemia of malignancy, or giant cell tumor of bone. <b>Eventy Injection:</b> 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 Forteo.  **Treatment failure is defined as documented continued bone loss or fracture after one or more years despite treatment with an oral bisphosphonate.

## BOTULINUM TOXINS

All products require PA	Botox <sup>®</sup> (onabotulinumtoxinA) Dysport <sup>®</sup> (abobotulinumtoxinA) Myobloc <sup>®</sup> (rimabotulinumtoxinB) Xeomin <sup>®</sup> (incobotulinumtoxinA)	<b>Criteria for approval of ALL drugs:</b> 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. <i>Additional criteria for Severe Axillary Hyperhidrosis (Botox only):</i> the patient failed an adequate trial of topical therapy. <i>Additional criteria for Overactive bladder or detrusor overactivity (Botox only):</i> the patient failed an adequate trial of at least TWO urinary antispasmodics (either short- or long-acting formulations) <i>Additional criteria for Chronic migraine (Botox only):</i> the patient has $\geq 15$ headache days per month, of which $\geq 8$ are migraine days, for at least 3 months AND the member has failed or has a contraindication to an adequate trial of at least TWO medications for migraine prophylaxis from at least two different classes (tricyclic antidepressants, 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. <i>Additional criteria for chronic sialorrhea (Myobloc and Xeomin):</i> the patient has a documented side effect, allergy, treatment failure, or contraindication to at least two anticholinergic agents (e.g. scopolamine, glycopyrrolate). <b>LIMITATIONS:</b> 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
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PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
covered)		
<b>BPH AGENTS</b>		
<p><b><u>ALPHA BLOCKERS</u></b>  ALFUZOSIN ER (compare to Uroxatral®)  <i>QTY LIMIT:</i> 1 tablet/day  DOXAZOSIN (compare to Cardura®)  TAMSULOSIN (compare to Flomax®)  <i>QTY LIMIT:</i> 2 capsules/day  TERAZOSIN (formerly Hytrin®)</p> <p><b><u>ANDROGEN HORMONE INHIBITORS</u></b>  DUTASTERIDE (compare to Avodart®)  <i>QTY LIMIT:</i> 1 capsule/day  FINASTERIDE (compare to Proscar®)  <i>QTY LIMIT:</i> 1 tablet/day</p> <p><b><u>COMBINATION PRODUCT</u></b></p>	<p>Cardura® (doxazosin)  Cardura XL® (doxazosin)  <i>QTY LIMIT:</i> 1 tablet/day  Flomax® (tamsulosin)  <i>QTY LIMIT:</i> 2 capsules/day  Rapaflo® (silodosin)  <i>QTY LIMIT:</i> 1 tablet/day  Silodosin (compare to Rapaflo®)  <i>QTY LIMIT:</i> 1 tablet/day</p> <p>Avodart® (dutasteride)  <i>QTY LIMIT:</i> 1 capsule/day  Finasteride (compare to Proscar®) females; males age &lt; 45  <i>QTY LIMIT:</i> 1 tablet/day  Proscar® (finasteride)  <i>QTY LIMIT:</i> 1 tablet/day</p> <p>Dutasteride/tamsulosin (compare to Jalyn®)  <i>QTY LIMIT:</i> 1 capsule/day  Jalyn® (dutasteride/tamsulosin)  <i>QTY LIMIT:</i> 1 capsule/day</p>	<p><b>Cardura, Cardura XL:</b> The patient has had a documented side effect, allergy or treatment failure with two alpha blockers, one of which must be generic doxazosin.</p> <p><b>Flomax:</b> The patient has had a documented side effect, allergy or treatment failure with two preferred alpha blockers, one of which must be generic tamsulosin.</p> <p><b>Rapaflo, Silodosin:</b> The patient has had a documented side effect, allergy or treatment failure with two preferred alpha blockers</p> <p><b>Avodart, Proscar</b> The patient has a documented intolerance to the generic equivalent.</p> <p><b>Finasteride for males age &lt; 45:</b> The patient has a diagnosis of BPH (benign prostatic hypertrophy)</p> <p><b>Dutasteride/tamsulosin, Jalyn:</b> 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.</p> <p><b>LIMITATIONS:</b> Coverage of androgen hormone inhibitors will not be approved for cosmetic use in men or women (male-pattern baldness/alopecia or hirsutism). (This includes Propecia (finasteride) and its generic equivalent whose only FDA approved indication is for treatment of male pattern hair loss.) Current clinical guidelines recommend the use of Cialis (tadalafil) only in men with concomitant erectile dysfunction or pulmonary hypertension. Medicaid programs do not receive Federal funding for drugs used in the treatment of erectile dysfunction so Cialis will not be approved for use in BPH.</p>
<b>BULK POWDERS</b>		
<a href="https://dvha.vermont.gov/sites/dvha/files/documents/providers/Pharmacy/Covered%20Compounding%20Products_09.25.20.pdf">https://dvha.vermont.gov/sites/dvha/files/documents/providers/Pharmacy/Covered%20Compounding%20Products_09.25.20.pdf</a>		

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

DIGOXIN DIGOXIN Oral Solution		
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**CHEMICAL DEPENDENCY**

**ALCOHOL DEPENDENCY**

ACAMPROSATE DISULFIRAM 250 mg, 500 mg tab (compare to Antabuse®) NALTREXONE oral  <u><i>Preferred After Clinical Criteria Are Met</i></u> VIVITROL® (naltrexone for extended-release injectable suspension) <i>QTY LIMIT:</i> 1 injection (380 mg) per 30 days	Antabuse® (disulfiram)	<b>Antabuse:</b> The patient has had a documented intolerance to the generic equivalent product
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**OPIATE DEPENDENCY**

NALTREXONE oral BUPRENORPHINE/NALOXONE (formerly Suboxone®) sublingual TABLET <i>QTY LIMIT:</i> 8 mg = 2 tablets/day (Maximum Daily Dose = 16 mg/day, PA required for over 16 mg)  SUBOXONE® sublingual FILM (buprenorphine/naloxone) <i>QTY LIMIT:</i> 8 mg = 2 films per day, 4 and 12 mg = 1 film per day (Maximum daily Dose = 16 mg/day, PA required for over 16 mg)  <b>*Maximum days supply for Suboxone Films, Buprenorphine/naloxone tablets is 30 days*</b>  Note: Methadone for opiate dependency can only be prescribed through a Methadone Maintenance Clinic  <u><i>Preferred After Clinical Criteria Are Met</i></u> VIVITROL® (naltrexone for extended-release injectable suspension)	Buprenorphine sublingual TABLET (formerly Subutex®) <i>QTY LIMIT:</i> 2 mg = 3 tablets per day, 8 mg = 2 tablets/day Maximum Daily Dose = 16 mg/day  Buprenorphine/naloxone (compare to Suboxone®) sublingual FILM <i>QTY LIMIT:</i> 8 mg = 2 films per day, 4 and 12 mg = 1 film per day Maximum daily Dose = 16 mg/day Bunavail® (buprenorphine/naloxone) buccal film <i>QTY LIMIT:</i> 2.1/0.3 mg = 1 film per day, 4.2/0.7 mg = 2 films per day Zubsolv® (buprenorphine/naloxone) sublingual tablet <i>QTY LIMIT:</i> 1 film per day of all strengths  <b>**Maximum days supply for oral buprenorphine/naloxone films or buprenorphine is 30 days**</b>  Probuphine® (buprenorphine) subdermal implant <i>QTY LIMIT:</i> 4 implants per 6 months	<b>CLINICAL CONSIDERATIONS:</b> Prescriber must have a DATA 2000 waiver ID number (“X DEA License”) in order to prescribe buprenorphine or buprenorphine/naloxone combination products used for the treatment of opioid dependence. These products are not FDA approved for alleviation of pain. For this indication, please refer to the Opioid Analgesics PDL category. <b>Bunavail, Zubsolv:</b> Clinical documentation is submitted detailing a provider-observed reaction to both Suboxone films and buprenorphine/naloxone tablets severe enough to require discontinuation (documentation of measures tried to mitigate/manage symptoms is required). <b>Buprenorphine:</b> Patient is either pregnant and copy of positive pregnancy test has been submitted (duration of PA will be one 1 month post anticipated delivery date) OR Patient is breastfeeding an opiate dependent baby and history from the neonatologist or pediatrician has been submitted. Other requests will be considered after a documented trial and failure of all oral buprenorphine/naloxone combination products. <b>Requests to exceed quantity limits or maximum daily dose:</b> documentation must be submitted detailing medical necessity for requested dosage regimen. <b>Probuphine:</b> Patient must have achieved and sustained prolonged clinical stability on transmucosal buprenorphine AND is currently on a maintenance dose of ≤ 8mg per day of Suboxone® or it’s transmucosal buprenorphine product equivalent (defined as stable on transmucosal buprenorphine dose of ≤ 8mg for
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PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<p><i>QTY LIMIT:</i> 1 injection (380 mg) per 30 days</p>	<p>Maximum length of therapy = 1 year</p> <p>Sublocade® (buprenorphine extended-release) injection <i>QTY LIMIT:</i> Maximum 30-day supply</p>	<p>3 months or longer without any need for supplemental dosing or adjustments) AND the provider and patient are both enrolled in the Probuphine® REMS program AND clinical justification must be provided detailing why the member cannot use a more cost effective buprenorphine formulation. <b>Note:</b> Probuphine® will be approved as a medical benefit ONLY and will NOT be approved if billed through pharmacy point of sale. Probuphine® will not be approved for new entrants to treatment. Initial approval will be granted for 6 months with extension considered for an additional 6 months (There is no clinical experience with insertion of Probuphine® beyond a single insertion in each arm).</p> <p><b>Sublocade:</b> Diagnosis of opiate use disorder confirmed (will not be approved for alleviation of pain) AND patient has been stabilized (clinically controlled cravings and withdrawal symptoms) on a steady dose of 8mg to 24mg of a transmucosal buprenorphine product for at least 7 days AND clinical justification must be provided detailing why the member cannot use a more cost effective buprenorphine formulation. <b>Note:</b> Approval will be granted for 300mg monthly for the first 2 months followed by a maintenance dose of 100mg thereafter for a total length of approval not to exceed 6 months. 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 directly to a healthcare provider and will not be approved for dispensing to the patient.</p> <p><b>Vivitrol:</b> There must be a documented trial of oral naltrexone to establish tolerability AND Patient should be opiate free for &gt; 7 -10 days prior to initiation of Vivitrol. If the diagnosis is alcohol dependence, the patient should not be actively drinking at the time of initial Vivitrol administration.</p>
OPIATE WITHDRAWAL TREATMENT		
<p><b>Central Alpha Agonists</b> CLONIDINE IR tablets (compare to Catapres®)</p> <p><b>Note:</b> Methadone for opiate dependency or withdrawal can only be prescribed through a Methadone Maintenance Clinic</p>	<p>Lucemyra® (lofexidine) Maximum length of therapy = 14 days</p>	<p><b>Lucemyra:</b> 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.</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<b>OVERDOSE TREATMENT</b>		
NALOXONE HCL Prefilled luer-lock needleless syringe plus intranasal mucosal atomizing device (Rescue kit) NARCAN® (naloxone hcl) Nasal Spray <i>QTY LIMIT: 4 single-use sprays/28days</i>		<b>Limitations: Effective 4/1/17, Evzio® is not classified as a covered outpatient drug and is therefore not covered by Vermont Medicaid.</b>
<b>CUSHING'S DISEASE</b>		
All products require PA	Isturisa® (osilodrostat) tablets Korlym® tablets (mifepristone) <i>QTY LIMIT: 4 tablets/day</i> Signifor® (pasireotide) Ampules <i>QTY LIMIT: all strengths = 2 ml (2 amps)/day</i> Maximum day supply = 30 days	<p><b>Korlym:</b> 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 &gt;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, pimozone, quinidine, sirolimus, or tacrolimus).</p> <p><b>Isturisa, Signifor:</b> 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).</p>
<b>GASTROINTESTINAL AGENTS: BOWEL PREP AGENTS, CONSTIPATION/DIARRHEA, IRRITABLE BOWEL SYNDROME-CONSTRICTION (IBS-C), IRRITABLE BOWEL SYNDROME-DIARRHEA (IBS-D), SHORT BOWEL SYNDROME, OPIOID INDUCED CONSTIPATION</b>		
<b>Constipation: Chronic, IBS_C, or Opioid-Induced:</b> Length of approval for non-preferred agents: Initial PA of 3 months and & 12 months thereafter		
<u><b>BULK-PRODUCING LAXATIVES</b></u> PSYLLIUM		<b>Linzess 72mcg:</b> The patient is 18 years of age or older. AND The patient has a

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<p><b><u>OSMOTIC LAXATIVES</u></b> LACTULOSE POLYETHYLENE GLYCOL 3350 (PEG)</p> <p><b><u>STIMULANT LAXATIVE</u></b> BISACODYL SENNA</p> <p><b><u>STOOL SOFTENER</u></b> DOCUSATE</p> <p><b><u>MISCELLANEOUS</u></b> DICYCLOMINE</p> <p><b><u>GUANYLATE CYCLASE-C AGONIST</u></b> LINZESS® (linaclotide) 145 mcg and 290 mcg <i>QTY LIMIT: 1 capsule/day</i></p> <p><b><u>CIC-2 CHLORIDE CHANNEL ACTIVATORS</u></b> AMITIZA® (lubiprostone) <i>QTY LIMIT: 2 capsules/day</i></p> <p><b><u>OPIOID ANTAGONISTS</u></b> MOVANTIK® (naloxegol) <i>QTY LIMIT: 1 tablet/day</i></p> <p><b><u>5-HT4 RECEPTOR ANTAGONISTS</u></b> All products require PA</p>	<p>Linzess® (linaclotide) 72mcg <i>QTY LIMIT: 1 capsule/day</i> Trulance (plecanatide) <i>QTY LIMIT: 1 tablet/day</i></p> <p>Relistor® (methylnaltrexone) tablets <i>QTY LIMIT: 3 tablets/day</i> Relistor® (methylnaltrexone) injection Symproic® (naldemedine) <i>QTY LIMIT: 1 tablet/day</i></p> <p>Motegrity® (prucalopride) <i>QTY LIMIT: 1 tablet/day</i></p>	<p>diagnosis of chronic idiopathic constipation (CIC) AND the patient is unable to tolerate the 145 mcg dose</p> <p><b>Relistor Tablets, Symproic:</b> The patient is current using an opiate for at least 4 weeks AND has documented opioid-induced constipation AND The patient has had a documented side effect, allergy or treatment failure to a 1 week trial of at least 2 preferred laxatives, one of which must be from the Osmotic Laxative category AND has had a documented side effect, allergy, or treatment failure to Amitiza and Movantik.</p> <p><b>Relistor Injection:</b> 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.</p> <p><b>Motegrity, Trulance:</b> The patient is 18 years of age or older. AND The patient has had a diagnosis of chronic idiopathic constipation (CIC)AND The patient has had a documented treatment failure to lifestyle and dietary modification (increased fiber and fluid intake and increased physical activity) AND The patient has had a documented side effect, allergy or treatment failure to a 1 week trial of at least 2 preferred laxatives, one of which must be from the Osmotic Laxative category AND the patient has had a documented side effect, allergy or treatment failure to Amitiza and Linzess.</p>
<p><b>Short Bowel Syndrome (SBS):</b> Length of approval: 6 Months</p>		
	<p>Gattex® (teduglutide) Vials Maximum day supply = 30 days</p>	<p><b>Gattex:</b> Patient has a diagnosis of short bowel syndrome AND Patient is receiving specialized nutritional support administered intravenously (i.e. parenteral nutrition) AND Patient is 18 years of age or older AND Patient does not have an active gastrointestinal malignancy (gastrointestinal tract, hepatobiliary,</p>

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pancreatic), colorectal cancer, or small bowel cancer. Note: Re-approval requires evidence of decreased parenteral nutrition support from baseline.		
<b>Antidiarrheal: HIV/AIDS:</b> Length of approval: Initial approval 3 months, subsequent 1 year		
DIPHENOXYLATE/ATROPINE LOPERAMIDE	Mytesi® (crofelemer) 125 mg DR Tablets <i>QTY LIMIT:</i> 2 tablets/day	<b>Mytesi:</b> 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)
<b>Antidiarrheal: IBS-D:</b> 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) <i>QTY LIMIT:</i> 3 tablets/day	<b>Lotronex/alosetron:</b> 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 loperamide, cholestyramine, and TCA's. For approval of generic alosetron, the patient must have documented intolerance to brand Lotronex. <b>Viberzi:</b> 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 loperamide, cholestyramine, and TCA's. <b>Xermelo:</b> The patient has a diagnosis of carcinoid syndrome diarrhea AND had an inadequate treatment response (defined as 4 or more bowel movements per day) 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. <b>Note:</b> Xermelo will not be approved in treatment naïve patients or as monotherapy.
<b>BOWEL PREP AGENTS</b>		
GAVILTYE-G, GAVILTYE-H, GAVILTYE-N MOVIPREP PEG-3350 SUPREP®	Clenpiq® Gavilyte-C Golytely Nulytely Plenvu®	<b>Non-preferred agents:</b> 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.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Sutab®	
<b>CONTINUOUS GLUCOSE MONITORS</b>		
Initial approval will be granted for 6 months; renewals up to 1 year thereafter		
<p><b><u>Preferred After Clinical Criteria Are Met</u></b> DEXCOM G6  <b>Initial prescription:</b> 1 receiver, 1 wireless transmitter, and 1 3-pack of sensors  <b>Refill Quantity Limits:</b> 1 transmitter every 3 months, 1 sensor every 10 days (maximum of 9 sensors every 90 days)</p> <p>FREESTYLE LIBRE PRO (10-DAY SENSORS)  <b>Initial Prescription:</b> 1 reader, 3 sensors  <b>Refill Quantity Limits:</b> 1 sensor every 10 days (maximum of 9 sensors every 90 days)</p> <p>FREESTYLE LIBRE 14 DAY (14-DAY SENSORS)  <b>Initial Prescription:</b> 1 reader, 2 sensors  <b>Refill Quantity Limits:</b> 1 sensor every 14 days (maximum of 6 sensors every 84 days)</p> <p>FREESTYLE LIBRE 2 (14-DAY SENSORS)  <b>Initial Prescription:</b> 1 reader, 2 sensors  <b>Refill Quantity Limits:</b> 1 sensor every 14 days (maximum of 6 sensors every 84 days)</p>	<p>Medtronic Guardian™ Connect  <b>Initial Prescription:</b> 1 transmitter, 5 sensors  <b>Refill Quantity Limits:</b> 1 sensor every 7 days (maximum of 5 sensors every 35 days)</p>	<p>Patient has a diagnosis of Diabetes Mellitus AND</p> <ul style="list-style-type: none"> <li>• 2 years of age or older for Dexcom G6, ≥ 14 years for Medtronic Guardian, or ≥ 4 years for Freestyle Libre 2, or ≥ 18 for Freestyle Libre</li> <li>• Patient requires use of insulin at least 3 times per day or is on an insulin pump.</li> <li>• Frequent adjustments to treatment regimen are necessary based on blood glucose testing results.</li> <li>• At least one of the following are documented: <ul style="list-style-type: none"> <li>○ Hypoglycemic unawareness</li> <li>○ Recurrent episodes of severe hypoglycemia (&lt;55 mg/dL) or hyperglycemia (&gt;300 mg/dL) persisting despite adjustments to therapy based on previous short-term CGM or self-monitoring.</li> <li>○ Nocturnal hypoglycemia</li> <li>○ Patient cannot achieve glycemic control (defined as HbA1c ≤ 7%) despite good compliance and understanding of current treatment plan. (Note: pharmacy claims will be reviewed for the past 6 months to assess compliance).</li> <li>○ Recurring diabetic ketoacidosis</li> </ul> </li> <li>• 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.</li> </ul> <p><b>Re-authorization:</b></p> <ul style="list-style-type: none"> <li>• There is documented evidence of compliance to CGM (log data and/or office visit notes required).</li> <li>• There is evidence of improved glycemic control (defined by patient achieving a hemoglobin A1c ≤ 7% or a reduction of ≥ 0.5% from baseline) and/or reduced incidences of hypoglycemia or hyperglycemia.</li> <li>• Replacement will be considered when medically necessary and not for recent technology upgrades (device must be malfunctioning and out of warranty).</li> </ul>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<b>CONTRACEPTIVES</b>		
<b>SELECT PRODUCTS:</b> Length of approval: 1 year <b>MONOPHASIC AGENTS:</b>		
<p>Due to the extensive list of products, any monophasic BCP not listed as non-preferred is considered preferred.</p>	<p>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)  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)</p>	<p><b>Non-preferred agents:</b> Trial with at least three preferred contraceptive products including the preferred formulation of the requested non-preferred agent</p>
<b>BIPHASIC AGENTS</b>		
<p>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)</p>	<p>Lo Loestrin FE (norethindrone/ ethinyl estradiol/FE)  Mircette (desogestrel/ ethinyl estradiol)</p>	<p><b>Non-preferred agents:</b> Trial with at least three preferred contraceptive products including the preferred formulation of the requested non-preferred agent</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
VOLNEA (desogestrel/ethinyl estradiol)		
<b>TRIPHASIC AGENTS</b>		
ALYACEN (norethindrone ethinyl estradiol) ARANELLE (norethindrone/ethinyl estradiol) CAZIAN (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)	<b>Non-preferred agents:</b> Trial with at least three preferred contraceptive products including the preferred formulation of the requested non-preferred agent
<b>EXTENDED CYCLE</b>		
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)	Fayosim (levonorgestrel/ ethinyl estradiol) Quartette (levonorgestrel/ ethinyl estradiol) Rivelsa (levonorgestrel/ ethinyl estradiol)	<b>Non-preferred agents:</b> Trial with at least three preferred contraceptive products including the preferred formulation of the requested non-preferred agent

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
JOLESSA (levonorgestrel/ ethinyl estradiol 3MTH) LEVONORGESTREL ETHINYL ESTRADIOL TBDSPK 3 month LO-SEASONIQUE (levonorgestrel/ ethinyl estradiol) SIMPESSSE (levonorgestrel/ ethinyl estradiol) SEASONIQUE (levonorgestrel/ ethinyl estradiol) SETLAKIN (levonorgestrel/ethinyl estradiol)		
<b>PROGESTIN ONLY CONTRACEPTIVES</b>		
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)	Ortho® Micronor (norethindrone) Slynd® (drospirenone)	<b>Non-preferred agents:</b> Trial with at least three preferred contraceptive products including the preferred formulation of the requested non-preferred agent.
<b>INJECTABLE CONTRACEPTIVES</b>		
MEDROXYPROGESTERONE ACETATE 150MG (IM) VIAL/SYRINGE DEPO-PROVERA 104 (SUB-Q) SYRINGE (medroxyprogesterone acetate)	Depo-Provera (IM) (medroxyprogesterone acetate) 150 mg Susp vial/syringe	<b>Depo-Provera IM:</b> Patient must have a documented intolerance to medroxyprogesterone acetate 150mg.
<b>VAGINAL RING</b>		
NUVARING® (etonogestrel/ethinyl estradiol vaginal ring)	Annovera® (segesterone acetate/ethinyl estradiol vaginal ring) <i>QTY LIMIT:</i> 1 ring/year Eluryng (etonogestrel/ethinyl estradiol vaginal ring) Etonogestrel/ ethinyl estradiol vaginal ring	<b>Non-preferred agents:</b> Trial with at least three preferred contraceptive products including the preferred formulation of the requested non-preferred agent.
<b>LONG ACTING REVERSIBLE CONTRACEPTIVES (LARCs)</b>		
KYLEENA (levonorgestrel) IUD LILETTA (levonorgestrel) IUD MIRENA (levonorgestrel) IUD		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
PARAGARD (copper) IUD SKYLA (levonorgestrel) IUD NEXPLANON (etonogestrel) Implant		
<b>TOPICAL CONTRACEPTIVES</b>		
XULANE PATCH (norelgestromin/ ethinyl estradiol)	Twirla® (levonorgestrel/ethinyl estradiol) patch	<b>Twirla:</b> Trial with at least three preferred contraceptive products including the preferred formulation of the requested non-preferred agent
<b>VAGINAL CONTRACEPTIVES</b>		
Please refer to the DVHA website for covered OTC spermicidal gels <a href="https://dvha.vermont.gov/sites/dvha/files/documents/providers/Pharmacy/OTCWebList.pdf">https://dvha.vermont.gov/sites/dvha/files/documents/providers/Pharmacy/OTCWebList.pdf</a>	Phexxi™ (lactic acid, citric acid, and potassium bitartrate) vaginal gel	<b>Phexxi:</b> Use of hormonal contraceptives is contraindicated AND the patient has a documented side effect or allergy to nonoxynol-9
<b>EMERGENCY CONTRACEPTIVES</b>		
AFTERA (levonorgestrel) ECONTRA EZ (levonorgestrel) LEVONORGESTREL MY CHOICE (levonorgestrel) MY WAY (levonorgestrel) NEW DAY (levonorgestrel) OPCICON ONE-STEP (levonorgestrel) OPTION 2 (levonorgestrel) TAKE ACTION (levonorgestrel)		
<b>CORONARY VASODILATORS/ANTIANGINALS/SINUS NODE INHIBITORS</b>		
<b>ORAL</b>		
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®) <i>QTY LIMIT:</i> 500 mg = 3 tablets/day, 1000 mg = 2 tablets/day	BiDil® (isosorbide dinitrate/hydralazine) Dilatrate-SR® (isosorbide dinitrate SR capsule) Isosorbide dinitrate SL tablet Isordil® (isosorbide dinitrate tablet) Nitrolingual Pump Spray® Ranexa® (ranolazine) <i>QTY LIMIT:</i> 500 mg = 3 tablets/day, 1000 mg = 2 tablets/day	<b>Dilatrate-SR, Isosorbide dinitrate SL tablet, Isordil:</b> the patient has had a side effect, allergy, or treatment failure to at least two preferred agents. <b>Nitrolingual Pump Spray:</b> the patient has had a side effect, allergy, or treatment failure to Nitroglycerin spray lingual. <b>Bidil:</b> The prescriber provides a clinically valid reason why the patient cannot use isosorbide dinitrate and hydralazine as separate agents. <b>Ranexa:</b> 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
<b>TOPICAL</b>		
NITRO-BID <sup>®</sup> (nitroglycerin ointment) NITROGLYCERIN TRANSDERMAL PATCHES (compare to Nitro-Dur <sup>®</sup> )	Nitro-Dur <sup>®</sup> (nitroglycerin transdermal patch)	<b>Nitro-Dur:</b> patient has had a side effect, allergy, or treatment failure to generic nitroglycerin transdermal patches.
<b>SINUS NODE INHIBITORS</b>		
	Corlanor <sup>®</sup> (ivabradine) <i>QTY LIMIT:</i> 60 tabs/30 days	<b>Corlanor Clinical Criteria:</b> <ul style="list-style-type: none"> <li>• Diagnosis of stable, symptomatic heart failure AND</li> <li>• Left ventricular ejection fraction of <math>\leq 35\%</math> AND</li> <li>• Resting heart rate <math>\geq 70</math> bpm AND</li> <li>• In sinus rhythm AND</li> <li>• Persisting symptoms despite maximally tolerated doses of beta blockers or who have contraindication to beta blocker therapy</li> </ul>
<b>CORTICOSTEROIDS: ORAL</b>		
DEXAMETHASONE tablets, elixir, intensol, solution DEXPAK <sup>®</sup> tabs (dexamethasone taper pack) HYDROCORTISONE tab (compare to Cortef <sup>®</sup> ) MEDROL <sup>®</sup> (methylprednisolone) 2mg tablets METHYLPREDNISOLONE (compare to Medrol <sup>®</sup> ) tabs METHYLPREDNISOLONE DOSE PACK (compare to Medrol Dose Pak <sup>®</sup> ) tabs PREDNISOLONE 3 mg/ml oral solution, syrup PREDNISOLONE SODIUM PHOSPHATE 3 mg/ml oral solution (compare to Orapred <sup>®</sup> ) PREDNISOLONE SOD PHOSPHATE ORAL SOLUTION 6.7mg/5ml (5mg/5ml base) (compare to Pediapred <sup>®</sup> ) PREDNISONE intensol, solution, tablets	Alkindi <sup>®</sup> Sprinkle (hydrocortisone) granule Cortef <sup>®</sup> (hydrocortisone) tablets Hemady <sup>®</sup> (dexamethasone) tablets Medrol <sup>®</sup> (methylprednisolone) tablets Medrol Dose Pak <sup>®</sup> (methylprednisolone) tabs Prednisolone sodium phosphate oral solution 25 mg/5ml Rayos <sup>®</sup> (prednisone) Delayed Release Tablet <i>QTY LIMIT:</i> 1 tablet/day	<b>Rayos:</b> 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. <b>All Others:</b> 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.
<b>COUGH AND COLD PREPARATIONS</b>		
All generics MUCINEX <sup>®</sup> (guaifenesin)	Hydrocodone/chlorpheniramine (compare to Tussionex <sup>®</sup> )	<b>Tussionex, TussiCaps, Hydrocodone/chlorpheniramine suspension (generic):</b> The patient has had a documented side effect, allergy, or treatment failure to

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	<p><i>QTY LIMIT:</i> 60 ml/RX Tussionex<sup>®</sup> (hydrocodone/chlorpheniramine) <i>QTY LIMIT:</i> 60 ml/RX TussiCaps<sup>®</sup> (hydrocodone/chlorpheniramine) <i>QTY LIMIT:</i> 12 capsules/RX</p> <p>All other brands</p>	<p>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.</p> <p><b>All Other Brands:</b> 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.</p>

## CYSTIC FIBROSIS MEDICATIONS

<p><b><u>Preferred After Clinical Criteria Are Met</u></b></p> <p>BETHKIS<sup>®</sup> (tobramycin) inhalation solution <i>QTY LIMIT:</i> 56 vials/56 days; maximum day supply = 56 days (2 vials/day for 28 days, then 28 days off)</p> <p>KITABIS<sup>®</sup> (tobramycin sol) <i>QTY LIMIT:</i> 56 vials/56 days; maximum day supply = 56 days (2 vials/day for 28 days, then 28 days off)</p> <p>TOBI<sup>®</sup> (tobramycin PODHaler capsules for inhalation) <i>QTY LIMIT:</i> 224 capsules/56 days; maximum day supply = 56 days (4 capsules twice daily for 28 days, then 28 days off)</p>	<p>Cayston<sup>®</sup> (aztreonam) inhalation solution <i>QTY LIMIT:</i> 84 vials/56 days; maximum day supply = 56 days (3 vials/day for 28 days, then 28 days off)</p> <p>Kalydeco<sup>®</sup> (ivacaftor) tablets <i>QTY LIMIT:</i> 2 tablets/day, maximum day supply = 30 days</p> <p>Kalydeco<sup>®</sup> (ivacaftor) packets <i>QTY LIMIT:</i> 2 packets/day; maximum day supply = 30 days</p> <p>Orkambi<sup>®</sup> (lumacaftor/ivacaftor) <i>QTY LIMIT:</i> 120/30 days; maximum day supply=30 days</p> <p>Pulmozyme<sup>®</sup> (dornase alfa) inhalation solution <i>QTY LIMIT:</i> 60/30 days; maximum day supply=30 days</p> <p>Symdeko<sup>®</sup> (tezacaftor/ivacaftor and ivacaftor) <i>QTY LIMIT:</i> 56/28 days; maximum day supply = 28 days</p> <p>TOBI<sup>®</sup> (tobramycin) inhalation solution <i>QTY LIMIT:</i> 56 vials/56 days; maximum day supply = 56 days (2 vials/day for 28 days, then 28 days off)</p> <p>Tobramycin inhalation solution (compare to Tobi<sup>®</sup>) <i>QTY LIMIT:</i> 56 vials/56 days; maximum day supply = 56 days (2 vials/day for 28 days, then 28 days off)</p> <p>Trikafta<sup>®</sup> (elixacaftor/tezacaftor/ivacaftor)</p>	<p><b>Bethkis, Kitabis, Pulmozyme:</b> diagnosis or indication is cystic fibrosis</p> <p><b>TOBI, tobramycin inhalation solutions:</b> Diagnosis or indication is cystic fibrosis and the patient has a documented failure or intolerance to Kitabis and Bethkis.</p> <p><b>Cayston:</b> diagnosis or indication is cystic fibrosis and the patient has had a documented failure, intolerance or inadequate response to inhaled tobramycin therapy alone</p> <p><b>Kalydeco:</b> 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 <math>\geq 6</math> months old. Note: Renewal of Prior Authorization will require documentation of member response.</p> <p><b>TOBI PODHALER:</b> allowed after a trial of another form of inhaled tobramycin</p> <p><b>Orkambi/Symdeko/Trikafta:</b> The patient has a diagnosis of Cystic Fibrosis AND</p> <p><u>Initial Criteria</u></p> <ul style="list-style-type: none"> <li>• <math>\geq 2</math> years of age for Orkambi or <math>\geq 6</math> years of age for Symdeko or <math>\geq 12</math> years of age for Trikafta</li> <li>• Patient must have a confirmed mutation in the CFTR gene shown to be responsive to the requested medication per FDA approval (documentation provided)</li> <li>• If the patient is under the age of 18, they must have undergone a baseline ophthalmic examination to monitor for lens opacities/cataracts</li> <li>• Prescriber is a CF specialist or pulmonologist</li> </ul> <p><u>Ongoing Approval Criteria</u></p> <ul style="list-style-type: none"> <li>• Patient has clinically documented improvement in lung function (will be applied to the first renewal request only; requirement waived on subsequent renewals)</li> </ul>
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PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	QTY LIMIT: 84/28 days; maximum day supply = 28 days	<ul style="list-style-type: none"> <li>• Patient has LFTs/bilirubin monitored every 3 months for the first year of therapy and annually after the first year</li> <li>• ALT or AST <math>\leq 5 \times</math> the upper limit of normal or ALT/AST <math>\leq 3 \times</math> the upper limits of normal and bilirubin is <math>\leq 2 \times</math> the upper limit of normal</li> <li>• For patients under the age of 18, have follow up ophthalmic exam at least annually</li> </ul>

## DERMATOLOGICAL AGENTS

### ACTINIC KERATOSIS THERAPY

IMIQUIMOD 5% Cream  
 EFUDEX<sup>®</sup> (fluorouracil) 5% cream  
 CARAC<sup>®</sup> (fluorouracil) 0.5% cream

*C=cream, F=foam, G=gel, L=lotion, O=ointment,  
 S=solution*

Aldara<sup>®</sup> (imiquimod) 5 % Cream  
 Diclofenac Sodium 3 % Gel (compare to Solaraze<sup>®</sup>)  
*QTY LIMIT: 1 tube/30 days*  
 Fluorouracil (compare to Efudex<sup>®</sup>) 5% cream, 5%, 2% solution  
 Fluorouracil (compare to CARAC<sup>®</sup>) 0.5% cream  
 Picato<sup>®</sup> (ingenol mebutate) 0.015 % Gel  
*QTY LIMIT: 3 tubes*  
 Picato<sup>®</sup> (ingenol mebutate) 0.05 % Gel  
*QTY LIMIT: 2 tubes*  
 Tolak<sup>®</sup> (fluorouracil) 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  
**Fluorouracil:** The patient has a documented intolerance to brand Efudex or Carac (depending on desired strength).  
**Picato:** 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 and generic imiquimod  
**Tolak, 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 Aldara or generic imiquimod 5% cream. OR The treatment area is greater than 25 cm<sup>2</sup> 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  
 MUPIROICIN OINTMENT (compare to Bactroban<sup>®</sup>)

#### COMBINATION PRODUCTS

BACITRACIN-POLYMYXIN  
 NEOMYCIN-BACITRACIN-POLYMYXIN

*C=cream, F=foam, G=gel, L=lotion, O=ointment,  
 S=solution*

Centany<sup>®</sup> Ointment (mupirocin)  
 Gentamicin Cream or Ointment  
 Mupirocin cream (compare to Bactroban<sup>®</sup>)  
 Xepi cream (ozenoxacin)  
  
 Cortisporin<sup>®</sup> Cream (neomycin-polymyxin-hydrocortisone)  
 Cortisporin<sup>®</sup> Ointment(bacitracin-neomycin-polymyxin-hydrocortisone)  
  
 All other branded products

**Mupirocin cream, Centany Ointment, Xepi cream:** The patient has had a documented intolerance with generic mupirocin ointment  
**Cortisporin Cream or 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

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<b>ANTIFUNGALS: ONYCHOMYCOSIS</b>		
CICLOPIROX 8 % solution (compare to Penlac® Nail Lacquer) <i>QTY LIMIT: 6.6 ml/90 days</i>	Ciclodan® (ciclopirox 8% solution) Penlac® Nail Lacquer (ciclopirox 8 % solution) <i>QTY LIMIT: 6.6 ml/90 days</i> Kerydin® (tavaborole 5% solution) Jublia® (efinaconazole 10% solution) <i>QTY LIMIT: 48 weeks treatment</i>	<b>Ciclodan, Jublia, Kerydin, Penlac Sol:</b> The patient meets at least 1 of the following criteria: Pain to affected area that limits normal activity, Diabetes Mellitus, Patient is immunocompromised, Patient has diagnosis of systemic dermatosis, Patient has significant vascular compromise AND Documented intolerance to generic ciclopirox 8% solution. <b>LIMITATIONS:</b> Coverage of Onychomycosis agents will NOT be approved solely for cosmetic purposes. Kits with multiple drug products or non-drug items not covered.
<b>ANTIFUNGALS: TOPICAL</b>		
<p><b><u>SINGLE AGENT</u></b></p> CICLOPIROX (compare to Loprox®) 0.77% C, Sus, G; 1% Sh CLOTRIMAZOLE 1% C, S KETOCONAZOLE (compare to Kuric®, Nizoral®) 2% C, 2% Sh MICONAZOLE all generic/OTC products NYSTATIN O, C, P (compare to Mycostatin®, Nystop®, Nyamyc®) TOLNAFTATE (compare to Tinactin®) 1% C, P, S	Ciclodan® (ciclopirox) C Econazole 1% C Ertaczo® (sertaconazole) 2% C Exelderm® (sulconazole) 1% C, S Extina® (ketoconazole) 2% F Ketoconazole (compare to Extina®) 2 % Foam Lamisil RX/OTC® (terbinafine) 1% C, S, Sp, G Luliconazole 1% C Luzu® (luliconazole) 1% Cream Mentax® 1% C Naftifine (compare to Naftin®) 1% & 2% C, 1% G Naftin® (naftifine) 1% & 2% C, 1%, 2% G Nizoral® (ketoconazole) 2% Sh Nystop®, Nyamyc® (nystatin) P Oxistat® (oxiconazole) 1% C	<p><b>All Non-Preferred Agents (except Vusion):</b> 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.</p> <p><b>Miconazole w/ Zinc Oxide, Vusion:</b> 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.</p>
<p><b><u>COMBINATION PRODUCTS</u></b></p> CLOTRIMAZOLE W/ BETAMETHASONE (compare to Lotrisone®) C, L  <i>C=cream, F=foam, G=gel, L=lotion, P=powder, S=solution, Sh=shampoo, Sp=spray, Sus=suspension</i>	Lotrisone® (clotrimazole w/ betamethasone) C Miconazole w/ zinc oxide (compare to Vusion®) O <i>QTY LIMIT: 50 g/30 days</i> Nystatin w/ triamcinolone C, O Vusion® (miconazole w/zinc oxide) O <i>QTY LIMIT: 50 g/30 days</i>	<p><b>All other branded products</b></p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	<b>Note:</b> Please refer to “Dermatological: Antifungals: Onychomycosis” for ciclopirox solution and Penlac <sup>®</sup> Nail Lacquer	
<b>ANTIVIRALS: TOPICAL</b>		
<p>ABREVA OTC (docosanol) 10% C DOCOSANOL (compare to Abreva) 10% C</p> <p><i>C=cream, O=ointment</i></p> <p>Note: See Anti-Infectives: Antivirals: Herpes: Oral for Sitavig<sup>®</sup></p>	<p>Acyclovir (compare to Zovirax<sup>®</sup>) 5 % O Denavir<sup>®</sup> (penciclovir) 1% C Zovirax<sup>®</sup> (acyclovir) 5% C, O Xerese<sup>®</sup> (acyclovir 5%/hydrocortisone 1%) C</p>	<p><b>Acyclovir, Denavir, Xerese, Zovirax:</b> The patient has a diagnosis of oral herpes simplex infection and a failure of both oral antiviral and Abreva OTC AND for approval of generic acyclovir ointment, the patient must also have documented intolerance to brand Zovirax.</p> <p>** Topical antiviral therapy offers minimal clinical benefit in the treatment of genital herpes and its use is discouraged by the CDC so topical antiviral therapy will not be approved for this indication. **</p>
<b>AXILLARY HYPERHIDROSIS THERAPY</b>		
<p>Xerac-AC (aluminum chloride) 6.25% Solution</p>	<p>Qbrexza<sup>™</sup> (glycopyrronium) 2.4% single use pads <i>QTY LIMIT:</i> 30 pads/month</p>	<p><b>Qbrexza:</b> the patient has had a documented side effect, allergy, or treatment failure with Xerac-AC</p>
<b>CORTICOSTEROIDS: LOW POTENCY</b>		
<p>ALCLOMETASONE 0.05% C, O FLUOCINOLONE 0.01% C, S, oil (compare to Derma-Smoothe, Synalar<sup>®</sup>) HYDROCORTISONE 0.5%, 1%, 2.5% C; 1%, 2.5% L, 0.5%, 1%, 2.5% O</p> <p><i>C=cream, F=foam, G=gel, L=lotion, O=ointment, S=solution</i></p>	<p>Capex<sup>®</sup> (fluocinolone) 0.01% shampoo Derma-Smoothe<sup>®</sup> (fluocinolone 0.01%) oil Desonate<sup>®</sup> (desonide) 0.05% G Desonide 0.05% C, L, O Synalar<sup>®</sup> (fluocinolone) 0.01% S</p> <p>All other brands</p>	<p><b>CRITERIA FOR APPROVAL (NON-PREFERRED AGENTS):</b> 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.)</p>
<b>CORTICOSTEROIDS: MEDIUM POTENCY</b>		
<p>BETAMETHASONE DIPROPIONATE 0.05% C, L, O BETAMETHASONE VALERATE 0.1% C, L, O BETAMETHASONE VALERATE 0.12% (compare to Luxiq<sup>®</sup>) F FLUOCINOLONE 0.025% C, O (compare to Synalar<sup>®</sup>) FLUTICASONE 0.05% C; 0.005% O (compare to Cutivate<sup>®</sup>) <b>HYDROCORTISONE VALERATE 0.2% C, O</b> MOMETASONE FUROATE 0.1% C, L, O, S</p>	<p>Beser<sup>™</sup> (fluticasone) 0.05% L Clocortolone 0.1% C (compare to Cloderm<sup>®</sup>) Cloderm<sup>®</sup> (clocortolone) 0.1% C Cutivate<sup>®</sup> (fluticasone) 0.05% L Desoximetasone 0.05% C, O (compare to Topicort<sup>®</sup>) Flurandrenolide (compare to Cordran<sup>®</sup>) C, L, O Fluticasone (compare to Cutivate<sup>®</sup>) 0.05%, L Hydrocortisone Butyrate 0.1% C, O, S Kenalog<sup>®</sup> (triamcinolone) Aerosol Spray Luxiq<sup>®</sup> (betamethasone valerate) F Prednicarbate 0.1% C, O</p>	<p><b>CRITERIA FOR APPROVAL (NON-PREFERRED AGENTS):</b> 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.)</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<p>(compare to Elocon®)            TRIAMCINOLONE ACETONIDE 0.025%, 0.1% C, L, O</p> <p><i>C=cream, F=foam, G=gel, L=lotion, O=ointment, S=solution</i></p>	<p>Sernivo® (betamethasone dipropionate) 0.05% Spray            Synalar® (fluocinolone) 0.025% C, O            Topicort® (desoximetasone) 0.05% C, O            Triamcinolone Aerosol Spray            Trianex® (triamcinolone) 0.05% O</p> <p>All other brands</p>	
<b>CORTICOSTEROIDS: HIGH POTENCY</b>		
<p>AUGMENTED BETAMETHASONE 0.05% C, L (compare to Diprolene® AF)            BETAMETHASONE VALERATE 0.1% C, O            DESOXIMETASONE 0.05% G; 0.25% C, O (compare to Topicort®)            FLUOCINONIDE 0.05% C, G, O,            TRIAMCINOLONE ACETONIDE 0.5% C, O</p> <p><i>C=cream, F=foam, G=gel, L=lotion, O=ointment, S=solution</i></p>	<p>Amcinonide            Apexicon E® (diflorasone) 0.05% C            Diflorasone diacetate 0.05% C, O (compare to Apexicon E®)            Diprolene® AF (augmented betamethasone) 0.05% C, L  <b>Halcinonide 0.1% C</b>            Halog® (halcinonide) all products            Topicort® (desoximetasone) 0.05% G; 0.25% C, O, Spray</p> <p>All other brands</p>	<p><b>CRITERIA FOR APPROVAL (NON-PREFERRED AGENTS):</b> 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.)</p>
<b>CORTICOSTEROIDS: VERY HIGH POTENCY</b>		
<p>AUGMENTED BETAMETHASONE 0.05% C, L, O (compare to Diprolene®) 0.05% G            CLOBETASOL PROPIONATE (compare to Temovate®/Cormax®) 0.05%, C, G, L, O, S, <b>Spray</b>            HALOBETASOL PROPIONATE (compare to Ultravate®) <b>0.05% C, O</b></p> <p><i>C=cream, F=foam, G=gel, L=lotion, O=ointment, S=solution</i></p>	<p>Bryhali® (halobetasol propionate) L            Clobetasol propionate (compare to Clobex®) 0.05% Sh            Clobetasol 0.05% F (compare to Oulux®)            Clobetasol propionate emulsion (compare to Olux E®) 0.05% F            Clobex® (clobetasol propionate) 0.05% L, Sh, Spray            Diprolene® (augmented betamethasone) 0.05% L, O            Diprolene® AF 0.05% C            Fluocinonide (compare to Vanos®) 0.1% C  <b>Halobetasol (compare to Lexette™) 0.05% F</b>            Lexette™ (halobetasol) 0.05% F            Olux®/Olux E® (clobetasol propionate) 0.05% F            Temovate® (clobetasol propionate) 0.05% C, O            Tovet® (clobetasol propionate aerosol) 0.05% F            Vanos® (fluocinonide) 0.1% C            Ultravate® (halobetasol propionate) 0.05% C, O</p> <p>All other brands</p>	<p><b>CRITERIA FOR APPROVAL (NON-PREFERRED AGENTS):</b> 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.)</p>
<b>GENITAL WART THERAPY</b>		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<p>IMIQUIMOD 5 % (compare to Aldara®) cream            PODOFILOX SOLUTION (compare to Condylox®)</p>	<p>Aldara® (imiquimod) 5% cream            Condylox® Gel (podofilox gel)            Imiquimod (compare to Zyclara®) 3.75% Cream Pump  <i>QTY LIMIT: 2 pumps/ 8 weeks</i>            Veregan® (sinecatechins ointment)  <i>QTY LIMIT: 15 grams (1 tube)/per 30 days</i>            Zyclara® (imiquimod 2.5%, 3.75%) Cream  <i>QTY LIMIT: 56 packets/per 8 weeks</i>            Zyclara® (imiquimod 3.75%) Cream Pump  <i>QTY LIMIT: 2 pumps/per 8 weeks</i></p>	<p><b>Aldara cream, Zyclara cream:</b> The patient has had a documented intolerance to generic imiquimod  <b>Condylox gel, Veregan:</b> The patient has had a documented side effect, allergy, or treatment failure with imiquimod.  <b>Imiquimod pump, Zyclara pump:</b> The patient has had a documented intolerance to generic imiquimod cream and Zyclara cream.</p>
<b>IMMUNOMODULATORS</b>		
<p><u><i>Preferred After Clinical Criteria Are Met</i></u>            PIMECROLIMUS cream (compare to Elidel®)            (authorized generic, labeler code 68682 is the only preferred form)            PROTOPIC® (tacrolimus)</p> <p><i>Note:</i> please refer to <i>Dermatological Agents: Corticosteroids</i> category for preferred topical corticosteroids.</p>	<p>Dupixent® (dupilumab) subcutaneous injection, pre-filled syringe and auto-injector pen  <i>QTY LIMIT: 4 syringes/pens the first 28 days then 2 Syringes/pens every 28 days thereafter</i>            Elidel® (pimecrolimus)            Eucrisa® (crisaborole) Ointment            Pimecrolimus cream (compare to Elidel®) (non-authorized generic forms)            Tacrolimus Ointment (compare to Protopic®)</p>	<p><b>Criteria for Approval (topical medications):</b> The patient has a diagnosis of 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.</p> <p><b>Note:</b> Protopic ointment 0.1% is not indicated for use in children 2 to 15 years of age, only the 0.03% strength. 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.</p> <p><b>Elidel, Pimecrolimus additional criteria:</b> The patient is ≥2 years of age AND the quantity requested does not exceed 30 grams/fill and 90 grams/6 months. AND If the request is for non-authorized generic forms of pimecrolimus or Elidel, the patient has a documented intolerance to the authorized generic.</p> <p><b>Protopic, Tacrolimus additional criteria:</b> The patient is ≥2 years of age AND the quantity requested does not exceed 30 grams/fill and 90 grams/6 months. AND If the request is for generic tacrolimus ointment, the patient has a documented intolerance to the brand name equivalent.</p> <p><b>Eucrisa additional criteria:</b> 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 inhibitor will be waived for patients ≥ 3 months through &lt; 2 years of age.</p> <p><b>Dupixent:</b></p> <ul style="list-style-type: none"> <li>• The patient is ≥ 6 years of age AND</li> <li>• The patient has a diagnosis of moderate to severe atopic dermatitis AND</li> </ul>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		<ul style="list-style-type: none"> <li>• The prescription is initiated in consultation with a dermatologist, allergist, or immunologist AND</li> <li>• At least 10% of the body's surface area is involved AND</li> <li>• 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</li> <li>• The patient has had a documented side effect, allergy, or treatment failure to at least one of the following systemic therapies: cyclosporine, azathioprine, methotrexate, mycophenolate, or tacrolimus</li> <li>• Initial approval will be granted for 3 months. For re-approval after 3 months, the prescriber must submit documentation of clinical improvement in symptoms. Renewals may be granted for up to 1 year.</li> </ul>
<b>SCABICIDES AND PEDICULOCIDES</b>		
<p><b><u>SCABICIDES</u></b> PERMETHRIN 5 % (compare to Elimite®) C</p> <p><b><u>PEDICULICIDES (lice treatment)</u></b> PERMETHRIN 1 % CR, L PIPERONYL BUTOXIDE AND PYRETHRINS G, S, Sh NATROBA® (spinosad 0.9 %) Ss</p> <p><i>C=cream, CR=crème rinse, G=gel, L=lotion, S=solution, Sh=shampoo, Sp=spray, Ss=suspension</i></p>	<p>Elimite™ (permethrin 5%) C Eurax® (crotamiton 10 %) C, L Lindane L</p> <p>Lindane Sh Malathion L (compare to Ovide®) Ovide® (malathion) L Sklice® (Ivermectin 0.5 %) L Spinosad (compare to Natroba) Ss</p> <p>All other brand and generic Scabicides and Pediculicides</p>	<p><b>Non-preferred Scabicides:</b> The patient has had a documented side effect or allergy to permethrin cream or treatment failure with two treatments of permethrin cream.</p> <p><b>Non-Preferred Pediculicides:</b> 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.</p>
<b>DESMOPRESSIN: INTRANASAL/ORAL</b>		
<p><b><u>INTRANASAL</u></b> All products require PA</p> <p><b><u>ORAL</u></b> DESMOPRESSIN</p>	<p>DDAVP® (desmopressin) Nasal Solution or Spray 0.01%</p> <p>Desmopressin Nasal Solution or Spray 0.01 % (compare to DDAVP®)</p> <p>Noctiva™ (desmopressin) Nasal Spray</p> <p>Stimate® (desmopressin) Nasal Solution 1.5 mg/ml</p> <p>Nocturna® (desmopressin) SL tablets</p>	<p><b>CRITERIA FOR APPROVAL:</b></p> <p><b>Intranasal (except as indicated below):</b> 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.</p> <p><b>Oral:</b> 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</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	<p><i>QTY LIMIT:</i> 1 tablet/day DDAVP<sup>®</sup> (desmopressin) tablets</p>	<p>desmopressin tablets</p> <p><b>Nocturna, Noctiva:</b> Patient is ≥18 years of age (Nocturna) 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 &gt; 50ml/min/1.73m<sup>2</sup> 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.</p> <p><b>LIMITATIONS:</b> 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.</p>

## DIABETIC TESTING SUPPLIES

MONITORS/METERS		
<p>Please refer to the DVHA website for covered Diabetic testing supplies.</p> <p><a href="https://dvha.vermont.gov/sites/dvha/files/documents/providers/Pharmacy/Vermont%20PDSL%20July%202020.pdf">https://dvha.vermont.gov/sites/dvha/files/documents/providers/Pharmacy/Vermont%20PDSL%20July%202020.pdf</a></p>		<p><b>CRITERIA FOR APPROVAL:</b> 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.</p> <p><b>LIMITATIONS:</b> Talking monitors are not covered under the pharmacy benefit.</p>
TEST STRIPS/LANCETS		
<p><b><u>DIABETIC TEST STRIPS</u></b> Please refer to the DVHA website for covered Diabetic testing supplies.</p> <p><b><u>LANCETS</u></b> All brands and store brands</p>		<p><b>CRITERIA FOR APPROVAL:</b> 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.</p> <p><b>LIMITATIONS:</b> Talking monitors are not covered under the pharmacy benefit.</p>

## ENDOMETRIOSIS/UTERINE FIBROIDS AGENTS

<p>LUPRON DEPOT<sup>®</sup> (leuprolide acetate for depot suspension) <i>QTY LIMIT:</i> 3.75 mg kit/month or 11.25 mg kit/3 months SYNAREL<sup>®</sup> (nafarelin acetate) nasal solution</p>	<p>Lupaneta Pack<sup>™</sup> (leuprolide acetate for depot suspension and norethindrone acetate tablets) <i>QTY LIMIT:</i> 3.75 mg kit/month or 11.25 mg kit/3 months</p>	<p><b>Lupaneta Pack:</b> patient has a documented intolerance to Lupron Depot and norethindrone tablets used in combination.</p> <p><b>Orilissa:</b> Patient has a diagnosis of moderate-severe endometriosis pain and has a documented side effect, allergy, or treatment failure to at least TWO medications</p>
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PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<p>ZOLADEX® (goserelin acetate) implant <i>QTY LIMIT: 3.6 mg/month</i></p> <p><b><u>Preferred After Clinical Criteria are Met</u></b>            ORIAHNN® (elagolix and elagolix/estradiol/norethindrone) capsules            ORILISSA® (elagolix) tablets</p>		<p>from at least 2 different classes (oral contraceptives, NSAIDs, progestins). <b>Note:</b> Approval for 200mg dose will be limited to 2 tablets/day for a maximum of 6 months. Approval for 150mg dose will be limited to 1 tablet/day. Maximum length of therapy 2 years.</p> <p><b>Oriahnn:</b> Patient is premenopausal and is experiencing heavy menstrual bleeding associated with uterine leiomyomas (fibroids) AND 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). <b>Note:</b> Approval will be limited to 2 tablets/day for a maximum length of therapy of 2 years</p>
<b>EPINEPHRINE: SELF-ADMINISTERED</b>		
<p>EPINEPHRINE INJ (compare to EpiPen-Jr®) (authorized generic, Mylan labeler code 49502 is the only preferred form) 0.15mg</p> <p>EPINEPHRINE INJ (compare to EpiPen®) (authorized generic, Mylan labeler code 49502 is the only preferred form) 0.3mg</p>	<p>Epinephrine Inj 0.15 mg            Epinephrine Inj 0.3 mg            EpiPen® 2-PAK inj 0.3 mg            EpiPen-Jr® 2-PAK inj 0.15 mg            Symjepi® Inj 0.15mg            Symjepi® Inj 0.3mg</p>	<p><b>Non-preferred Agents:</b> The patient must have a documented intolerance to the authorized generic epinephrine.</p> <p><b>Limitations:</b> Auvi-Q® is not classified as a covered outpatient drug and is therefore, not covered by Vermont Medicaid</p>
<b>ESTROGENS: VAGINAL</b>		
<p><b><u>ESTRADIOL</u></b>            ESTRACE VAGINAL® Cream            ESTRING® Vaginal Ring            VAGIFEM® Vaginal Tablets</p> <p><b><u>CONJUGATED ESTROGENS</u></b>            PREMARIN VAGINAL® Cream</p> <p><b><u>ESTRADIOL ACETATE</u></b>            FEMRING® Vaginal Ring</p>		



PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		<p>mercaptopurine, cyclosporine, etc.).</p> <p><b>Avsola, Inflectra:</b> the prescriber must provide a clinically valid reason why Humira and Remicade or Renflexis cannot be used.</p> <p><b>Entyvio, Simponi, Stelara additional criteria:</b> Age &gt; 18 years AND the prescriber must provide a clinically valid reason why Humira and Remicade/Renflexis cannot be used.</p> <p><b>Xeljanz, Xeljanz XR additional criteria:</b> Age &gt; 18 years AND the prescriber must provide a clinically valid reason why Humira and Remicade cannot be used. <b>Note:</b> 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.</p>
<b>H. PYLORI COMBINATION THERAPY</b>		
<p>LANSOPRAZOLE, AMOXICILLIN, CLARITHROMYCIN <i>QTY LIMIT:</i> 112 caps &amp; tabs/14 days PYLERA® (bismuth subcitrate, metronidazole, tetracycline) capsules <i>QTY LIMIT:</i> 120 caps/10 days</p>	<p>Omeclamox-Pak® (omeprazole, clarithromycin, amoxicillin) <i>QTY LIMIT:</i> 80 caps &amp; tabs/10 days Talicia® (omeprazole, amoxicillin, rifabutin) delayed release capsules <i>QTY LIMIT:</i> 168 caps/14 days</p>	<p><b>CRITERIA FOR APPROVAL:</b> The patient has a documented treatment failure with Lansoprazole, amoxicillin, clarithromycin combo package or Pylera used in combination with a PPI.</p>
<b>H-2 BLOCKERS</b>		
<p>FAMOTIDINE (compare to Pepcid®) tablet</p> <p><b><u>SYRUPS AND SPECIAL DOSAGE FORMS</u></b> CIMETIDINE ORAL SOLUTION FAMOTIDINE oral suspension (compare to Pepcid®) age ≤ 2 years</p>	<p>Cimetidine (compare to Tagamet®) tablet Nizatidine capsule Pepcid® (famotidine) tablet Zantac® (ranitidine) tablet</p> <p>Famotidine (compare to Pepcid®) oral suspension Nizatidine Oral Solution Pepcid® (famotidine) Oral Suspension</p>	<p><b>Cimetidine tablet, Nizatidine capsule, Pepcid tablet:</b> The patient has had a documented side effect, allergy, or treatment failure to famotidine.</p> <p><b>Famotidine Oral Suspension, Nizatidine Oral Solution, Pepcid Oral Suspension (Age &gt;2):</b> The patient has had a documented side effect, allergy, or treatment failure to cimetidine oral solution.</p>
<b>INFLAMMATORY BOWEL AGENTS (ORAL &amp; RECTAL PRODUCTS)</b>		
<p><b><u>MESALAMINE PRODUCTS</u></b> <b><u>ORAL</u></b> ASACOL HD® (mesalamine tablet delayed release) APRISO® (mesalamine capsule extended release) LIALDA® (mesalamine tablet extended release) PENTASA ER® (mesalamine cap CR)</p>	<p>Delzicol® (mesalamine capsule delayed-release) <i>QTY LIMIT:</i> 6 capsules/day Mesalamine capsule delayed release (compare to Delzicol®)</p>	<p><b>Azulfidine, Colazal:</b> patient has had a documented intolerance to the generic equivalent of the requested medication.</p> <p><b>Budesonide ER 9mg, Uceris:</b> The diagnosis is ulcerative colitis AND induction therapy with mesalamine (≥2 gram/day), balsalazide, or olsalazine has failed or is not tolerated AND for approval of Uceris, the patient must have a</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<p><b><u>RECTAL</u></b> MESALAMINE ENEMA (compare to Rowasa®) MESALAMINE SUPPOSITORY</p> <p><b><u>CORTICOSTEROIDS</u></b> <b><u>ORAL</u></b> BUDESONIDE 24HR 3mg (compare to Entocort EC®) <i>QTY LIMIT:</i> 3 capsules/day</p> <p><b><u>RECTAL</u></b> All products require PA</p> <p><b><u>OTHER</u></b> BALSALAZIDE (compare to Colazal®) DIPENTUM® (olsalazine) SULFAZINE SULFAZINE EC SULFASALAZINE (compare to Azulfidine®) SULFASALAZINE DR</p>	<p><i>QTY LIMIT:</i> 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®)</p> <p>sfRowasa® (mesalamine enema sulfate free)</p> <p>Budesonide ER 9 mg tablet (compare to Uceris®) <i>QTY LIMIT:</i> 1 tablet/day Entocort EC® (budesonide 24 hr cap) <i>QTY LIMIT:</i> 3 capsules/day Ortikos® (budesonide) ER capsule <i>QTY LIMIT:</i> 1 capsule/day Uceris® (budesonide) ER Tablet <i>QTY LIMIT:</i> 1 tablet/day</p> <p>Uceris® Rectal Foam (budesonide)</p> <p>Azulfidine® (sulfasalazine) Colazal® (balsalazide)</p>	<p>documented intolerance to the generic budesonide ER 9mg tablets. <b>Delzicol, mesalamine capsule DR, Mesalamine tablet DR, Mesalamine tablet ER:</b> The patient has had a documented side effect, allergy, or treatment failure to 2 preferred oral mesalamine products. <b>Entocort EC, Ortikos:</b> The patient had a documented intolerance to the generic budesonide 3mg 24 hr capsules. <b>sfRowasa, Uceris Rectal Foam:</b> The patient has had a documented intolerance to mesalamine enema or suppositories. <b>LIMITATIONS:</b> Kits with non-drug products are not covered.</p>
<b>PROKINETIC AGENTS</b>		
<p><b><u>TABLETS</u></b> METOCLOPRAMIDE tabs (compare to Reglan®)</p> <p><b><u>ORAL SOLUTION</u></b> METOCLOPRAMIDE oral solution</p>	<p>Reglan® (metoclopramide)</p>	<p><b>Reglan:</b> The patient has had a documented intolerance to generic metoclopramide tablets.</p>
<b>PROTON PUMP INHIBITORS</b>		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<p><b><u>ORAL CAPULES/TABLETS</u></b>  ESOMEPRAZOLE (compare to Nexium®)  <i>QTY LIMIT: 1 cap/day</i>  LANSOPRAZOLE generic RX capsules (compare to Prevacid®)  <i>QTY LIMIT: 1 cap/day</i>  OMEPRAZOLE RX capsules (compare to Prilosec®)  <i>QTY LIMIT: 1 cap/day</i>  PANTOPRAZOLE tablets (compare to Protonix®)  <i>QTY LIMIT: 1 tab/day</i></p>	<p>Aciphex® (rabeprazole) tablets  <i>QTY LIMIT: 1 tab/day</i>  Dexilant® (dexlansoprazole) capsules  <i>QTY LIMIT: 1 cap/day</i>  Nexium® (esomeprazole) capsules  <i>QTY LIMIT: 1 cap/day</i>  Omeprazole generic OTC tablets  <i>QTY LIMIT: 1 tab/day</i>  Omeprazole magnesium generic OTC 20 mg capsules  <i>QTY LIMIT: 1 cap/day</i>  Omeprazole/sodium bicarb capsules RX (compare to Zegerid®)  <i>QTY LIMIT: 1 cap/day</i>  Prevacid® RX (lansoprazole) capsules  <i>QTY LIMIT: 1 cap/day</i>  Prevacid® 24 hr OTC (lansoprazole) capsules  <i>QTY LIMIT: 1 cap/day</i>  Protonix® (pantoprazole) tablets  <i>QTY LIMIT: 1 tab/day</i>  Rabeprazole (compare to Aciphex®) tablets  <i>QTY LIMIT: 1 tab/day</i>  Zegerid RX® (omeprazole/sodium bicarb) caps, oral, suspension  <i>QTY LIMIT: 1 cap/day</i></p>	<p><b>Nexium powder for suspension (for patients ≥ 12 years old):</b> The patient has a requirement for a non-solid oral dosage form (e.g. an oral liquid, dissolving tablet or sprinkle).  <b>Aciphex Sprinkle, Prevacid Solutabs, Prilosec packet, and Protonix packet:</b> 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.  <b>Other non-preferred medications:</b> 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.  <b>CRITERIA FOR APPROVAL (twice daily dosing):</b>  <b>Gastroesophageal Reflux Disease (GERD)</b> – If member has had an adequate trial (e.g. 8 weeks) of standard once daily dosing for GERD, twice daily dosing may be approved. <b>Note:</b> 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.  <b>Zollinger-Ellison (ZE) syndrome</b> – Up to triple dose PPI may be approved.  <b>Hypersecretory conditions (endocrine adenomas or systemic mastocytosis)</b> – Double dose PPI may be approved.  <b>Erosive Esophagitis, Esophageal stricture, Barrett’s esophagitis (complicated GERD)</b> – Double dose PPI may be approved.  <b>Treatment of ulcers caused by H. Pylori</b> – Double dose PPI may be approved for up to 2 weeks.  <b>Laryngopharyngeal reflux</b> – Double dose PPI may be approved.  <b>LIMITATIONS:</b> First-Lansoprazole® and First-Omeprazole Suspension Kits are not covered as Federal Rebate is no longer offered.</p>
<p><b><u>SUSPENSION &amp; SPECIAL DOSAGE FORMS</u></b>  NEXIUM® (esomeprazole) powder for suspension (age &lt; 12 years)  <i>QTY LIMIT: 1 packet/day</i></p>	<p>Aciphex® Sprinkle (rabeprazole) DR Capsule  <i>QTY LIMIT: 1 cap/day</i>  Lansoprazole ODT (compare to Prevacid Solutab®)  <i>QTY LIMIT: 1 tab/day</i>  Nexium® (esomeprazole) powder for suspension (age ≥ 12 years)  <i>QTY LIMIT: 1 packet/day</i>  Prevacid Solutabs® (lansoprazole)  <i>QTY LIMIT: 1 tab/day</i>  Prilosec® (omeprazole magnesium) packet  <i>QTY LIMIT: 2 packets/day</i>  Protonix® (pantoprazole) packet</p>	

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
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*QTY LIMIT:* 1 packet/day

## GAUCHER'S DISEASE MEDICATIONS

<p>All products require PA</p>	<p>Cerezyme® (imiglucerase for injection)  Cerdelga® (eliglustat)  <i>QTY LIMIT:</i> 2 caps/day  Elelyso® (taliglucerase alfa for injection)  Vpriv® (velaglucerase alfa for injection)</p> <p>Miglustat (compare to Zavesca®)  <i>QTY LIMIT:</i> 3 caps/day  Zavesca® (miglustat)  <i>QTY LIMIT:</i> 3 caps/day</p> <p><b>**Maximum days supply per fill for all drugs is 14 days**</b></p>	<p><b>CRITERIA FOR APPROVAL:</b> The diagnosis or indication is Gaucher disease (GD) type I. AND The diagnosis has been confirmed by molecular or enzymatic testing.</p> <p><b>Age Limits</b>  <b>Elelyso, Vpriv:</b> for patients ≥ 4 years old  <b>Cerezyme:</b> for patients ≥ 2 years old  <b>Cerdelga, Miglustat, Zavesca:</b> for patients ≥ 18 years old</p> <p><b>Cerezyme/Vpriv additional criteria:</b> Failure, intolerance or other contraindication to enzyme replacement therapy with Elelyso</p> <p><b>Cerdelga additional criteria:</b></p> <ul style="list-style-type: none"> <li>• Testing to verify if CYP2D6 extensive metabolizer (EM), intermediate metabolizer (IM), poor metabolizer (PM), or if CYP2D6 genotype cannot be determined <ul style="list-style-type: none"> <li>○ Dose max: 84mg twice/day if EM or IM</li> <li>○ Dose max: 84mg/day if PM</li> <li>○ Case by case determination if CYP2D6 cannot be determined</li> </ul> </li> </ul> <p><b>Miglustat, Zavesca additional criteria:</b></p> <ul style="list-style-type: none"> <li>• For whom enzyme replacement therapy is not a therapeutic option (e.g. due to allergy, hypersensitivity, or poor venous access)</li> </ul>
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## GOUT AGENTS

<p>ALLOPURINOL (compare to Zyloprim®)  COLCHICINE CAPSULES (Hikma labeler code 00143 is the only preferred form)  COLCHICINE/PROBENECID  PROBENECID</p>	<p>Colcrys® (colchicine) tablet  <i>QTY LIMIT:</i> 3 tablets/day (gout) or 4 tablets/day (FMF)</p> <p>Colchicine tablets (compare to Colcrys®)  Colchicine capsules (all other labelers)  Febuxostat (compare to Uloric®)  <i>QTY LIMIT:</i> 40 mg tablets = 1 tablet/day  Gloperba® (colchicine) oral solution  <i>QTY LIMIT:</i> 10 ml/day  Mitigare® (colchicine) capsule  <i>QTY LIMIT:</i> 2 capsules/day</p>	<p><b>Colcrys, colchicine tablets:</b>  <i>Diagnosis or indication is Familial Mediterranean Fever (FMF):</i> The patient has had a documented side effect or treatment failure with at least one drug from the NSAID class OR the patient is not a candidate for therapy with at least one drug from the NSAID class due to one of the following:</p> <ul style="list-style-type: none"> <li>• The patient is 60 years of age or older</li> <li>• The patient has a history of GI bleed</li> <li>• The patient is currently taking an anticoagulant (warfarin or heparin), an oral corticosteroid, or methotrexate. OR</li> </ul>
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PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Zyloprim <sup>®</sup> (allopurinol) Uloric <sup>®</sup> (febuxostat) <i>QTY LIMIT: 40 mg tablets = 1 tablet/day</i>	<p><i>Diagnosis or indication is acute treatment of gout flares or prophylaxis of gout flares in adults: the patient must have a documented intolerance to colchicine capsules (Hikma labeler code 00143).</i></p> <p><b>Colchicine capsules (non-preferred manufacturers), Mitigare capsules:</b> the diagnosis or indication is prophylaxis of gout flares in adults AND the patient must have a documented intolerance to Hikma (labeler 00143) colchicine capsules.</p> <p><b>Febuxostat, Uloric:</b> 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 &lt; 6 mg/dl with allopurinol doses of 600 mg/day taken consistently. Additionally, renal impairment is not considered a contraindication to allopurinol use.</p> <p><b>Gloperba:</b> Medical necessity for a specialty dosage form has been provided.</p> <p><b>Zyloprim:</b> The patient has had a documented intolerance to generic allopurinol</p>

## GROWTH STIMULATING AGENTS

<p><u><i>Preferred After Clinical Criteria Are Met</i></u></p> GENOTROPIN <sup>®</sup> NORDITROPIN <sup>®</sup>	Nutropin <sup>®</sup> AQ Omnitrope <sup>®</sup> Saizen <sup>®</sup> Zomacton <sup>®</sup> <p><b><u>Specialized Indications – See Specific Criteria</u></b></p> Increlex <sup>®</sup> (mecasermin) Serostim <sup>®</sup> Zorbtive <sup>®</sup>	<p><b>Criteria for Approval Pediatric:</b> 1) The patient must have one of the following indications for growth hormone: <input type="checkbox"/> Turner syndrome confirmed by genetic testing. <input type="checkbox"/> Prader-Willi Syndrome confirmed by genetic testing. <input type="checkbox"/> Growth deficiency due to chronic renal failure. <input type="checkbox"/> 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 &lt;37 weeks or a birth weight or length below the 3rd percentile for gestational age). OR <input type="checkbox"/> 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) &lt;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 &gt; age 12 and males &gt; 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.</p> <p><b>Criteria for Approval Adult:</b> 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,</p>
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PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		<p>arginine, levodopa, propranolol, clonidine, or glucagon) showing results (peak level) &lt;5ng/ml. Growth hormone deficient children must be retested after completion of growth.</p> <p><b>LIMITATIONS:</b> Coverage of Growth Hormone products will not be approved for patients who have Idiopathic Short Stature.</p> <p><b>NUTROPIN AQ, OMNITROPE, SAIZEN, ZOMACTON:</b> The patient has a documented side effect, allergy, or treatment failure to both preferred agents.</p> <p><b>Increlex:</b> 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 &lt; -3 AND Basal IGF-1 standard deviation score &lt; -3 AND Normal or elevated growth hormone level Member is ≥ 2 years old (safety and efficacy has not been established in patients younger than 2), AND Member has open epiphysis, AND Member is under the care of an endocrinologist or other specialist trained to diagnose and treat growth disorders.</p> <p><b>Serostim:</b> A diagnosis of AIDS associated wasting/anorexia</p> <p><b>Zorbtive:</b> A diagnosis of short bowel syndrome. Concomitant use of specialized nutritional support (specialty TPN) Prescription must be issued by gastroenterologist (specialist)</p>

### hATTR TREATMENTS

	<p>Onpattro® (patisiran) 10 mg/5ml intravenous injection  Weight &lt; 100kg (0.3 mg/kg every 3 weeks)  Weight ≥ 100kg (30 mg every 3 weeks)</p> <p>Tegsedi® (inotersen) 284 mg/1.5ml injection for subcutaneous use  <i>QTY LIMIT:</i> 4 syringes/28 days</p> <p>Vyndamax® (tafamidis)  <i>QTY LIMIT:</i> 1 capsule/day</p> <p>Vyndaqel® (tafamidis meglumine)  <i>QTY LIMIT:</i> 4 capsules/day</p>	<p><b>Onpattro, Tegsedi:</b></p> <ul style="list-style-type: none"> <li>• 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 and the presence of amyloid deposits via tissue biopsy has been submitted) AND</li> <li>• The medication is being prescribed by or in consultation with a neurologist AND</li> <li>• 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</li> <li>• The patient has tried or is currently receiving at least one systemic agent for symptoms of polyneuropathy from the tricyclic antidepressant (TCA) class and/or anticonvulsant class AND</li> <li>• Patient is receiving vitamin A supplementation AND</li> <li>• For approval of Tegsedi, the patient has had a documented side effect, allergy, or treatment failure with Onpattro AND the prescriber, patient, and pharmacy are registered with the REMS program.</li> </ul> <p>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</p>
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PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		<p>would otherwise be expected.</p> <p><b>Vyndamax, Vyndaqel:</b></p> <ul style="list-style-type: none"> <li>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</li> <li>Documentation of TTR mutation by genetic testing and the presence of amyloid deposits showing cardiac involvement via tissue biopsy or imaging has been submitted AND <ul style="list-style-type: none"> <li>The medication is being prescribed by or in consultation with a cardiologist AND</li> </ul> </li> </ul> <p>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.</p>
<b>HEART FAILURE</b>		
<b>ANGIOTENSIN RECEPTOR – NEPRILYSIN INHIBITOR (ARNI)</b>		
<p><u><i>Preferred After Clinical Criteria Are Met</i></u></p> <p>ENTRESTO® (valsartan/sacubitril) <i>QTY LIMIT: 2 tablets/day</i></p>		<p><b>Entresto:</b> Diagnosis is chronic heart failure. <b>Note:</b> This is processed via automated (electronic) PA.</p>
<b>SODIUM-GLUCOSE CO-TRANSPORTER 2 (SGLT2) INHIBITORS AND COMBINATIONS</b>		
<p>FARXIGA® (dapagliflozin) <i>QTY LIMIT: 1 tab/day</i></p>		
<b>HEMATOPOIETICS</b>		
<b>Colony Stimulating Factors</b>		
<p>FULPHILA™ (pegfilgrastim-jmdb) Syringe GRANIX® (tbo-filgrastim) Vial NEULASTA® (pegfilgrastim) Syringe NEULASTA® Onpro® (pegfilgrastim) kit NEUPOGEN® (filgrastim) Vial UDENYCA™ (pegfilgrastim-cbqv)</p>	<p>Granix® (tbo-filgrastim) Syringe Leukine® (sargramostim) Vial Neupogen® (filgrastim) Syringe Nivestym™ (figrastim-aafi) Vial, Syringe Zarxio® (filgrastim-sndz) Syringe Ziextenzo® (pegfilgrastim-bmez)</p>	<p><b>Granix Syringe, Leukine, Neupogen syringe, Nivestym, Zarxio syringe, Ziextenzo:</b> 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.</p>
<b>Erythropoietic Stimulating Agents</b>		
<p><u><i>Preferred After Clinical Criteria Are Met</i></u></p> <p>EPOGEN® (epoetin alpha)</p>	<p>Aranesp® (darbepoetin alfa) Mircera® (methoxypolyethylene glycolepoetin beta)</p>	<p><b>Aranesp, Procrit, Epogen, Retacrit:</b> 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</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
RETACRIT® (epoetin alpha-epbx)	Procrit® (epoetin alpha)	<p>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 &lt;10 g/dL OR for patients currently maintained on therapy, hemoglobin level is &lt; 11 g/dL in dialysis patients with chronic kidney disease, &lt; 10 g/dL in non-dialysis patients with chronic kidney disease, or &lt; 12 g/dL in patients treated for other indications AND for approval of Aranesp or Procrit, the patient has had a documented side effect, allergy, or treatment failure to the preferred agents.</p> <p><b>Mircera:</b> 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 &lt;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 AND The patient has had a documented side effect, allergy, or treatment failure to the preferred agents.</p>

## HEMOPHILIA FACTORS

AHF-Factor VII		
	Novoseven® RT Sevenfact®	<p><b>Novoseven RT:</b> 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.</p> <p><b>Sevenfact:</b> 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.</p>
AHF-Factor VIII		
ADVATE® AFSTYLA® Hemlibra® (emicizumab-kxwh) HEMOFIL® M KOATE®-DVI KOGENATE FS® NOVOEIGHT® NUWIQ® OBIZUR® XYNTHA®	Adynovate® Eloctate® Esperoct® Hemlibra® Jivi® Kovaltry® Recombinate®	<p><b>All Non-Preferred Products:</b> 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.</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<b>AHF-Factor IX</b>		
ALPHANINE® SD ALPROLIX® BENEFIX® IXINITY® MONONINE® PROFILNINE® RIXUBIS®	Idelvion® Kcentra® Rebinyn®	<b>All Non-Preferred Products:</b> 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 Idelvion or Rebinyn, documentation must include why the member is unable to use the preferred extended half-life concentrate Alprolix.
<b>AHF-Von Willebrand Factor</b>		
ALPHANATE® HUMATE-P® WILATE®	Vonvendi®	<b>All Non-Preferred Products:</b> 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.
<b>AHF-Anti-Inhibitor Coagulation Complex</b>		
	Feiba®	<b>Feiba:</b> medication is being used for the treatment of acute bleeding episodes or routine prophylaxis in a patient with Hemophilia A or B with inhibitors.
<b>HEPATITIS B AGENTS</b>		
ENTECAVIR (compare to Baraclude®) VIREAD® (tenofovir disoproxil fumarate)	Adefovir (compare to Hepsera®) Baraclude® (entecavir) Epivir-HBV® (lamivudine) Hepsera® (adefovir dipivoxil) Lamivudine HBV (compare to Epivir-HBV®) Vemlidy® (tenofovir alafenamide fumarate)	<b>Adefovir, Hepsera, Lamivudine HBV, Epivir-HBV:</b> 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 AND for approval of brand Hepsera or Epivir-HBV, the patient has a documented intolerance to the generic. <b>Note:</b> AASLD and WHO guidelines recommend these not be utilized first line due to potential for the development of resistance. <b>Baraclude tabs:</b> the patient has a documented intolerance to generic entecavir. <b>Baraclude suspension:</b> the patient has a medical necessity for a non-solid oral dosage form. <b>Vemlidy:</b> 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
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## HEPATITIS C AGENTS

Initial PA: 3 months; subsequent maximum 3 months

**RIBAVIRIN PRODUCTS**

RIBAVIRIN 200 mg tablets

Ribavirin 200 mg capsules

**Non-preferred Ribavirin Brands/strengths:** The patient is unable to use generic ribavirin 200 mg tablets

**PEGINTERFERON PRODUCTS**

PEG-INTRON/PEG-INTRON REDIPEN  
(peginterferon alfa-2b)  
*QTY LIMIT:* 1 kit (4 pens per) 28 days

Pegasys® (peginterferon alfa-2a)  
*QTY LIMIT:* 4 vials/28 days  
Pegasys Convenience PAK® (peg-interferon alfa-2a)  
*QTY LIMIT:* 1 kit/28 days

**Pegasys:** Diagnosis is hepatitis C AND the patient has a documented side effect, allergy or treatment failure to Peg-Intron

**DIRECT ACTING ANTIVIRALS**

**Preferred After Clinical Criteria Are Met**

MAVYRET™ (glecaprevir/pibrentasvir)  
SOFOSBUVIR/VELPATASVIR (compare to Epclusa®)

Epclusa® (sofosbuvir/velpatasvir)  
Harvoni® (ledipasvir/sofosbuvir)  
Ledipasvir/sofosbuvir (compare to Harvoni®)  
Sovaldi® (sofosbuvir)  
Viekira PAK® (ombitasvir, paritaprevir, ritonavir tablet with dasabuvir tablet)  
Vosevi® (sofosbuvir/velpatasvir/voxilaprevir)  
Zepatier® (elbasvir/grazoprevir)

**Direct Acting Agents: Epclusa, Harvoni, Ledipasvir/sofosbuvir, Mavyret, Sofosbuvir/velpatasvir, Sovaldi, Viekira pak, Vosevi, Zepatier:**

- Hep C PA form must be completed, and clinical documentation supplied.
- Combination therapy will be either approved or denied in its entirety.
- An infection for at least 6 months has been documented or can be reasonably inferred.
- 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 transplation, 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 AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<p><b><u>Preferred After Clinical Criteria are Met</u></b>            BERINERT® (human C1 inhibitor)            ICATIBANT (compare to Firazyr®)  <i>QTY LIMIT: 3 syringes (9 ml)/fill</i></p>	<p>Firazyr® (icatibant)  <i>QTY LIMIT: 3 syringes (9 ml)/fill</i>            Kalbitor® (escallantide)  <i>QTY LIMIT: 6 vials (2 packs) per fill</i>            Ruconest® (recombinant C1 esterase inhibitor)  <i>QTY LIMIT: 4 vials/fill</i></p>	<p><b>Berinert, Firazyr, Icatibant:</b> 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).  <b>Kalbitor, Ruconest:</b> 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 (Approval may be granted so that 2 doses may be kept on hand.)</p>
<b>PROPHYLACTIC</b>		
<p><b><u>Preferred After Clinical Criteria are Met</u></b>            CINRYZE® (human C1 inhibitor)  <i>QTY LIMIT: 20 vials/30days</i>            HAEGARDA® (human C1 inhibitor)            TAKHZYRO™ (lanadelumab-flyo)  <i>QTY LIMIT: 2 vials/28 days</i></p>		<p><b>Cinryze, Haegarda, Takhzyro:</b> The diagnosis or indication is prophylaxis of Hereditary Angioedema (HAE) attacks.</p>
<b>HYPERKALEMIA AGENTS</b>		
<p>Lokelma™ (sodium zirconium cyclosilicate)            SPS® (sodium polystyrene sulfonate) suspension</p>	<p>Veltassa® (patiromer sorbitex calcium) powder packets  <i>QTY LIMIT: 1 packet/day</i></p>	<p><b>Veltassa:</b> 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).</p>
<b>IDIOPATHIC PULMONARY FIBROSIS (IPF)</b>		
	<p>Esbriet® (pirfenidone)  <i>QTY LIMIT: 267 mg tablets = 270 tabs/month, 801 mg tablets = 90 tabs/month</i>            Ofev® (nintedanib)  <i>QTY LIMIT: 60 tabs/month</i></p>	<p><b>Clinical Criteria: Esbriet, Ofev</b></p> <ul style="list-style-type: none"> <li>○ Age ≥ 18</li> <li>○ Diagnosis of idiopathic pulmonary fibrosis (Esbriet and Ofev) OR chronic fibrosing interstitial lung disease or systemic sclerosis associated interstitial lung disease (Ofev Only)</li> <li>○ May not be used in combination with Ofev® or Esbriet® respectively.</li> <li>○ The prescriber is a pulmonologist.</li> <li>○ Clinical documentation that the member is a non-smoker or has not</li> </ul>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		<p>smoked in 6 weeks.</p> <ul style="list-style-type: none"> <li>○ FVC ≥ 50% of predicted</li> </ul> <p><b>Reauthorization Criteria:</b></p> <ul style="list-style-type: none"> <li>○ Documentation the patient is receiving clinical benefit to Esbrit® or Ofev® therapy as evidenced by &lt; 10% decline in percent predicted FVC of &lt; 200mL decrease in FVC AND</li> <li>○ There is clinical documentation that the member has remained tobacco-free.</li> </ul>

### IMMUNOLOGIC THERAPIES FOR ASTHMA

Initial 3 months, Renewal 1 year		
<p><u><b>Preferred After Clinical Criteria are Met</b></u>            CINQAIR® (reslizumab) Intravenous injection            FASENRA® (benralizumab) subcutaneous Injection, pre-filled syringe and auto-injector pen  <i>QTY LIMIT:</i> 1 mL every 28 days for 3 doses then 1 mL every 56 days</p>	<p>Dupixent® (dupilumab) subcutaneous injection, pre-filled syringe and auto-injector pen  <i>QTY LIMIT:</i> 4 syringes/pens the first 28 days then 2 Syringes/pens every 28 days thereafter            Nucala® (mepolizumab) subcutaneous injection, vial, pre-filled syringe, and auto-injector pen  <i>QTY LIMIT:</i> 1mL every 28 days            Xolair® (omalizumab) subcutaneous injection vial, pre-filled syringe  <i>QTY LIMIT:</i> 900 mg every 28 days</p>	<p><b>Xolair:</b>  <i>Diagnosis of moderate to severe persistent asthma:</i></p> <ul style="list-style-type: none"> <li>• The patient must be 6 years of age or older AND</li> <li>• 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 given in combination with a leukotriene receptor antagonist or long-acting bronchodilator (e.g. tiotropium) for a minimum of 3 consecutive months, with or without oral corticosteroids. Pharmacy claims will be evaluated to assess compliance with therapy. AND</li> <li>• The prescriber is a pulmonologist, allergist, or immunologist AND</li> <li>• Patient has tested positive to at least one perennial aeroallergen by skin or blood test (i.e.: RAST, CAP, intracutaneous test) AND</li> <li>• 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. AND</li> <li>• For approval of prefilled syringe, a clinically compelling reason must be provided detailing why vials cannot be used.</li> </ul> <p><i>Diagnosis of chronic idiopathic urticaria:</i></p> <ul style="list-style-type: none"> <li>• The patient must be 12 years of age or older AND</li> <li>• The patient has a therapeutic failure or contraindication to an H1 antihistamine (e.g. cetirizine, fexofenadine) at double the daily dose AND</li> <li>• The patient has therapeutic failure or contraindication to a leukotriene receptor antagonist. AND</li> <li>• For approval of prefilled syringe, a clinically compelling reason must be</li> </ul>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		<p>provided detailing why vials cannot be used.</p> <p><b>Limitations:</b> 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.</p> <p><b>Fasenra, Nucala, Cinqair:</b></p> <ul style="list-style-type: none"> <li>• 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</li> <li>• The patient must have a diagnosis of severe persistent asthma with an eosinophilic phenotype as defined by pre-treatment blood eosinophil count of <math>\geq 150</math> cells per mL within the previous 6 weeks or <math>\geq 300</math> cells per mL within 12 months prior to initiation of therapy AND</li> <li>• The patient has a history of uncontrolled asthma symptoms (symptoms occurring almost daily or waking at night with asthma at least one a week) or 2 or more exacerbations in the previous year despite regular use of medium-high dose ICS/LABA given in combination with a leukotriene receptor antagonist or long-acting broncodilator (e.g. tiotropium) for a minimum of 3 consecutive months, with or without oral corticosteroids. Pharmacy claims will be evaluated to assess compliance with therapy. AND</li> <li>• The prescriber is an allergist, immunologist, or pulmonologist. AND</li> <li>• For approval of Nucala, the patient must have a documented side effect, allergy, or treatment failure with Cinqair or Fasenra.</li> <li>• For continuation of therapy after the initial 3 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<sub>1</sub> from baseline.</li> </ul> <p><b>Dupixent:</b></p> <p><i>Diagnosis of severe persistent asthma:</i></p> <ul style="list-style-type: none"> <li>• The patient must be 12 years of age or older AND</li> <li>• The patient must have an eosinophilic phenotype as defined by pre-treatment blood eosinophil count of <math>\geq 150</math> cells per mL within the previous 6 weeks or <math>\geq 300</math> cells per mL within 12 months prior to initiation of therapy AND</li> <li>• 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 given in combination with a leukotriene receptor antagonist or long-acting bronchodilator for a minimum of 3 consecutive months, with or without oral corticosteroids. Pharmacy claims will be evaluated to assess compliance with therapy. AND</li> <li>• The prescriber is an allergist, immunologist, or pulmonologist AND</li> </ul>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		<ul style="list-style-type: none"> <li>The patient must have a documented side effect, allergy, or treatment failure with Cinqair or Fasenra.</li> <li>For continuation of therapy after the initial 3 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.</li> </ul> <p><i>Diagnosis of Chronic Rhinosinusitis with Nasal Polyps:</i></p> <ul style="list-style-type: none"> <li>Patient is 18 years of age or older AND</li> <li>Prescriber is an allergist or ENT specialist AND</li> <li>Patient has had an inadequate response to at least a 3-month trial of 2 different nasal corticosteroids AND</li> <li>Patient has had an inadequate response to at least a 10–14-day course of oral corticosteroids AND</li> <li>Patient will use Dupixent concurrently with an intranasal corticosteroid</li> <li>For continuation of therapy after the initial 3 month authorization, the patient must continue to receive therapy with an intranasal corticosteroid AND there must be documented improvement in nasal symptoms.</li> </ul> <p><b>Limitations:</b> Dupixent®, Fasenra®, Nucala® and Cinqair® will not be considered in patients who are currently smoking or in combination with omalizumab.</p>

### IMMUNOSUPPRESSANTS, ORAL

<p>AZATHIOPRINE tablet  CYCLOSPORINE capsule  CYCLOSPORINE MODIFIED  MYCOPHENOLATE MOFETIL tablet, capsule, suspension  MYCOPHENOLIC ACID delayed release tablet  SIROLIMUS tablet  TACROLIMUS capsule</p>	<p>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  Myfortic® (mycophenolic acid) delayed release tablet  Neoral® (cyclosporine modified) capsule, solution  Prograf® (tacrolimus) capsule, granules for suspension  Rapamune® (sirolimus) tablet, solution  Sandimmune® (cyclosporine) capsule, solution  Zortress® (everolimus) tablet</p>	<p><b>Criteria:</b> 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 an AB rated generic, there must be a trial of the generic formulation).</p>
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PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
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**CRYOPYRIN ASSOCIATED PERIODIC SYNDROMES (CAPS) AND PERIODIC FEVER SYNDROME (PFS)**

	<p>Arcalyst® (riloncept)  <i>QTY LIMIT:</i> 2 vials for loading dose, then 1 vial per Week            Ilaris® (canakinumab)</p>	<p><b>Ilaris:</b> 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 &gt; 4 years old  <b>Arcalyst:</b> 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 &gt; 12 years old <b>Note:</b> 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.</p>
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**IRON CHELATING AGENTS**

EXJADE® (deferasirox)	<p>Deferasirox            Ferriprox® (deferiprone)            Jadenu®(deferasirox)</p>	<p><b>Deferasirox, Jadenu, Ferriprox:</b> patient has had a documented side effect allergy or treatment failure to Exjade AND for approval of Jadenu, the patient must have a documented intolerance to generic deferasirox tablets</p>
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**LIPOTROPICS**

**BILE ACID SEQUESTRANTS**

<p>CHOLESTYRAMINE powder (compare to Questran®)            CHOLESTYRAMINE LIGHT powder (compare to Questran Light®)            COLESTIPOL tablets, granules (compare to Colestid®)            WELCHOL® (colesevelam) tablets, powder packets</p>	<p>Colesevelam (compare to Welchol®)            Colestid® tablets, granules (colestipol)            Prevalite powder (cholestyramine light)            Questran® powder (cholestyramine)            Questran Light® powder (cholestyramine light)</p>	<p><b>Colesevelam:</b> The patient has had a documented intolerance to the brand name equivalent.  <b>Prevalite, Questran, Questran Light, Colestid:</b> The patient has had a documented intolerance to the preferred generic formulation.</p>
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**FIBRIC ACID DERIVATIVES**

<p>GEMFIBROZIL (compare to Lopid®) 600 mg            FENOFIBRATE NANOCRYSTALIZED (compare to Tricor®) 48 mg, 145 mg tablets</p>	<p>Antara® (fenofibrate micronized) 30 mg, 43 mg, 90 mg, 130 mg            Fenofibrate tablets (compare to Lofibra® tablets) 54 mg,</p>	<p><b>Lopid:</b> The patient has had a documented intolerance to generic gemfibrozil.  <b>Antara, Fenofibrate, Fenofibrate micronized, Fenofibric acid (all strengths), Fenoglide, Lipofen, Tricor, and Trilipix:</b> The patient is taking a statin</p>
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PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<i>QTY LIMIT:</i> 1 tablet/day	160 mg Fenofibrate capsule (compare to (Lipofen <sup>®</sup> ) 50 mg, 150 mg Fenofibrate micronized capsule (compare to Lofibra <sup>®</sup> capsules) 67 mg, 134 mg, 200 mg Fenofibrate micronized (compare to Antara <sup>®</sup> ) 43 mg, 130 mg Fenofibric acid (compare to Trilipix) 45 mg, 135 mg delayed release capsule Fenofibric acid 35 mg, 105 mg <i>QTY LIMIT:</i> 1 capsule/day Fenoglide <sup>®</sup> (fenofibrate MeltDose) 40 mg, 120 mg Lipofen <sup>®</sup> (fenofibrate) 50 mg, 150 mg Lopid <sup>®</sup> (gemfibrozil) 600 mg Tricor <sup>®</sup> (fenofibrate nanocrystallized) 48 mg, 145 mg Trilipix (fenofibric acid) 45 mg, 135 mg delayed release capsule	concurrently and has had a documented side effect, allergy, or treatment failure with preferred fenofibrate nanocrystallized. (If a product has an AB rated generic, there must have been a trial with the generic formulation.) OR The patient has had a documented side effect, allergy, or treatment failure to gemfibrozil and preferred fenofibrate nanocrystallized. (If a product has an AB rated generic, there must have been a trial with the generic formulation.)
<b>MISC. HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMA (HoFH) AGENTS</b>		
All products require PA	Juxtapid <sup>®</sup> (Iomitapide) Capsule <i>QTY LIMIT: 5 and 10 mg caps = 1/day, 20 mg cap = 3/day</i>  <b>Maximum day supply per fill is 28 days</b>	<b>CRITERIA FOR APPROVAL:</b> <ul style="list-style-type: none"> <li>Total cholesterol and LDL-C &gt; 600 mg/dL and TG within reference range or Confirmation of diagnosis by gene testing AND</li> <li>Documented adherence to prescribed lipid lowering medications for the previous 90 days AND</li> <li>Recommended or prescribed by a lipidologist or Cardiologist AND</li> <li>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</li> </ul>
<b>NICOTINIC ACID DERIVATIVES</b>		
NIACIN NIASPAN <sup>®</sup> (niacin extended release)	Niacin extended release (compare to Niaspan <sup>®</sup> )	<b>CRITERIA FOR APPROVAL:</b> The patient has a documented intolerance to the branded product.
<b>STATINS</b>		
ATORVASTATIN (compare to Lipitor <sup>®</sup> ) LOVASTATIN PRAVASTAIN (compare to Pravachol <sup>®</sup> ) ROSUVASTATIN (compare to Crestor <sup>®</sup> ) SIMVASTATIN (compare to Zocor <sup>®</sup> )	Altprev <sup>®</sup> (lovastatin SR) Crestor <sup>®</sup> (rosuvastatin) Ezallor <sup>®</sup> (rosuvastatin) sprinkle capsule Fluvastatin Fluvastatin ER (compare to Lescol <sup>®</sup> XL) Lescol <sup>®</sup> XL (fluvastatin ER)	<b>Non-preferred agents (except as noted below):</b> 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. <b>Ezallor:</b> medical necessity for a specialty dosage form has been provided <b>Zypitamag:</b> 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
<p><b>Note:</b> All preferred agents have a quantity limit of 1 tablet/day except Lovastatin 40mg which has a quantity limit of 2 tablets/day</p>	<p>Lipitor® (atorvastatin) Livalo® (pitavastatin) Pravachol® (pravastatin) Zocor® (simvastatin) Zypitamag™ (pitavastatin)</p> <p><b>Note:</b> All non-preferred agents have a quantity limit of 1 tablet/day except fluvastatin IR which has a quantity limit of 2 tablets/day.</p>	<p>failure to 3 preferred statins AND clinical justification is provided documenting why the patient is unable to use Livalo.</p> <p><b>LIMITATIONS: Simvastatin 80 mg:</b> 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</p>
<b>MISCELLANEOUS/COMBOS</b>		
<p>Ezetimibe (compare to Zetia®) <i>QTY LIMIT:</i> 1 tab/day</p>	<p>Amlodipine/atorvastatin (compare to Caduet®) <i>QTY LIMIT:</i> 1 tab/day Caduet® (atorvastatin/amlodipine) <i>QTY LIMIT:</i> 1 tab/day Ezetimibe/simvastatin (compare to Vytorin®) Lovaza® (omega-3-acid ethyl esters) Omega-3-acid ethyl esters (compare to Lovaza®) Nexletol® (bempedoic acid) <i>QTY LIMIT: 1 tab/day</i> Nexlizet® (bempedoic acid/ezetimibe) <i>QTY LIMIT: 1 tab/day</i> Vascepa® (icosapent ethyl) <i>QTY LIMIT: 4 caps/day</i> Vytorin® (ezetimibe/simvastatin) <i>QTY LIMIT: 1 tab/day</i> Zetia® (ezetimibe) <i>QTY LIMIT: 1 tab/day</i></p>	<p><b>Zetia:</b> patient must have a documented intolerance to the generic equivalent.</p> <p><b>Lovaza, Vascepa, Omega-3-acid ethyl esters:</b> The patient has been started and stabilized on this medication (Note: samples are not considered adequate justification for stabilization.) OR The patient has triglyceride levels &gt; 500 mg/dL AND The patient has a documented contraindication, side effect, allergy, or treatment failure to a fibric acid derivative and niacin. AND If the request is for brand Lovaza, the patient has a documented intolerance to the generic equivalent.</p> <p><b>Amlodipine/atorvastatin, Caduet:</b> 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.</p> <p><b>Nexletol, Nexlizet:</b> 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</p> <p><b>Vytorin, ezetimibe/simvastatin:</b> The patient must be unable to use the individual separate agents AND If the request is for Vytorin 10/80, the patient has been taking this dose for 12 or more months without evidence of muscle toxicity.</p>
<b>PCSK9 INHIBITORS</b>		
<p><b><u>Preferred After Clinical Criteria Are Met</u></b> PRALUENT® (alirocumab) (Sanofi US labeler 72733 is the only preferred form) <i>QTY LIMIT:</i> 2ml (75 mg injection every 2 weeks or 300 mg every month)/28 days Max 28-day supply</p>	<p>Repatha® (evolocumab) Sureclick, prefilled syringe <i>QTY LIMIT:</i> 2ml (2 injections)/28 days Max 28-day supply Repatha® (evolocumab) Pushtronix™ <i>QTY LIMIT:</i> 3.5ml (One single-use infusor and</p>	<p><b>Criteria for approval:</b></p> <ul style="list-style-type: none"> <li>• The patients' age is FDA approved for the given indication</li> <li>• Concurrent use with statin therapy</li> <li>• Documented adherence to prescribed lipid lowering medications for the previous 90 days</li> <li>• Recommended or prescribed by a lipidologist or cardiologist</li> </ul>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	prefilled cartridge)/28 days Max 28-day supply	<ul style="list-style-type: none"> <li>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) and ezetimibe 10mg daily</li> <li>Approval of Praluent NDC's with labeler code 00024 will be considered only if labeler code 72733 NDC's are on a long-term backorder and unavailable from the manufacturer.</li> </ul> <p><b>Additional criteria for the diagnosis of heterozygous familial hypercholesterolemia (HeFH): (both are required)</b></p> <ul style="list-style-type: none"> <li>Total cholesterol &gt; 290 mg/dL OR LDL-C &gt; 190 mg/dL AND one of the following             <ul style="list-style-type: none"> <li>Presence of tendon xanthomas <b>OR</b></li> <li>In 1<sup>st</sup> or 2<sup>nd</sup> degree relative-documented tendon xanthomas, MI at age ≤ 60 years or TC &gt; 290 mg/dL</li> </ul> </li> <li>For approval of Repatha, the patient must have a documented side effect, allergy, or treatment failure with Praluent.</li> </ul> <p><b>Additional criteria for the diagnosis of clinical atherosclerotic cardiovascular disease:</b></p> <ul style="list-style-type: none"> <li>History of MI, angina, coronary or other arterial revascularization, stroke, TIA, or PVD of atherosclerotic origin</li> <li>For approval of Repatha, the patient must have a documented side effect, allergy, or treatment failure with Praluent.</li> </ul> <p><b>Additional criteria for the diagnosis of homozygous familial hypercholesterolemia (Repatha only):</b></p> <ul style="list-style-type: none"> <li>Total cholesterol and LDL-C &gt; 600 mg/dL and TG within reference range <b>OR</b></li> <li>Confirmation of diagnosis by gene testing</li> </ul>
<b>MISCELLANEOUS</b>		
GLYCOPYRROLATE 1 mg, 2 mg tablets (compare to Robinul <sup>®</sup> , Robinul Forte <sup>®</sup> ) KUVAN <sup>®</sup> (sapropterin) PYRIDOSTIGMINE BROMIDE (Compare to Mestinon) RILUZOLE (Compare to Rilutek <sup>®</sup> )  <u><b>Preferred After Clinical Criteria Are Met</b></u> CARBAGLU <sup>®</sup> dispersible tablets (carglumic acid) Maximum days supply per fill = 14 days CRYSVITA <sup>®</sup> (burosumab-twza)	Benlysta <sup>®</sup> (belimumab) Maximum days supply per fill = 28 days Brineura <sup>™</sup> (cerliponase alfa) <i>QTY LIMIT:</i> 1 package per 14 days (Brineura Injection, 2 vials of 150mg/5ml, and Intraventricular Electrolytes Injection, 1 vial of 5ml) Cuvposa <sup>®</sup> oral solution (glycopyrrolate) Maximum days supply per fill is 30 days Elaprase <sup>®</sup> (idursulfase) <i>QTY LIMIT:</i> calculated dose/week Fensolvi <sup>®</sup> (leuprolide acetate) subcutaneous injection	<p><b>Benlysta:</b> The diagnosis or indication is active systemic lupus erythematosus (SLE) AND The patient is positive for autoantibodies (anti-nuclear antibody (ANA) and/or anti-double-stranded DNA (anti-dsDNA). AND The patient has had a documented inadequate response or intolerance to at least TWO of the following agents: NSAIDs, hydroxychloroquine, prednisone, azathioprine, methotrexate, mycophenolate.</p> <p><b>Note:</b> The efficacy of Benlysta<sup>®</sup> has not been evaluated in patients with severe active lupus nephritis or severe active central nervous system lupus. Benlysta has not been studied in combination with other biologics or intravenous cyclophosphamide. Use of Benlysta is not recommended in these situations. Initial approval will be granted for 3 months. For therapy continuation, clinical</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
FABRAZYME (agalsidase beta) IV	<p><i>QTY LIMIT:</i> 1 vial every 6 months</p> <p>Firdapse® (amifampridine) <i>QTY LIMIT:</i> 8 tablets/day</p> <p>Galafold™ (migalastat) <i>QTY LIMIT:</i> 14 caps/28 days Maximum day supply = 28 days</p> <p>Gamifant® (emapalumab-lzsg)</p> <p>Hetlioz® (tasimelteon) 20 mg oral capsule <i>QTY LIMIT:</i> 1 capsule/day Maximum days supply per fill is 30 days</p> <p>Hydroxyprogesterone caproate 250 mg/ml vial (intramuscular injection)</p> <p>Luxturna® (voretigine neparvovec-rzyl) suspension for subretinal injection <i>QTY LIMIT:</i> one injection per eye per lifetime</p> <p>Lysteda® tablets (tranexamic acid) <i>QTY LIMIT:</i> 30 tablets/28 days</p> <p>Mestinon®</p> <p>Myalept® (metreleptin) vial for subcutaneous injection <i>QTY LIMIT:</i> one vial/day Maximum day supply per fill = 30 days</p> <p>Oxlumo™ (lumasiran)</p> <p>Palynziq™ (pegvaliase-pqpz)</p> <p>Radicava® (edaravone) IV injection</p> <p>Rilutek® (riluzole)</p> <p>Ruzurgi® (amifampridine) <i>QTY LIMIT:</i> 10 tablets/day</p> <p>Tiglutik™ (riluzole) suspension</p> <p>Tranexamic acid (compare to Lysteda®) <i>QTY LIMIT:</i> 30 tablets/28 days</p> <p>Ultomiris® (ravulizumab-cwvz)</p> <p>Xatmep™ (methotrexate) oral solution</p> <p>Zinplava™ (Bezlotoxumab) injection</p>	<p>documentation must be submitted documenting stable disease activity OR reduction in disease activity or corticosteroid dose.</p> <p><b>Brineura:</b></p> <ul style="list-style-type: none"> <li>• Patient is 3 years of age or older AND</li> <li>• 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</li> <li>• The prescriber is a neurologist or other physician specializing in intraventricular administration</li> </ul> <p><b>Note:</b> 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.</p> <p><b>Carbaglu:</b> The diagnosis or indication for the requested medication is hyperammonemia due to N-acetylglutamate synthetase (NAGS) deficiency AND The prescriber is a specialist in metabolic disorders (e.g., medical geneticist) or prescriber is in consultation with a specialist</p> <p><b>Cuvposa:</b> The diagnosis or indication for the requested medication is Sialorrhea or a neurologic condition associated with excessive drooling (e.g. cerebral palsy, mental retardation, Parkinson's disease). AND The dose cannot be obtained from the tablet formulation. AND (For patients &gt;18 years of age) The patient has had a documented side effect, allergy, treatment failure, or a contraindication to scopolamine patches.</p> <p><b>Crysvita:</b></p> <ul style="list-style-type: none"> <li>• Patient is ≥ 1 year of age AND</li> <li>• Patient has a diagnosis of X-linked hypophosphatemia AND</li> <li>• Medication is prescribed by or in consultation with an endocrinologist or nephrologist AND</li> <li>• Patient has not received oral phosphate or vitamin D analogs within 1 week prior to starting therapy AND</li> <li>• Baseline fasting serum phosphorous level is below the lower limit of the laboratory normal reference range AND</li> <li>• Patient does not have severe renal impairment, defined as a GFR of &lt; 30mL/min AND</li> <li>• Dose does not exceed 90mg every 14 days (pediatrics) or 90mg every 28 days (adults)</li> </ul> <p><b>Note:</b> Initial approval will be granted for 6 months. Renewal may be granted for up to</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		<p>1 year. For therapy continuation, patient must have disease response as indicated by one of the following:</p> <ul style="list-style-type: none"> <li>• Increased serum phosphate levels, not exceeding the upper limit of the laboratory normal range.</li> <li>• A reduction in serum total alkaline phosphatase activity.</li> <li>• Improvement in symptoms (e.g. skeletal pain, linear growth, etc.).</li> <li>• Improvement in radiographic imaging of Rickets/osteomalacia.</li> </ul> <p><b>Elapraxe (Hunter's Syndrome Injectable):</b> The diagnosis or indication for the requested medication is Hunter's Syndrome</p> <p><b>Cuvposa:</b> The diagnosis or indication for the requested medication is Sialorrhea or a neurologic condition associated with excessive drooling (e.g. cerebral palsy, mental retardation, Parkinson's disease). AND The dose cannot be obtained from the tablet formulation. AND (For patients &gt;18 years of age) The patient has had a documented side effect, allergy, treatment failure, or a contraindication to scopolamine patches.</p> <p><b>Fabrazyme:</b> Diagnosis or indication is Fabry Disease.</p> <p><b>Fensolvi:</b> There is a documented diagnosis of Central Precocious Puberty (CPP) AND All other underlying causes have been ruled out including a brain tumor, spinal cord tumor, hypothyroidism, brain defect at birth (e.g. hematoma or hydrocephalus), injury to the brain or spinal cord, McCune-Albright syndrome, congenital adrenal hyperplasia, radiation to the spinal cord or brain AND There is a documented inability to tolerate (not due to pain) monthly injections of Leuprolide IM</p> <p><b>Firdapse, Ruzurgi:</b> 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</p> <p><b>Galafold:</b> Patient is <math>\geq 18</math> 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).</p> <p><b>Gamifant:</b> 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</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		<p><b>Hetlioz:</b> Patient has documentation of Non-24-Hour Sleep-Wake Disorder (Non-24) AND Patient has documentation of total blindness AND Patient has had a documented side effect, allergy or treatment failure with Rozerem and at least one OTC melatonin product.</p> <p><b>Luxturna:</b> 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.</p> <p><b>Lysteda, Tranexamic acid:</b> The diagnosis or indication is clinically significant heavy menstrual bleeding AND The patient has been started and stabilized on oral tranexamic acid within the previous 360 days OR The patient does not have a contraindication to therapy with oral tranexamic acid (i.e., active thrombotic disease, history of thrombosis/thromboembolism, or an intrinsic risk of thrombosis/thromboembolism), and if oral tranexamic acid is to be used concomitantly with an estrogen containing hormonal contraceptive product, the risks of combination therapy have been discussed with the patient. AND The patient has had a documented side effect, allergy, contraindication, or an inadequate response with at least one oral contraceptive or progestin containing product despite an adequate trial of at least 90 days, or a rationale for why these products cannot be used (e.g. actively attempting to conceive). AND The patient has had a documented side effect, allergy, contraindication, or an inadequate response with at least one regularly scheduled (not PRN) NSAID or a rationale for why these products cannot be used (e.g. actively attempting to conceive). AND If the request is for brand Lysteda, the patient has had a documented intolerance to the generic product.</p> <p><b>Myalept:</b> 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 &gt; 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.</p> <p><b>Oxlumo:</b> 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 &gt;</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		<p>0.5mmol/1.73 m<sup>2</sup> 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</p> <p><b>Palynziq:</b> Patient is 18 years of age or older AND has a diagnosis of phenylketonuria AND has uncontrolled blood phenylalanine (PHE) concentrations (&gt; 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. <b>Note:</b> 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.</p> <p><b>Radicava:</b></p> <ul style="list-style-type: none"> <li>• The diagnosis is amyotrophic lateral sclerosis (ALS) AND</li> <li>• Disease duration is ≤ 2 years AND</li> <li>• Patient has functionally retained most activities of daily living AND</li> <li>• Patient has normal respiratory function (defined as a % predicted forced vital capacity of ≥ 80%) AND</li> <li>• Patient does not have a sulfite allergy AND</li> <li>• Initial approval will be granted for 14 doses/28 days and all subsequent approvals will be for 10 doses/28 days</li> </ul> <p><b>Rilutek:</b> patient must have a documented intolerance with riluzole</p> <p><b>Note:</b> Initial approval will be granted for 4 loading doses (the first 3 loading doses should be administered at 14-day intervals; the 4<sup>th</sup> loading dose should be administered 30 days after the 3<sup>rd</sup> 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.</p> <p><b>Tiglutik:</b> patient must be unable to take whole or crushed Riluzole tablets</p> <p><b>Ultomiris:</b> 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. <b>Note:</b> Dose requested must be within the weight based parameters for loading and maintenance dose</p> <p><b>Xatmep:</b> The patient has a diagnosis of polyarticular juvenile idiopathic arthritis or acute lymphoblastic leukemia (ALL) AND patient has a requirement for an oral</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		<p>liquid dosage form (i.e. swallowing disorder, inability to take oral medications)</p> <p><b>Zinplava:</b></p> <ul style="list-style-type: none"> <li>• The patient is 18 years of age or older AND</li> <li>• The patient has a diagnosis of <i>Clostridium difficile</i> infection (CDI) confirmed by a positive stool test collected within the past 7 days AND</li> <li>• The patient is or will receive concomitant Standard of Care antibacterial therapy for CDI (e.g. metronidazole, vancomycin, or fidaxomicin) AND</li> <li>• The patient is at high risk for recurrence based on at least one of the following: <ul style="list-style-type: none"> <li>○ Age ≥ 65 years</li> <li>○ Two or more episodes of CDI within the past 6 months</li> <li>○ The patient is immunocompromised</li> <li>○ The patient has clinically severe CDI (e.g. fever, abdominal tenderness, WBC ≥ 15,000 cells/mm<sup>3</sup>, albumin &lt;30g/L, or renal failure)</li> </ul> </li> </ul> <p><b>Note:</b> 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.</p>
<p><b>INJECTABLE METHOTREXATE</b> METHOTREXATE 25 MG/ML solution for injection</p>	<p>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</p>	<p><b>Otrexup, Rasuvo, Reditrex:</b> 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)</p>
<p><b>NEUROMYELITIS OPTICA SPECTRUM DISORDERS (NMOSD)</b> All Products Require PA</p>	<p>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</p>	<p><b>Enspryng, Soliris, Uplizna:</b></p> <ul style="list-style-type: none"> <li>• The patient is ≥ 18 years AND</li> <li>• Diagnosis or indication is the treatment of neuromyelitis optica spectrum disorder (NMOSD) AND</li> <li>• Patient is anti aquaporin-4 (AQP4) antibody positive AND</li> <li>• 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</li> <li>• Patient must have a documented side effect, allergy, treatment failure, or contraindication to rituximab.</li> <li>• 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.</li> </ul> <p><b>Soliris, Uplizna additional criteria:</b> The patient must have a documented side effect, allergy, treatment failure or contraindication to Enspryng.</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<b>SOMATOSTATIN ANALOGS</b>		
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	<p><b>Bynfezia, Sandostatin:</b> the patient has a documented intolerance to Octreotide injection.</p> <p><b>Mycapssa:</b> the diagnosis or indication is long-term maintenance treatment of acromegaly AND the patient has already responded to and tolerated treatment with an injectable somatostatin analog AND there is a clinically valid reason why the patient is unable to use Sandostatin LAR Depot.</p> <p><b>Somatuline:</b> the patient has a documented side effect, allergy, treatment failure, or contraindication to Sandostatin LAR Depot.</p>
<b>SPINAL MUSCULAR ATROPHY</b>		
<p><u>Preferred After Clinical Criteria Are Met</u></p> ZOLGENSMA® (onasemnogene abeparvovec-xioi) intravenous suspension	Evrysdi® (risdiplam) oral solution Spinraza (nusinersen) injection 12mg/5ml single-dose vial	<p><b>Evrysdi:</b></p> <ul style="list-style-type: none"> <li>• The diagnosis is spinal muscular atrophy (SMA) AND</li> <li>• Patient is 2 months of age or older AND</li> <li>• Medication is prescribed per the dosing guidelines in the package insert AND</li> <li>• 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</li> <li>• The patient does not have impaired hepatic function AND</li> <li>• 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.</li> </ul> <p><b>Note:</b> For therapy continuation, clinical documentation must be submitted documenting improvement or maintenance of motor ability OR slower disease progression than would otherwise be expected.</p> <p><b>Spinraza:</b></p> <ul style="list-style-type: none"> <li>• The diagnosis is spinal muscular atrophy (SMA) type 1,2, or 3 (results of genetic testing must be submitted) AND</li> <li>• The patient has at least 2 copies of the SMN2 gene AND</li> <li>• The need for invasive or noninvasive ventilation (if applicable) does not exceed more than 16 hours per 24 hour period AND</li> <li>• Baseline motor ability has been established using one of the following exams:               <ul style="list-style-type: none"> <li>○ Hammersmith Infant Neurological Exam (HINE)</li> <li>○ Hammersmith Functional Motor Scale Expanded (HFMSE)</li> <li>○ Upper Limb Module Test (non-ambulatory)</li> <li>○ Children’s Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND) AND</li> </ul> </li> <li>• 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</li> </ul>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		<ul style="list-style-type: none"> <li>Concurrent use with Evrysdi will not be approved.</li> </ul> <p><b>Note:</b> 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.</p> <p><b>Zolgensma:</b></p> <ul style="list-style-type: none"> <li>The patient is less than 2 years of age AND</li> <li>The diagnosis is spinal muscular atrophy (SMA) AND</li> <li>The patient has bi-allelic mutations of the SMN1 gene AND</li> <li>The patient does not have advanced SMA (e.g. complete paralysis of limbs or permanent ventilator dependence) AND</li> <li>Medication is prescribed per the dosing guidelines in the package insert (recommended dose is 1.1 x 10<sup>4</sup> vector genomes per kilogram) AND</li> <li>Baseline anti-AAV9 antibodies are less than 1:50 AND</li> <li>Prior to starting therapy and periodically for at least 3 months, the following laboratory tests will be conducted: Liver function (AST, ALT, total bilirubin, prothrombin time), platelet counts, and troponin-I</li> </ul> <p><b>Note:</b> The safety and effectiveness of repeat administration has not been evaluated. Approval is limited to a single intravenous infusion.</p>
<b>MOOD STABILIZERS</b>		
LITHIUM CARBONATE (formerly Eskalith®) LITHIUM CARBONATE SR (compare to Lithobid®, formerly Eskalith CR®) LITHIUM CITRATE SYRUP	Equetro® (carbamazepine SR) Lithobid® (lithium carbonate SR)	<p><b>Lithobid:</b> The patient has had a documented side effect, allergy, or treatment failure with the generic equivalent of the requested medication.</p> <p><b>Equetro:</b> The patient has had a documented side effect, allergy, or treatment failure with a carbamazepine product from the anticonvulsant therapeutic drug category</p>

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

<p><b><u>Preferred After Clinical Criteria Are Met</u></b>  TETRABENAZINE (compare to Xenazine®)  <i>QTY LIMIT:</i> 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</p>	<p>Austedo® (deutetrabenazine) tablets  <i>QTY LIMIT:</i> 48 mg/day  Maximum 1-month supply per fill  Ingrezza® (valbenazine tosylate) capsules  <i>QTY LIMIT:</i> 80 mg/day  Maximum 1-month supply per fill  Xenazine® (tetrabenazine) tablets  <i>QTY LIMIT:</i> 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</p>	<p><b>Austedo:</b> 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 AND the patient has a documented side effect, allergy, contraindication or treatment failure with tetrabenazine. For re-approved, a 30% improvement from baseline in AIMS score must be documented.</p> <p><b>Ingrezza:</b> The diagnosis or indication for the requested medication is Tardive Dyskinesia (TD) AND the results of an Abnormal Involuntary Movement Scare (AIMS) exam have been submitted AND the patient is ≥18 years of age AND the patient has a documented side effect, allergy, contraindication or treatment failure with tetrabenazine. For re-approval, a 30% improvement from baseline in the AIMS score must be documented.</p> <p><b>Tetrabenazine, Xenazine:</b> 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.</p> <p><b>Note:</b> Austedo, Tetrabenazine, and Xenazine are contraindicated in patients with Huntington’s Disease who are suicidal or with untreated/inadequately treated depression.</p>
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**MULTIPLE SCLEROSIS MEDICATIONS**

<p><b><u>INJECTABLES</u></b>  <b><u>INTERFERONS</u></b>  AVONEX® (interferon B-1a)  BETASERON® (interferon B-1b)  REBIF® (interferon B-1a)  REBIF® REBIDOSE (interferon B-1a)</p> <p><b><u>OTHER</u></b>  COPAXONE® 20 mg (glatiramer acetate)  <i>QTY LIMIT:</i> 1 kit/30 days</p> <p style="background-color: yellow;"><b><u>Preferred After Clinical Criteria are Met</u></b></p>	<p>Extavia® (interferon beta-1b)  Copaxone® 40 mg (glatiramer)  <i>QTY LIMIT:</i> 12 syringes (12 ml)/28 days  Glatiramer Acetate (compare to Copaxone® )20 mg  <i>QTY LIMIT:</i> 1 kit/30days  Glatiramer Acetate (compare to Copaxone®) 40 mg  <i>QTY LIMIT:</i> 12 syringes (12 ml)/28 days  Glatopa® 20 mg (glatiramer acetate)  <i>QTY LIMIT:</i> 1 carton (30 syringes/30 days  Glatopa® 40 mg (glatiramer)</p>	<p><b>Ampyra, Tecfidera:</b> patient must have a documented intolerance to the generic e</p> <p><b>Bafertam, Vumerity:</b> 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. equivalent.</p> <p><b>Copaxone 40 mg Syringe:</b> The patient is unable to tolerate or be compliant with Copaxone 20 mg daily dosing.</p> <p><b>Extavia:</b> Patient has a diagnosis of multiple sclerosis. AND The provider provides a clinical reason why Betaseron cannot be prescribed.</p> <p><b>Glatiramer, Glatopa:</b> Patient is ≥ 18 years AND diagnosis of relapsing forms of Multiple Sclerosis AND the provider provides a clinical reason why Copaxone cannot be prescribed.</p>
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PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<p><b>Tysabri® (natalizumab)</b></p> <p><b>ORAL</b>  <b>AUBAGIO® (teriflunamide) tablet</b>  <i>QTY LIMIT:</i> 1 tablet/day  Maximum 30-day supply per fill  <b>DALFAMPRIDINE ER tablet (compare to Ampyra®)</b>  <i>QTY LIMIT:</i> 2 tablets/day  Maximum 30-day supply per fill  <b>DIMETHYL FUMARATE</b>  <i>QTY LIMIT:</i> 2 capsules/day  Maximum 30-day supply per fill  <b>GILENYA® (fingolimod) capsule</b>  <i>QTY LIMIT:</i> 1 capsule/day  Maximum 30-day supply per fill</p>	<p><i>QTY LIMIT:</i> 12 syringes (12 ml)/28 days  <b>Kesimpta® (ofatumumab)</b>  Lemtrada® (alemtuzumab) intravenous  Ocrevus® (ocrelizumab)  <i>QTY LIMIT:</i> 300 mg X 2 doses, then 600 mg every 6 months thereafter  Plegridy® (peginterferon beta-1a)</p> <p>Ampyra® (dalfampridine ER) tablet  <i>QTY LIMIT:</i> 2 tablets/day  Maximum 30-day supply per fill  Bafiertam® (monomethyl fumarate) capsule  <i>QTY LIMIT:</i> 4 capsules/day  Maximum 30-day supply per fill  Maximum 30-day supply per fill  Mavenclad® (cladribine) tablet  Mayzent® (siponimod) tablet  Tecfidera® (dimethyl fumarate)  <i>QTY LIMIT:</i> 2 capsules/day  Maximum 30-day supply per fill  Vumerity® (diroximel fumarate) capsule  <i>QTY LIMIT:</i> 4 capsules/day  Zeposia® (ozanimod) capsule  <i>QTY LIMIT:</i> 1 capsule/day</p>	<p><b>Mavenclad:</b> 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.</p> <p><b>Mayzent:</b>  <i>Diagnosis of relapsing-remitting MS or Clinical Isolated Syndrome:</i></p> <ul style="list-style-type: none"> <li>• Patient is ≥ 18 years AND</li> <li>• Patient CYP2C9 variant status has been tested to determine genotyping (required for dosing; therapy is contraindicated in CYP2C9*3/*3) AND</li> <li>• Baseline CBC, electrocardiogram (ECG), and ophthalmic evaluation have been completed AND</li> <li>• Patient has a documented side effect, allergy, treatment failure or contraindication to at least two preferred drugs</li> </ul> <p><i>Diagnosis of Active Secondary Progressive MS (SPMS):</i></p> <ul style="list-style-type: none"> <li>• Patient is ≥ 18 years AND</li> <li>• Patient CYP2C9 variant status has been tested to determine genotyping (required for dosing; therapy is contraindicated in CYP2C9*3/*3) AND</li> <li>• Baseline CBC, electrocardiogram (ECG), and ophthalmic evaluation have been completed AND</li> <li>• Documentation is provided showing ≥ 1 relapse within the past year OR new or enlarging T2 lesions as evidenced by MRI</li> </ul> <p><b>Kesimpta, Lemtrada, Ocrevus:</b> 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 Gilenya or Tysabri, unless contraindicated. OR Patient is ≥18 years AND has a diagnosis of primary progressive multiple sclerosis (Ocrevus only).</p> <p><b>Plegridy:</b> Patient is ≥ 18 years. Diagnosis of relapsing form of Multiple Sclerosis. Documented side effect, allergy, treatment failure or contraindication to at least three preferred drugs including at least one preferred form of interferon.</p> <p><b>Tysabri:</b> Patient is ≥ 18 years AND has a diagnosis of relapsing multiple sclerosis (including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease)</p> <p><b>Zeposia:</b> Patient is ≥ 18 years AND has a diagnosis of relapsing-remitting MS (RRMS), Clinically Isolated Syndrome or active secondary progressive MS (SPMS) AND Documentation is provided showing ≥ 1 relapse within the past year</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		AND baseline CBC w/ diff (including lymphocyte count), liver function tests, electrocardiogram (ECG), and ophthalmic evaluation have been completed AND patient has a documented side effect, allergy, treatment failure or contraindication to at least three drugs used to treat relapsing MS (may be preferred or non-preferred)
<b>MUSCLE RELAXANTS, SKELETAL</b>		
<p><b><u>MUSCULOSKELETAL AGENTS</u></b> <b><u>SINGLE AGENTS</u></b> CYCLOBENZAPRINE 5 mg, 10 mg tablets (compare to Flexeril<sup>®</sup>) <i>QTY LIMIT:</i> 5 mg = 6 tablets/day, 10 mg = 3 tablets/day METHOCARBAMOL tablets (compare to Robaxin<sup>®</sup>) <i>QTY LIMIT:</i> 8 tablets/day ORPHENADRINE CITRATE ER 100 mg tablet <i>QTY LIMIT:</i> 2 tablets/day</p> <p><b><u>COMBINATION PRODUCT</u></b> All products require PA  ASA = aspirin  <b>Maximum duration of therapy all musculoskeletal agents = 90 days</b></p> <p><b><u>ANTISPASTICITY AGENTS</u></b> BACLOFEN DANTROLENE (compare to Dantrium<sup>®</sup>) TIZANIDINE (compare to Zanaflex<sup>®</sup>) tablets</p>	<p>Amrix<sup>®</sup> (cyclobenzaprine sustained-release) capsule <i>QTY LIMIT:</i> 1 capsule/day Carisoprodol tablets <i>QTY LIMIT:</i> 8 tablets/day Chlorzoxazone tablets <i>QTY LIMIT:</i> 4 tablets/day Cyclobenzaprine 7.5 mg tab (compare to Fexmid<sup>®</sup>) <i>QTY LIMIT:</i> 3 tablets/day Fexmid<sup>®</sup> (cyclobenzaprine) 7.5 mg tablet <i>QTY LIMIT:</i> 3 tablets/day Lorzone<sup>®</sup> (chlorzoxazone) tablets <i>QTY LIMIT:</i> 4 tablets/day Metaxalone (compare to Skelaxin<sup>®</sup>) tablets <i>QTY LIMIT:</i> 4 tablets/day Robaxin<sup>®</sup> (methocarbamol) tablets <i>QTY LIMIT:</i> 8 tablets/day Skelaxin<sup>®</sup> (metaxalone) tablets <i>QTY LIMIT:</i> 4 tablets/day Soma<sup>®</sup> (carisoprodol) tablets <i>QTY LIMIT:</i> 4 tablets/day</p> <p>Carisoprodol, ASA, codeine <i>QTY LIMIT:</i> 4 tablets/day</p> <p>Dantrium<sup>®</sup> (dantrolene) Tizanidine (compare to Zanaflex<sup>®</sup>) capsules Zanaflex<sup>®</sup> (tizanidine) capsules Zanaflex<sup>®</sup> (tizanidine) tablets</p>	<p><b>Amrix, cyclobenzaprine 7.5 mg, Fexmid:</b> The prescriber must provide a clinically valid reason why a preferred generic cyclobenzaprine cannot be used. For approval of Fexmid, the patient must also have a documented intolerance to the generic equivalent.</p> <p><b>Brand skeletal muscle relaxants with generics available (Flexeril, Robaxin):</b> The patient has had a documented side effect, allergy or treatment failure with two different preferred musculoskeletal agents (One trial must be the AB rated generic).</p> <p><b>Carisoprodol, carisoprodol/ASA/codeine, chlorzoxazone, Lorzone, Soma, metaxalone, Skelaxin:</b> 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.</p> <p><b>Dantrium, Zanaflex tablets:</b> The patient must have a documented intolerance with the AB rated generic product.</p> <p><b>Tizanidine capsules, Zanaflex capsules:</b> 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</p>

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

	<p>Emflaza™ (deflazacort)  Maximum 30-day supply per fill  Exondys 51™ (eteplirsen)  Viltepso® (viltorsen)  Vyondys 53™ (golodirsen)</p>	<p><b>Emflaza:</b></p> <ul style="list-style-type: none"> <li>• The patient must be ≥ 2 years of age AND</li> <li>• The patient must have a diagnosis of Duchenne Muscular Dystrophy AND</li> <li>• There is documented improvement in muscle function or strength with use of prednisone, but the patient has experienced weight gain &gt;10% of body weight within 3 months or &gt;25% within 1 year.</li> </ul> <p><b>Exondys, Viltepso, Vyondys:</b></p> <ul style="list-style-type: none"> <li>• The patient must have a diagnosis of Duchenne Muscular Dystrophy with a confirmed mutation of the DMD gene that is amenable to exon 51 skipping (for Exondys) or exon 53 skipping (for Viltepso, Vyondys) (results of genetic testing must be submitted) AND</li> <li>• The prescriber is, or has consulted with, a neuromuscular disorder specialist AND</li> <li>• The dose does not exceed 30mg/kg once weekly (for Exondys, Vyondys) or 80mg/kg once weekly (for Viltepso) AND</li> <li>• The patient is currently on a stable corticosteroid dose for at least 6 months.</li> <li>• Note: Initial approval will be granted for 6 months. For re-approval after 6 months, the patient must demonstrate a response to therapy as evidenced by continued or improved clinically meaningful function.</li> </ul>
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### NEUROGENIC ORTHOSTATIC HYPOTENSION

<p>FLUDROCORTISONE MIDODRINE</p>	<p>Northera®</p>	<p><b>Quantity Limits:</b></p> <ul style="list-style-type: none"> <li>• Initial 2 weeks approval</li> <li>• Continued therapy approvals based on documentation of continued benefit clinically and as evidenced by positional blood pressure readings</li> </ul> <p><b>Clinical Criteria:</b></p> <ul style="list-style-type: none"> <li>• 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</li> <li>• the presentation of symptoms including dizziness, lightheadedness, and</li> </ul>
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PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		<p>the feeling of “blacking out” AND</p> <ul style="list-style-type: none"> <li>• Failure of multiple non-pharmacologic measures as appropriate (e.g. removal of offending medications, compression stockings, increased fluid and salt intake) AND</li> <li>• Failure, intolerance or contra-indication to fludrocortisone AND midodrine</li> </ul>

### NEUROPATHIC PAIN & FIBROMYALGIA AGENTS

Oral		
<p>DULOXETINE (compare to Cymbalta®) <i>QTY LIMIT: 2 capsules/day</i></p> <p>PREGABALIN (compare to Lyrica®) capsules <i>QTY LIMIT: 3 capsules/day</i></p>	<p>Cymbalta® (duloxetine) <b><i>QTY LIMIT: 2 capsules/day</i></b></p> <p>Gralise® (gabapentin) tablet, starter pack <i>QTY LIMIT: 3 tablets/day</i> Maximum 30-day supply per fill</p> <p>Horizant® (gabapentin enacarbil) ER Tablet FDA maximum recommended dose = 1200 mg/day</p> <p>Lyrica® (pregabalin) capsules <i>QTY LIMIT: 3 capsules/day</i></p> <p>Lyrica® CR (pregabalin, extended release) FDA maximum recommended dose = 330 mg/day (DPN), 660 MG/day (PHN)</p> <p>Lyrica® (pregabalin) solution <b><i>Pregabalin (compare to Lyrica®) solution</i></b></p> <p>Savella® (milnacipran) tablet, titration pack <i>QTY LIMIT: 2 tablets/day</i></p>	<p><b>Cymbalta, Lyrica:</b> the patient has had a documented intolerance with generic duloxetine.</p> <p><b>Gralise, Horizant:</b> 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.</p> <p><b>Lyrica CR:</b> The patient has a diagnosis of post-herpetic neuralgia (PHN) or diabetic peripheral neuropathy (DPN) AND has had a documented side effect, allergy, or treatment failure to TWO drugs from the following: gabapentin, tricyclic antidepressant, SSRI antidepressant, SNRI antidepressant, or miscellaneous antidepressant AND patient has not been able to be adherent to a twice daily dosing schedule of <b>pregabalin</b> immediate release resulting in a significant clinical impact. <b>Note:</b> 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.</p> <p><b>Pregabalin solution, Lyrica solution:</b> 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.</p> <p><b>Savella:</b> The diagnosis or indication is treatment of fibromyalgia AND The patient has had a documented side effect, allergy, or treatment failure to TWO drugs from the following: gabapentin, tricyclic antidepressant, SSRI antidepressant, SNRI antidepressant, miscellaneous antidepressant, cyclobenzaprine or <b>pregabalin</b>.</p>

### NUTRITIONALS, LIQUID ORAL SUPPLEMENTS

All products require PA	Note: Nutritional supplements administered via tube feeds may be provided through the Medical Benefit	<b>EleCare, EleCare Jr:</b> 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
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PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		<p>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.</p> <p><b>All Others:</b> Requested nutritional supplement will be administered via tube feeding. OR Patient has one of the following conditions where feeding is difficult or malabsorption or maldigestion occurs: AIDS, Cancer, Celiac Disease, Cerebral Palsy, Chronic Diarrhea, Cognitive Impairment, Cystic Fibrosis, Dementia (includes Alzheimer's), Developmental Delays, Difficulty with chewing/swallowing food, Inflammatory Bowel Disease, Parkinson's, Short Gut. OR Patient has experienced unplanned weight loss or is extremely low weight (see further definitions below) OR Patient has demonstrated nutritional deficiency identified by low serum protein levels (albumin or pre-albumin levels to be provided) (albumin &lt;3.5 g/dL /pre-albumin &lt;15 mg/dL)</p> <p><b>Unplanned Weight Loss/Low Weight Table:</b></p> <p><b>Adult:</b> <input type="checkbox"/> Involuntary loss of &gt; 10 % of body weight within 6 months <input type="checkbox"/>  Involuntary loss of &gt; 5% of body weight within 1 month <input type="checkbox"/> Loss of &gt; 2% of body weight within one week <input type="checkbox"/> BMI of &lt; 18.5 kg/m<sup>2</sup></p> <p><b>Elderly:</b> (&gt;65): <input type="checkbox"/> Involuntary loss of &gt; 10 % of body weight within 6 months <input type="checkbox"/>  Involuntary loss of &gt; 5 % of body weight within 3 months <input type="checkbox"/> Loss of &gt; 2 % of body weight within one month <input type="checkbox"/> BMI of &lt; 18.5 kg/m<sup>2</sup></p> <p><b>Children:</b> <input type="checkbox"/> &lt; 80 % of expected weight-for-height <input type="checkbox"/> &lt; 90 % of expected height-for-age <input type="checkbox"/> Mid-upper arm circumference/head circumference ratio &lt; 0.25</p> <p><b>Limitations:</b> Infant formulas are not covered under the pharmacy benefit. Please contact WIC.</p>
<b>ONCOLOGY: ORAL (select)</b>		
<p>See Oncology: Oral order form for details of medication that must be obtained through a DVHA enrolled specialty pharmacy provider. A current list of approved providers may be found at <a href="https://dvha.vermont.gov/sites/dvha/files/documents/providers/Pharmacy/Specialty%20Pharmacy%20List.pdf">https://dvha.vermont.gov/sites/dvha/files/documents/providers/Pharmacy/Specialty%20Pharmacy%20List.pdf</a></p>		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<b>OPHTHALMICS</b>		
<b>ANTIBIOTICS</b>		
<p><b><u>QUINOLONES</u></b>            BESIVANCE<sup>®</sup> (besifloxacin) suspension            CILOXAN<sup>®</sup> ointment            CIPROFLOXACIN HCL (compare to Ciloxan<sup>®</sup>) solution            MOXIFLOXACIN 0.5% solution</p> <p><b><u>MACROLIDES</u></b>            ERYTHROMYCIN ointment</p> <p><b><u>AMINOGLYCOSIDES</u></b>  <b><u>SINGLE AGENT</u></b>            AK-TOB (tobramycin) solution            GARAMYCIN<sup>®</sup> (gentamicin) ointment, solution            GENTAK (gentamicin) ointment, solution            GENTAMICIN ointment, solution            TOBRAMYCIN solution (compare to Tobrex<sup>®</sup>)</p> <p><b><u>COMBINATION</u></b>            TOBRADEX<sup>®</sup> (tobramycin/dexamethasone) suspension, ointment            ZYLET<sup>®</sup> (tobramycin/loteprednol) suspension</p> <p><b><u>MISCELLANEOUS</u></b>  <b><u>SINGLE AGENT</u></b>            All products require PA</p> <p><b><u>Combination</u></b>            BACITRACIN ZINC W/POLYMYXIN B</p>	<p>Ciloxan<sup>®</sup> (ciprofloxacin) solution            Gatifloxacin 0.5% solution (compare to Zymaxid<sup>®</sup>)            Levofloxacin 0.5 % solution            Moxeza<sup>®</sup> (moxifloxacin 0.5%) (preservative free) solution            Ocuflor<sup>®</sup> (ofloxacin) solution            Ofloxacin (compare to Ocuflor<sup>®</sup>) solution            Vigamox<sup>®</sup> (moxifloxacin 0.5%) (preservative free) solution            Zymaxid<sup>®</sup> (gatifloxacin 0.5%) solution</p> <p>Asasite<sup>®</sup> (azithromycin) solution            All other brands</p> <p>Tobrex<sup>®</sup> ointment, solution (tobramycin)            Tobramycin w/Dexamethasone (compare to Tobradex<sup>®</sup>) suspension            Tobradex ST<sup>®</sup> (tobramycin/dexamethasone) suspension            Pred-G<sup>®</sup> S.O.P. (gentamicin/prednisolone) ointment            Pred-G<sup>®</sup> (gentamicin/prednisolone) ointment, suspension</p> <p>Bacitracin ointment            Bleph-10<sup>®</sup> (sulfacetamide) solution            Sulfacetamide sodium (compare to Bleph-10<sup>®</sup>) solution            Sulfacetamide sodium ointment</p>	<p><b>Single and Combination Agents (except noted below):</b> 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.)</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ointment NEOMYCIN/BACITRACIN/POLYMYXIN ointment NEOMYCIN/POLYMYXIN W/DEXAMETHASONE (compare to Maxitrol <sup>®</sup> ) ointment, suspension NEOMYCIN/POLYMYXIN/BACITRACIN/ HYDROCORTISONE ointment POLYMYXIN B W/TRIMETHOPRIM (compare to Polytrim <sup>®</sup> ) solution SULFACETAMIDE W/PREDNISOLONE SOD PHOSPHATE solution	Blephamide <sup>®</sup> (sulfacetamide/prednisolone acetate) suspension Blephamide <sup>®</sup> S.O.P. (sulfacetamide/prednisolone acetate) ointment Maxitrol <sup>®</sup> (neomycin/polymyxin/dexamethasone) suspension, ointment Neomycin/Polymyxin W/Gramicidin solution Neomycin/Polymyxin w/Hydrocortisone ointment, suspension Polytrim <sup>®</sup> (polymyxin B/trimethoprim) soln	
<b>ANTI-HISTAMINES</b>		
AZELASTINE (compare to Optivar <sup>®</sup> ) <i>QTY LIMIT:</i> 1 bottle/month KETOTIFEN 0.025 % (e.g. Alaway <sup>®</sup> , Zaditor <sup>®</sup> OTC, others) <i>QTY LIMIT:</i> 1 bottle/month OLOPATADINE 0.1%, 0.2% <i>QTY LIMIT:</i> 1 bottle/month	Bepreve <sup>®</sup> (bepotastine besilate) Epinastine <i>QTY LIMIT:</i> 1 bottle/month Lastacaft <sup>®</sup> (alcaftadine) <i>QTY LIMIT:</i> 1 bottle/month Zerviate <sup>®</sup> (cetirizine 0.24%) <i>QTY LIMIT:</i> 60 vials/30 days	<b>Bepreve, Epinastine:</b> The patient has had a documented side effect, allergy, or treatment failure to a preferred Olopatadine product. <b>Lastacaft:</b> The patient is pregnant, and the diagnosis is allergic conjunctivitis OR The patient has had a documented side effect, allergy, or treatment failure to ketotifen. AND The patient has had a documented side effect, allergy, or treatment failure to a preferred olopatadine product. <b>Zerviate:</b> The patient has had a documented side effect, allergy, or treatment failure to TWO preferred ophthalmic antihistamines.
<b>CORTICOSTEROIDS: TOPICAL</b>		
ALREX <sup>®</sup> (loteprednol) 0.2% suspension DEXAMETHASONE sodium phosphate 0.1% solution DUREZOL <sup>®</sup> (difluprednate) 0.05% emulsion FLAREX <sup>®</sup> (fluorometholone acetate) 0.1% suspension FML Forte <sup>®</sup> (fluorometholone) 0.25% suspension FLUOROMETHOLONE 0.1% suspension FML <sup>®</sup> (fluorometholone) 0.1% ointment LOTEMAX <sup>®</sup> (loteprednol) 0.5% suspension, ointment MAXIDEX <sup>®</sup> (dexamethasone) suspension PRED MILD <sup>®</sup> (prednisolone acetate) 0.12% suspension PREDNISOLONE ACETATE 1% suspension PREDNISOLONE SODIUM PHOSPHATE 1% solution	FML Liquifilm <sup>®</sup> (fluorometholone) 0.1% suspension Inveltys <sup>™</sup> (loteprednol) suspension Lotemax <sup>®</sup> (loteprednol) 0.5% gel Lotemax SM (loteprednol) 0.038% gel drops Loteprednol suspension Pred Forte <sup>®</sup> (prednisolone acetate) 1% suspension  All other brands	<b>Non-preferred agents:</b> 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)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<b>CYSTEAMINE</b>		
All products require PA	<p>Cystadrops® (cysteamine) 0.37% ophthalmic solution  <b>QTY LIMIT: 4 bottles (20 ml)/28 days</b>  <b>Maximum day supply/Rx = 28 days</b></p> <p>Cystaran® (cysteamine) 0.44% ophthalmic solution  <b>QTY LIMIT: 4 bottles (60 ml)/ 28 days</b>  <b>Maximum day supply/RX = 28 days</b></p>	<b>Cystadrops, Cystaran:</b> The indication for use is corneal cystine accumulation in patients with cystinosis.
<b>DRY EYE SYNDROME</b>		
<p><b><u>OCULAR LUBRICANTS</u></b>  ARTIFICIAL TEARS Ointment  ARTIFICIAL TEARS Solution  GENTEAL Solution  GENTEAL P.M. Ointment  LUBRIFRESH P.M. Ointment  REFRESH P.M. Ointment  REFRESH Lacri-lube Ointment  REFRESH PLUS Solution  TEARS NATURALE Solution</p> <p><b><u>IMMUNOMODULATORS</u></b>  RESTASIS® (cyclosporine ophthalmic emulsion)  0.05% dropperette (NDC 00023916330 and  00023916360 are the only preferred NDC's)  <b>QTY LIMIT: 180 vials per 90 days</b></p>	<p>Cequa™ (cyclosporine ophthalmic solution) 0.09%  Restasis® (cyclosporine ophthalmic emulsion) 0.05%  multidose bottle  <b>QTY LIMIT: 1 bottle (5.5ml) per 25 days</b>  Xiidra® (lifitegrast) solution  <b>QTY LIMIT: 60 vials per 30 days</b></p>	<p><b>Cequa, Xiidra:</b> The patient has a diagnosis of Dry Eye Disease AND has a documented side effect, allergy or treatment failure to Restasis.  <b>Restasis Multidose:</b> Both package sizes of the dropperettes must be on a long-term backorder and unavailable from the manufacturer.</p>
<b>GLAUCOMA AGENTS/MIOTICS</b>		
<p><b><u>ALPHA-2 ADRENERGIC SINGLE AGENT</u></b>  ALPHAGAN P® 0.1 %, 0.15 % (brimonidine tartrate)  BRIMONIDINE TARTRATE 0.2 %</p> <p><b><u>COMBINATION</u></b>  COMBIGAN® (brimonidine tartrate/timolol maleate)  SIMBRINZA® (brinzolamide 1% and brimonidine  0.2%) Suspension</p>	<p>Apraclonidine (compare to Iopidine®)  Brimonidine tartrate 0.15 % (compare to Alphagan P®)  Iopidine® (apraclonidine)</p>	<p><b>ALPHA 2 ADRENERGIC AGENTS:</b> 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%.</p> <p><b>BETA BLOCKERS:</b> The patient has had a documented side effect, allergy or treatment failure with at least one preferred ophthalmic beta blocker.</p> <p><b>PROSTAGLANDIN INHIBITORS</b>  <b>Bimatoprost, Vyzulta, Xalatan, Xelpros, Zioptan:</b> The patient has had a documented side effect, allergy or treatment failure with at least 2 preferred</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<p><b><u>BETA BLOCKER</u></b>  CARTEOLOL HCL  LEVOBUNOLOL HCL  TIMOLOL MALEATE (compare to Timoptic®)</p> <p><b><u>PROSTAGLANDIN INHIBITORS</u></b>  LATANOPROST (compare to Xalatan®)  LUMIGAN®(bimatoprost)  TRAVATAN Z® (travoprost) (BAK free)</p> <p><b><u>RHO KINASE INHIBITORS</u></b>  <b><u>SINGLE AGENT</u></b>  RHOPRESSA® (netarsudil)</p> <p><b><u>COMBINATION</u></b>  ROCKLATAN® (netarsudil/latanoprost)</p> <p><b><u>CARBONIC ANHYDRASE INHIBITOR</u></b>  <b><u>SINGLE AGENT</u></b>  AZOPT® (brinzolamide 1%)  DORZOLAMIDE 2 % (compare to Trusopt®)</p> <p><b><u>COMBINATION</u></b>  DORZOLAMIDE w/TIMOLOL (compare to Cosopt®)</p> <p><b><u>MISCELLANEOUS</u></b>  ISOPTO® CARPINE (pilocarpine)  PILOCARPINE HCL  PHOSPHOLINE IODIDE® (echothiophate)</p>	<p>Betaxolol HCl solution  Betoptic S® (betaxolol suspension)  Istalol® (timolol)  Timoptic® (timolol maleate)  Timoptic XE® (timolol maleate gel)  Timolol maleate gel (compare to Timotic XE®)</p> <p>Bimatoprost 0.03% (Lumigan®)  Durysta® (bimatoprost) 10 mcg implant  Vyzulta® (latanoprostene bunod)  Xelpros® (latanoprost) (BAK free)  Zioptan® (tafluprost)</p> <p>Trusopt® (dorzolamide 2 %)</p> <p>Cosopt PF® (dorzolamide w/timolol) (pres-free)</p> <p>Miochol-E® (acetylcholine)</p>	<p>prostaglandin inhibitors.</p> <p><b>Durysta:</b> 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:</p> <ul style="list-style-type: none"> <li>History of prior corneal transplantation or endothelial cell transplants (e.g. Descemet's Stripping Automated Endothelial Keratoplasty)</li> <li>Diagnosis of corneal endothelial dystrophy (e.g. Fuchs' Dystrophy)</li> <li>Absent or ruptured posterior lens capsule</li> </ul> <p>Approval will be limited to a single implant per eye without retreatment.</p> <p><b>CARBONIC ANHYDRASE INHIBITORS</b></p> <p><b>Trusopt:</b> The patient has had a documented intolerance to the generic equivalent product.</p> <p><b>Cosopt PF:</b> The patient has had a documented intolerance to the preservatives in the generic combination product.</p> <p><b>Miscellaneous:</b> 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)</p>
<p><b><u>MAST CELL STABILIZERS</u></b></p> <p>CROMOLYN SODIUM (formerly Crolom®)</p>	<p>Alocril® (nedocromil sodium)  Alomide® (lodoxamide)</p>	<p><b>Criteria for Approval:</b> The patient has had a documented side effect, allergy, or treatment failure with generic cromolyn sodium</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<b>NEUROTROPHIC KERATITIS</b>		
All products require PA	Oxervate™ (cenegermin-bkbj) ophthalmic solution 0.002% <i>QTY LIMIT:</i> 1 vial (1mL) per eye per day Maximum of 8 weeks therapy	<b>Oxervate:</b> 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.
<b>NON-STEROIDAL ANTI-INFLAMMATORY DRUGS (NSAIDs)</b>		
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 <i>QTY LIMIT:</i> 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%) Prolensa® ophthalmic solution (bromfenac 0.07%)	<b>Acuvail:</b> 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. <b>All other non-preferred agents:</b> 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.
<b>OTIC ANTI-INFECTIVES</b>		
<p><b><u>ANTI-INFECTIVE</u></b> <b><u>SINGLE AGENT</u></b> OFLOXACIN 0.3% Otic solution</p> <p><b><u>ANTI-INFECTIVE/CORTICOSTEROID</u></b> <b><u>COMBINATION</u></b> CIPRODEX® (ciprofloxacin 0.3%/dexamethasone 0.1%) otic suspension CIPRO-HC® (ciprofloxacin 0.2%/hydrocortisone 1%) otic suspension NEOMYCIN/POLYMYXIN B SULFATE/HYDROCORTISONE SOLUTION, SUSPENSION</p> <p><b><u>MISCELLANEOUS AGENTS</u></b></p>	<p>Ciprofloxacin 0.2% otic solution <i>QTY LIMIT:</i> 14-unit dose packages/ 7 days Otiprio® (ciprofloxacin 6%) otic suspension</p> <p>Cortisporin-TC® (neomycin/colistin/thonzium/hydrocortisone) Otovel® (ciprofloxacin 0.3%/fluocinolone 0.025%) otic solution <i>QTY LIMIT:</i> 28-unit dose packages/7days</p>	<b>All non-preferred products:</b> The patient has had a documented side effect, allergy, or treatment failure to two preferred products.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ACETIC ACID Otic solution	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.

<https://dvha.vermont.gov/sites/dvha/files/documents/providers/Pharmacy/OTCWebList-12.2.20.pdf>

## PANCREATIC ENZYME PRODUCTS

CREON® DR Capsule ZENPEP® DR Capsule	Pancreaze® DR Capsule Pertzye® DR Capsule Viokace® DR Capsule	<b>Pancreaze, Pertzye, Viokace:</b> 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.
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## PARATHYROID AGENTS

CALCITRIOL (compare to Rocaltrol®) ERGOCALCIFEROL (compare to Drisdol®) PARICALCITOL (compare to Zemplar®) SENSIPAR® (cinacalcet)	Cinacalcet (compare to Sensipar®) Doxercalciferol (compare to Hectoral®) Drisdol® (ergocalciferol) Hectoral® (doxercalciferol) Natpara® (parathyroid hormone) <i>QTY LIMIT: 2 cartridges per 28 days</i> Parsabiv™ (etelcalcetide) Rayaldee® (calcifediol ER) Rocaltrol® (calcitriol) Zemplar® (paricalcitol)	<b>Cinacalcet:</b> The patient must have a documented intolerance to brand Sensipar. <b>Doxercalciferol, Drisdol/Hectoral/Royaldee/Rocaltrol/Zemplar:</b> 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. <b>Natpara:</b> <ul style="list-style-type: none"> <li>▪ Natpara: diagnosis of hypocalcemia secondary to hypoparathyroidism (but NOT acute post-surgical hypoparathyroidism within 6 months of surgery) <b>AND</b></li> <li>▪ Natpara PA form must be completed and clinical and lab documentation supplied <b>AND</b></li> <li>▪ Must be prescribed by an endocrinologist <b>AND</b></li> <li>▪ Must be documented by <b>ALL</b> of the following:               <ul style="list-style-type: none"> <li>○ History of hypoparathyroidism &gt;18 months <b>AND</b></li> <li>○ Biochemical evidence of hypocalcemia <b>AND</b></li> <li>○ 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 <b>AND</b></li> </ul> </li> <li>▪ No history of the following:               <ul style="list-style-type: none"> <li>○ mutation in CaSR gene <b>OR</b></li> </ul> </li> </ul>
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PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		<ul style="list-style-type: none"> <li>○pseudohypoparathyroidism <b>OR</b></li> <li>○a condition with an increased risk of osteosarcoma <b>AND</b></li> <li>▪ Hypocalcemia is not corrected by calcium supplements and preferred active forms of vitamin D alone <b>AND</b></li> <li>▪ Patients must be taking vitamin D metabolite/analog therapy with calcitriol <math>\geq 0.25</math> <math>\mu\text{g}</math> per day <b>OR</b> equivalent <b>AND</b></li> <li>▪ Must be taking supplemental oral calcium treatment <math>\geq 1000</math> mg per day over and above normal dietary calcium intake <b>AND</b></li> <li>▪ Serum calcium must be <math>\geq 7.5</math> mg/dl prior to starting Natpara <b>AND</b></li> <li>▪ Serum thyroid function tests and serum magnesium levels must be within normal limits <b>AND</b></li> <li>▪ Documentation of creatinine clearance <math>&gt; 30</math> mL/min on two separate measurements <b>OR</b> creatinine clearance <math>&gt; 60</math> mL/min <b>AND</b> serum creatinine <math>&lt; 1.5</math> mg/dL</li> </ul> <p><b>Parsabiv:</b> indication is for the treatment of secondary hyperparathyroidism in a patient with Chronic Kidney Disease (CKD) receiving hemodialysis <b>AND</b> the patient has a documented side effect, allergy, or treatment failure with Sensipar. Note: treatment failure is defined as <math>&lt; 30\%</math> reduction from baseline in mean pre-dialysis PTH concentrations.</p>

## PARKINSON'S MEDICATIONS

<p><b><u>DOPAMINE PRECURSOR</u></b>            CARBIDOPA/LEVODOPA (compare to Sinemet®)            CARBIDOPA/LEVODOPA ER (compare to Sinemet® CR)            CARBIDOPA/LEVODOPA ODT</p> <p><b><u>DOPAMINE AGONISTS (ORAL)</u></b>            BROMOCRIPTINE (compare to Parlodel®)            PRAMIPEXOLE (compare to Mirapex®)            ROPINIROLE (compare to Requip®)</p>	<p>Inbrija® (levodopa capsule for inhalation)  <i>QTY LIMIT:</i> 10 caps/day            Rytary® (carbidopa/levodopa ER caps)            Sinemet® (carbidopa/levodopa)            Sinemet CR® (carbidopa/levodopa ER)</p> <p>Mirapex® (pramipexole)            Mirapex ER® (pramipexole ER)  <i>QTY LIMIT:</i> 1 tab/day            Pramipexole ER (compare to Mirapex ER®)  <i>QTY LIMIT:</i> 1 tab/day            Requip® (ropinirole)            Ropinirole XL  <i>QTY LIMIT:</i> 12 mg = 2 tabs/day,            All other strengths = 1 tab/day</p>	<p><b>Inbrija:</b> The patient has a diagnosis of Parkinson's disease with intermittent presence of OFF episodes <b>AND</b> the patient is currently taking Carbidopa/Levodopa <b>AND</b> the patient has had a documented side effect, allergy, or treatment failure with Apokyn®</p> <p><b>Comtan, Sinemet, Sinemet CR, Mirapex, Parlodel, Requip, Stalevo:</b> The patient has had a documented intolerance to the generic product.</p> <p><b>Ongentys:</b> The diagnosis or indication is Parkinson's disease <b>AND</b> the patient has had a documented side effect, allergy, or treatment failure with entacapone.</p> <p><b>Rytary:</b> The patient has a diagnosis of Parkinson's disease, post-encephalitic parkinsonism, or parkinsonism following intoxication from carbon monoxide or manganese <b>AND</b> the prescriber is a neurologist <b>AND</b> the patient is having breakthrough symptoms despite a combination of concurrent IR and ER formulations of carbidopa/levodopa</p> <p><b>Azilect, rasagiline:</b> The diagnosis or indication is Parkinson's disease. <b>AND</b> The patient has had a documented side effect, allergy, or treatment failure with selegiline. <b>AND</b> The dose requested does not exceed 1 mg/day</p> <p><b>Gocovri:</b> diagnosis or indication is for the treatment of dyskinesia in a patient with Parkinson's Disease <b>AND</b> the patient is currently receiving levodopa-based therapy (with or without concomitant dopaminergic medications) <b>AND</b> the patient has a documented side effect, allergy, or treatment failure with</p>
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PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<p><b><u>DOPAMINE AGONISTS (TRANSDERMAL)</u></b> All products require PA</p> <p><b><u>COMT INHIBITORS</u></b> ENTACAPONE (compare to Comtan®)</p> <p><b><u>MAO-B INHIBITORS</u></b> SELEGILINE</p> <p><b><u>ANTICHOLINERGICS</u></b> BENZTROPINE TRIHENXYPHENIDYL</p> <p><b><u>ADENSOSINE RECEPTOR AGONIST</u></b> All products require PA</p> <p><b><u>OTHER</u></b> APOKYN® (apomorphine) AMANTADINE syrup AMANTADINE capsules, tablets (PA required for ≤10-day supply) CARBIDOPA/LEVODOPA/ENTACAPONE (compare to Stalevo®)</p>	<p>Neupro® (rotigotine) transdermal patch <i>QTY LIMIT: 2, 4, 6, and 8 mg = 1 patch/day</i></p> <p>Comtan® (entacapone) Ongentys® (opicapone) Tasmar® (tolcapone) Tolcapone (compare to Tasmar®)</p> <p>Azilect® (rasagiline) <i>QTY LIMIT: 1 mg/day</i> Rasagiline (compare to Azilect®) <i>QTY LIMIT: 1 mg/day</i> Xadago® (safinamide) <i>QTY LIMIT: 1 tab/day</i> Zelapar® (selegiline ODT) <i>QTY LIMIT: 2.5 mg/day</i></p> <p>Nourianz (istradefylline) <i>QTY LIMIT: 1 tab/day</i></p> <p>Gocovri™ (amantadine extended release) <i>QTY LIMIT: 2 tabs/day</i> Kynmobi® (apomorphine) sublingual film Osmolex® ER (amantadine extended-release) <i>QTY LIMIT: 1 tablet/strength/day</i> Stalevo® (carbidopa/levodopa/entacapone)</p>	<p>immediate release amantadine. <b>Note:</b> 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.</p> <p><b>Kynmobi:</b> 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 treatment failure with Apokyn.</p> <p><b>Miramax ER, pramipexole ER, ropinirole XL:</b> 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.</p> <p><b>Neupro:</b> The patient has a medical necessity for a specialty dosage form.</p> <p><b>Nourianz:</b> 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.</p> <p><b>Osmolex ER:</b> patient has not been able to be adherent to the dosing schedule of amantadine immediate release resulting in a significant clinical impact.</p> <p><b>Tasmar, Tolcapone:</b> 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.</p> <p><b>Xadago:</b> 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.</p> <p><b>Zelapar:</b> 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</p> <p><b>Limitations:</b> To prevent the use of amantadine in influenza</p>

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treatment/prophylaxis, days supply < 10 days will require PA.		
<b>PLATELET INHIBITORS</b>		
<p><b><u>AGGREGATION INHIBITORS</u></b></p> <p>BRILINTA<sup>®</sup> (ticagrelor) Tablet  <i>QTY LIMIT: 2 tablets/day</i></p> <p>CILOSTAZOL</p> <p>CLOPIDOGREL 75 mg (compare to Plavix<sup>®</sup>)  PRASUGREL (compare to Effient<sup>®</sup>)</p> <p>TICLOPIDINE (formerly Ticlid<sup>®</sup>)</p> <p><b><u>OTHER</u></b></p> <p>ANAGRELIDE (compare to Agrylin<sup>®</sup>)  ASPIRIN  DIPYRIDAMOLE  <b>DYPYRIDAMOLE/ASPIRIN</b></p>	<p>Effient<sup>®</sup> (prasugrel) Tablet  <i>QTY LIMIT: 1 tablet/day</i></p> <p>Plavix<sup>®</sup> 75 mg (clopidogrel bisulfate)</p> <p>Zontivity<sup>®</sup> (vorapaxar) Tablet  <i>QTY LIMIT: 1 tablet/day</i></p> <p>Agrylin<sup>®</sup> (anagrelide)  Dipyridamole/Aspirin</p>	<p><b>Agrylin, Effient, Plavix:</b> The patient has had a documented intolerance to the generic formulation of the medication.</p> <p><b>Zontivity:</b> 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.</p> <p><b>Limitations:</b> Plavix/clopidogrel 300 mg is not an outpatient dose and is not covered in the pharmacy benefit.</p>
<b>PLATELET STIMULATING AGENTS</b>		
<p><b><u>Preferred After Clinical Criteria Are Met</u></b></p> <p>PROMACTA<sup>®</sup> (eltrombopag)</p>	<p>Doptelet<sup>®</sup> (avatrombopag)  Mulpleta<sup>®</sup> (lusutrombopag)  Nplate<sup>®</sup> (romiplostim)  Tavalisse<sup>™</sup> (fostamatinib disodium hexahydrate)</p>	<p><b>Doptelet:</b>  <i>Indication for use is chronic immune (idiopathic) thrombocytopenic purpura (ITP):</i>  The patient's platelet count is less than 30,000/<math>\mu</math>L (&lt; 30 x 10<sup>9</sup>/L) or the patient is actively bleeding AND The patient has an insufficient response or documented intolerance to corticosteroids, immunoglobulins, or splenectomy AND Promacta.</p> <p><i>Indication for use is thrombocytopenia in a patient with chronic liver disease scheduled to undergo an elective surgical or dental procedure:</i> The patient is at least 18 years of age AND the patient's platelet count is less than 50,000/<math>\mu</math>L (&lt; 50 x 10<sup>9</sup>/L) AND approval will be limited to a maximum of 5 days' supply per procedure</p> <p><b>Mulpleta:</b> 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/<math>\mu</math>L (&lt; 50 x 10<sup>9</sup>/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.</p> <p><b>Nplate:</b> The diagnosis or indication is chronic immune (idiopathic) thrombocytopenic purpura (ITP). AND The patient's platelet count is less than</p>

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		<p>30,000/<math>\mu</math>L (&lt; 30 x 10<sup>9</sup>/L) or the patient is actively bleeding. AND The patient has an insufficient response or documented intolerance to corticosteroids, immunoglobulins, or splenectomy AND Promacta.</p> <p><b>Promacta:</b>  <i>Indication for use is chronic immune thrombocytopenia (ITP):</i> The patient's platelet count is less than 30,000/<math>\mu</math>L (&lt; 30 x 10<sup>9</sup>/L) or the patient is actively bleeding, AND the patient has had an insufficient response or documented intolerance to corticosteroids, immunoglobulins, or splenectomy.  <i>Indication for use is chronic Hepatitis-C associated thrombocytopenia:</i> The patient is at least 18 years of age AND medication is used to initiate or maintain interferon-based therapy.  <i>Indication for use is Severe Aplastic Anemia:</i> patient has had an inadequate response to standard immunosuppressive therapy (e.g. cyclosporine).</p> <p><b>Tavalisse:</b> 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 &lt; 30 x 10<sup>9</sup>/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.). <b>Note:</b> 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<sup>9</sup>/L and/or have a documented decrease in rescue treatment(s) with platelet transfusions.</p>
<b>PSEUDOBULBAR AFFECT AGENTS</b>		
All products require PA	Nuedexta® capsules (dextromethorphan/quinidine) <i>QTY LIMIT:</i> 2 capsules/day	<b>Nuedexta:</b> 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 Liability 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
<b>PROGESTATIONAL AGENTS</b>		
<u><i>Preferred After Clinical Criteria Are Met</i></u> MAKENA® (hydroxyprogesterone caproate)	Hydroxyprogesterone caproate 250 mg/ml vial (intramuscular injection)	<b>Hydroxyprogesterone caproate:</b> Diagnosis or indication for use is adenocarcinoma of the uterus, management of amenorrhea and abnormal bleeding due to hormonal imbalance in the absence of organic pathology (e.g. uterine cancer), testing for

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<p>275 mg/1.1ml auto-injector (subcutaneous injection) <i>QTY LIMIT:</i> 28-day supply</p>		<p>endogenous estrogen production, or production and desquamation of secretory endometrium OR for prophylaxis of preterm labor, the patient must meet criteria outlined for Makena AND the patient must be unable to use Makena. <b>Makena:</b> Patient is 16 years of age or older AND Patient has a history of singleton spontaneous preterm birth AND Patient is having a singleton (single offspring) pregnancy AND Therapy will be started between 16 weeks, 0 days and 20 weeks, 6 days of gestation AND Therapy will be continued until week 37 (through 36 weeks, 6 days) of gestation or delivery, whichever occurs first.</p>
<b>PSORIASIS</b>		
<b>BIOLOGICS:</b> Initial approval is 3 months, renewals are 1 year		
<p><b><i>Preferred After Clinical Criteria Are Met</i></b> <b><u>INJECTABLE</u></b></p> <p>ENBREL® (etanercept) <i>QTY LIMIT:</i> 50 mg = 8 syringes/28 days for the first 3 months; then 4 syringes/28 days 25 mg = 8 syringes/28 days subsequently</p> <p>HUMIRA® (adalimumab) <i>QTY LIMIT:</i> 4 syringes/28 days for one month; 2 syringes/28 days subsequently</p> <p>TALTZ® (ixekizumab) <i>QTY LIMIT:</i> 3 syringes/28 days for the first month, 2 syringes/28 days months 2 and 3 and 1 syringe/28 days subsequently</p> <p><b><u>ORAL</u></b> All products require PA</p>	<p>Avsola® (infliximab-axxq) biosimilar to Remicade® Cimzia® (certolizumab pegol) <i>QTY LIMIT:</i> 1 kit/28 days (starter X 1, then regular)</p> <p>Cosentyx® (secukinumab) Ilumya™ (tildrakizumab-asmn) <i>QTY LIMIT:</i> 2 ml (2 syringes) for the first month then 1 ml (1 syringe)/84 days subsequently</p> <p>Inflectra® (infliximab-dyyb) biosimilar to Remicade® Remicade® (infliximab) Renflexis™ (infliximab-abda) biosimilar to Remicade® Siliq™ (brodalumab) injection <i>QTY LIMIT:</i> 6 ml (4 syringes) for the first month then 3 ml (2 syringes)/28 days subsequently</p> <p>Skyrizi™ (risankizumab-rzaa) <i>QTY LIMIT:</i> 4 syringes for the first month followed by 2 syringes (150 mg) every 12 weeks thereafter</p> <p>Stelara® (ustekinumab) <i>QTY LIMIT:</i> 45 mg (0.5 ml) or 90 mg (1 ml) per dose (90mg dose only permitted if patient weight &gt; 100kg)</p> <p>Tremfya® (guselkumab) <i>QTY LIMIT:</i> 2 syringes/28 days for the first month, then 1 syringe every 56 days thereafter</p> <p>Otezla® tablet (apremilast) <i>QTY LIMIT:</i> Starter Pack = 55 tablets/28 days, 30 mg = 2 tablets/day</p>	<p><b>Clinical Criteria:</b> <b>For all drugs:</b> 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 &gt; 10% of the body surface area (BSA) and/or has involvement of the palms, soles, head and neck, or genitalia and has had a documented side effect, allergy, inadequate treatment response, or treatment failure to at least 2 different categories of therapy [i.e. at least 2 topical agents and at least 1 oral systemic agent, (unless otherwise contraindicated)] from the following categories: Topical agents: emollients, keratolytics, corticosteroids, calcipotriene, tazarotene, etc. Systemic agents: methotrexate, sulfasalazine, azathioprine, cyclosporine, tacrolimus, mycophenolate mofetil, etc. Phototherapy: ultraviolet A and topical psoralens (topical PUVA), ultraviolet A and oral psoralens (systemic PUVA, narrow band ultraviolet B (NUVA), etc.</p> <p><b>Additional Criteria for Taltz:</b> The prescriber must provide evidence of a trial and failure or contraindication to Humira®</p> <p><b>Additional Criteria for Cimzia, Cosentyx, Ilumya, Otezla, Remicade, Renflexis, Siliq, Skyrizi, Stelara, Tremfya:</b> The prescriber must provide a clinically valid reason why both Humira® and Taltz® cannot be used. <b>Note:</b> 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.</p> <p><b>Additional Criteria for Avsola, Inflectra:</b> The prescriber must provide a clinically valid reason why Humira®, Taltz®, and Remicade/Renflexis cannot be used.</p>

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<b>NON-BIOLOGICS</b>		
<p><b><u>ORAL</u></b>  ACTRETIN (compare to Soriatane®) capsules  CYCLOSPORINE (generic)  METHOTREXATE (generic)</p> <p><b><u>TOPICAL</u></b>  CALCIPOTRIENE Ointment, Solution  DOVONEX® cream (calcipotriene)</p>	<p>Methoxsalen (compare to Oxsoralen-Ultra®)  Oxsoralen-Ultra® (methoxsalen)  Soriatane® (acitretin) capsules</p> <p>Calcitriol (compare to Vectical®) Ointment  <i>QTY LIMIT: 200 g (2 tubes)/week</i>  Calcipotriene Cream (compare to Dovonex®)  Calcipotriene/betamethasone ointment (compare to Taclonex®)  <i>QTY LIMIT: Initial fill = 60 grams</i>  Duobrii™ (halobetasol propionate/tazarotene) lotion  Enstilar® (calcipotriene/betamethasone) foam  Sorilux® (calcipotriene) foam  Taclonex® (calcipotriene/betamethasone ointment/scalp suspension)  <i>QTY LIMIT: Initial fill = 60 grams</i>  Tazarotene Cream  Vectical® Ointment (calcitriol)  <i>QTY LIMIT: 200 g (2 tubes)/week</i></p>	<p><b>Soriatane:</b> The patient has a documented intolerance to the generic equivalent.</p> <p><b>Calcipotriene cream:</b> The patient has a documented intolerance to Brand Dovonex cream.</p> <p><b>Duobrii lotion:</b> the patient has had an inadequate response to at least 2 different preferred high or very high potency corticosteroids AND tazarotene cream.</p> <p><b>Enstilar, Taclonex or Calcipotriene/betamethasone dipropionate Ointment or Scalp Suspension:</b> 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.</p> <p><b>Tazarotene, Vectical Ointment, Calcitriol Ointment:</b> The patient has a diagnosis of mild-to-moderate plaque psoriasis AND The patient has demonstrated inadequate response, adverse reaction or contraindication to calcipotriene.</p> <p><b>Sorilux:</b> The patient ≥ 18 years of age AND The patient has a diagnosis of plaque psoriasis AND The patient has demonstrated inadequate response or intolerance to other dosage forms of calcipotriene (brand or generic)</p> <p><b>Methoxsalen, Oxsoralen Ultra:</b> The patient has a documented diagnosis of moderate to severe psoriasis affecting &gt; 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.</p> <p><b>Limitations:</b> Kits with non-drug or combinations of 2 drug products are not covered.</p>
<b>PULMONARY AGENTS</b>		
<b>ANTICOLINERGICS: INHALED</b>		
<p><b><u>SHORT-ACTING BRONCHODILATORS</u></b>  ATROVENT HFA® (ipratropium)  COMBIVENT® RESPIMAT (ipratropium/albuterol)  <i>QTY LIMIT: 3 inhalers (12 grams)/90 days</i>  IPRATROPIUM NEBULIZER SOLN  IPRATROPIUM/ALBUTEROL NEBULIZER SOLN</p> <p><b><u>LONG-ACTING BRONCHODILATORS (LAMA)</u></b>  SPIRIVA® HANDIHALER (tiotropium)</p>	<p>Incruse Ellipta® (umeclidinium bromide)</p>	<p><b>Incruse Ellipta/ Tudorza:</b> The patient has had documented side effect, allergy or treatment failure Spiriva.</p> <p><b>Duaklir Pressiar, Stiolto Respimat:</b> The patient has a documented side effect, allergy, or treatment failure to TWO preferred LAMA/LABA combinations.</p> <p><b>Lonhala Magnair, Yupelri:</b> 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.</p> <p><b>Breztri:</b> 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</p>

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<p><i>QTY LIMIT:</i> 1 capsule/day SPIRIVA® RESPIMAT (tiotropium) <i>QTY LIMIT:</i> 3 inhalers/90 days</p> <p><b><u>COMBINATION LONG-ACTING BRONCHODILATORS (LAMA &amp; LABA)</u></b> ANORO® ELLIPTA (umeclidinium/vilanterol) <i>QTY LIMIT:</i> 3 inhalers (180 blisters)/90 days BEVESPI AEROSPHERE® (glycopyrrolate/formoterol) <i>QTY LIMIT:</i> 3 inhalers/90 days</p> <p><b><u>LAMA/LABA/ICS COMBINATION</u></b> All products require PA</p>	<p><i>QTY LIMIT:</i> 1 inhaler/30 days Lonhala® Magnair (glycopyrrolate) inhalation solution <i>QTY LIMIT:</i> 60 vials/30 days Tudorza® Pressair® (aclidinium bromide) <i>QTY LIMIT:</i> 3 inhalers/90 days Yupelri™ (revefenacin) inhalation solution <i>QTY LIMIT:</i> 300 vials/30 days</p> <p>Duaklir® Pressair (aclidinium bromide/ formoterol fumarate) <i>QTY LIMIT:</i> 3 inhalers/90 days Stiolto® Respimat (tiotropium/olodaterol) <i>QTY LIMIT:</i> 3 inhalers/90 days</p> <p>Breztri® Aerosphere (budesonide/glycopyrrolate/formoterol fumarate) <i>QTY LIMIT:</i> 1 inhaler (120 blisters)/30 days Trelegy® Ellipta (fluticasone/umeclidinium/vilanterol) <i>QTY LIMIT:</i> 1 inhaler (60 blisters)/30 days</p>	<p>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. <b>Trelegy Ellipta:</b> 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.</p>
<b>ANTI-HISTAMINES: INTRANASAL</b>		
<p>AZELASTINE 0.1% Nasal Spray <i>QTY LIMIT:</i> 1 bottle (30 ml)/25 days</p> <p><b><u>COMBO WITH CORTICOSTEROID</u></b> DYMISTA® (azelastine/fluticasone) Nasal Spray <i>QTY LIMIT:</i> 1 bottle (23 gm)/30 days</p>	<p><b><u>SINGLE AGENT</u></b> Azelastine 0.15 % Nasal Spray <i>QTY LIMIT:</i> 1 bottle (30 ml)/25 days Olopatadine 0.6% (compare to Patanase®) Nasal Spray <i>QTY LIMIT:</i> 1 bottle (31 gm)/30 days Patanase® (olopatadine 0.6%) Nasal Spray <i>QTY LIMIT:</i> 1 bottle (31 gm)/30 days</p> <p>Azelastine/fluticasone (compare to Dymista®) Nasal Spray <i>QTY LIMIT:</i> 1 bottle (23 gm)/30 days</p>	<p><b>Azelastine/Fluticasone:</b> The patient has a documented intolerance to brand Dymista. <b>Azelastine 0.15%, Olopatadine, Patanase:</b> The patient has a documented side effect, allergy, or treatment failure to Azelastine 0.1%</p>
<b>ANTI-HISTAMINES: 1<sup>ST</sup> GENERATION</b>		
<p>All generic antihistamines All generic antihistamine/decongestant combinations</p>	<p>All brand antihistamines (example: Benadryl®) All brand antihistamine/decongestant combinations (example: Deconamine SR®, Rynatan®, Ryna-12®)</p>	<p><b>CRITERIA FOR APPROVAL:</b> The prescriber must provide a clinically valid reason for the use of the requested medication including reasons why any of the generically available products would not be a suitable alternative.</p>

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<b>ANTI-HISTAMINES: 2<sup>ND</sup> GENERATION</b>		
<p><b><u>SINGLE AGENT TABLET</u></b>            CETIRIZINE OTC 5 mg, 10 mg tablets            LEVOCETIRIZINE 5mg tablets            LORATADINE</p> <p><b><u>COMBINATION WITH PSEUDOEPHEDRINE</u></b>            CETIRIZINE/PSEUDOEPHEDRINE SR 12hr 5 mg/120 mg            LORATADINE/PSEUDOEPHEDRINE SR 12hr 5 mg/120 mg            LORATADINE/PSEUDOEPHEDRINE SR 24hr 10 mg/240 mg</p> <p><b><u>SINGLE AGENT ORAL LIQUID</u></b>            CETIRIZINE syrup            LORATADINE syrup</p> <p><b><u>CHEWABLE/ORALLY DISINTEGRATING TABLET</u></b>            LORATADINE rapidly disintegrating tablet (RDT) 10 mg</p>	<p>Clarinetex<sup>®</sup> (desloratadine) 5 mg tablet            Desloratadine (compare to Clarinetex<sup>®</sup>) 5 mg tablet            Fexofenadine tablets</p> <p>All other brands</p> <p>Clarinetex-D<sup>®</sup> 12 hr (desloratadine/pseudoephedrine 2.5 mg/120 mg)</p> <p>Fexofenadine (compare to Allegra<sup>®</sup>) suspension            Levocetirizine Solution</p> <p>Cetirizine OTC Chewable Tablets 5 mg, 10 mg            Desloratadine ODT (compare to Clarinetex Reditabs<sup>®</sup>) 2.5 mg, 5 mg</p> <p>All other brands</p>	<p><b>FEXOFENADINE TABLETS, CLARINEX TABLETS, DESLORATADINE TABLETS:</b> The patient has had a documented side effect, allergy, or treatment failure to loratadine AND cetirizine AND If they request is for Clarinetex, the patient must also have a documented intolerance to the generic equivalent tablets.</p> <p><b>CETIRIZINE CHEWABLE TABLETS, DESLORATADINE ODT:</b> The patient has had a documented side effect, allergy, or treatment failure to loratadine (OTC) rapidly disintegrating tablets and a preferred oral liquid.</p> <p><b>FEXOFENADINE SUSPENSION, LEVOCETIRIZINE SOLUTION:</b> the patient has had a documented side effect, allergy, or treatment failure to loratadine syrup AND cetirizine syrup.</p> <p><b>CLARINEX-D:</b> The patient has had a documented side effect, allergy, or treatment failure to loratadine-D and cetirizine-D.</p> <p><b>LIMITATIONS:</b> Many Allegra<sup>®</sup> and Zyrtec<sup>®</sup> brand products as well as Claritin capsules are not covered as no Federal Rebate is offered. Fexofenadine/pseudoephedrine combination products (brand and generic) are not covered – individual components may be prescribed separately.</p>
<b>BETA-ADRENERGIC AGENTS</b>		
<p><b><u>METERED-DOSE INHALERS (SHORT-ACTING)</u></b>            PROAIR<sup>®</sup> HFA (albuterol)            PROAIR<sup>®</sup> Respiclick (albuterol)            VENTOLIN<sup>®</sup> HFA (albuterol)</p> <p><b><u>METERED-DOSE INHALERS (LONG-ACTING)</u></b></p>	<p>Albuterol HFA (compare to Proventil<sup>®</sup> HFA, ProAir<sup>®</sup> HFA, Ventolin<sup>®</sup> HFA)            Levalbuterol Aerosol (compare to Xopenex<sup>®</sup> HFA)            ProAir<sup>®</sup> Digihaler (albuterol)            Proventil<sup>®</sup> HFA (albuterol)            Xopenex<sup>®</sup> HFA (levalbuterol)</p>	<p><b>Albuterol HFA, Levalbuterol (aerosol), Proventil HFA, Xopenex HFA:</b> patient has a documented side effect, allergy, or treatment failure to two preferred short acting metered dose inhalers. AND for approval of levalbuterol aerosol, the patient must have a documented intolerance to brand Xopenex HFA.</p> <p><b>ProAir Digihaler:</b> Preferred albuterol metered dose inhalers and Xopenex HFA are on a long-term backorder and unavailable from the manufacturer</p> <p><b>Serevent:</b> 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.</p> <p><b>Striverdi:</b> The patient has a diagnosis of COPD (not FDA approved for asthma).</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<p><u><b>Preferred After Clinical Criteria Are Met</b></u> SEREVENT<sup>®</sup> DISKUS (salmeterol xinafoate) <i>QTY LIMIT:</i> 1 inhaler (60 blisters)/30 days</p> <p><u><b>NEBULIZER SOLUTIONS (SHORT-ACTING)</b></u> ALBUTEROL neb solution (all strengths) LEVALBUTEROL neb solution (age ≤ 12 years)</p> <p><u><b>NEBULIZER SOLUTIONS (LONG-ACTING)</b></u> All products require PA</p> <p><u><b>TABLETS/SYRUP (SHORT-ACTING)</b></u> ALBUTEROL tablets/syrup</p> <p><u><b>TABLETS (LONG-ACTING)</b></u> ALBUTEROL ER tablets</p>	<p>Striverdi Respimat<sup>®</sup> (olodaterol)</p> <p>Levalbuterol neb solution (compare to Xopenex<sup>®</sup>) (age &gt; 12 years) Xopenex<sup>®</sup> neb solution (all ages)</p> <p>Brovana<sup>®</sup> (arformoterol) <i>QTY LIMIT:</i> 2 vials/day Perforomist<sup>®</sup> (formoterol) <i>QTY LIMIT:</i> 2 vials/day</p> <p>Metaproterenol tablets/syrup Terbutaline tablets</p>	<p>AND The patient has a documented side effect, allergy, or treatment failure to Serevent.</p> <p><b>Levalbuterol, Xopenex nebulizer solution (age &gt; 12 years):</b> The patient must have had a documented side effect, allergy, or treatment failure to albuterol nebulizer. AND for approval of brand Xopenex, the patient must have had a documented intolerance to the generic.</p> <p><b>Xopenex (age &lt;12 years):</b> The patient must have a documented intolerance to generic levalbuterol nebulizer solution</p> <p><b>Brovana or Perforomist Nebulizer Solution:</b> 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</p> <p><b>Metaproterenol tablets/syrup:</b> The patient has had a documented side effect, allergy or treatment failure with generic albuterol tablets/syrup.</p> <p><b>Terbutaline tablets:</b> The medication is not being prescribed for the prevention/treatment of preterm labor.</p>
<b>CORTICOSTEROIDS/COMBINATIONS: INHALED</b>		
<p><u><b>METERED DOSE INHALERS (SINGLE AGENT)</b></u> ASMANEX<sup>®</sup> (mometasone furoate) <i>QTY LIMIT:</i> 3 inhalers/90 days FLOVENT<sup>®</sup> DISKUS (fluticasone propionate) <i>QTY LIMIT:</i> 3 inhalers/90 days FLOVENT<sup>®</sup> HFA (fluticasone propionate) <i>QTY LIMIT:</i> 3 inhalers (36 gm)/90 days PULMICORT FLEXHALER<sup>®</sup> (budesonide) <i>QTY LIMIT:</i> 6 inhalers/90 days QVAR<sup>®</sup> REDIHALER™ 40mcg/inh <i>QTY LIMIT:</i> 2 inhalers (21.2 gm)/90 days QVAR<sup>®</sup> REDIHALER™ 80mcg/inh <i>QTY LIMIT:</i> 3 inhalers (31.8 gm)/90 days</p> <p><u><b>METERED DOSE INHALERS (COMBINATION PRODUCT)</b></u></p>	<p>Aerospan<sup>®</sup> (flunisolide HFA) <i>QTY LIMIT:</i> 6 inhalers (53.4 gm)/90 days Armonair<sup>®</sup> Digihaler (fluticasone propionate) <i>QTY LIMIT =</i> 3 inhalers/90 days Alvesco<sup>®</sup> (ciclesonide) <i>QTY LIMIT:</i> 80 mcg = 3 inhalers (18.3 gm)/90 days 160 mcg = 3 inhalers (36.6 gm)/90 days Arnuity Ellipta 100 or 200 mcg/inh (fluticasone furoate) <i>QTY LIMIT:</i> 90 blisters/90 days Asmanex<sup>®</sup> (mometasone furoate) HFA <i>QTY LIMIT:</i> 3 inhalers (39 gm)/90 days</p>	<p><b>Metered-dose inhalers (single agent):</b> 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.</p> <p><b>AirDuo Digihaler, AirDuo Resplick, Breo Ellipta, Fluticasone/Salmeterol (non-authorized generics):</b> The patient has had a documented side effect, allergy, or treatment failure to any 2 of the following: Advair HFA, Advair Diskus, Dulera, or Symbicort.</p> <p><b>Budesonide/formoterol:</b> the patient has a documented intolerance to brand Symbicort.</p> <p><b>Budesonide Inh Suspension:</b> The patient requires a nebulizer formulation AND if the dose is 1mg, the patient must be unable to use two 0.5 mg vials</p> <p><b>Fluticasone/salmeterol powder (authorized generic), Wixela Inhub:</b> A clinically compelling reason must be provided detailing why the patient is unable to use Advair HFA or Advair Diskus.</p> <p><b>Pulmicort Respules:</b> The patient requires a nebulizer formulation AND if the dose is 1 mg, the patient must be unable to use two 0.5 mg vials AND the</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<p>ADVAIR® DISKUS (fluticasone/salmeterol) <i>QTY LIMIT: 3 inhalers/90 days</i></p> <p>ADVAIR® HFA (fluticasone/salmeterol) <i>QTY LIMIT: 3 inhalers (36 gm)/90 days</i></p> <p>DULERA® (mometasone/formoterol) <i>QTY LIMIT: 3 inhalers (39 gm)/90 days</i></p> <p>SYMBICORT® (budesonide/formoterol) <i>QTY LIMIT: 9 inhalers (91.8gm)/90 days</i></p> <p><b><u>NEBULIZER SOLUTIONS</u></b> BUDESONIDE INH SUSPENSION 0.25mg, 0.5mg (Age ≤ 12 yrs)</p>	<p>AirDuo® Digihaler (fluticasone/salmeterol) <i>QTY LIMIT: 3 inhalers/90 days</i></p> <p>AirDuo Respiclick® (fluticasone/salmeterol) <i>QTY LIMIT: 3 inhalers/90 days</i></p> <p>Breo Ellipta® (fluticasone furoate/vilanterol) <i>QTY LIMIT: 3 inhalers (180 blisters) 90 days</i></p> <p>Budesonide/formoterol (compare to Symbicort®) <i>QTY LIMIT: 9 inhalers (91.8gm)/90 days</i></p> <p>Fluticasone/salmeterol (compare to AirDuo Respiclick®) <i>QTY LIMIT: 3 inhalers/90 days</i></p> <p>Fluticasone/salmeterol inhalation Powder (compare to Advair® Diskus) <i>QTY LIMIT: 3 inhalers/90 days</i></p> <p>Wixela™ Inhub™ (fluticasone/salmeterol inhalation powder) (compare to Advair® Diskus) <i>QTY LIMIT: 3 inhalers/90 days</i></p> <p>Budesonide Inh Suspension 1mg (all ages), 0.25mg and 0.5mg (age &gt;12 years) Pulmicort Respules® (budesonide)</p>	<p>patient has a documented intolerance to the generic.</p>
<b>CORTICOSTEROIDS: INTRANASAL</b>		
<b><u>SINGLE AGENT</u></b>		
<p>BUDESONIDE <i>QTY LIMIT: 1 inhaler (8.43 ml)/30 days</i></p> <p>FLUTICASONE PROPIONATE <i>QTY LIMIT: 1 inhaler (16 gm)/30 days</i></p> <p>OMNARIS® (ciclesonide) <i>QTY LIMIT: 1 inhaler (12.5 gm)/30 days</i></p> <p>TRIAMCINOLONE <i>QTY LIMIT: 1 inhaler (16.9 ml)/30 days</i></p> <p>ZETONNA® (ciclesonide) <i>QTY LIMIT: 1 inhaler (6.1 gm)/30 days</i></p>	<p>Beconase AQ® (beclomethasone) <i>QTY LIMIT: 2 inhalers (50 gm)/30 days</i></p> <p>Flunisolide 25 mcg/spray <i>QTY LIMIT: 2 inhalers (50 ml)/30 days</i></p> <p>Mometasone (compare to Nasonex®) <i>QTY LIMIT: 1 inhaler (17 gm)/30 days</i></p> <p>Nasonex® (mometasone) <i>QTY LIMIT: 1 inhaler (17 gm)/30 days</i></p> <p>QNASL® (beclomethasone dipropionate) HFA <i>QTY LIMIT: 1 inhaler (10.6 gm)/30 days</i></p> <p>Xhance™ (fluticasone propionate) <i>QTY LIMIT: 1 inhaler (16 ml)/30 days</i></p>	<p><b>Beconase AQ, Flunisolide 25 mcg/spray, Nasonex, Mometasone, QNASL:</b> 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.</p> <p><b>Xhance:</b> The patient has had a documented side effect, allergy, or treatment failure of three preferred nasal glucocorticoids, one of which must be fluticasone.</p> <p><b>Limitations:</b> Nasacort Allergy OTC and Flonase are not covered as no Federal Rebate is offered.</p>
<b>LEUKOTRIENE MODIFIERS</b>		
<p><b><u>Preferred After Age Criteria Are Met</u></b> MONTELUKAST SODIUM (compare to Singulair®) tablets, 10mg for ages ≥ 15</p>	<p>Accolate® (zafirlukast) <i>QTY LIMIT: 2 tablets/day</i></p>	<p><b>Montelukast:</b> Clinical rationale must be provided for prescribing a dose and formulation that differs from age recommendations AND If the request is for</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<p>MONTELUKAST SODIUM (compare to Singulair®) chews, 4 mg for ages 2-5, 5 mg for age 6-14</p> <p>MONTELUKAST SODIUM (compare to Singulair®) granules, ages 6 months-23 months</p>	<p>Singulair® (montelukast sodium) tablets, chew tabs, granules  <i>QTY LIMIT</i>: 1 tablet or packet per day</p> <p>Zafirlukast (compare to Accolate®)  Zileuton ER (compare to Zflo CR®)  <i>QTY LIMIT</i>: 4 tablets/day</p> <p>Zyflo (zileuton)  <i>QTY LIMIT</i>: 4 tablets/day</p>	<p>brand Singulair, the patient has a documented intolerance to the generic equivalent montelukast preparation.</p> <p><b>Zafirlukast, Accolate:</b> 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.</p> <p><b>Zileuton ER, Zflo:</b> 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</p>
<b>PHOSPHODIESTERASE-4 (PDE-4) INHIBITORS</b>		
	<p>Daliresp® tablet (roflumilast)  <i>QTY LIMIT</i>: 1 tablet/day</p> <p><b>* Maximum days' supply per fill = 30 *</b></p>	<p><b>Daliresp:</b> 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.</p>
<b>SYNAGIS</b>		
	<p>SYNAGIS® (palivizumab)  <i>QTY LIMIT</i>: 50 mg = 1 vial/month, 100 mg = 2 vials/month</p>	<p><b>CRITERIA FOR APPROVAL:</b></p> <ul style="list-style-type: none"> <li>• Infants born at 28 weeks of gestation or earlier (i.e., ≤ 28 weeks, 6 days) and under twelve months of age at the start of the RSV season (maximum 5 doses).</li> <li>• 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 &gt;21% oxygen for at least the first 28 days after birth (maximum 5 doses).</li> <li>• Children under 24 months of age with chronic lung disease of prematurity defined as born at 31 weeks, 6 days or less who required &gt;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).</li> <li>• 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</li> </ul>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		<p>procedures, Moderate to severe pulmonary hypertension, Cyanotic heart disease and recommended for Synagis therapy by Pediatric Cardiologist</p> <ul style="list-style-type: none"> <li>• 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</li> <li>• Infants and children less than 24 months of age who will undergo a heart transplant during the RSV season</li> <li>• 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).</li> </ul> <p><b>EXCLUDED FROM APPROVAL:</b></p> <ul style="list-style-type: none"> <li>• Infants and children with hemodynamically insignificant heart disease.</li> <li>• Infants with cardiac lesions adequately corrected by surgery, unless they continue to require medication for congestive heart failure.</li> <li>• Infants with mild cardiomyopathy who are not receiving medical therapy.</li> <li>• Breakthrough hospitalization for RSV disease (Synagis therapy should be discontinued for the season once hospitalization for RSV has occurred).</li> <li>• Infants and children with Down syndrome unless other indications above are present.</li> <li>• Infants and children with cystic fibrosis unless other specific conditions are present</li> </ul> <p>This drug must be obtained and billed through a DVHA enrolled specialty pharmacy and processed through the DVHA POS prescription processing system using NDC values. Under no circumstances will claims processed through the medical benefit be accepted.</p>

### PULMONARY ARTERIAL HYPERTENSION MEDICATIONS

<p><b><u>ENDOTHELIN RECEPTOR ANTAGONISTS</u></b>            LETAIRIS® (ambrisentan) Tablet  <i>QTY LIMIT:</i> 1 tablet/day            TRACLEER® (bosentan) tablet (62.5 mg, 125 mg)  <i>QTY LIMIT:</i> 2 tablets/day</p>	<p>Ambrisentan (compare to Letairis®)  <i>QTY LIMIT:</i> 1 tablet/day            Bosentan (compare to Tracleer)  <i>QTY LIMIT:</i> 2 tablets/day</p>	<p><b>Adempas:</b> 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</p>
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PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<p><b><u>PROSTACYCLIN AGONISTS</u></b> <b><u>INJECTION</u></b> EPOPROSTENOL (compare to Flolan®) REMODULIN® (treprostinil sodium injection) VELETRI® (epoprostinil)</p> <p><b><u>INHALATION</u></b> TYVASO® (treprostinil inhalation solution) VENTAVIS® (iloprost inhalation solution)</p> <p><b><u>ORAL</u></b> ORENITRAM® (treprostinil) ER Tablet</p> <p><b><u>sGC STIMULATOR</u></b> All products require PA</p> <p><b>**Maximum days supply for all drugs is 30 days**</b></p>	<p>Opsumit® (macitentan) Tablet <i>QTY LIMIT: 1 tablet/day</i></p> <p>Tracleer® tablets for oral suspension (32 mg)</p> <p>Flolan® (epoprostenol) Treprostinil sodium injection (compare to Remodulin®)</p> <p>Upravi® (selexipag) tablets <i>QTY LIMIT: 200 mcg = 140 tablets/30 days for the first 2 months, then 2 tablets/day thereafter</i> All other strengths = 2 tablets/day</p> <p>Adempas® (riociguat) Tablets <i>QTY LIMIT: 3 tablets/day</i></p>	<p>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</p> <p><b>Ambrisentan, Bosentan:</b> patient has a documented intolerance to the brand name equivalent</p> <p><b>Tracleer tablets for oral suspension:</b> Patient has a diagnosis of PAH with NYHA Functional Class II or III AND patient is ≤ 12 years of age and &lt;40kg.</p> <p><b>Bosentan:</b> Patient has a documented intolerance to Tracleer.</p> <p><b>Flolan:</b> Clinical diagnosis of pulmonary hypertension AND The patient has had a documented intolerance to the generic epoprostenol.</p> <p><b>Opsumit:</b> 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 ambrisentan.</p> <p><b>Treprostinil:</b> Patient has a diagnosis of pulmonary arterial hypertension AND The patient has had a documented intolerance to the brand Remodulin.</p> <p><b>Upravi:</b> 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, one of which must be Orenitram</p>
<p><b>PHOSPHODIESTERASE-5 (PDE-5) INHIBITORS</b> 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.</p>		
<p><b><u>Preferred After Clinical Criteria Are Met</u></b> SILDENAFIL CITRATE (compare to Revatio®) tablet <i>QTY LIMIT: 3 tablets/day</i> TADALAFIL (compare to Adcirca®) <i>QTY LIMIT: 2 tablets/day</i></p>	<p>Adcirca® (tadalafil) <i>QTY LIMIT: 2 tablets/day</i> Revatio® (sildenafil) tabs <i>QTY LIMIT: 3 tablets/day</i> Revatio® (sildenafil citrate) suspension Revatio® (sildenafil citrate) vial <i>QTY LIMIT: 3 vials/day</i> Maximum 14-day supply per fill</p>	<p><b>Sildenafil, tadalafil:</b> Clinical Diagnosis of Pulmonary Hypertension <b>Adcirca (tadalafil) 20 mg, Revatio (sildenafil citrate) 20 mg:</b> Clinical diagnosis of pulmonary hypertension AND No concomitant use of organic nitrate-containing products AND patient has a documented intolerance to the generic equivalent.</p> <p><b>Revatio Suspension:</b> 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.</p> <p><b>Revatio IV:</b> Clinical diagnosis of pulmonary hypertension AND No concomitant use of organic nitrate-containing products AND The patient has a requirement</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
for an injectable dosage form. AND Arrangements have been made for IV bolus administration outside of an inpatient hospital setting.		
<b>RENAL DISEASE: PHOSPHATE BINDERS</b>		
<p>CALCIUM ACETATE (compare to Phos Lo®) capsule  CALCIUM ACETATE tablet  SEVELAMER CARBONATE (compare to Renvela®) tablets</p> <p><b><u>ORAL SOLUTIONS</u></b>  PHOSLYRA® (calcium acetate) oral solution</p>	<p>Auryxia® (ferric citrate)  <i>QTY LIMIT: 12/day</i>  Fosrenol® (lanthanum carbonate)  Lanthanum carbonate (compare to Fosrenol)  Renagel® (sevelamer)  Renvela® (sevelamer carbonate) Oral Suspension Packet  <i>QTY LIMIT: 0.8 g = 2 packs/day</i>  Renvela® (sevelamer carbonate) tablets  Sevelamer carbonate Oral Suspension Packet (compare to Renvela®)  <i>QTY LIMIT: 0.8 g = 2 packs/day</i>  Sevelamer hydrochloride (compare to Renagel®)  Velphoro® (sucroferric oxyhydroxide) Chew Tablet</p>	<p><b>Renvela Oral Suspension Packet, Sevelamer Packet:</b> The patient has a requirement for a liquid dosage form.  <b>Auryxia, lanthanum carbonate, Renagel, Renvela tablets, sevelamer hydrochloride tablets, Velphoro Chew Tablet:</b> The patient must have a documented side effect, allergy, or inadequate response to one preferred phosphate binder.</p>
<b>RESTLESS LEG SYNDROME MEDICATIONS</b>		
<p><b><u>DOPAMINE AGONISTS (ORAL)</u></b>  PRAMIPEXOLE (compare to Mirapex®)  ROPINIROLE (compare to Requip®)</p> <p><b><u>DOPAMINE AGONISTS (TRANSDERMAL)</u></b>  All products require PA</p> <p><b><u>GAMMA-AMINO BUTYRIC ACID ANALOG</u></b>  GABAPENTIN IR</p>	<p>Mirapex® (pramipexole)  Requip® (ropinirole)</p> <p>Neupro® (rotigotine) transdermal patch  <i>QTY LIMIT: 1, 2, and 3 mg ONLY = 1 patch/day</i></p> <p>Horizant® (gabapentin enacarbil) ER Tablet  <i>QTY LIMIT: 1 tablet/day</i></p>	<p><b>Mirapex, Requip:</b> The patient has had a documented intolerance to the generic product.  <b>Neupro:</b> The patient has a medical necessity for a specialty dosage form.  <b>Horizant:</b> 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 (pramipexole IR, ropinirole IR, Neupro) AND gabapentin IR. <b>Limitations:</b> Requests for Mirapex ER and Requip XL will not be approved for Restless Leg Syndrome (RLS).</p>
<b>RHEUMATOID, JUVENILE &amp; PSORIATIC ARTHRITIS: IMMUNOMODULATORS</b>		
<p><b><u>Preferred After Clinical Criteria Are Met</u></b>  <b><u>INJECTABLE</u></b>  ENBREL® (etanercept)  <i>QTY LIMIT: 50 mg = 4 syringes/28 days, 25 mg = 8 syringes/28 days</i></p>	<p>Actemra® (tocilizumab) Intravenous Infusion  <i>QTY LIMIT: 80 mg vial = 4 vials/28 days, 200 mg vial = 3 vials/28 days, 400 mg vial = 2 vials/28 days</i></p>	<p><b>Clinical Criteria for all drugs:</b> 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</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<p>HUMIRA® (adalimumab) <i>QTY LIMIT:</i> 4 syringes/28 days</p> <p>TALTZ® (ixekizumab) <i>QTY LIMIT:</i> 80 mg prefilled syringe or autoinjector = 2/28 days for the first month and 1/28 days subsequently</p> <p><b>ORAL</b></p> <p>XELJANZ® (tofacitinib) 5 mg tablet <i>QTY LIMIT:</i> 2 tablets/day Maximum 30 days supply</p> <p><b>Note:</b> 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.</p>	<p>Actemra® (tocilizumab) Subcutaneous <i>QTY LIMIT:</i> 4 prefilled syringes (3.6ml)/28 days</p> <p>Avsola® (infliximab-axxq) biosimilar to Remicade® Cimzia® (certolizumab pegol) <i>QTY LIMIT:</i> 1 kit/28 days</p> <p>Cosentyx® (secukinumab) Inflectra® (Infliximab-dyyb) biosimilar to Remicade® Kevzara® (sarilumab) <i>QTY LIMIT:</i> 2 syringes/28 days</p> <p>Kineret® (anakinra) <i>QTY LIMIT:</i> 1 syringe/day</p> <p>Ilaris® (canakinumab) Orencia® (abatacept) Subcutaneous Injection <i>QTY LIMIT:</i> 4 syringes/28 days</p> <p>Orencia® (abatacept) Intravenous Infusion Remicade® (infliximab) Renflexis™ (Infliximab-abda) biosimilar to Remicade® Simponi® (golimumab) Subcutaneous <i>QTY LIMIT:</i> 50 mg = 1 prefilled syringe or autoinjector/28 days</p> <p>Simponi Aria® (golimumab) 50 mg/4 ml Vial for Intravenous Infusion Stelara® (ustekinumab) <i>QTY LIMIT:</i> 45 mg (0.5 ml) or 90 mg (1 ml) per dose (90 mg dose only permitted for pt weight &gt; 100 kg)</p> <p>Olumiant® (baricitinib) tablets <i>QTY LIMIT:</i> 1 tablet/day Maximum 30 days supply</p> <p>Otezla® tablet (apremilast) <i>QTY LIMIT:</i> Starter Pack = 55 tablets/28 days, 30 mg = 2 tablets/day Maximum 30 days supply</p> <p>Rinvoq® (upadactinib) extended release tablet <i>QTY LIMIT:</i> 1 tablet/day Maximum 30 days supply</p> <p>Xeljanz® XR (tofacitinib) tablet <i>QTY LIMIT:</i> 1 tablet/day Maximum 30 days supply</p>	<p>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</p> <p><b>Taltz additional criteria:</b> patient must be ≥ 18 years of age AND the prescriber must provide evidence of a trial and failure or contraindication to Humira (indication only for psoriatic arthritis)</p> <p><b>Actemra, Avsola, Cimzia, Kevzara, Otezla, Remicade, Renflexis, Simponi (subcutaneous), and Stelara additional criteria:</b> The prescriber must provide clinically valid reason why at least 2 preferred agents cannot be used.</p> <p><b>Ilaris:</b> The diagnosis is systemic juvenile idiopathic arthritis (sJIA) with active systemic features and varying degrees of synovitis with continued disease activity after initial therapy (initial therapy defined as 1 month of anakinra (Kineret), 2 weeks of glucocorticoid monotherapy (oral or IV) or one month of NSAIDs). AND patient is &gt; 2 years of age.</p> <p><b>Avsola, Inflectra additional criteria:</b> 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 Remicade/Renflexis.</p> <p><b>Simponi Aria additional criteria:</b> 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.</p> <p><b>Kineret, Orencia additional criteria:</b> The prescriber must provide a clinically valid reason why at least 2 preferred agents cannot be used.</p> <p><b>Xeljanz XR additional criteria:</b> Patient has not been able to tolerate or adhere to twice daily dosing of immediate release Xeljanz, resulting in significant clinical impact.</p> <p><b>Olumiant, Rinvoq additional criteria:</b> The patient must be ≥ 18 years of age AND The prescriber must provide a clinically valid reason why Humira, Enbrel, and Xeljanz cannot be used.</p> <p><b>Note:</b> 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).</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
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### SICKLE CELL DISEASE THERAPIES

<p>DROXIA® (hydroxyurea) 200 mg, 300 mg, 400 mg cap HYDROXYUREA (compare to Hydrea®) 500 mg cap</p>	<p>Adakveo® (crizanlizumab-tmca) Endari (L-glutamine powder for oral solution) <i>QTY LIMIT:</i> maximum of 30-day supply Hydrea® (hydroxyurea) 500 mg cap Oxbryta® (voxelotor) 500 mg tablet <i>QTY LIMIT:</i> 3 tablets/day Siklos® (hydroxyurea) 100 mg, 1000 mg tablet</p>	<p><b>Adakveo:</b> 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. <b>Note:</b> Adakveo will not be approved in conjunction with Oxbryta.</p> <p><b>Endari:</b> 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 (&lt;30kg = 2 packets/day, 30-65kg = 4 packets/day, &gt; 65kg = 6 packets/day).</p> <p><b>Hydrea:</b> Patient has had a documented intolerance to the generic equivalent.</p> <p><b>Oxbryta:</b> Patient has a diagnosis of Sickle Cell Disease AND patient is at least 12 years of age or older AND patient has a baseline hemoglobin (Hb) ≥ 5.5-10.5 g/dL 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. <b>Note:</b> Oxbryta will not be approved in conjunction with Adakveo.</p> <p><b>Siklos:</b> Patient has a diagnosis of Sickle Cell Anemia with recurrent moderate to severe pain crises AND the required dose is &lt; 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.</p>
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### SALIVA STIMULANTS

<p>PILOCARPINE (compare to Salagen®) CEVIMELINE (compare to Evoxac®) EVOXAC® (cevimeline)</p>	<p>Salagen® (pilocarpine)</p>	<p><b>Salagen:</b> The patient has had a documented side effect, allergy, or treatment failure to generic pilocarpine.</p>
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### SEDATIVE/HYPNOTICS

BENZODIAZEPINE		
<p>ESTAZOLAM TEMAZEPAM 15 mg, 30 mg (compare to Restoril®)</p>	<p>Flurazepam Halcion® (triazolam) Restoril® (temazepam)</p>	<p><b>Criteria for Approval:</b> The patient has had a documented side effect, allergy, or treatment failure with two preferred benzodiazepine sedative/hypnotics. If a</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Temazepam 7.5 mg, 22.5 mg (compare to Restoril®) Triazolam (compare to Halcion®)	product has an AB rated generic, one trial must be the generic.
<b>NON BENZODIAZEPINE, NON BARBITURATE</b>		
<p>ESZOPICLONE (compare to Lunesta) <i>QTY LIMIT:</i> 1 tab/day</p> <p>ZALEPLON <i>QTY LIMIT:</i> 5 mg = 1 cap/day, 10 mg = 2 caps/day</p> <p>ZOLPIDEM (compare to Ambien®) <i>QTY LIMIT:</i> 1 tab/day</p>	<p>Ambien® (zolpidem) <i>QTY LIMIT:</i> 1 tab/day</p> <p>Ambien CR® (zolpidem) <i>QTY LIMIT:</i> 1 tab/day</p> <p>Belsomra® (suvorexant) <i>QTY LIMIT:</i> 1 tab/day</p> <p>Dayvigo® (lemborexant) tablet <i>QTY LIMIT:</i> 1 tab/day</p> <p>Edluar® (zolpidem) sublingual tablet <i>QTY LIMIT:</i> 1 tab/day</p> <p>Intermezzo® (zolpidem) sublingual tablet <i>QTY LIMIT:</i> 1 tab/day</p> <p>Lunesta® (eszopiclone) <i>QTY LIMIT:</i> 1 tab/day</p> <p>Ramelteon (compare to Rozerem®) <i>QTY LIMIT:</i> 1 tab/day</p> <p>Rozerem® (ramelteon) <i>QTY LIMIT:</i> 1 tab/day</p> <p>Silenor® (doxepin) <i>QTY LIMIT:</i> 1 tab/day</p> <p>Zolpidem CR (compare to Ambien CR®) <i>QTY LIMIT:</i> 1 tab/day</p>	<p><b>Ambien, Lunesta:</b> The patient has had a documented intolerance to the generic equivalent.</p> <p><b>Ambien CR, Belsomra, Zolpidem CR:</b> The patient has had a documented side effect, allergy or treatment failure to two preferred sedative/hypnotics. If the request is for brand Ambien CR, there has also been a documented intolerance to the generic.</p> <p><b>Dayvigo:</b> The patient has had a documented side effect, allergy, or treatment failure to two preferred sedative/hypnotics and Belsomra.</p> <p><b>Edluar:</b> The patient has a medical necessity for a disintegrating tablet formulation (i.e. swallowing disorder).</p> <p><b>Intermezzo:</b> The patient has insomnia characterized by middle-of-the night awakening followed by difficulty returning to sleep AND The patient has had a documented inadequate response to two preferred sedative/hypnotics.</p> <p><b>Ramelteon, Rozerem:</b> The patient has had a documented side effect, allergy, contraindication, or treatment failure to one preferred sedative/hypnotic OR 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.</p> <p><b>Silenor:</b> 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 generic doxepin or there is another clinically valid reason why a generic doxepin (capsule or oral solution) cannot be used.</p>
<b>SMOKING CESSATION THERAPIES</b>		
<b><u>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.</u></b>		
NICOTINE GUM NICOTINE LOZENGE NICOTINE PATCH OTC	Nicotrol Inhaler® Nicotrol Nasal Spray®	<b>Nicotrol Inhaler, Nicotrol Nasal Spray:</b> The patient has had a documented treatment failure with nicotine patch used in combination with nicotine gum or lozenge.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<p><b><u>ORAL THERAPY</u></b>            BUPROPION SR (compare to Zyban®)            CHANTIX® (varenicline) (Limited to 18 years and older)  <i>QTY LIMIT:</i> 2 tabs/day            Max duration 24 weeks (2x12 weeks)/365 days)</p>		<p>*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*</p> <p><b>Vermont QUIT LINE</b> (available free to all patients) 1-800-QUIT-NOW (1-800-784-8669) <a href="https://802quits.org/">https://802quits.org/</a></p> <p><b>GETQUIT™</b> Support Plan available free to all Chantix® patients 1-877-CHANTIX (242-6849) <a href="https://www.get-quit.com/">https://www.get-quit.com/</a></p>

## TESTOSTERONE REPLACEMENT THERAPY

<b>TOPICAL</b>		
<p>ANDRODERM® Transdermal 2 mg, 4 mg (testosterone patch)  <i>QTY LIMIT:</i> 1 patch/day/strength            ANDROGEL® GEL (testosterone) 1% gel packets  <i>QTY LIMIT:</i> 2.5 gm packet = 1 packet/day, 5 gm packet = 2 packets/day            TESTOSTERONE 1.62% Gel Packets  <i>QTY LIMIT:</i> 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®)  <i>QTY LIMIT:</i> 2 bottles/30 days</p>	<p>Androgel® gel (testosterone) 1.62% gel packets  <i>QTY LIMIT:</i> 1.25 gm packet (1.62%) = 1 packet/day, 2.5 gm packet (1.62%) = 2 packets/day            Androgel® pump 1.62% (testosterone pump bottles)  <i>QTY LIMIT:</i> 2 bottles/30 days            Axiron (testosterone 2% solution) 90 ml Pump Bottle  <i>QTY LIMIT:</i> 2 bottles/30 days            Fortesta® (testosterone 2% Gel) 60 gm Pump Bottle  <i>QTY LIMIT:</i> 2 bottles/30 days            Testim® Gel 5 gm (testosterone 1% gel tube)  <i>QTY LIMIT:</i> 2 tubes/day            Testosterone 1% Gel Packets (compare to Androgel®, Vogelxo®)  <i>QTY LIMIT:</i> 2.5 gm packet = 1 packet/day, 5 gm packet = 2 packets/day            Testosterone 1% gel tube (compare to Testim® Gel 5 gm, Vogelxo®, Androgel®)  <i>QTY LIMIT:</i> 2 tubes/day            Testosterone 1% Gel Pump (Vogelxo®)  <i>QTY LIMIT:</i> 4 bottles/30 days            Testosterone 2% gel 60 gm pump bottle (compare to Fortesta®)  <i>QTY LIMIT:</i> 2 bottles/30 days</p>	<p><b>Non-preferred agents:</b> The patient has a documented side effect, allergy, or treatment failure to at least two preferred topical products.</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Testosterone 2% solution 90ml Pump Bottle (compare to Axiron®) <i>QTY LIMIT:</i> 2 bottles/30 days Vogelxo® 1% (testosterone 1%) gel, pump <i>QTY LIMIT:</i> 2 tubes/day (5 gm gel tubes), 4 bottles/30 days (gel pump bottle)	
<b>ORAL</b>		
	Methitest (methyltestosterone) tablet 10 mg Methyltestosterone capsule 10 mg Jatenzo (testosterone undecanoate) capsule  *Maximum day supply all products is 30 days*	<b>Oral non-preferred agents:</b> 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 Jatenzo.
<b>INJECTABLE</b>		
TESTOSTERONE CYPIONATE IM (compare to Depo®-Testosterone) TESTOSTERONE ENANTHATE IM	Aved® (testosterone undecanoate) IM Depo®-Testosterone (testosterone cypionate) IM Testopel® (testosterone) implant pellets Xyosted™ (testosterone enanthate) SC	<b>Depo-Testosterone:</b> The patient has a documented intolerance to generic testosterone cypionate. <b>Aved, Testopel, Xyosted:</b> 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.
<b>URINARY ANTISPASMODICS</b>		
<u><b>SHORT-ACTING AGENTS</b></u> OXYBUTYNIN  <u><b>LONG-ACTING AGENTS</b></u> OXYBUTYNIN XL (compare to Ditropan® XL) <i>QTY LIMIT:</i> 1/day SOLIFENACIN (compare to Vesicare®) <i>QTY LIMIT:</i> 1/day TOVIAZ® (fesoterodine) <i>QTY LIMIT:</i> 1/day	Flavoxate Detrol® (tolterodine) Tolterodine (compare to Detrol®) Trospium  Darifenacin ER (compare to Enablex®) Ditropan XL® (oxybutynin XL) Enablex® (darifenacin) Tolterodine SR (compare to Detrol LA®) Trospium ER Vesicare® (solifenacin)	<b>Please note:</b> Patients < 21 years of age are exempt from all ORAL ANTIMUSCARINIC Urinary Antispasmodics PA requirements <b>Darifenacin, Detrol, Ditropan XL, Enablex, tolterodine (generic), tolterodine SR (generic), trospium (generic), trospium ER (generic), Vesicare:</b> 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. <b>Gelnique 10%, Oxytrol:</b> 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. <b>Myrbetriq:</b> The patient has had a documented side effect, allergy, treatment failure, or contraindication with one preferred long-acting urinary antimuscarinic agent.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<p><b><u>TRANSDERMAL/TOPICAL</u></b> All products require PA</p> <p><b><u>BETA-3 ADRENERGIC AGONISTS</u></b> All products require PA</p>	<p>Gelnique 10%<sup>®</sup> (oxybutynin topical gel) <i>QTY LIMIT</i>: 1 sachet/day</p> <p>Oxytrol<sup>®</sup> (oxybutynin transdermal) <i>QTY LIMIT</i>: 8 patches/28 days</p> <p>Myrbetriq<sup>®</sup> (mirabegron) ER Tablet <i>QTY LIMIT</i>: 1 tablet/day</p>	<p><b>Limitations:</b> Oxytrol (for Women) OTC not covered. Oxytrol RX is available but subject to prior authorization.</p>
<b>VAGINAL ANTI-INFECTIVES</b>		
<p>CLEOCIN<sup>®</sup> Vaginal Ovules (clindamycin vaginal suppositories) CLINDAMYCIN VAGINAL (clindamycin vaginal cream 2%)</p> <p>CLINDESSE<sup>®</sup> (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% NUVESSA<sup>™</sup> (metronidazole 1.3% Vaginal Gel)</p>	<p>Cleocin<sup>®</sup> (clindamycin vaginal cream 2%) Gynazole-1<sup>®</sup> (butoconazole vaginal cream 2%) Solosec<sup>™</sup> (secnidazole) oral granules packet Terconazole (compare to Terazol<sup>®</sup>) vaginal cream 0.4%, 0.8%, vaginal suppositories 80 mg Vandazole (metronidazole vaginal 0.75%)</p>	<p><b>Cleocin:</b> The patient has had a documented side effect, allergy, or treatment failure to a preferred clindamycin vaginal cream.</p> <p><b>Vandazole:</b> The patient has had a documented side effect, allergy, or treatment failure to preferred metronidazole vaginal gel.</p> <p><b>Solosec:</b> The patient has had a documented side effect, allergy, or treatment failure to a preferred topical anti-infective and oral metronidazole.</p> <p><b>Gynazole, Terconazole:</b> The patient has a documented side effect, allergy, or treatment failure to a preferred miconazole or clotrimazole formulation.</p>
<b>VASOPRESSIN RECEPTOR ANTAGONIST</b>		
	<p>Jynarque<sup>®</sup> tablets (tolvaptan) <i>QTY LIMIT</i>: 56 tablets/28 days</p> <p>Samsca<sup>®</sup> tablets (tolvaptan) <i>QTY LIMIT</i>: 15 mg = 1 tablet/day, 30 mg 2 tablets/day</p>	<p><b>Jynarque:</b> The patient must be ≥ 18 years of age AND the patient is at risk of rapidly progressing Autosomal Polycystic Kidney Disease (ADPKD) AND the patient has normal serum sodium concentrations before starting the medication (results must be submitted) AND the patient and provider are enrolled in the Jynarque<sup>®</sup> REMS program</p> <p><b>Samsca:</b> The agent is being used for the treatment of euvolemic or hypervolemic hyponatremia AND Despite optimal fluid restriction, the patient's serum sodium &lt; 120 mEq/L or the patient is symptomatic with a serum sodium &lt; 125 mEq/L. AND The treatment will be initiated or is being reinitiated in a hospital setting where serum sodium can be monitored</p>

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<b>VITAMINS: PRENATAL MULTIVITAMINS</b>		
C-NATE DHA NIVA-PLUS PRENATAL PLUS IRON PRENATAL VITAMINS PLUS PREPLUS PRETAB SE-NATAL CHEW	All others	<b>All Non-Preferred:</b> 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.