EFFECTIVE
Version
Updated: 05/31/19

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 bothof these categories there may be drugs or even drug classes that are subject to Quantity Limit Parameters.

Therapeutic class criteria are listed alphabetically. Within each category the 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.

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

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

Drugs highlighted in yellow denote a change in PDL status.

To search the PDL, press CTRL + F

Contents

ACNE AGENTS 5
ADHD AND NARCOLEPSY CATAPLEXY MEDICATIONS 6
ALLERGEN IMMUNOTHERAPY 9
ALPHA1-PROTEINASE INHIBITORS 9
ALZHEIMER'S MEDICATIONS 9
COX-2 INHIBITORS 10
ANALGESICS 11
ANKYLOSING SPONDYLITIS: INJECTABLES 15
ANTI-ANXIETY: ANXIOLYTICS 16
ANTICOAGULANTS 17
ANTICONVULSANTS 18
ANTIDEPRESSANTS 20
ANTI-DIABETICS 23
ANTI-EMETICS 27
ANTI-HYPERTENSIVES 30
ANTI-INFECTIVES ANTIBIOTICS 34
ANTI-INFECTIVES ANTIFUNGAL 40
ANTI-INFECTIVES ANTIMALARIALS: QUININE 41
ANTI-PARASITICS 41
ANTI-INFECTIVES ANTI-VIRALS 41
ANTI-MIGRAINE AGENTS 44
ANTI-PSYCHOTIC ATYPICAL & COMBINATIONS (CHILDREN < 18 YEARS OLD) 46
ANTI-PSYCHOTIC ATYPICAL & COMBINATIONS (ADULTS > 18 YEARS OLD) 48
ANTI-PSYCHOTIC: TYPICALS 51
ANTIRETROVIRAL THERAPY HUMAN IMMUNODEFICIENCY VIRUS (HIV) 51
BILE SALTS AND BILIARY AGENTS 54
BONE RESORPTION INHIBITORS 54
BOTULINUM TOXINS 56
BPH AGENTS 57
BULK POWDERS 58
CARDIAC GLYCOSIDES 58
CHEMICAL DEPENDENCY 58
GASTROINTESTINAL AGENTS: CONSTIPATION/DIARRHEA, IRRITABLE BOWEL SYNDROME-CONSTRIPATION (IBS-C), IRRITABLE BOWEL SYNDROME-DIARRHEA (IBS-D), SHORT BOWEL SYNDROME, OPIOID INDUCED CONSTIPATION 60
CONTRACEPTIVES 62
CORONARY VASODILATORS/ANTIANGINALS/SINUS NODE INHIBITORS 65
CORTICOSTEROIDS: ORAL 66
COUGH AND COLD PREPARATIONS 66

CYSTIC FIBROSIS MEDICATIONS 67
DERMATOLOGICAL AGENTS 68
DESMOPRESSIN: INTRANASAL/ORAL 73
DIABETIC TESTING SUPPLIES 73
ENDOMETRIOSIS AGENTS 74
EPINEPHRINE: AUTO-INJECTOR 74
ESTROGENS: VAGINAL 74
GASTROINTESTINAL 75
GAUCHER'S DISEASE MEDICATIONS 79
GOUT AGENTS 79
GROWTH STIMULATING AGENTS 80
HEMATOPOIETICS 81
HEMOPHILIA FACTORS 82
HEPATITIS B AGENTS 83
HEPATITIS C AGENTS 83
HEREDITARY ANGIOEDEMA MEDICATIONS 84
HYPERKALEMIA AGENTS 85
IDIOPATHIC PULMONARY FIBROSIS (IPF) 85
IMMUNOLOGIC THERAPIES FOR ASTHMA 85
IMMUNOSUPPRESANTS, ORAL 87
INTERLEUKIN (IL)-1 RECEPTOR BLOCKERS 87
IRON CHELATING AGENTS 88
LIPOTROPICS 88
MISCELLANEOUS 91
MOOD STABILIZERS 96
MOVEMENT DISORDERS 96
MUCOSAL COATING AGENTS 97
MULTIPLE SCLEROSIS MEDICATIONS 97
MUSCLE RELAXANTS, SKELETAL 98
MUSCULAR DYSTROPHY AGENTS 99
NEUROGENIC ORTHOSTATIC HYPOTENSION 100
NEUROPATHIC PAIN & FIBROMYALGIA AGENTS 100
NUTRITIONALS, LIQUID ORAL SUPPLEMENTS 101
ONCOLOGY: ORAL (select) 101
OPHTHALMICS 102
OTIC ANTI-INFECTIVES 106
OVER THE COUNTER (OTC) MEDICATIONS 106
PANCREATIC ENZYME PRODUCTS 107
PARATHYROID AGENTS 107
PARKINSON'S MEDICATIONS 108

PHOSPHODIESTERASE-4 (PDE-4) INHIBITORS 109
PHOSPHODIESTERASE-5 (PDE-5) INHIBITORS 109
PLATELET INHIBITORS 110
PSEUDOBULBAR AFFECT AGENTS 111
PROGESTATIONAL AGENTS 111
PLATELET STIMULATING AGENTS 111
PSORIASIS 112
PULMONARY AGENTS 114
PULMONARY ARTERIAL HYPERTENSION MEDICATIONS 119
RENAL DISEASE: PHOSPHATE BINDERS 120
RESTLESS LEG SYNDROME MEDICATIONS 121
RHEUMATOID, JUVENILE & PSORIATIC ARTHRITIS: IMMUNOMODULATORS 121
SICKLE CELL DISEASE THERAPIES 122
SILIVA STIMULANTS 123
SEDATIVE/HYPNOTICS 123
SMOKING CESSATION THERAPIES 124
TESTOSTERONE REPLACEMENT THERAPY 124
URINARY ANTISPASMODICS 125
VAGINAL ANTI-INFECTIVES 126
VASOPRESSIN RECEPTOR ANTAGONIST 127
VITAMINS: PRENATAL MULTIVITAMINS 127

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ACNE AGENTS		
ORAL AGENTS		
ISOTRETINOIN CAP (AMNESTEEM, CLARAVIS, MYORISAN)	Absorica® (isotretinoin) capsules Zenatane (isotrentinoin) capsules	**Absorica/Zenatane:** patient has had a documented side effect, allergy, or treatment failure with at least two isotretinoin preferred products.
TOPICAL AGENTS		
<u>BENZOYL PEROXIDE PRODUCTS</u> BENZOYL PEROXIDE 2.5%, 5%, 10% ; 3%, 5%, 6%, 10% CL; 5%, 6%, 10% L; 5.3%, 9.8% F PANOXYL 10% B; 4%, 10% CL, 3% G		**Single ingredient products :** patient has had a documented side effect, allergy, or treatment failure with two preferred products including one from the same sub-category, if there is one available. If a product has an AB rated generic, there must have been a trial of the generic. **Combination products :** patient has had a documented side effect, allergy, or treatment failure with generic erythroymycin/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. **Azelex:** 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, erythroymcin/benzoyl peroxide,) **Limitations:** Kits with non-drug products are not covered **Onexton :** Prior authorization and be available to the few patients who are unable to tolerate or who have failed on preferred medications.
<u>CLINDAMYCIN PRODUCTS</u> CLINDAMYCIN 1% *S, G, L, P,*	Clindamycin 1%F Cleocin-T®* (clindamycin) 1% S, P, L, G	
<u>ERYTHROMYCIN PRODUCTS</u> ERYTHROMYCIN 2% *S, G, P*	Erygel®* (erythromycin 2% G)	
<u>SODIUM SULFACETAMIDE PRODUCTS</u> All Products Require PA	Klaron®* (sodium sulfacetamide 10% L) Sodium Sulfacetamide 10% *L*	
<u>COMBINATION PRODUCTS</u>		
ERYTHROMYCIN / BENZOYL PEROXIDE	Benzaclin® (clindamycin/benyoyl peroxide)	
CLINDAMYCIN/BENZOYL PEROXIDE (compare to Benzaclin®)	Azelex® (azelaic acid 20%C) DUAC® (clindamycin/benzoyl peroxide) gel	
<u>OTHER</u>	Benzamycin®* (erythromycin/benzoyl peroxide) Onexton® (clindamycin/benzoyl peroxide) Sodium Sulfacetamide/Sulfur C*L, C, P, E,* Sodium Sulfacetamide/Sulfur *W*	
C=cream, CL=cleanser, E=emulsion, F=Foam, G=gel, L=lotion,O=ointment, P=pads,	Sumaxin ® (sulfacetamide/sulfur*L,P,W*)	

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
S=solution, W=wash, B=bar	Rosula®* (sulfacetamide/sulfur P, W) Aczone® (dapsone 5% G) Dapsone (compare to Aczone) 5% G All other brands any topical acne anti-infective medication	
TOPICAL - RETINOIDS		
AVITA® (tretinoin) DIFFERIN® (adapalene) 0.1% C, G; L 0.3% G FABIOR® (tazarotene 0.1% F) RETIN-A® (tretinoin) 0.025%, 0.05%, 0.1% C; 0.01%, 0.025% G TAZORAC® (tazarotene) 0.1% *C, G* C= *cream*, G=*gel*, L=*lotion*	Adapalene (compare to Differin®) 0.1% C, G, 0.3% G Altreno™ (tretinoin) 0.05% L Atralin® (tretinoin) 0.05% G Plixda® (adapalene) 0.1% swabs Retin-A Micro® (tretinoin microsphere) 0.04%, 0.06%, 0.08%, 0.1% G Tretinoin (compare to Retin-A®) 0.025%, 0.05%, 0.1% C; 0.01%, 0.025% G Tretinoin microsphere (compare to Retin-A Micro®) 0.1%, 0.04%	**Altreno, Atralin, Retin-A Micro, tretinoin, tretinoin microsphere:** diagnosis or indication is acne vulgaris, actinic keratosis, or rosacea AND patient has had a documented side effect, allergy, or treatment failure with a preferred topical tretinoin product (Avita or Retin-A®). **Adapalene:** patient has had a documented side effect, allergy, or treatment failure with brand Differin. **Plixda:** patient has had a documentd side effect, allergy, or treatment failure with brand Differin AND a generic adapalene product. **Limitations:** Coverage of topical retinoid products will not be approved for cosmetic use (wrinkles age spots, etc.) (i.e. Avage, Renova, Tri-Luma).
TOPICAL - ROSACEA		
FINACEA® (azelaic acid) 15% *G*, F METRONIDAZOLE 0.75% *C, G, L* *C=cream, F=Foam, G=gel, L=lotion*	All brand metronidazole products (MetroCream®* 0.75% *C*, Metrogel® 1% *G*, MetroLotion®* 0.75% *L*, Noritate® 1% *C* etc.) Metronidazole 1% *G* Rhofade™ (oxymetazoline) 1%C Soolantra® (ivermectin)	**Brand name metronidazole products, metronidazole 1% gel (generic), Rhofade and Soolantra**: diagnosis or indication is roacea AND patient has had a documented side effect, allergy or treatment failure with a preferred generic topical metronidazole product. If a product has an AB rated generic, there must have also been a trial of the generic formulation. **Limitations**: The use of Mirvaso (brimonidine topical gel) for treating skin redness is considered cosmetic. Medications used for cosmetic purposes are excluded from coverage. Mirvaso topical gel has not been shown to improve any other symptom of rosacea (e.g. pustules, papules, flushing, etc) or to alter the course of the disease.
ADHD AND NARCOLEPSY CATAPLEXY MEDICATIONS		
SHORT/INTERMEDIATE ACTING STIMULANTS		
DEXMETHYLPHENIDATE (compare to Focalin®)	Dextroamphetamine IR (Zenzedi 5 or 10mg, formerly	**Clinical Criteria for ALL non-preferred drugs:** patient has a diagnosis of

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
METADATE ER® (compare to Ritalin® SR) METHYLIN® (compare to Ritalin®) solution METHYLPHENIDATE (compare to Ritalin®) tablets, chewable tablets AMPHETAMINE/DETROAMPHETAMINE (compare to Adderall®)	Dexedrine®) Evekeo® (amphetamine sulfate) Focalin® (dexmethylphenidate) Ritalin®* (methylphenidate) Adderall®* (amphetamine/dextroamphetamine) Desoxyn® (methamphetamine) Dextroamphetamine sulfate 1 mg/ml oral solution Methamphetamine (compare to Desoxyn®) Methylphenidate solution Methylphenidate SR (compare to Ritalin® SR) Procentra® (dextroamphetamine sulfate) 1 mg/ml oral solution Zenzedi® (dextroamphetamine IR) 2.5 mg, 7.5 mg, 15 mg, 20 mg, 30 mg tablets	ADD, ADHD or narcolepsy AND patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR patient meets additional clinical criteria outlined below. **Focalin, Adderall, Ritalin:** the patient must have had a documented intolerance to the preferred generic equivalent. **Methamphetamine and Desoxyn:** Given the high abuse potential of methamphetamine and Desoxyn, the patient must have a diagnosis of ADD, ADHD or narcolepsy and have failed all preferred treatment alternatives. In addition, for approval of brand name Desoxyn, the patient must have had a documented intolerance to generic methamphetamine. **Methylphenidate solution:** patient has a documented intolerance to Methylin solution. **Methylphenidate SR:** the patient has had a documented side-effect, allergy, or treatment failure to at least 2 preferred methylphenidate products (may be short or long acting due to intermediate duration of action) **Procentra, dextroamphetamine oral solution:** patient has a medical necessity for an oral liquid dosage form. (eg. Swallowing disorder). AND if the request is for Procentra, the patient has a documented intolerance to the generic equivalent. **Dextroamphetamine IR, Zenzedi, Evekeo:** the patient has had a documented side-effect, allergy, or treatment failure of at least 2 preferred agents.
LONG ACTING STIMULANTS		
Methylphenidate Products **Oral** APTENSIO®XR (methylphenidate DR 24HR IR/.ER, 40:60%) CONCERTA®* (methylphenidate SA OSM IR/ER, 22:78%) FOCALIN® XR (dexmethylphenidate SR 24 HR IR/ER, 50:50%) QUILLICHEW ER ™ (methylphenidate IR/ER, 30:70%) chewable tablets **Oral Suspension** QUILLIVANT XR® (methylphenidate IR/ER, 20:80%) QL = 1 bottle (60ml, 120ml, 150ml)/30days 2 bottles (180ml)/30days **Transdermal** DAYTRANA® (methylphenidate patch) (*QL = 1 patch/day)* **Amphetamine Products**	Cotempla® XR (methylphenidate IR/ER 25:75%) ODT Dexmethylphenidate SR 24 HR IR/ER, 50:50% (compare to Focalin XR®) 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® (methylphenidateSR 24 HR, IR/ER, 50:50%)	**Clinical criterial for ALL non-preferred drugs:** the patient has a diagnosis of ADD, ADHD or narcolepsy AND has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization) OR meets the additional clinical criteria outlined below. **Cotempla XR ODT, Ritalin LA, and Methylphenidate CR, Methylphenidate SR 24 HR:** patient has had a documented side-effect, allergy, or treatment failure on. 2 preferred long-acting Methylphenidate products AND for approval of Ritalin LA, the patient must have a documented intolerance to the generic equivalent. **dexmethylphenidate SR 24 HR ER (generic):** patient must have a documented intolerance to the brand name equivalent. **Methylphenidate SA OSM (AB-rated and BX-rated generics for Concerta):** the patient must have a documented intolerance to brand Concerta. **Adderall XR, Dexedrine CR, dextroamphetamine SR, Dyanavel, Mydayis:** patient must have a documented intolerance to two preferred amphetamine products. For approval of Adderall XR or brand Dexedrine CR, the patient must also have a documented intolerance to the generic equivalent. **Adzenys XR ODT, Adzenys ER suspension:** patient has had a documented side-effect, allergy, or treatment failure to Vyvanse chewable.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
Oral AMPHETAMINE/DEXTROAMPHETAMINE SR 24 HR, IR/ER, 50:50% (compare to Adderall XR®) VYVANSE® (lisdexamfetamine) capsule, chewable tablet *(QL = 1 cap or tab/day)*	Adderall XR® (amphetamine/dextroamphetamine SR 24 HR, IR/ER, 50:50%) Adzenys XR® ODT (amphetamine SR 24 HR, IR/ER, 50:50%) (QL= 1 cap/day) Adzenys ER™ suspension (amphetamine SR 24 HR, IR/ER, 50:50%) Dyanavel ™ suspension (amphetamine/dextroamphetamine SR) (QL=240ml/30days) Dexedrine CR®* (dextroamphetamine 24 hr SR) Dextroamphetamine 24 hr SR (compare to Dexedrine CR®) Mydayis® (mixed amphetamine salts) extened-release capsules	
MISCELLANEOUS		
ARMODAFINIL (compare to Nuvigil®) *Qty Limit:* 50mg = 2 tabs/day *150mg/200mg/250mg = 1 tab/day (max days supply = 30 days)* ATOMOXETINE (compare to Strattera®) *Qty limit:10, 18, 25 and 40 mg = 2 capsules/day* *60, 80 and 100 mg = 1 capsule/day* *FDA maximum recommended dose = 100 mg/day* CLONIDINE ER (compare to Kapvay®) *Qty limit = 4 tabs/day* GUANFACINE ER (Intuniv®) KAPVAY® (clonidine extended release) Tablet *Qty limit = 4 tablets/day* MODAFINIL(compare to Provigil®) *Qty limit: 100 mg = 1.5 tablets/day;200 mg = 2 tablets/day* *Maximum Daily Dose = 400 mg*	Nuvigil® (armodafinil) *Qty limit: 50 mg = 2 tablets/day; 150 mg/200 mg/250 mg = 1 tablet/day* Provigil® (modafinil) *Qty limit: 100 mg = 1.5 tablets/day;200 mg = 2 tablets/day* *Maximum Daily Dose = 400 mg* ***(Max days supply = 30 days)*** Intuniv® (guanfacine extended release) Tablet *Qty limit = 1 tablet/day* Strattera® (atomoxetine) *Qty limit:10, 18, 25 and 40 mg = 2 capsules/day* *60, 80 and 100 mg = 1 capsule/day* *FDA maximum recommended dose = 100 mg/day* Xyrem® (sodium oxybate) oral solution *Qty limit = 540 ml/30 days*	**Intuniv, Nuvigil, Provigil, Strattera:** patient must have a documented intolerance to the generic equivalent.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
Max days supply = 30 days)		
ALLERGEN IMMUNOTHERAPY		
	Oralair® *(QL = 1 tablet/day)*	**Clinical Criteria** • Patient age ≥10 years and ≤65 years • Prescriber must provide the testing to show that the patient is allergic to the components in the prescribed therapy and must provide a clinically valid rationale why single agent sublingual therapy is being chosen over subcutaneous therapy • Treatment must start 12 weeks before expected onset of pollen season and only after confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for any of the 5 grass species contained in Oralair • Have an auto-injectable epinephrine on-hand •
ALPHA1-PROTEINASE INHIBITORS		
	Aralast NP® Glassia® Prolastin-C® Zemaira® **Maximum days supply per fill for all drugs is 14 days**	**Criteria for Approval:** The indication for use is treatment of alpha1 -proteinase inhibitor deficiency-associated lung disease when all of the following criteria are met: Patient's alpha1 -antitrypsin (ATT) concentration < 80 mg per dl [or < 11 micromolar] AND patient has obstructive lung disease as defined by a forced expiratory volume in one second (FEV1) OF 30 - 65% of predicted or a rapid decline in lung function defined as a change in FEV1 of > 120 mL/year. AND medication is being administered intravenously (inhalation administration will not be approved) AND patient is a non-smoker OR patient meets above criteria except lung function has deteriorated beneath above limits while on therapy.
ALZHEIMER'S MEDICATIONS		
CHOLINESTERASE INHIBITORS		
DONEPEZIL (compare to Aricept®) tablet *(QL = 1 tablet/day)* EXELON® (rivastigmine) Capsule *(QL = 2 capsules/day)*	Aricept® (donepezil) Tablet *(QL = 1 tablet/day)* Razadyne® (galantamine) Tablet Razadyne ER® (galantamine) Capsule	**Razadyne Tablet, Razadyne ER Capsule:** 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

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
DONEPEZIL ODT (compare to Aricept® ODT) *(QL = 1 tablet/day)* RIVASTIGMINE (compare to Exelon®) capsule *(QL = 2 capsules/day)* GALANTAMINE tablet (compare to Razadyne®) Tablet GALANTAMINE ER capsule (compare to Razadyne® ER) **SOLUTION** EXELON® (rivastigmine) Oral Solution **TRANSDERMAL** EXELON® (rivastigmine transdermal) Patch *(QL = 1 patch/day)*	Aricept® ODT (donepezil) *(QL = 1 tablet/day)* galantamine (compare to Razadyne®) Oral Solution Rivastigmine (compare to Exelon®) patch (QL = 1 patch/day)	effect, allergy or treatment failure to donepezil and Exelon. AND if the product has an AB rated generic, the patient has a documented intolerance to the generic. **Aricept:** diagnosis or indication for the requested medication is Alzheimer's disease. AND the patient has a documented intolerance to the generic product. **Galantamine Oral Solution:** diagnosis or indication for the requested medication is Alzheimer's disease. AND patient has been started and stabilized on the requested medication (Note: samples are not considered adequate justification for stabilization) OR the patient had a documented side effect, allergy or treatment failure to Exelon Oral Solution. **Rivastigmine Patch:** the patient has a documented intolerance to brand Exelon Patch. **Aricept ODT**diagnosis or indication for the requested medication is Alzheimer's disease. AND medical necessity for a specialty dosage form has been provided. AND the patient has a documented intolerance to the generic formulation.
NMDA RECEPTOR ANTAGONIST		
MEMANTINE Tablets NAMENDA® (memantine) Oral Solution	Namenda® (memantine) Tablet Namenda® XR (memantine ER) Oral Capsule *(QL = 1 capsule/day)*	**Namenda:** Patient has a documented intolerance to the generic. **Namenda XR:** Patient has not been able to tolerate twice daily dosing of immediate release memantine, resulting in significant clinical impact.
CHOLINESTERASE INHIBITOR/NMDA COMBINATION		
	Namzaric® (donepezil/memantine) Capsule (QL = 1 capsule/day)	**Namzaric:** Clinically compelling reason why the individual ingredients of donepezil and memantine cannot be used
COX-2 INHIBITORS		
Clinical PA Required CELECOXIB *(QL = 2 caps/day)*	Celebrex® (celecoxib) *(QL = 2 capsules/day)*	**Celebrex:** patient does not have a history of a sulfonamide allergy. AND patient has had a documented side effect, allergy, or treatment failure to two or more preferred generic NSAIDS and has had a previous trial of generic celecoxib. OR patient is not a candidate for therapy with a preferred generic NSAID due to one of the following: patient is 60 years of age or older, patient has a history of GI bleed and has had a previous trial of generic celecoxib, patient is currently taking an anticoagulant (warfarin or heparin) and has had a previous trial of generic celecoxib, Patient is currently taking an oral corticosteroid and has had a previous trial of generic celecoxib, and Patient is currently taking methotrexate and has had a previous trial of generic celecoxib.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ANALGESICS		
MISCELLANEOUS: TOPICAL AND TRANSDERMAL PATCH		
Lidocaine 3% Cream Lidocaine 4% solution Lidocaine 5% Ointment, Cream Lidocaine/Prilocaine 2.5-2.5% Cream Synera® (lidocaine/tetracaine) patch	Lidocaine 5% patch (compare to Lidoderm®) *(QL = 3 patches/day)* Lidoderm® Patch (lidocaine 5 %) *(QL = 3 patches/day)* Qutenza® Patch (capsaicin 8 %) (*QL =4 patches/90 days)* Ztlido™ Patch (lidocaine 1.8%) (QL = 3 patches/day) (Note: Please refer to Analgesics: COX IIs and NSAID s for topical NSAIDS)	**Lidoderm, Lidocaine Patch:** diagnosis or indication is neuropathic pain/post-herpetic neuralgia AND patient has had a documented side effect, allergy, treatment failure or contraindication to 2 drugs in the tricyclic antidepressant (TCA) class and/or anticonvulsant class OR patient has a medical necessity for a transdermal formulation (ex. dysphagia, inability to take oral medications), AND if the request is for brand Lidoderm, the patient has had a documented intolerance to the generic equivalent.. **Qutenza, Ztlido:** diagnosis or indication is post-herpetic neuralgia AND patient has had a documented side effect, allergy, treatment failure or contraindication to 2 drugs in the tricyclic antidepressant (TCA) class and/or anticonvulsant class as well as Lyrica and Lidocaine patch. OR patient has a medical necessity for transdermal formulation (ex. dysphagia, inability to take oral medications) AND patient has had a documented side effect, allergy, treatment failure or contraindication to Lidocaine patch.
OPIOIDS: SHORT ACTING		
ACETAMINOPHEN W/CODEINE (compare to Tylenol® w/codeine) ACETAMINOPHEN W/HYDROCODONE (compare to Vicodin®, Lorcet®, Maxidone®, Norco®, Zydone®) *(QL 5/500 = 8 tablets/day, 10/500 = 8 tablets/day, 7.5/750 = 5 tablets/day)* ACETAMINOPHEN W/OXYCODONE (compare to Percocet®) *(QL 10/650 = 6 tablets/day)* ASPIRIN W/CODEINE BUTALBITAL COMP. W/CODEINE (compare to Fiorinal® w/codeine) CODEINE SULFATE DIHYDROCODEINE COMPOUND ENDOCET® (oxycodone w/ acetaminophen) HYDROCODONE (plain, w/acetaminophen, or w/ibuprofen) (some exceptions apply) HYDROMORPHONE tablets (compare to	Abstral® (fentanyl) Sublingual Tablets Acetaminophen w/codeine: *all branded products* Acetaminophen w/hydrocodone: *all branded products* *(QL 5/500 = 8 tablets/day, 10/500 = 8 tablets/day, 7.5/750 = 5 tablets/day)* Acetaminophen w/hydrocodone *(QL=13 tablets/day)* Acetaminophen w/oxycodone: *all branded products* *(QL 10/650 = 6 tablets/day)* Actiq® (fentanyl lozenge on a stick: 200 mcg, 400 mcg, 600 mcg, 800 mcg, 1200 mcg, 1600 mcg) Butorphanol Nasal Spray (Qty Limit = 2 bottles/month) Demerol* (meperidine) Dilaudid®*(hydromorphone) tablets *(Qty limit = 16 tablets/day)* Dilaudid-5®(hydromorphone) oral solution fentanyl citrate transmucosal (compare to Actiq®) Fentora® (fentanyl citrate buccal tablets) Hydrocodone-Acetaminophen Soln 10-325 Mg/15ml Hydromorphone oral soln (compare to Dilaudid-5®) Ibudone®* (hydrocodone w/ ibuprofen)	**Note:** The initial fill for all short-acting opiates will be limited to 50 Morphine Milligram Equivalents (MME) and 7-day supply for patients ≥ 18 years of age OR 24 MME and 3-day supply for patients ≤ 17 years of age. **Butorphanol Nasal Spray:** documented site effect, allergy, treatment failure, or contraindication to codeine, hydrocodone, morphine, & oxycodone (all 4 generic entities) as single or combination products. OR is unable to use tablet or liquid formulations. **Abstral, Actiq, fentanyl transmucosal, Fentora, Lazanda, Subsys:** indication of cancer breakthrough pain AND patient is opioid tolerant AND is on a long acting opioid formulation AND is 18 years of age or older (Actiq 16 years of age or older) AND prescriber is registered in the Transmucosal Immediate Release Fentanyl (TIRF) Risk Evaluation and Mitigation Strategy (REMS) Access program AND member has had a documented treatment failure with or intolerance to 2 of the following 3 immediate release treatment options: morphine, hydromorphone or oxycodone. OR is unable to use tablet or liquid formulations AND if the request is for brand name Actiq, member has a documented intolerance to generic fentanyl transmucosal. **Dilaudid - 5 Oral Solution, Hydromorphone Oral Solution:** member has had a documented side effect, allergy or treatment failure with oxycodone oral solution and morphine oral solution OR has been started and stabilized on another dosage form of hydromorphone AND if the request is for the branded product, patient has a documented intolerance to the generic product. **Oxycodone (generic) Capsules:** member has a documented intolerance to generic oxycodone tablets. **Ultram, Ultracet:** member has a documented intolerance to the generic

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
Dilaudid®) *(Qty limit = 16 tablets/day)* MEPERIDINE (compare to Demerol®) (30 tabs or 5 day supply) MORPHINE SULFATE MORPHINE SULFATE (compare to Roxanol®) OXYCODONE (plain) *(For tablets, Qty limit = 12 tablets/day)* OXYCODONE (w/acetaminophen, w/aspirin or w/ibuprofen) TRAMADOL (compare to Ultram®) *(Qty Limit = 8 tablets/day) (Age ≥ 16)* TRAMADOL/APAP (compare to Ultracet®) *(Qty Limit = 8 tablets/day)* (Age ≥18)	Lazanda® (fentanyl) Nasal Spray Lortab®*(hydrocodone w/ acetaminophen) Meperidine (Qty > 30 tabs or 5 day supply) Nucynta® (tapentadol) Opana® (oxymorphone) Oxycodone (plain) capsules (Qty limit = 12 capsules/day) Oxymorphone (compare to Opana®) Pentazocine w/acetaminophen Pentazocine w/naloxone Roxanol®*(morphine sulfate) Roxybond™ (oxycodone) Subsys® (fentanyl) Sublingual Spray Tylenol® #3*,#4*(acetaminophen w/codeine) Ultracet® (tramadol w/ acetaminophen) (Qty Limit = 8 tablets/day) Ultram®* (tramadol) (Qty Limit = 8 tablets/day)	formulation **Other Short acting Opioids:** member has had a documented side effect, allergy, or treatment failure to at least 3 medications not requiring prior approval. (If a product has an AB rated generic, one trial must be the generic) **PA Requests to Exceed QL for Oxycodone IR or Hydromorphone IR:** if dose consolidation is not possible (i.e. use of higher strength dosage form), all requests will be referred to the DVHA Medical Director for review unless the medication is being prescribed for pain related to an oncology diagnosis which will be approved by the Clinical Call Center. **Limitations:** APAP containing products: daily doses that result in > 4 grams of acetaminophen/day will reject for PA; Meperidine 75mg/ml injection no longer available - 25mg/ml, 50mg/ml and 100mg/ml available. Brand name Demerol 75mg/ml and 100mg/2ml not covered - no generic equivalents. `
OPIOIDS: LONG ACTING		
TRANSDERMAL BUTRANS (buprenorphine) TRANSDERMAL SYSTEM *(QL = 2 patches/14 days) (Maximum 14-day fill)* FENTANYL PATCH (compare to Duragesic®) 12 mcg/hr, 25 mcg/hr, 50 mcg/hr (*QL=15 patches/30 days)* 75 mcg/hr, 100 mcg/hr (*QL=30 patches/30 days)* **BUCCAL** All Products require PA **ORAL** MORPHINE SULFATE CR 12 hr tablet (compare to MS Contin® (*QL=90 tablets/strength/30 days)*	Buprenorphine patch (compare to Butrans®) (QL = 2 patches/14 days) (Maximum 14-day fill) Duragesic®* (fentanyl patch) 12 mcg/hr, 25 mcg/hr, 50 mcg/hr (QL=15 patches/30 days) 75 mcg/hr, 100 mcg/hr (QL= 30 patches/30 days) Fentanyl patch 37.5mcg/hr, 62.5mcg/hr, 87.5mcg/hr Belbuca® (buprenorphine hcl buccal film) (*QL= 28 films/14 days, Maximum 14-day fill)* hydromorphone XR tablet (QL= 30 tablets/30 days (8 mg, 12 mg, 16 mg tabs)) Dolophine® (methadone) tablets Methadone (compare to Dolophine®) 5 mg, 10 mg tablets Methadone oral solution (no PA required for patient less than 1 year old)	**CLINICAL CONSIDERATIONS:** Long acting opioid dosage forms are intended for use in opioid tolerant patients only. These tablet/capsule/topical medication strengths may cause fatal respiratory depression when administered to patients not previously exposed to opioids. LA opioids should be prescribed for patients with a diagnosis or condition that requires a continuous, around-the-clock analgesic. LA opioids should be reserved for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain. LA opioids are NOT intended for use as 'prn' analgesic. LA opioids are NOT indicated for pain in the immediate post-operative period (the first 12-24 hours following surgery) or if the pain is mild, or not expected to persist for an extended period of time. LA opioids are not intended to be used in a dosage frequency other than FDA approved regimens. Patients should not be using other extended release opioids prescribed by another physician. Prescribers should consult the VPMS (Vermont Prescription Monitoring System) to review a patient's Schedule II - IV medication use before prescribing long acting opioids. **Belbuca Films, Buprenorphine Patch:** the patient has had a documented intolerance to Butrans patches **Duragesic Patches:** patient has had a documented intolerance to generic fentanyl patches. **Fentanyl patches 37.5mcg/hr, 62.5mcg/hr, 87.5mcg/hr:** provider must submit clinical rationale detailing why the patient is unable to use a combination of the preferred strengths.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Methadone oral concentrate 10 mg/ml ****Maximum initial daily dose all products = 30 mg/day**** Kadian® (morphine sulfate XR*) (QL= 60 capsules/strength/30 days)* MS Contin®* (morphine sulfate CR 12 hr) Tablets (*QL=90 tablets/strength/30 days)* Morphine sulfate SR 24hr capsule (compare to Kadian®) *(QL= 60 capsules/strength/30 days)* Morphine sulfate SR beads 24hr capsule *(QL 30 capsules/strength/30 days)* Oxycodone ER (compare to OxyContin®) *(QL= 90 tablets/strength/30 days)* Oxymorphone ER *(QL=60 tablets/strength/30 days)* Nucynta ER® (tapentadol ER) *(QL=2 tablets/day)* Conzip® (tramadol ER biphasic release) Capsule *(QL = 1 capsule/day)* Tramadol SR (compare to Ultram ER®) *(Qty Limit = 1 tablet/day)* Tramadol ER biphasic-release® Capsule *(Qty Limit = 1 capsule/day) (150 mg strength)* Tramadol ER biphasic-release tablet (formerly Ryzolt®) *(Qty Limit = 1 tablet/day)* Zohydro ER® (hydrocodone bitartrate)	**Methadone Tablet:** patient has had a documented side effect, allergy, or treatment failure to morphine sulfate CR 12 hr tablets AND the initial methadone daily dose does not exceed 30mg AND for approval of brand Dolophine tablets, the patient must have a documented intolerance to the equivalent generic tablet. (Note: Methadone products, when used for treatment of opioid addiction in detoxification or maintenance programs, shall be dispensed ONLY by certified opioid treatment programs as stipulated in 42 CFR 8.12, NOT retail pharmacy) **Methadone Liquid:** Patient must have a medical necessity for an oral liquid (i.e. swallowing disorder, inability to take oral medications) AND the initial daily dose does not exceed 30mg OR patient has been started and stabilized on the requested oral liquid medicationNote: Methadone products, when used for treatment of opioid addiction in detoxification or maintenance programs, shall be dispensed ONLY by certified opioid treatment programs as stipulated in 42 CFR 8.12, NOT retail pharmacy **Conzip, Tramadol ER biphasic-release Capsule, Tramadol ER biphasic-release Tablet, Tramadol ER/SR:** member has had a documented treatment failure to a preferred short-acting tramadol product. In addition, for approval of tramadol ER biphasic-release capsule or tablet orthe patient must have a documented intolerance to generic tramadol ER/SR. **Oral Non-Preferred (except methadone & tramadol containing products):** the patient has had a documented side effect, allergy, or treatment failure to morphine sulfate CR 12hr tablet (generic) AND generic fentanyl patch. (If a product has an AB rated generic, there must have been a trial of the generic). AND the patient must have a documented side effect, allergy, or treatment failure to the preferred abuse deterrent formulation (Embeda) before Arymo ER, Morphabond ER, OxyContin or Xtampza ER will be approved. **Hysingla ER/Zohydro ER:** Available with PA for those unable to tolerate any preferred medications. All requests will go to the DVHA Medical Director for approval. **Limitations:** Methadone 40mg dispersible tablet not approved for retail dispensing.
ORAL, ABUSE-DETERRENT FORMULATIONS EMBEDA® (morphine sulfate/naltrexone hydrochloride) Capsules *(QL=2 capsules/day)*	Arymo® ER (morphine sulfate, extended release) (QL=90 tablets/strength/30 days) Hysingla ER® (hydrocodone bitartrate) *(Qty Limit = 1 tablet/ day)* Morphabond® ER (morphine sulfate, extended release) (QL=90 tablets/strength/30 days) OxyContin® (Oxycodone ER) *(QL= 90 tablets/strength/30 days)* Xtampza ER® (oxycodone ER) *(QL = 60*	

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	tabs/strength/30days)	
NSAIDS		
ORAL **SINGLE AGENT** 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®) *(QL = 20 doses/5 day supply every 90 days)* MECLOFENAMATE SODIUM MELOXICAM tabs (compare to Mobic®) NABUMETONE NAPROXEN (compare to Naprosyn®) NAPROXEN ENTERIC COATED (compare to EC-	Cambia® (diclofenac potassium) packet for oral solution *(QL = 9 packets/month))* Daypro®* (oxaprozin) EC-Naprosyn® * (naproxen sodium enteric coated) Etodolac ER Feldene®* (piroxicam) Fenoprofen 400mg cap Fenoprofen 600 mg tab Indocin®* (indomethacin) suspension, suppository Ketoprofen ER mefenamic acid capsules (compare to Ponstel®) Mobic®* (meloxicam) tablets Nalfon® (fenoprofen) 400 mg capsules Naprelan®* (naproxen sodium ER) Naproxen sodium ER Naprosyn®* (naproxen sodium)	**Arthrotec, diclofenac/misoprostol, Duexis:** patient has a documented side effect or treatment failure to 2 or more preferred generic NSAIDs OR patient is not a candidate for therapy with a preferred generic NSAID mono-therapy due to one of the following: patient is 60 years of age or older, Patient has a history of GI bleed, Patient is currently taking an oral corticosteroid, Patient is currently taking methotrexate AND 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. **Cambia:** drug is being prescribed for treatment of acute migraine attacks AND patient has had a documented side effect or treatment failure to 2 or more preferred generic NSAIDs, one of which must be generic diclofenac OR drug is being prescribed for treatment of acute migraine attacks AND patient has a requirement for an oral liquid dosage form (i.e. swallowing disorder, inability to take oral medications) AND patient has had a documented side effect or treatment failure with the generic ibuprofen suspension and the generic naproxen suspension. **Flector Patch, Pennsaid, Diclofenac 1.5% Topical Solution:** diagnosis or indication is osteoarthritis or acute pain caused by minor strains, sprains, and contusions AND patient has had a documented side effect or inadequate response to Voltaren gel OR patient is not a candidate for therapy with a

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
Naprosyn®) NAPROXEN SODIUM (compare to Anaprox®, Anaprox DS®, Naprelan®) OXAPROZIN (compare to Daypro®) PIROXICAM (compare to Feldene®) JLINDAC **INJECTABLE** KETOROLAC Injection (formerly Toradol®) *(QL = 1 dose per fill)* **NASAL SPRAY** **All products require PA.** **TOPICAL** Voltaren® (diclofenac) 1% Gel **TRANSDERMAL** **All products require PA.** **NSAID/ANTI-ULCER** **All products require PA.** Note: Please refer to "Dermatological: Actinic Keratosis Therapy" for Solaraze® or Diclofenac 3% Gel	Ponstel® (mefenamic acid) Tivorbex (indomethacin) capsules (QL=3 caps/day) Vivlodex® (meloxicam) capsules Zipsor® (diclofenac potassium) Zorvolex® (diclofenac) Capsules *(QL = 3 capsules/day)* Sprix® (ketorolac) Nasal Spray *(QL = 5 bottles/5 days – once every 90 days)* diclofenac (compare to Pennsaid®) 1.5 % Topical Solution Flector® (diclofenac) 1.3 % Patch *(QL = 2 patches/day)* Pennsaid® (diclofenac) 2% Topical Solution Arthrotec® (diclofenac sodium w/misoprostol) diclofenac sodium w/misoprostol (compare to Arthrotec®) Duexis® (ibuprofen/famotidine) *(QL = 3 tablets/day)* Vimovo® (naproxen/esomeprazole) *(QL = 2 tablets/day)*	preferred generic NSAID due to one of the following: Patient is 60 years of age or older, Patient has a history of GI bleed, Patient is currently taking an oral corticosteroid, Patient is currently taking methotrexate OR patient has a documented medical necessity for a topical/transdermal formulation (ex. dysphagia, inability to take oral medications), AND for approval of Pennsaid 1.5%, the patient has had a documented intolerance to the generic equivalent. **Sprix:** indication or diagnosis is moderate to moderately severe pain. AND patient has had a documented inadequate response or intolerance to generic ketorolac tablets. OR patient has a documented medical necessity for the specialty dosage form (i.e. inability to take medication orally (NPO)). **Tivorbex:** patient has had a documented side effect, allergy, or treatment failure to 4 or more preferred generic NSAIDs, including generic indomethacin. **Vivlodex®:** patient has had a documented side effect, allergy, or treatment failure to 4 or more preferred generic NSAIDs, including generic meloxicam. **Diclofenac 1% Gel:** the patient must have had a documented intolerance to Brand Voltaren. **Vimovo:** 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 generis NSAID due to one of the following: Patient is 60 years of age or older, Patient has a history of GI bleed, Patient is currently taking an oral corticosteroid, Patient is currently taking methotrexate AND patient is unable to take naproxen and a preferred proton pump inhibitor, separately. **Zipsor, Zorvolex:** patient has had a documented intolerance to diclofenac tablets. AND patient has had a documented side effect, allergy, or treatment failure to 4 or more preferred generic NSAIDs. **All other PA requiring NSAIDs:** patient has had a documented side effect or treatment failure to 2 or more preferred generic NSAIDS. (If a product has an AB rated generic, one trial must be the generic.) AND if the request is for a non-preferred extended release formulation, the patient has not been able to adhere to the dosing schedule of the immediate release formulation resulting in significant clinical impact.
ANKYLOSING SPONDYLITIS: INJECTABLES		
Length of Authorization: Initial PA 3 months; 12 months thereafter		
PREFERRED AFTER CLINICAL CRITERIA ARE MET	Cimzia® (certolizumab pegol) *(Quantity limit = 1 kit/28 days (starter X 1, then regular))* Inflectra® (infliximab-dyyb) biosimilar to Remicade®	**Enbrel/Humira:** 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

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
COSENTYX® (secukinumab) Subcutaneous ENBREL® (etanercept) *Qty Limit = 4 syringes/28 days (50 mg), 8 syringes/28 days (25 mg)* HUMIRA® (adalimumab) *Qty Limit = 2 syringes/28 days*	Remicade® (infliximab) Renflexis™ (infliximab-abda) biosimilar to Remicade® Simponi® (golimumab) Subcutaneous *Qty Limit = 1 of 50 mg prefilled syringe or autoinjector/28 days)*	reaction, inadequate response, or treatment failure. If methotrexate is contraindicated, another DMARD should be tried. Notes: Approval should be granted in cases where patients have been treated with infliximab but have lost response to therapy. **Cosentyx:** patient must be ≥ 18 years of age with a diagnosis of ankylosing spondylitis (AS) and has already been stabilized on the medication OR patient must be ≥ 18 years of age with a 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. AND the patient has a trial and failure or contraindication to Humira. **Note:** Cosentyx approvals for 300mg dose(s) must use "300DOSE" package (containing 2 x 150mg pens or syringes). Approval will not be granted for 2 separate 150mg packages. **Cimzia, Inflectra, Remicade, Renflexis, Simponi:** patient has a diagnosis of ankylosing spondylitis (AS) and has already been stabilized on the medication being requested OR diagnosis is AS, and conventional NSAID treatment and DMARD therapy (e.g. methotrexate therapy) resulted in an adverse effect, allergic reaction, inadequate response, or treatment failure. If methotrexate is contraindicated, another DMARD should be tried. AND the prescriber must provide a clinically valid reason why BOTH Humira and Enbrel cannot be used. **Additional criteria for Simponi:** Patient must be ≥ 18 years of age. Safety and efficacy has not been established in pediatric patients. **Additional criteria for Inflectra, Renflexis:** the prescriber must provide a clinically valid reason why Remicade cannot be used. * Patients with documented diagnosis of active axial involvement should have a trial with two NSAIDs, but a trial with DMARD is not required. If no active axial skeletal involvement, then NSAID trial and a DMARD trial are required (unless otherwise contraindicated) prior to receiving Humira, Cimzia, Cosentyx, Enbrel, Remicade, or Simponi.
ANTI-ANXIETY: ANXIOLYTICS		
BENZODIAZEPINE		
CHLORDIAZEPOXIDE (formerly Librium®) CLONAZEPAM (compare to Klonopin®) *(QL = 4 tabs/day except 2 mg (QL = 3 tabs/day))* CLONAZEPAM ODT (formerly Klonopin Wafers®) *(QL = 4 tabs/day except 2 mg (QL = 3 tabs/day))* DIAZEPAM (compare to Valium®)	alprazolam (compare to Xanax®) *(QL = 4 tablets/day)* alprazolam ER†, alprazolam XR® (compare to Xanax XR®) *(QL = 2 tablets/day)* alprazolam ODT (compare to Niravam®)	**Non-preferred Benzodiazepines (except for alprazolam ODT, Klonopin Wafers, Niravam & Intensol Products):** patient has a documented side effect, allergy, or treatment failure to at least 2 preferred benzodiazepine medications. (If a product has an AB rated generic, there must also be a trial of the generic formulation) **Alprazolam ODT and Niravam:** patient has a documented side effect, allergy, or treatment failure to at least 2 preferred benzodiazepine medications. (If a 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

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
LORAZEPAM (compare to Ativan®) *(QL = 4 tablets/day)* OXAZEPAM (formerly Serax®)	*(QL = 3 tablets/day)* Alprazolam Intensol® (alprazolam concentrate) Ativan®* (lorazepam) *(QL = 4 tablets/day)* Clorazepate tabs (compare to Tranxene T®) Diazepam Intensol® (diazepam concentrate) Klonopin®* (clonazepam) *(QL = 4 tabs/day except 2 mg (QL = 3 tabs/day))* Lorazepam Intensol® (lorazepam concentrate) Niravam® (alprazolam ODT) *(QL = 3 tablets/day)* Tranxene T®* (clorazepate tablets) Valium®* (diazepam) Xanax® (alprazolam) *(QL = 4 tablets/day)* Xanax XR® (alprazolam XR) *(QL = 2 tablets/day)*	administration (i.e. inability to swallow tablets) AND patient has a documented side effect, allergy or treatment failure to clonazepam ODT. **Alprazolam Intensol, Diazepam Intensol, and Lorazepam Intensol:** patient has a medical necessity for the specialty dosage form (i.e. swallowing disorder). AND the medication cannot be administered by crushing oral tablets.
NON-BENZODIAZEPINE		
BUSPIRONE (formerly Buspar®) HYDROXYZINE HYDROCHLORIDE (formerly Atarax®) HYDROXYZINE PAMOATE (compare to Vistaril®) (all strengths except 100 mg) MEPROBAMATE (formerly Miltown®)	Hydroxyzine Pamoate (100 mg strength ONLY) (compare to Vistaril®) Vistaril®* (hydroxyzine pamoate)	**Hydroxyzine Pamote 100mg strength ONLY:** patient is unable to use generic 50mg capsules **Vistaril:** patient has a documented intolerance to the generic formulation. **PA Requests to Exceed QL:** all requests will be referred to the DVHA Medical Director for review unless (a) the medication is being prescribed for acute alcohol withdrawal for a maximum 10-day supply or (b) the patient has been started and stabilized on the requested quantity for treatment of a seizure disorder.
ANTICOAGULANTS		
ORAL		
Vitamin K Antagonist WARFARIN (compare to Coumadin®) **Direct Thrombin Inhibitor** PRADAXA® (dabigatran etexilate) *(Quantity Limit = 2 capsules/day)*	Coumadin®* (warfarin) Savaysa® (edoxaban) *(Quantity limits=1 tablet/daily*	**Coumadin:** patient has been started and stabilized on the requested medication OR patient has had a documented intolerance to generic warfarin. **Savaysa:** 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

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
Factor Xa Inhibitor Eliquis® (apixaban) *(Quantity Limit = 2 tablets/day)* *(Quantity limit 5mg = 4 tablets/day for 7 days if indication is treatment of DVT or PE) (followed by 5 mg twice daily)* XARELTO® (rivaroxaban) *(10mg- Quantity Limit = 1 tablet/day, maximum 30-day supply to complete total 35 days/every 180 days)* *(15m & 20mg -Quantity Limit = 1 tablet/day)* *(Quantity limit 15 mg = 2 tablets/day for 21 days if indication is treatment of DVT or PE)(followed by 20mg once daily)* Starter Pack (15 mg/20 mg) *(Quantity Limit = 51 tablets/30 days)*		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
INJECTABLE		
UNFRACTIONATED HEPARIN INJECTABLE HEPARIN **LOW MOLECULAR WEIGHT HEPARINS INJECTABLE** ENOXAPARIN (compare to Lovenox®) *(QL = 2 syringes/day calculated in ml volume)* **SELECTIVE FACTOR XA INHIBITOR INJECTABLE** FONDAPARINUX (compare to Arixtra®)	n/a Lovenox® (enoxaparin) *(QL = 2 syringes/day calculated in ml volume)* Fragmin® (dalteparin) Arixtra®* (fondaparinux)	**Arixtra:** patient has a documented intolerance to generic fondaparinux. **Lovenox and Fragmin:** patient has a documented intolerance to generic enoxaparin
ANTICONVULSANTS		
ORAL		
CARBAMAZEPINE Tablets (compare to Tegretol®) CARBAMAZEPINE Capsules (compare to Carbatrol®) CARBAMAZEPINE extended release (compare to Tegretol XR®)	Aptiom® (eslicarbazepine acetate) *QL = 1 tab/day (200, 400 and 800 mg) and 2 tabs/day (600 mg)* Banzel® (rufinamide) *QL = 8 tabs/day (400 mg) and 16 tabs/day (200 mg)* Banzel® (rufinamide) oral suspension	**Criteria for approval of ALL non-preferred drugs:** patient has been started and stabilized on the requested medication (Note: samples are not considered adequate justification for stabilization.) OR patient meets additional criteria outlined below. **Aptiom:** the diagnosis is adjunctive therapy of partial-onset seizures and the patient has had a documented side effect, allergy, treatment failure/inadequate response or a contraindication to at least TWO preferred anticonvulsants, one of which is oxcarbazepine.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
CELONTIN® (methsuxamide) CLONAZEPAM (compare to Klonopin®) *QL = 4 tablets/day* CLONAZEPAM ODT (formerly Klonopin Wafers®) *QL = 4 tablets/day* DIAZEPAM (compare to Valium®) DILANTIN® (phenytoin) chewable tablets, capsules DILVALPROEX SODIUM capsules (compare to Depakote Sprinkles®) DIVALPROEX SODIUM (compare to Depakote®) DIVALPROEX SODIUM ER (compare to Depakote ER®) EPITOL (carbamazepine) ETHOSUXAMIDE (compare to Zarontin®) GABAPENTIN 100 mg, 300 mg, 400 mg capsules, 600 mg, 800 mg tablets, 250 mg/5 ml oral solution (compare to Neurontin®) GABITRIL® (tiagabine) LAMOTRIGINE chew tabs (compare to Lamictal® chew tabs) LAMOTRIGINE tabs (compare to Lamictal® tabs) LEVETIRACETAM tabs (compare to Keppra® tabs) LEVETIRACETAM oral soln (compare to Keppra® oral soln) LYRICA® (pregabalin) cap *(Quantity Limit = 3 capsules/day)* OXCARBAZEPINE tablets (compare to Trileptal®) OXCARBAZEPINE oral suspension (compare to Trileptal®) PEGANONE® (ethotoin) PHENYTEK® (phenytoin) PHENYTOIN (compare to Dilantin®) PHENYTOIN EX cap (compare to Phenytek®) PRIMIDONE (compare to Mysoline®) TEGRETOL® (carbamazepine) suspension TEGRETOL XR® (carbamazepine) 100 mg ONLY TOPIRAMATE ER	*QL = 80 ml/day (3,200 mg/day)* Briviact® (brivaracetam) tablets, oral suspension Carbatrol® (carbamazepine) capsules Clorazepate (compare to Tranxene-T®) tablets Clobazam (compare to Onfi®) (Quantity Limit = 3 tabs/day (10 mg), 2 tabs/day (20 mg)) Depakene®* (valproic acid) Depakote®* (divalproex sodium) Depakote ER®* (divalproex sodium) Depakote Sprinkles® (divalproex sodium caps) Dilantin® (phenytoin) suspension felbamate (compare to Felbatol®) Epidiolex® (cannabidiol) oral solution QL = 20mg/kg/day Felbatol® (felbamate) Fycompa® (perampanel) tablets *QL = 1 tablet/day* Keppra®* (levetiracetam) tablets, oral solution Keppra XR® (levetiracetam extended release) Klonopin®* (clonazepam) *QL = 4 tablets/day* Lamictal®* tabs (lamotrigine tabs) Lamictal®* chew tabs (lamotrigine chew tabs) Lamictal ODT® (lamorigine orally disintegrating tablets) Lamictal XR® tablets (lamotrigine extended release) lamotrigine ER (compare to Lamictal XR®) lamotrigine ODT (compare to Lamictal ODT®) levetiracetam ER (compare to Keppra XR®) Lyrica® (pregabalin) oral solution Mysoline®* (primidone) Neurontin®* (gabapentin) capsules, tablets and solution Onfi® (clobazam) Oral Suspension 2.5 mg/ml *(Quantity limit = 16 ml/day)* Onfi® (clobazam) Tablets *(Quantity Limit = 3 tabs/day (10 mg), 2 tabs/day (20 mg))* Oxtellar® XR (oxcarbazapine ER) tablet Qudexy® XR (topiramate) capsules	**Briviact:** 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. **Carbatrol, Depakene, Depakote, Depakote ER, Depakote Sprinkles, Dilantin Suspension, Keppra tabs or oral solution, Klonopin, Klonopin Wafers, Lamictal tabs or chew tabs, Mysline, Neurontin caps, tabs, sol, Tegretol Tabs, Tegretol XR (200mg & 400mg), Topamax tabs, Topamax sprinkles, Trileptal tabs, Trileptal oral suspension, Zarontin, Zonegran:** patient has had a documented intolerance to the generic equivalent of the requested medication. **Banzel:** 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) **Epidiolex:** *Diagnosis or indication is treatment of Lennox-Gastaut Syndrome:* 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. *Diagnosis or indication is treatment of Dravet Syndrome:* 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 **Felbamate, Felbatol:** patient information/consent describing aplastic anemia and liver injury has been completed AND diagnosis is adjunctive therapy of partial-onset seizures or Lennox-Gastaut seizures and the patient has had a documented side effect, allergy, treatment failure/inadequate response or a contraindication to at least THREE preferred anticonvulsants. Additionally, if brand is requested, the patient has a documented intolerance to the generic product. **Tiagabine generic:** patient has had a documented intolerance to the brand name product. **Keppra XR, Lamictal XR, lamotrigine ER, levetiracetam ER, Oxtellar XR:** patient has been unable to be compliant with or tolerate twice daily dosing of the immediate release product. Additionally, if brand Keppra XR or Lamictal XR is requested, the patient has a documented intolerance to the generic product. **Lamictal ODT, lamotrigine ODT:** medical necessity for a specialty dosage form has been provided AND lamotrigine chewable tabs cannot be used. For

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
TOPIRAMATE tabs (compare to Topamax® tabs) TOPIRAMATE sprinkle caps (compare to Topamax® Sprinkles) VALPROIC ACID (compare to Depakene®) ZONISAMIDE (compare to Zonegran®)	Sabril® (vigabatrin) Spritam® (levetiracetam) tablets for oral suspension Tegretol®* (carbamazepine) tablets Tegretol XR® (carbamazepine) (200 and 400 mg strengths) tiagabine (compare to Gabitril®) Topamax®* (topiramate) tablets Topamax®* (topiramate) Sprinkle Capsules Tranxene-T®* (clorazepate) tablets Trileptal®* tablets (oxcarbazepine) Trileptal® oral suspension (oxcarbazepine) Trokendi XR® (topiramate SR 24hr) Capsules *(Quantity limit = 2 caps/day (200mg), 1 cap/day all others)* Vigabatrin (compare to Sabril®) Vimpat® (lacosamide) tablets, oral solution Zarontin®* (ethosuxamide) Zonegran®* (zonisamide)	approval of brand Lamictal ODT, the patient must have a documented intolerance to the generic equivalent. **Spritam**: medical necessity for a specialty dosage form has been provided AND patient must have a documented intolerance to levetiracetam oral solution. **Lyrica oral solution:** the patient is unable to use Lyrica capsules (i.e. swallowing disorder) **Clobazam, Onfi** 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 for approval of Onfi, the patient must have documented intolerance to the generic product.. **Clorazepate, Fycompa:** diagnosis is adjunctive therapy or 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. **Sabril, Vigabatrin:** prescriber and patient are registered with the REMS program AND diagnosis is infantile spasms OR patient is > 16 years old and the indication is adjunctive therapy in refractory complex partial seizures and failure of THREE other preferred anticonvulsants. **Trokendi XR, Qudexy XR:** patient has failed treatment with topiramate ER **Vimpat:** diagnosis is monotherapy adjunctive therapy of partial-onset seizures and the patient has had a documented side effect, allergy, treatment failure/inadequate response or a contraindication to at least TWO preferred anticonvulsants AND if the request is for the oral solution, the patient is unable to use Vimpat tables (eg. swallowing disorder). **PA Requests to Exceed QL for clonazepam/clonazepam ODT or Klonopin**: all requests will be referred to the DVHA Medical Director for review unless the patient has been started and stabilized on the requested quantity for treatment of a seizure disorder.
RECTAL		
DIASTAT® (diazepam rectal gel)	Diazepam rectal gel	**Diazepam Rectal Gel:** patient has had a documented intolerance to Diastat rectal gel.
ANTIDEPRESSANTS		
MAO INHIBITORS – Length of Authorization: Duration of Need for Mental Health Indications		
PHENELZINE SULFATE (compare to Nardil®) *FDA maximum recommended dose = 90 mg/day* TRANYLCYPROMINE (compare to Parnate®) *FDA maximum recommended dose = 60 mg/day*	Emsam® (selegiline) *(QL = 1 patch/day)* Marplan® (isocarboxazid) Nardil®* (phenylzine) *FDA maximum recommended dose = 90 mg/day* Parnate®* (tranylcypromine)	**Marplan:** patient has been started and stabilized on the requested medication (Note: samples are not considered adequate justification for stabilization). OR patient has had a documented side effect, allergy, or treatment failure to phenelzine and tranylcypromine. **Nardil, Parnate:** patient has had a documented intolerance to generic equivalent product. **Emsam:** patient has had a documented side effect, allergy, or treatment failure

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	FDA maximum recommended dose = 60 mg/day	with at least 3 antidepressants from 2 of the major antidepressants classes (Miscellaneous, SNRIs, SSRIs, and Tricyclic Antidepressants). OR patient is unable to tolerate oral medication.
MISCELLANEOUS - Length of Authorization: Duration of Need for Mental Health Indications, 1 Year for Other Indications		
BUPROPION SR (compare to Wellbutrin SR®) *FDA maximum recommended dose = 400mg/day* BUPROPION XL (compare to Wellbutrin XL®) *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 *Quantity Limit = 1 tablet/day* Trintellix® (vortioxetine) Tablet *Quantity Limit = 1 tablet/day* Forfivo XL® (bupropion SR 24hr) 450 mg tablet *FDA maximum recommended dose = 450 mg/day* *Quantity Limit = 1 tablet/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* Viibryd® (vilazodone) Tablet *Quantity Limit = 1 tablet/day* Wellbutrin SR®* (bupropion SR) *FDA maximum recommended dose = 400mg/day* Wellbutrin XL®* (bupropion XL) *FDA maximum recommended dose = 450 mg/day*	**Criteria for approval for ALL non-preferred drugs:** The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR The patient meets additional criteria as outlined below. **Aplenzin:** 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. **Forfivo XL**: The patient is unable to take the equivalent dose as generic bupropion XL **Nefazodone:** The patient has had a documented side effect, allergy, or inadequate response to at least 3 different antidepressants from the SSRI, SNRI and/or Miscellaneous Antidepressant categories (may be preferred or non-preferred) **Remeron, Remeron SolTab, Wellbutrin SR, and Wellbutrin XL:** The patient has had a documented intolerance to the generic formulation of the requested medication. **Trintellix, Viibryd:** The diagnosis or indication is MDD AND The patient has had a documented side effect, allergy, or inadequate response (defined by at least 4 weeks of therapy) to at least 3 different antidepressants from the SSRI, SNRI, and/or Miscellaneous Antidepressant categories (may be preferred or non-preferred. **Note:** After a 4-month lapse in use of a non-preferred agent for a mental health indication, or if there is a change in therapy, a lookback through claims information will identify the need to re-initiate therapy following the PDL and clinical criteria.
SNRI - Length of Authorization: Duration of Need for Mental Health Indications, 1 Year for Other Indications		
DULOXETINE (compare to Cymbalta®) Capsule *FDA maximum recommended dose = 120 g/day (MDD and GAD), 60 mg/day all others* *Quantity limit = 2 capsules/day* VENLAFAXINE ER capsule (compare to Effexor XR®) *FDA maximum recommended dose = 225 mg/day, Quantity limit = 1 capsule/day (37.5 mg & 75 mg)*	Cymbalta® (duloxetine) Capsule *FDA maximum recommended dose = 120 mg/day (MDD and GAD), 60 mg/day all others* *Quantity limit = 2 capsules/day* Desvenlafax ER (desvenlafaxine fumarate SR 24hr) Tablet *FDA maximum recommended dose = 400 mg/day,* *Quantity limit = 1 tablet/day (50 mg tablet only)* Desvenlafaxine ER® (desvenlafaxine base SR) *FDA maximum recommended dose = 400 mg/day,*	**Criteria for approval of ALL non-preferred drugs:** The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR The patient meets additional criteria as outlined below. **Venlafaxine IR:** The patient has had a documented side effect, allergy, or inadequate response to at least 2 different antidepressants. **Venlafaxine ER tablet (generic), Effexor XR Capsule (brand):** The patient has had a documented intolerance to generic venlafaxine ER caps. **Fetzima, Pristiq:** The diagnosis or indication is Major Depressive Disorder (MDD) AND The patient has had a documented side effect, allergy, or inadequate response to at least 3(three) different antidepressants, one of which

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Quantity limit = 1 tablet/day (50 mg tablet only) Effexor XR® (venlafaxine XR) capsule *FDA maximum recommended dose = 225 mg/day,* *Quantity limit = 1 capsule/day (37.5 mg & 75 mg)* Fetzima® (levomilnacipran ER) capsule *FDA maximum recommended dose = 120 mg/day* *Quantity limit = 1 capsule/day* Fetzima® (levomilnacipran ER) capsule titration pack *(QL = 1 pack per lifetime)* *FDA maximum recommended dose = 120 mg/day* Khedezla® (desvenlafaxine base SR) *FDA maximum recommended dose = 400 mg/day,* *Quantity limit = 1 tablet/day (50 mg tablet only)* Pristiq® (desvenlafaxine succinate SR) *FDA maximum recommended dose = 400 mg/day,* *Quantity limit = 1 tablet/day (50 mg tablet only)* Venlafaxine ER® tablet *FDA maximum recommended dose = 225 mg/day,* *Quantity limit = 1 tablet/day (37.5 mg & 75 mg)* venlafaxine IR † *FDA maximum recommended dose = 225 mg/day*	must be Venlafaxine ER capsule. **Desvenlafaxine ER, Khedezla:** The patient has had a documented side effect, allergy, or inadequate response to at least 2 different antidepressants, one of which must be venlafaxine ER capsule AND The patient has had a documented intolerance with Pristiq. **Cymbalta:** There must be a clinically compelling reason why the dosing needs cannot be accomplished with generic duloxetine. **Note:** After a 4-month lapse in use of a non-preferred agent for a mental health indication, or if there is a change in therapy, a lookback through claims information will identify the need to re-initiate therapy following the PDL and clinical criteria.
SSRIs – Length of Authorization: Duration of Need for Mental Health Indications, 1 Year for Other Indications		
CITALOPRAM (compare to Celexa®) *FDA maximum recommended dose = 40 mg/day* ESCITALOPRAM (compare to Lexapro®) TABLETS *FDA maximum recommended dose = 20mg/day* *QL = 1.5 tabs/ day (5mg & 10mg tabs)* FLUOXETINE (compare to Prozac®) CAPSULES, SOLUTION *FDA maximum recommended dose = 80 mg/day* FLUVOXAMINE (formerly Luvox®) *FDA maximum recommended dose = 300 mg/day* PAROXETINE tablet (compare to Paxil®) *FDA maximum recommended dose = 60 mg/day* SERTRALINE (compare to Zoloft®) *FDA maximum recommended dose = 200 mg/day,* *Quantity limit = 1.5 tabs/day (25 mg & 50 mg tabs)*	Brisdelle® (paroxetine) *Quantity Limit = 1 capsule/day* Celexa®* (citalopram) *FDA maximum recommended dose = 40 mg/day* escitalopram solution (compare to Lexapro® solution) *FDA maximum recommended dose = 20 mg/day,* Fluoxetine®Tablets *FDA maximum recommended dose = 80 mg/day* fluoxetine 90 mg (compare to Prozac Weekly®) *FDA maximum recommended dose = 90 mg/week* Lexapro® (escitalopram) *FDA maximum recommended dose = 20 mg/day,* *Quantity limit = 1.5 tabs/day (5 mg & 10 mg tabs)* fluvoxamine CR (compare to Luvox CR®) *FDA maximum recommended dose = 300 mg/day,* *Quantity limit = 2 capsules/day* paroxetine suspension (compare to Paxil® susp) *FDA maximum recommended dose = 60 mg/day*	**Celexa, fluvoxamine CR, Lexapro, Paxil tablet, Pexva, Paroxetine CR, Paxil CR, Prozac, Sarafem, Zoloft:** The patient had a documented side effect, allergy, or treatment failure with 2 preferred SSRIs. One trial must be the generic formulation or IR formulation if CR formulation requested. **Brisdelle:** The indication for use is moderate to severe vasomotor symptoms (VMS) associated with menopause. AND The patient has tried and failed generic paroxetine. **Paroxetine suspension, Paxil suspension, Escitalopram solution, Lexapro solution:** The patient has a requirement for an oral liquid dosage form. AND The patient had a documented side effect, allergy, or treatment failure with 2 preferred SSRIs. If the request is for the brand product, the patient also has a documented intolerance to the generic equivalent. **Fluoxetine tablet:** Prescriber must provide a clinically compelling reason why the patient is unable to use capsules **Fluoxetine 90mg:** The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR The patient failed and is not a candidate for daily fluoxetine. AND The prescriber provides clinically compelling rationale for once-weekly dosing. **Note:** After a 4-month lapse in use of a non-preferred agent for a mental health indication, or if there is a change in therapy, a lookback through claims

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Paroxetine CR (compare to Paxil CR®) *FDA maximum recommended dose = 75 mg/day* Paxil®* (paroxetine) *FDA maximum recommended dose = 60 mg/day* Paxil® suspension (paroxetine) *FDA maximum recommended dose = 60 mg/day* Paxil CR® (paroxetine CR) *FDA maximum recommended dose = 75 mg/day* Pexeva® (paroxetine) *FDA maximum recommended dose = 60 mg/day* Prozac®* (fluoxetine) *FDA maximum recommended dose = 80 mg/day* Sarafem® (fluoxetine pmdd) *FDA maximum recommended dose = 80 mg/day* Zoloft®* (sertraline) *FDA maximum recommended dose = 200 mg/day, Quantity limit = 1.5 tabs/day (25 mg & 50 mg tabs)*	information will identify the need to re-initiate therapy following the PDL and clinical criteria.
TRICYCLICS – Length of Authorization: Duration of Need for Mental Health Information, 1 Year for Other Indications		
AMITRIPTYLINE *FDA maximum recommended dose = 300 mg/day* AMOXAPINE CLOMIPRAMINE (compare to Anafranil®) DOXEPIN (formerly Sinequan®) IMIPRAMINE (compare to Tofranil®) *FDA maximum recommended dose = 300 mg/day* NORTRIPTYLINE (compare to Pamelor®) NORTRIPTYLINE Oral Solution PROTRIPTYLINE	Anafranil®* (clomipramine) Imipramine Pamoate capsules Desipramine (compare to Norpramin®) Norpramin®* (desipramine) Pamelor®* (nortriptyline) Surmontil® (trimipramine) Trimipramine (compare to Surmontil®) Tofranil®* (imipramine) *FDA maximum recommended dose = 300 mg/day*	**Criteria for approval of ALL non-preferred drugs:** patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR the patient meets additional criteria as outlined below. **Imipramine Pamoate:** The patient has had a documented side ffect, allergy, or treatment failure to 3 preferred TCAs, one of which must be imipramine tablets. **Desipramine:** The patient has had a documented side effect, allergy, or treatment failure to nortriptyline. **All other non-preferred agents:** The patient has had a documented side effect, allergy, or treatment failure to 2 or more preferred TCAs. One trial must be the AB rated generic formulation if available **Limitation:** Chlordiazepoxide/amitriptyline and amitriptyline/perphenazine combinations are not covered. Generic agents may be prescribed separately.
ANTI-DIABETICS		
ALPHA-GLUCOSIDASE INHIBITORS		
ACARBOSE (compare to Precose®) GLYSET® (miglitol)	Precose®* (acarbose)	**Precose:** patient must have a documented intolerance to generic acarbose

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
BIGUANIDES & COMBINATIONS		
SINGLE AGENT METFORMIN (compare to Glucophage®) METFORMIN XR (compare to Glucophage XR®) **COMBINATION** GLIPIZIDE/METFORMIN (compare to Metaglip®) GLYBURIDE/METFORMIN (compare to Glucovance®)	Fortamet® metformin ER Osmotic) Glucophage®* (metformin) Glucophage XR®* (metformin XR) Glumetza® (metformin ER) Metformin ER Osmotic (compare to Fortamet®) Glucovance®* (glyburide/metformin) Riomet® (metformin oral solution)	**Fortamet, Glucophage XR, Glumetza, Metformin ER osmotic:** patient has had a documented intolerance to generic metformin XR (if product has an AB rated generic, there must have been a trial of the generic) **Glucophage, Glucovance:** 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 raged generic, the trial must be the generic) **Riomet:** prescriber provides documentation of medical necessity for the specialty dosage form (i.e. inability to swallow tablets, dysphagia)
DIPEPTIDYL PEPTIDASE (DPP-4) INHIBITORS		
PREFERRED AFTER CLINICAL CRITERIA ARE MET **SINGLE AGENT** JANUVIA® (sitagliptin) *(Quantity Limit = 1 tablet/day)* TRADJENTA® *(linagliptin) (Quantity limit=1 tab/day)* **COMBINATION** JANUMET® (sitagliptin/metformin) *(Quantity Limit = 2 tablets/day)* JANUMET XR® (sitagliptin/metformin ER) *(Qty limit=1 tab/day of 50/500 mg or 100/1000 mg or 2 tabs/day of 50/1000 mg)* JENTADUETO® (linagliptin/metformin) *(Quantity limit=2 tabs/day)*	***NON-PREFERRED AFTER CLINICAL CRITERIA ARE MET*** Nesina® (alogliptin) *(Quantity limit=1 tablet/day)* Onglyza® (saxagliptin) *(Quantity limit=1 tablet/day)* Jentadueto XR (linagliptan/metformin ER) *(Quantity limit = 1 tab/day)* Kazano® (alogliptin/metformin) *(Quantity limit=2 tabs/day)* Kombiglyze XR® (saxagliptin/metformin ER) *(Quantity limit=1 tab/day)* Oseni® (alogliptin/pioglitazone) *(Quantity limit=1 tab/day)*	**Januvia, Tradjenta:** patient has had a documented side effect, allergy, contraindication OR treatment failure with metformin **Nesina, Onglyza:** 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. **Janumet, Janumet XR:** patient has had an inadequate response with Januvia OR Metformin/Metformin XR monotherapy OR patient has been started and stabilized on Januvia and Metformin/Metformin XR combination therapy. **Kazano, Kombiglyze XR:** patient has had a documented side effect, allergy OR treatment failure with at least one preferred DPP-4 combination agent. **Jentadueto XR:** patient is unable to take Tradjenta in combination with Metformin XR as the individual separate agents. **Jentadueto:** patient has had an inadequate response with Tradjenta OR Metformin monotherapy OR patient has been started and stabilized on Tradjenta and Metformin combination therapy **Oseni:** patient is unable to take Nesina and Actos (pioglitazone) as the individual separate agents (after meeting clinical criteria for each individual agent)
INSULINS		
RAPID-ACTING INJECTABLE HUMALOG® (insulin lispro) NOVOLOG® (Aspart) **SHORT-ACTING INJECTABLE** HUMULIN R® (Regular)	Admelog® (insulin lispro) Afrezza ® Inhaled (insulin human) Apidra® (insulin glulisine) Fiasp® (insulin aspart)	**Admelog, Fiasp:** Both Humalog and Novolog must be on a long-term backorder and unavailable from the manufacturer. **Apidra:** patient has had a documented side effect, allergy OR treatment failure to Novolog or Humalog **TOUJEO**: Diagnosis of diabetes mellitus AND Prescription is initiated in consultation with an Endocrinologist AND The patient is currently on insulin

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
NOVOLIN R® (Regular) **INTERMEDIATE-ACTING INJECTABLE** HUMULIN N® (NPH) NOVOLIN N® (NPH) **LONG-ACTING ANALOGS INJECTABLE** LANTUS® (insulin glargine) LEVEMIR® (insulin detemir) **MIXED INSULINS INJECTABLE** HUMULIN 70/30® (NPH/Regular) NOVOLIN 70/30® (NPH/Regular) NOVOLOG MIX 70/30® (Protamine/Aspart) HUMALOG MIX 50/50® (Protamine/Lispro) HUMALOG MIX 75/25® (Protamine/Lispro)	Toujeo® (insulin glargine) Tresiba® Flextouch (insulin degludec) Basaglar® (insulin glargine)	glargine U100 and cannot achieve glycemic control (defined as hemoglobin A1c ≤ 7%) because dose increases cannot be tolerated despite attempts at manipulating dosing time or splitting the dose and the volume at the injection site for each dose exceeds 1ml. **Note:** Pharmacy claims will be evaluated to assess compliance with insulin glargine U100 therapy prior to Toujeo 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 ≥ 0.5%. **TRESIBA FLEXTOUCH:** Diagnosis of diabetes mellitus AND prescription is initiated in consultation with an Endocrinologist AND the patient must have documented treatment failure with BOTH preferred long-acting agents. AND For approval of U200, the patient must currently be on Tresiba U100 and cannot achieve glycemic control (defined as hemoglobin A1c ≤ 7%) despite attempts as manipulating dosing time or splitting the dose and the volume at the injection site for each dose exceeds 1ml. **Note:** 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 ≥ 0.5%. **BASAGLAR:** Diagnosis of diabetes mellitus AND prescription is initiated in consultation with an Endocrinologist AND the patient cannot achieve glycemic control (defined as hemoglobin A1c ≤ 7%) despite a 5-year trial of Lantus. **Note:** Pharmacy claims will be evaluated to assess compliance with Lantus therapy prior to Basaglar 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 ≥ 0.5%. **AFREZZA INHALED INSULIN:** • Baseline PFT with FEV1 ≥ 70 % predicted • Patient does not have underlying lung disease (Asthma, COPD) • Patient is a non-smoker or has stopped smoking more than six months prior to starting Afrezza • Patient is currently using a long-acting insulin • Patient has failed to achieve HbA1c goal (defined as ≤ 7%) on a short-acting insulin in combination with a long-acting insulin • Initial approval is for 3 months and improved glycemic control must be documented for further approvals
MEGLITINIDES		
Single Agent NATEGLINIDE (compare to Starlix®) REPAGLINIDE (compate to Prandin®)	Prandin® (replaglinide) Starlix®* (nateglinide)	**Prandin,Starlix:** patient has had a documented intolerance to generic equivalent. **Repaglinide/metformin:** patient is unable to take repaglinide and metformin as the individual separate agents.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
COMBINATION All products require PA	Repaglinide/metformin	
PEPTIDE HORMONES		
Preferred Agents After Clinical Criteria Are Met **GLP-1 Receptor Agonists** **Single Agents** BYDUREON® (exenatide extended-release) *QL = 12 vials/84 days* BYETTA® (exenatide) *(QL =3 pen/90 days)* VICTOZA® (liraglutide) *QL=9 pens/90 days* **COMBINATION AGENTS** All products require PA **Amylinomimetics** All products require PA	Adlyxin® (lixisenatide) Bydureon® BCise™ (exenatide extended-release) QL = 4 pens/28 days Ozempic® (semaglutide) Trulicity® (dulaglutide) Soliqua® (insulin glargine/lixisenatide) QL = 3 pens/25 days Symlin® (pramlintide) *No Quantity Limit applies* Xultophy® (insulin degludec/liraglutide)	**Bydureon/Byetta/Victoza:** patient has a diagnosis of type 2 diabetes. AND patient is at least 18 years of age. AND patient has had a documented side effect, allergy, contraindication or treatment failure with metformin. **Adlyxin/Bydureon BCise/Ozempic/Trulicity:** 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 at least one preferred GLP-1 Receptor Agonist. For approval of Bydureon BCise , one failure must be Bydureon. **Soliqua/Xultophy:** 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. **Symlin:** patient has a diagnosis of diabetes mellitus. AND patient is at least 18 years of age. AND patient is on insulin.
SODIUM-GLUCOSE CO-TRANSPORTER 2 (SGLT2) INHIBITORS AND COMBINATIONS		
Preferred After Clinical Criteria Are Met FARXIGA® (dapagliflozin) *(Quantity limit = 1 tablet/day)* INVOKANA® (canagliflozin) *(Quantity limit = 1 tablet/day)* JARDIANCE (empagliflozin) *(Quantity limit = 1 tablet/day)*	Glyxambi® (empagliflozin/ linagliptin) *(Quantity limit = 1 tablet/day)* Invokamet (canagliflozin/metformin) *(Quantity limit = 1 tablet/day)* Invokamet® XR (canagliflozin/metformin ER) Qtern® (dapagliflozin/saxagliptin) Segluromet® (ertugliflozin/metformin) *(Quantity Limit = 2 tablets/day)* Steglatro® (ertugliflozin) *(Quantity limit = 1 tablet/day)* Steglujan® (ertugliflozin/sitagliptin) *(Quantity limit = 1 tablet/day)* Synjardy® (empagliflozin/metformin) *(Quantity Limit = 2 tablets/day)* Synjardy® XR (empagliflozin/metformin ER) *(Quantity Limit = 1 tablet/day)* Xigduo XR® (dapagliflozin & metformin ER) *(Quantity limit 5/1000mg = 2/day)* *(Quantity limit All Other Strengths = 1/day)*	**All Agents:** Patient is 18 years of age or older AND patient has a diagnosis of type 2 diabetes mellitus and has had an inadequate response to diet and exercise alone AND patient has had a documented side effect, allergy, contraindication OR treatment failure with metformin. **Steglatro additional criteria:** Patient has a documented side effect, allergy, or contraindication to two preferred SGLT2 inhibitors. **Invokamet/Invokamet XR/Segluromet/Synjardy/ Synjardy XR/Xigduo XR® additional criteria:** The patient has documentation of a failure of therapy with a preferred SGLT2 inhibitor used incombination with metformin/metformin XR **Glyxambi/Qtern/Steglujan additional criteria:** The patient has documentation of a failure of therapy with the combination of a preferred SGLT2 inhibitor plus a preferred DPP-4 inhibitor

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
SULFONYLUREAS 2ND GENERATION		
GLIMEPIRIDE (compare to Amaryl®) GLIPIZIDE (compare to Glucotrol®) GLIPIZIDE ER (compare to Glucotrol XL®) GLYBURIDE GLYBURIDE MICRONIZED	Amaryl®* (glimepiride) Glucotrol®* (glipizide) Glucotrol XL®* (glipizide ER) Glynase® (glyburide micronized)	Patient must have a documented side effect, allergy or treatment failure to two preferred sulfonureas. If a product has an AB rated generic, one trial must be the generic.
THIAZOLIDINEDIONES & COMBINATIONS		
Preferred After Clinical Criteria Are Met **SINGLE AGENT** PIOGLITAZONE (compare to Actos®) **COMBINATION** PIOGLITAZONE/GLIMEPIRIDE (compare to Duetact®) *(Quantity Limit = 1 tablet/day)* PIOGLITAZONE/METFORMIN (Compare to Actoplus Met®)	Actos® (pioglitazone) Avandia® (rosiglitazone) Actoplus Met® (pioglitazone/metformin) Actoplus Met XR (pioglitazone/metformin ER) Duetact® (pioglitazone/glimepiride) *(Quantity Limit = 1 tablet/day)*	**Actos (pioglitazone), Actoplus Met, Duetact, Pioglitazone/Metformin:** Patient has been started and stabilized on the requested medication OR patient has had a documented side effect, allergy, contraindication OR treatment failure with metformin AND if the request is for brand Actos Met or Duetact, patient has a documented intolerance to the generic product. **Actoplus Met XR:** patient has been started AND stabilized on the requested medication OR patient has had a documented treatment failure with generic Metformin XR OR patient has had a documented treatment failure OR has been unable to be adherent to a twice daily dosing schedule of Actoplus Met resulting in a significant clinical impact. **Avandia:** patient has been started and stabilized on the requested medication and appears to be benefiting from it and the patient acknowledges that they understand the risks OR patient is unable to achieve glycemic control using other medications (including a documented side effect, allergy, contraindication or treatment failure with metformin).
ANTI-EMETICS		
5HT3 ANTAGONISTS: Length of Authorization: 6 months for chemotherapy or radiotherapy; 3 months for hyperemesis gravadarum, 1 time for prevention of post-op nausea/vomiting: see clinical criteria. Monthly quantity limits apply, PA required to exceed.		
ONDANSETRON Injection (vial and premix) ONDANSETRON†tablet *Quantity Limit= 3 tabs/day, maximum of 30 days per fill* ONDANSETRON ODT *Quantity Limit= 3 tabs/day, maximum of 30 days per fill*	Akynzeo® (nutupitant/palonosetron) Anzemet® (dolansetron) 50 mg (4 tabs/28 days) Anzemet® (dolansetron) 100 mg (2 tabs/28 days) Granisetron 1 mg (6 tabs/28 days) Granisetron Injectable Ondansetron (generic) Oral Solution 4 mg/5 ml Sancuso® 3.1 mg/24 hrs Transdermal Patch (granisetron) (Qty Limit = 4 patches/28 days) Sustol® (granisetron) injection 10mg/0.4ml QL = 4 injections per 28 days	**Akynzeo:** Has a diagnosis of nausea and vomiting associated with cancer chemotherapy AND patient has a documented side effect, allergy, or treatment failure of a regimen consisting of a 5-HT3 antagonist, an NK1 antagonist, and dexamethasone **Anzemet, Granisetron:** 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. **Zofran:** 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.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Zofran®* (ondansetron) Injection Zofran®* (ondansetron) Oral Tablets and ODT 4 mg (12 tabs/28 days), 8 mg (6 tabs/28 days) Zofran® (ondansetron) Oral Solution 4 mg/5 ml Zuplenz® (ondansetron) Oral Soluble Film *(Quantity Limit =12 films/28 days (4 mg), 6 films/28 days (8 mg))*	**Ondansetron Oral Sol:** patient is unable to use ondansetron ODT or ondansetron tablets. **Sancuso:** patient has a diagnosis of nausea and vomiting associated with cancer chemotherapy. AND prescriber provides documentation of medical necessity for the transdermal formulation. OR patient has had a documented side effect, allergy or treatment failure with generic ondansetron. **Sustol:** Patient has a diagnosis of nausea and vomiting associated with cancer chemotherapy or radiotherapy AND prescriber provides documentation of medical necessity for the specialty dosage form (i.e. inability to swallow tablets, dysphagia) AND the patient has a documented side effect, allergy, or treatment failure with Ondansetron injection and Sancuso transdermal. **Zuplenz:** 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. **CRITERIA FOR APPROVAL (to exceed quantity limit):** **Zuplenz:** For nausea and vomiting associated with chemotherapy or radiation therapy, 3 tablets for each day of chemotherapy/radiation and 3 tablets for each day for 2 days after completion of chemotherapy/radiation may be approved. **Anzemet:** For nausea and vomiting associated with chemotherapy, 1 tablet for each day of chemotherapy and 1 tablet for 2 days after completion of chemotherapy may be approved. **Granisetron:** For nausea and vomiting associated with chemotherapy, 2 tablets for each day of chemotherapy and 2 tablets for 2 days after completion of chemotherapy may be approved. OR For nausea and vomiting associated with radiation therapy, 2 tablets for each day of radiation may be approved. **Sancuso:** For nausea and vomiting associated with chemotherapy, 1 patch for each chemotherapy cycle may be approved. **Limitations:** Aloxi and Anzemet injection are not considered outpatient medications and are not covered in the pharmacy benefit.
MISCELLANEOUS (PREGNANCY)		
	Bonjesta® (20mg doxylamine succinate and 20mg pyridoxine hydrochloride ER tablet) *(QL= 2 tablets/day)* Diclegis® (10 mg doxylamine succinate and 10 mg pyridoxine hydrochloride) DR tablet *(QL= 4 tablets/day)*	**Bonjesta:** 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. **Diclegis:** Patient has a diagnosis of nausea and vomiting of pregnancy AND Patient has tried and had an inadequate response to conservative management (i.e. change in dietary habits, ginger, or acupressure) AND Patient has tried and had an inadequate response to generic doxylamine and generic pyridoxine (Vitamin B6) AND Patient has tried and had an inadequate response to generic ondansetron.
NK1 ANTAGONISTS		
Preferred After Clinical Criteria Are Met	Aprepitant (compare to Emend®) 40 mg (1 cap/28 days)	**Cinvanti:** medication will be prescribed by an oncology practitioner. AND patient requires prevention of nausea and vomiting associated with moderate to highly

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
EMEND® (aprepitant) 40 mg (1 cap/28 days) EMEND® (aprepitant) 80 mg (2 caps/28 days) EMEND® (aprepitant) 125 mg (1 cap/28 days) EMEND® (aprepitant) Tri-fold Pack (1 pack/28 days)	Aprepitant (compare to Emend®) 80 mg (2 caps/28 days) Aprepitant (compare to Emend®) 125 mg (1 cap/28 days) Cinvanti® (aprepitant) Emend® (aprepitant) oral suspension Varubi® (rolapitant) *Quantity Limit = 4 tabs/ 28 days*	emetogenic cancer chemotherapy. AND The requested quantity does not exceed 1 dose (130mg, 18ml) per course of chemotherapy. Note: Cinvanti will be approved as a medical benefit ONLY and will NOT be approved if billed through pharmacy point of sale. **Aprepitant, Emend (aprepitant) 80 mg, 125 mg, and Tri-Fold pack:** medication will be prescribed by an oncology practitioner. AND patient requires prevention of nausea and vomiting associated with moderate to highly emetogenic cancer chemotherapy. AND The requested quantity does not exceed one 125 mg and two 80 mg capsules OR one Tri-Fold Pack per course of chemotherapy. Patients with multiple courses of chemotherapy per 28 days will be approved quantities sufficient for the number of courses of chemotherapy. For approval of generic aprepitant, the patient must have a documented intolerance to brand Emend. **Emend 40mg:** patient requires prevention of postoperative nausea and vomiting. AND The requested quantity does not exceed one 40 mg capsule per surgery or course of anesthesia. Patients with multiple surgeries or courses of anesthesia in a 28-day period will be approved quantities sufficient for the number of surgeries or courses of anesthesia. **Emend oral suspension:** medication will be prescribed by an oncology practitioner AND patient requires prevention of nausea and vomiting associated with moderate to highly emetogenic cancer chemotherapy **AND** patient has a documented medical necessity for the specialty dosage form (e.g. swallowing disorder) **Varubi:** 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®.
THC DERIVATIVES		
All products require PA	Dronabinol (compare to Marinol®) Marinol® (dronabinol) Cesamet® (nabilone) Syndros™ (dronabinol) oral solution	**Pharmacology:** Marinol® is a schedule III cannabinoid agent containing the same active ingredient, tetrahydrocannabinol, as marijuana. While its exact mechanism of action is unknown, it is speculated to inhibit medullary activity as well as suppress prostaglandin and endorphan synthesis. Cesamet® is a schedule II synthetic cannabinoid that acts by activating the endocannabinoid receptors, CB1 and CB2, which are involved in nausea/vomiting regulation. Both Marinol® and Cesamet® are FDA-approved for use in chemotherapy associated nausea and vomiting refractory to conventional antiemetics. In addition, Marinol® is indicated for patients with HIV/AIDS-related anorexia or wasting syndrome. **Dronabinol/Marinol:** patient has a diagnosis of chemotherapy-induced nausea/vomiting AND patient has had a documented side effect, allergy, or treatment failure to at least 2 antiemetic agents, of which, one must be a preferred 5HT3 receptor antagonist. If the request is for Marinol, the patient must additionally have a documented intolerance to generic dronabinol. OR patient has a diagnosis of HIV/AIDS associated anorexia. AND patient has had an inadequate response, adverse reaction, or contraindication to megestrol acetate. If the request is for Marinol, the patient must additionally have a documented intolerance to generic dronabinol.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		Syndros: patient must meet criteria as listed above for dronabinol AND patient has a requirement for an oral liquid dosage form (i.e. swallowing disorder, inability to take oral medications) **Cesamet:** patient has a diagnosis of chemotherapy-induced nausea/vomiting AND patient has had a documented side effect, allergy, or treatment failure to at least 2 antiemetic agents, of which, one must be a preferred 5HT3 receptor antagonist.
ANTI-HYPERTENSIVES		
ACE INHIBITORS		
BENAZEPRIL (compare to Lotensin®) ENALAPRIL (compare to Vasotec®) EPANED® (enalapril) oral solution (age < 12 years old) FOSINOPRIL LISINOPRIL (compare to Zestril®, Prinivil®) QUINAPRIL (compare to Accupril®) RAMIPRIL (compare to Altace®) TRANDOLAPRIL	Accupril® (quinapril) Altace® (Ramipril) Captopril Epaned® (enalapril) oral solution (age ≥ 12 years old) Lotensin® (benazepril) perindopril Moexepril Prinivil® (lisinopril) Qbrelis® (Lisinopril) 1mg/ml solution Vasotec® (enalapril) Zestril® (lisinopril)	**Epaned Oral Solution (Patients > 12 years old):** patient has a requirement for an oral liquid dosage form (i.e. swallowing disorder, inability to take oral medications). **Qbrelis Oral Solution:** patient has a requirement for an oral liquid dosage form (i.e. swallowing disorder, inability to take oral medications) AND has a side effect, allergy, or treatment failure to Epaned oral solution. **Other ACE Inhibitors:** patient has had a documented side effect, allergy, or treatment failure to all available preferred generic ACEI. If a medication has an AB rated generic, there must have been a trial of the generic formulation.
ACE INHIBITOR W/ HYDROCHLOROTHIAZIDE		
BENAZEPRIL/HYDROCHLOROTHIAZIDE (compare to Lotensin HCT®) CAPTOPRIL/HYDROCHLOROTHIAZIDE ENALAPRIL/HYDROCHLOROTHIAZIDE (compare to Vaseretic®) FOSINOPRIL/HYDROCHLOROTHIAZIDE LISINOPRIL/HYDROCHLOROTHIAZIDE (compare to Zestoretic®) MOEXIPRIL/HYDROCHLOROTHIAZIDE QUINAPRIL/HYDROCHLOROTHIAZIDE (compare to Accuretic®)	Accuretic®* (quinapril/HCTZ) Lotensin HCT®* (benazepril/HCTZ) Vaseretic®* (enalapril/HCTZ) Zestoretic®* (lisinopril/HCTZ)	**ACE Inhibitor/Hydrochlorothiazide combinations:** patient has had a documented side effect, allergy, or treatment failure to all available preferred generic ACEI/Hydrochlorothiazide combination. If a medication has an AB rated generic, there must have been a trial of the generic formulation.
ACE INHIBITOR W/CALCIUM CHANNEL BLOCKER		
AMLODIPINE/BENAZEPRIL (compare to Lotrel®)	Lotrel®* amlodipine/(benazepril) Prestalia® (perindopril/amlodipine)	**Lotrel:** The patient has had a documented side effect, allergy, or treatment failure to the generic formulation. **Prestalia, Tarka, Trandolapril/Verapamil ER:** The patient has had a

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Trandolapril/Verapamil ER(compare to Tarka®) Tarka® (trandolopril/verapamil)	documented side effect, allergy, or treatment failure to amlodipine/benazepril AND the patient is unable to take as the individual separate agents.
ANGIOTENSIN RECEPTOR BLOCKERS (ARBs)		
IRBESARTAN (compare to Avapro®) LOSARTAN (compare to Cozaar®) MICARDIS® (telmisartan) OLMESARTAN (compare to Benicar®) VALSARTAN (compare to Diovan®)	Avapro® (irbesartan) Benicar® (olmesartan) candesartan Cozaar® (losartan) Diovan® (valsartan) Edarbi® (azilsartan) Tablet *(Qty Limit = 1 tablet/day)* Eprosartan Telmisartan (compare to Micardis®)	**Avapro, Benicar, Candesartan, Cozaar, Diovan, Edarbi, Eprosartan, and Telmisartan:** Patient has had a documented side effect, allergy, or treatment failure with TWO a preferred Angiotensin Receptor Blocker (ARB) or ARB combinations. AND If brand name product with generic available, the patient has had a documented intolerance with the generic product.
ANGIOTENSIN RECEPTOR BLOCKER/DIURETIC COMBINATIONS		
IRBESARTAN/HYDROCHLOROTHIAZIDE (compare to Avalide®) LOSARTAN/HYDROCHLOROTHIAZIDE (compare to Hyzaar®) VALSARTAN/HYDROCHLOROTHIAZIDE (compare to Diovan HCT®)	Avalide® (irbesartan/hydrochlorothiazide) Benicar HCT® (olmesartan/hydrochlorothiazide) candesartan/hydrochlorothiazide Diovan HCT® (valsartan/hydrochlorothiazide) Edarbyclor® (azilsartan/chlorthalidone) Tablet *(Qty Limit = 1 tablet/day)* Micardis HCT® (telmisartan/hydrochlorothiazide) Hyzaar® (losartan/hydrochlorothiazide) Telmisartan/hydrochlorothiazide (compare to Micardis HCT®)	**Avalide, Benicar HCT, candesartan/HCTZ, Diovan HCT, Edarbyclor, Hyzaar, Micardis HCT and Telmisartan/HCTZ:** 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.
ANGIOTENSIN RECEPTOR BLOCKER/CALCIUM CHANNEL BLOCK COMBINATIONS		
VALSARTAN/AMLODIPINE (compare to Exforge®) *(QL= 1tab/day)*	Azor®(olmesartan/amlodipine) *(QL = 1 tablet/day)* amlodipine/telmisartan (compare to Twynsta®) *(QL = 1 tablet/day)* Exforge® (valsartan/amlodipine) *(QL = 1 tab/day)* Olmesartan/amlodipine (compare to Azor®) Twynsta® (amlodipine/telmisartan) *(QL = 1 tablet/day)*	**Azor, Amlodipine/Telmisartan, Exforge, Olmesartan/amolodipine, Olmesartan/amlodipine/HCTZ and Twynsta:** The patient has had a documented side effect, allergy, or treatment failure to Valsartan/amlodipine.
ANGIOTENSIN RECEPTOR BLOCKER/CALCIUM CHANNEL BLOCKER/HCTZ COMBO		
Valsartan/Amlodipine/HCTZ (compare to Exforge HCT®)	Exforge HCT® (amlodipine/valsartan/hydrochlorothiazide)	**Exforge HCT, Tribenzor:** patient has had a documented side effect, allergy, or treatment failure to Valsartan/amlodipine/HCTZ.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
(QL = 1tablet/day)	*(QL = 1 tablet/day)* Tribenzor® (amlodipine/olmesartan/hydrochlorothiazide) *(QL = 1 tablet/day)*	
ANGIOTENSIN RECEPTOR BLOCKER/MISCELLANEOUS COMBINATIONS		
Preferred Agent After Clinical Criteria Is Met ENTRESTO® (valsartan/sacubitril) (QL = 2 tabs/day)	Byvalson® (Nebivolol/Valsartan)	**Entresto:** Age ≥ 18 years of age AND Diagnosis of chronic heart failure NYHA Class II-IV with reduced ejection fraction. **Byvalson:** The patient must have a documented side effect, allergy, or treatment failure to at least 3 preferred beta blockers and a preferred ARB used in combination AND is unable to take Bystolic and valsartan as the individual separate agents.
BETA BLOCKERS		
SINGLE AGENT ACEBUTOLOL ATENOLOL (compare to Tenormin®) BISOPROLOL FUMARATE CARVEDILOL (compare to Coreg® LABETALOL (compare to Trandate®) METOPROLOL TARTRATE (compare to Lopressor®) METOPROLOL SUCCINATE XL (compare to Toprol XL®) PINDOLOL PROPRANOLOL PROPRANOLOL ER (compare to Inderal LA®) SOTALOL (compare to Betapace®, Betapace AF®) **BETA-BLOCKER/DIURETIC COMBINATION**	Betapace® (sotalol) Betapace AF® (sotalol) Betaxolol Bystolic® (nebivolol) *(QL = 1 tablet/day for 2.5 mg, 5 mg and 10 mg tablet strengths, 2 tablets/day for 20 mg tab)* Carvedilol CR (compare to Coreg®) *QL = 1 tablet/day* Coreg® (carvedilol) Coreg CR® (carvedilol CR) *(QL = 1 tablet/day* Corgard® (nadolol) Hemangeol® oral solution (propranolol) Inderal LA® (propranolol ER) Inderal XL® (propranolol SR) Innopran XL® (propranolol SR) Kapspargo Sprinkle™ (metoprolol succinate XL) Lopressor® (metoprolol tartrate) Nadolol Sorine® (sotalol) Tenormin® (atenolol) Timolol Toprol XL® (metoprolol succinate XL)	**Non-preferred drugs (except as noted below)** patient has had a documented side effect, allergy, or treatment failure to at least three preferred drugs. (If a medication has an AB rated generic, one trial must be the generic formulation.) **Carvedilol CR, Coreg CR:** Indication: Heart Failure: patient has been started and stabilized on the medication. (Note: Samples are not considered adequate justification for stabilization.) OR patient has had a documented side effect, allergy, or treatment failure to metoprolol SR or bisoprolol. AND patient has been unable to be compliant with or tolerate twice daily dosing of carvedilol IR. Indication; Hypertension: patient has been started and stabilized on the medication. (Note: Samples are not considered adequate justification for stabilization.) OR patient has had a documented side effect, allergy, or treatment failure to 3(three) preferred anti-hypertensive beta-blockers. **Hemangeol:** indication for use is the treatment of proliferating infantile hemangioma **Kapspargo:** patient is unable to take a solid oral dosage form and has a treatment failure with an immediate release oral solution or crushed tablets.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ATENOLOL/CHLORTHALIDONE (compare to Tenoretic®) BISOPROLOL/HYDROCHLOROTHIAZIDE (compare to Ziac®) METOPROLOL/HYDROCHLOROTHIAZIDE	Corzide® (nadolol/bendroflumethiazide) Nadolol/bendroflumethiazide (compare to Corzide®) Propranolol/HCTZ Tenoretic® (atenolol/chlorthalidone) Ziac® (bisoprolol/HCTZ)	
CALCIUM CHANNEL BLOCKERS		
SINGLE AGENT **Dihydropyridines** AMLODIPINE (compare to Norvasc®) FELODIPINE ER NIFEDIPINE IR (compare to Procardia®) NIFEDIPINE SR osmotic (compare to Procardia® XL) NIFEDIPINE SR (compare to Adalat® CC) **Miscellaneous** CARTIA® XT (diltiazem SR, compare to Cardizem® CD) DILT-XR® (diltiazem SR) DILTIAZEM (compare to Cardizem®) DILTIAZEM ER 24-hour capsules (compare to Tiazac®) DILTIAZEM SR 24-hour capsules (compare to Cardizem®CD) DILTIAZEM SR 24-hour tablets TAZTIA® XT (diltiazem ER, compare to Tiazac®) VERAPAMIL (compare to Calan®) VERAPAMIL CR (compare to Calan SR® VERAPAMIL SR 120 mg, 180 mg 240 mg and 360 mg (compare to Verelan®) VERAPAMIL SR 100 mg, 200 mg, 300mg (compare to Verelan PM®) **Note:** Please refer to the Anti-Hypertensives:	Adalat® CC (nifedipine SR) Isradipine Nicardipine Nimodipine Nisoldipine ER (compare to Sular®) Norvasc® (amlodipine) Nymalize® (nimodipine) Oral Solution Procardia® (nifedipine IR) Procardia XL® (nifedipine SR osmotic) Sular® (nisoldipine) Calan® (verapamil) Calan® SR (verapamil CR) Cardizem® (diltiazem) Cardizem® CD (diltiazem SR) Cardizem® LA (diltiazem SR) Diltiazem ER 12-hour capsules Diltiazem ER/Matzin LA (compare to Cardizem® LA) Tiazac®* (diltiazem ER) Verelan® (verapamil SR 120 mg, 180 mg, 240 mg and 360 mg) Verelan® PM (100 mg, 200 mg and 300 mg)	**Criteria for approval (except as noted below:)** patient has had a documented side effect, allergy, or treatment failure to at least three preferred drugs. (If a medication has an AB rated generic, one trial must be the generic formulation.) **Nymalize:** patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR patient has a medical necessity for a specialty dosage form (i.e. dysphagia, swallowing disorder).

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
Angiotensin Receptor Blockers (ARBs) PDL category for ARB/CCB combination therapies		
CENTRAL ALPHA AGONISTS		
ORAL **Tablet** CLONDIDNE IR Tablets (compare to Catapress®) GUANFACINE IR Tablets (compare to Tenex®) METHYLDOPA Tablets **TRANSDERMAL** CATAPRES-TTS® (clonidine) Transdermal Patch (Qty Limit = 1 patch/7 day)	Catapres®* (clonidine) Tablet Clonidine (compare to Catapres-TTS) Transdermal Patch *(Qty Limit = 1 patch/7 days)*	**Catapres tablets:** Patient has a documented intolerance to the generic product. **Clonidine Patches (generic):** patient has a documented intolerance to brand Catapres-TTS patches
GANGLIONIC BLOCKERS		
All products require a PA	Vecamyl®* (mecamylamine) Tablet	**Vecamyl tabs:** Patient has a diagnosis of moderately severe or severe hypertension AND patient has tried and failed, intolerant to, or contraindicated to at least THREE different antihypertension therapies of different mechanism of actions.
RENIN INHIBITOR		
	SINGLE AGENT Aliskiren (compare to Tekturna®) (Qty Limit = 1 tablet/day) Tekturna® (aliskiren) *(Quantity Limit = 1 tablet/day)* COMBINATIONS Tekturna HCT® (aliskiren/hydrochlorothiazide) *(Quantity Limit = 1 tablet/day)*	**Aliskiren,Tekturna:** patient is NOT a diabetic who will continue on therapy with an ACEI or ARB AND patient has a diagnosis of hypertension. AND patient has had a documented side effect, allergy, or treatment failure with an angiotensin Receptor Blocker (ARB). **Tekturna HCT:** the patient must meed criteria as listed above for Tekturna and is unable to use the individual separate agents.
ANTI-INFECTIVES ANTIBIOTICS		
AMINOGLYCOSIDES		
Neomycin Sulfate Paromycin	Arikayce® (amikacin inhalation suspension) *Qty limit* = 28 vials (235.2 mL)/28 days	**Arikayce:** Patient is ≥ 18 years of age AND indication for use is treatment of *Mycobacterium avium complex* (MAC) lung disease AND patient has not achieved negative sputum cultures after a minimum of 6 consecutive months of a

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		multidrug background regimen therapy (e.g. macrolide, rifampin, & ethambutol) within the past 12 months. **Note:** Initial approval will be granted for 6 months. For re-approval, the patient must have documentation of clinical improvement AND 3 consecutive monthly negative sputum cultures.
CEPHALOSPORINS 1ST GENERATION		
CAPSULES/TABLETS CEFADROXIL Capsules, Tablets CEPHALEXIN Capsules (compare to Keflex®) **SUSPENSION** CEFADROXIL Suspension CEPHALEXIN Suspension IV drugs are not managed at this time	Cephalexin® Tablets Keflex®* (cephalexin) Capsules Daxbia™ (cephalexin) capsules	**Cephalexin Tabs:** patient has had a documented intolerance to cephalexin generic capsules. **Keflex/Daxbia:** patient has had a documented side effect, allergy, or treatment failure to generic cefadroxil and cephalexin.
CEPHALOSPORINS 2ND GENERATION		
CAPSULES/TABLETS CEFACLOR CAPSULE CEFPROZIL TABLET CEFUROXIME (compare to Ceftin®) TABLET **SUSPENSION** CEFACLOR SUSPENSION CEFPROZIL SUSPENSION IV drugs are not managed at this time	Cefaclor® ER Tablet Ceftin®* (cefuroxime) tablet Ceftin® (cefuroxime) suspension	**Cefaclor ER Tabs:** patient has had a documented intolerance to cefaclor capsules. **Ceftin Tabs:** patient has had a documented side effect, allergy, or treatment failure to at least two of the following medications: cefaclor, cefprozil, and cefuroxime. One trial must be the generic formulation. **Ceftin Suspension:** patient has had a documented side effect, allergy, or treatment failure to both of the following suspensions: cefaclor and cefprozil.
CEPHALOSPORINS 3RD GENERATION		
CAPSULES/TABLETS CEFDINIR CAPSULE **SUSPENSION** CEFDINIR SUSPENSION IV drugs are not managed at this time	Cefpodoxime proxetil tablet Suprax® (cefixime) Capsule Suprax® (cefixime) Chewable Tablets Cefixime suspension Cefpodoxime proxetil suspension ceftibuten†suspension (compare to Cedax®) Suprax® (cefixime) suspension	**Spectracef tablet, Cefditoren tablet, Cefpodoxime Proxetil tablets:** patient is completing a course of therapy which was initiated in the hospital. OR patient has had a documented side effect, allergy, or treatment failure to one preferred cephalosporin. **Ceftibuten Susp, Cefpodoxime Proxetil Susp, Cefixime Susp, Suprax Susp:** patient is completing a course of therapy which was initiated in the hospital. OR patient has had a documented side effect or treatment failure to cefdinir suspension.
MACROLIDES		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
AZITHROMYCIN tabs, liquid (≤ 5 day supply) (compare to Zithromax®) (Maximum 10 days therapy/30 days) CLARITHROMYCIN (compare to Biaxin®) tablets IV drugs are not managed at this time	azithromycin tablets and liquid (if > 5 day supply) (compare to Zithromax®) Azithromycin packet (compare to Zithromax®) *(QL = 2 grams/fill)* Zithromax®* (azithromycin) tablets and liquid *QL = 5 days supply/RX, maximum 10 days therapy/30 days* Zithromax® (azithromycin) packet *(QL=2 grams/fill)* Zmax® Suspension (azithromycin extended release for oral suspension) *QL = 5 days supply/RX, maximum 10 days therapy/30 days* Clarithromycin SR (compare to Biaxin® XL) Clarithromycin suspension E.E.S® (erythromycin ethylsuccinate) ERY-TAB® (erythromycin base, delayed release) ERYTHROMYCIN BASE ERYTHROMYCIN ETHYLSUCCINATE (compare to E.E.S®) Eryped® (erythromycin ethylsuccinate) Erythrocin (erythromycin stearate) PCE Dispertab® (erythromycin base) Dificid® (fidaxomicin) tablet *(Quantity limit =2 tablets per day, 10 day supply per 30 days)*	**Non-preferred agents (except as below):** patient has a documented side-effect, allergy, or treatment failure to at least two of the preferred medications. (If a product has an AB rated generic, one trial must be the generic.) OR patient is completing a course of therapy with the requested medication that was initiated in the hospital. **Azithromycin/Zithromax packets:** A clinically valid reason why the dose cannot be obtained using generic azithromycin tablets AND If the request is for brand Zithromax, the patient has a documented intolerance to the generic product. **Azithromycin > 5 day supply (criteria for approval based on indication):** *Lyme Disease:* patient has had a documented side effect, allergy, or treatment failure to at least two of the following: doxycycline, amoxicillin, or a 2nd generation cephalosporin. For early Lyme disease, without neurologic or rheumatologic (arthritis) complications, the length of authorization is up to 10 days. For neurologic or rheumatologic Lyme disease, the length of authorization is up to 28 days *Cystic Fibrosis*: length of authorization up to 6 months *HIV/immunocompromised status:* azithromycin is being used for MAC or Toxoplasmosis treatment or prevention. (length of authorization up to 6 months) *Bacterial Sinusitis:* patient has had a documented side effect, allergy, or treatment failure to penicillin, amoxicillin, or sulfamethoxazole/trimethoprim (Bactrim). (length of authorization up to 10 days) *Severe Bronchiectasis or COPD with frequent exacerbations:*length of authorization up to 6 months *Babesiosis:* blood smear or PCR is positive (results must be submitted; positive serology is not sufficient) AND patient is symptomatic (length of authorization up to 10 days) **Dificid:** patient's diagnosis or indication is Clostridium difficile associated diarrhea (CDAD) AND patient has had a side-effect, allergy, treatment failure or contraindication to metronidazole. OR prescriber provides a clinically compelling rationale why metronidazole is not appropriate for the patient. (E.g. patient has severe Clostridium difficile infection, history of recurrent infections). AND patient has had a side-effect, allergy, treatment failure or contraindication to oral vancomycin capsules (Vancocin).
OXAZOLIDINONES		
IV form of this medication not managed at this time	Linezolid (compare to Zyvox®)	**Criteria for Approval:** patient has been started on intravenous or oral linezolid or

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	(QL = 56 tablets per 28 days) Linezolid (compare to Zyvox®) suspension (QL = 60 ml/day, maximum 28 days supply) Sivextro® (tedizolid) *(Quantity limit = 1 tabs/day)* Zyvox® (linezolid) *(QL = 56 tablets per 28 days)* Zyvox® (linezolid) suspension (*QL = 60 ml/day, maximum 28 days supply)*	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.
PENICILLINS (ORAL)		
SINGLE ENTITY AGENTS **Natural Penicillins** PENICILLIN V POTASSIUM tablets, oral solution **Penicillinase-Resistant Penicillins** DICLOXACILLIN Capsules **Aminopenicillins** AMOXICILLIN capsules, tablets, chewable tablets, suspension AMPICILLIN capsules, suspension **COMBINATION PRODUCTS** AMOXICILLIN/CLAVULANATE (compare to Augmentin®) tablets, chewable tablets, suspension	Amoxicillin/clavulanate ER (compare to Augmentin XR®) tablets Augmentin®*♣ (amoxicillin/clavulanate)suspension Augmentin XR® (amoxicillin/clavulanate) tablets PA will be granted for 125 mg/5 mL strength for patients < 12 weeks of age	**Augmentin:** patient has had a documented intolerance to the generic formulation of the requested medication. OR patient is < 12 weeks of age and requires the 125 mg/5 mL strength of Augmentin. **Amoxicillin/Clavulanate ER, Augmentin XR**: prescriber must provide a clinically valid reason for the use of the requested medication. Additionally, for approval of brand Augmentin XR, the patient must have a documented intolerance to generic Amoxicillin/Clavulanate ER **Limitations:** Brand Augmentin® tablets and Chewable tablets do not offer Federal Rebate and therefore cannot be provided.
QUINOLONES		
CIPROFLOXACIN (compare to Cipro®) tabs, oral suspension CIPRO® (ciprofloxacin) oral suspension LEVOFLOXACIN (compare to Levaquin®) tabs, sol	Avelox® (moxifloxacin HCL) Baxdela™ (delafloxacin) Cipro® * (ciprofloxacin) tabs Cipro XR® (ciprofloxacin)	**Baxdela:** patient is completing a course of therapy with the requested medication that was initiated in the hospital OR patient is ≥ 18 years of age AND has a confirmed diagnosis of acute bacterial skin and skin structure infection (ABSSSI) AND current culture and sensitivity (C&S) report shows isolated pathogen is a gram-positive or gram-negative organism susceptible to delafloxacin (If obtaining a C&S report is not

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
IV drugs are not managed at this time	ciprofloxacin ER (compare to Cipro XR®) Levaquin®* (levofloxacin) tabs,sol moxifloxacin (compare to Avelox®) Ofloxacin	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. **Cipro, Cipro XR, ciprofloxacin ER:** patient has had a documented side effect, allergy, or treatment failure to generic ciprofloxacin immediate-release tablets. AND If the request is for Cipro XR or Cipro the patient has had a documented intolerance to the generic equivalent. **Avelox, Moxifloxacin:** patient is completing a course of therapy with the requested medication that was initiated in the hospital. OR patient has had a documented side effect, allergy, or treatment failure to levofloxacin. AND If the request is for Avelox, the patient has had a documented intolerance to generic moxifloxacin. **Levaquin (brand):** patient has a documented intolerance with the generic levoflocacin **Ofloxacin:** patient has had a documented side effect, allergy, or treatment failure to ciprofloxacin or levofloxacin
RIFAMYCINS		
All products require PA	Xifaxan ® (rifaximin) 200 mg Tablets *(Qty limit depends on indication)* Xifaxan ® (rifaximin) 550 mg Tablets *(Qty limit depends on indication)*	**Criterial for Approval: Based on Indication:** **Hepatic Encephalopathy (Xifaxan 550 mg Tablets Only):** patient has a diagnosis of hepatic encephalopathy. AND Patient has had a documented side effect, allergy, treatment failure or contraindication to lactulose. AND Quantity limit is 2 tablets/day (550 mg tablets only). **Traveller's Diarrhea (Xifaxan 200 mg Tablets Only**): patient has a diagnosis of traveller's diarrhea caused by noninvasive strains of Escherichia coli. AND Patient has had a documented side effect, allergy, treatment failure or contraindication with a fluoroquinolone. AND Quantity limit is 9 tablets/RX (200 mg tablets only). **Small Intestinal Bacterial Overgrowth (Xifaxan 550 mg or 200 mg Tablets:** patient has a diagnosis of SIBO. AND Patient has attempted dietary modification and has had a documented side effect, allergy, treatment failure or contraindication to metronidazole or neomycin AND Quantity limit is 800 mg to 1,200 mg/day. **Irritable Bowel Syndrome (Xifaxan 550 mg or 200 mg Tablets):** patient has a diagnosis of irritable bowel syndrome without constipation or with symptoms of bloating. AND Patient has attempted dietary modification and has had a documented side effect, allergy, treatment failure or contraindication to two of the following classes (one of which must be an antibiotic): • Antibiotics (alone or in combination: amoxicillin-clavulanate, cephalosporin, metronidazole, fluoroquinolone, tetracycline, trimethoprim-sulfamethoxazole) • SSRIs • TCAs • Antispasmodics • Antidiarrheals • Cholestyramine resin AND Quantity limit is 1,200 mg to 1,650 mg/day.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		Inflammatory Bowel Disease: Crohn's Disease (Xifaxan 550 mg or 200 mg Tablets): patient has a diagnosis of Crohn's Disease. AND Patient has had a documented side effect, allergy, treatment failure or contraindication to two of the following: 6-mercaptopurine, aminosalicylates, azathioprine, corticosteroids, fluoroquinolone and/or metronidazole. AND Quantity limit is 600 mg to 1,600 mg/day. **Inflammatory Bowel Disease: Ulcerative Colitis (Xifaxan 200 mg Tablets):** patient has a diagnosis of Ulcerative Colitis. AND Patient has had a documented side effect, allergy, treatment failure or contraindication to two of the following: 6-mercaptopurine, aminosalicylates, azathioprine, corticosteroids, fluoroquinolone and/or metronidazole. AND Quantity limit is 800 mg/day (4 x 200 mg tablets/day). **Clostridium difficile Diarrhea (Xifaxan 200 mg Tablets):** patient has a diagnosis of C. difficile diarrhea. AND Patient has had a documented side effect, allergy, treatment failure or contraindication to metronidazole. AND Quantity limit is 800 mg/day (4 x 200 mg tablets/day).
TETRACYCLINES		
DOXYCYCLINE MONOHYDRATE 50MG, 100MG CAPS, TABS DOXYCYCLINE HYCLATE 50MG, 100MG CAPS, TABS DOXYCYCLINE MONOHYDRATE SUSP 25MG/5ML MINOCYCLINE 50MG, 100MG CAPS	Adoxa®* (doxycycline monohydrate) 150mg tab Doryx (doxycycline hyclate) tabs Doxycycline 75mg, 150mg caps, tabs Oracea® (doxycycline monohydrate) 40mg cap Vibramycin®* (doxycycline hyclate) cap, suspension Vibramycin® (doxycycline calcium) syrup Minocycline 50mg, 75mg, 100mg tabs Solodyn®(minocycline) tabs ER Tetracycline 250mg, 500mg cap Ximino® (minocycline) caps ER All other brands	**Non-preferred doxycycline/minocycline products (except as listed below):** 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. **Oracea:** patient has a diagnosis of Rosacea AND patient has had a documented side effect, allergy, or treatment failure with both a preferred doxycycline and minocycline. **Solodyn/Ximino:** patient is ≥ 12 years of age AND indication is to treat non-nodular inflammatory lesions of acne vulgaris AND patient has had a documented side effect, allergy, or treatment failure with a preferred minocycline. **Note:** no effect has been demonstrated on non-inflammatory acne lesions. **Vibramycin Suspension, Syrup:** patient has a medical necessity for a liquid dosage form AND a documented failure of preferred doxycycline suspension. **Tetracycline:** patient has had a documented side effect, allergy, or treatment failure with at least two preferred products OR the indication for use is the treatment of H. Pylori infection and the patient has a contraindication or treatment failure to clarithromycin.
VANCOMYCIN		
All products require PA IV vancomycin products are not managed at this time	Firvanq™ (vancomycin HCl) powder for oral solution QL = 1 bottle (150ml) per course of therapy. If more than 150ml is required, use of 300ml bottle is required.	**Criteria for Approval:** patient's diagnosis or indication is enterocolitis caused by Staphylococcus aureus. OR patient's diagnosis or indication is antibiotic-associated pseudomembranous colitis caused by Clostridium AND For approval of brand Vancocin, the patient must meet the above criteria and have

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Vancocin® (vancomycin) Capsules Vancomycin (compare to Vancocin®) Capsules	a documented intolerance to the generic.
ANTI-INFECTIVES ANTIFUNGAL		
ALLYLAMINES		
TERBINAFINE tabs (compare to Lamisil®) *QL = 30 tablets/month (therapy limit of 90 days)* GRISEOFULVIN MICROSIZE Suspension	Griseofulvin Microsize Tablets Griseofulvin Ultramicrosize Tablets Lamisil® tablets (terbinafine HCL) *QL = 30 tablets/month*	**Griseofulvin Microsize Tabs/Griseofulvin Ultramicrosize:** patient has had a documented side effect, allergy, or treatment failure with terbinafine tablets and a preferred formulation of griseofulvin. **Lamisil Tabs:** the patient must have a documented intolerance to generic terbinafine.
AZOLES		
FLUCONAZOLE (compare to Diflucan®) tabs, suspension CLOTRIMAZOLE Troche (compare to Mycelex®) IV drugs are not managed at this time.	Cresemba® (isavuconazonium) Caps Diflucan®* (fluconazole) tabs, suspension itraconazole (compare to Sporanox®) caps Ketoconazole tabs Noxafil® (posaconazole) oral suspension Noxafil® (posaconazole) DR Tablets *(QL=93 tablets/30 days)* Onmel® (itraconazole) 200 mg tablet *(QL=1 tab/day)* Oravig® (miconazole) 50mg buccal tablet Sporanox® (itraconazole) caps, solution VFend® (voriconazole) tabs, suspension voriconazole (compare to VFend®) tabs, suspension	**Cresemba:** • Diagnosis of either invasive aspergillosis or mucormycosis • Age ≥18 years old • Documented side effect, allergy, contraindication or treatment failure with voriconazole • Completion of regimen started by hospital **Ketoconazole/Itraconazole 100mg/Sporanox** patient has a documented side-effect, allergy, or treatment failure to at least ONE of the preferred medications OR patient is completing a course of therapy that was initiated in the hospital. For approval of Sporanox®capsules, the patient must have a documented intolerance to generic itraconazole. For approval of Sporanox solution, the patient must have a medical necessity for a liquid dosage form. **Onmel 200mg:** patient has a diagnosis of a toenail onychomycosis infection (confirmed with a positive KOH stain, PAS stain, fungal culture or physician clinical judgment) AND has a documented side-effect, allergy, contraindication, or treatment failure to oral terbinafine AND there is a clinical reason that itraconazole 100 mg generic capsules cannot be used AND meets at least 1 of the following criteria: Pain to affected area that limits normal activity, Diabetes Mellitus, Patient has significant vascular compromise **Limitations:** Coverage of Onychomycosis agents will NOT be approved solely for cosmetic purposes. **Voriconazole/Vfend:** Patient has a diagnosis of invasive aspergillosis. OR patient is completing a course of therapy with the requested medication that was initiated in the hospital. OR patient has a documented side-effect, allergy, or treatment failure to ONE of the preferred medications AND itraconazole.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		AND For approval of Vfend®, the patient must have a documented intolerance to generic voriconazole. AND For approval of voriconazole suspenion, the patient must have a medical necessity for a liquid dosage form. **Noxafil:** patient has a diagnosis of HIV/immunocompromised status (neutropenia secondary to chemotherapy, hematopoietic stem cell transplant recipients) AND Noxafil is being used for the prevention of invasive Aspergillosis/Candida infections. OR patient is completing a course of therapy with the requested medication that was initiated in the hospital. OR Oral Suspension ONLY patient has a documented side-effect, allergy, or treatment failure to ONE of the preferred medications AND itraconazole AND the patient is being treated for oropharyngeal candidiasis. **Diflucan (brand):** For approval of Diflucan brand name product, the patient must have a documented intolerance to generic fluconazole. **Oravig:** The indication for use is treatment of oropharyngeal candidiasis AND patient has had a documented side effecr, allergy, or treatment failure/inadequate response to both nystatin suspension and clotrimazole troche.
ANTI-INFECTIVES ANTIMALARIALS: QUININE		
	Quinine Sulfate (compare to Qualquin®) Qualaquin® (quinine sulfate)	**Criteria for Approval**: diagnosis or indication is for the treatment of malaria. (Use for leg cramps not permitted.) AND If the request is for brand Qualaquin, the patient has a documented intolerance to the generic equivalent.
ANTI-PARASITICS		
Albenza® (albendazole) Biltricide® (praziquantel) Ivermectin (compare to Stromectol®)	Benznidazole Emverm® (mebendazole) Stromectol® (ivermectin)	**Benznidazole:** patient must be between 2-12 years of age AND patient has a diagnosis of Chagas Disease (American trypanosomiasis) AND length of therapy does not exceed 60 days. **Emverm:** patient has a documented side effect, allergy, treatment failure, or contraindication to Albenza OR indication for use is hookworm infection (e.g. ancyclostomiasis, necatoriasis, uninariasis). **Stromectol:** patient has a documented intolerance to the generic product.
ANTI-INFECTIVES ANTI-VIRALS		
HERPES SIMPLEX VIRUS MEDICATIONS (ORAL)		
ACYCLOVIR (compare to Zovirax®) tablets, capsules	Famciclovir (compare to Famvir®) Famvir® (famciclovir)	**Acyclovir suspension (age > 12 yrs), Zovirax suspension** The 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

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ACYCLOVIR suspension (age ≤ 12 yrs) VALACYCLOVIR (compare to Valtrex®)	Sitavig® (acyclovir) Buccal Tablet *QL = 2 tablets/30 days* Valtrex®* (valacyclovir) Zovirax®*(acyclovir) tablets, capsules, suspension	suspension. **Famciclovir, Zovirax (tabs, caps):** patient has a documented side effect or allergy, or treatment failure (at least one course of ten or more days) with acyclovir AND valacyclovir. **Famvir:** patient has a documented side effect or allergy, or treatment failure (at least one course of ten or more days) with acyclovir AND valacyclovir. AND patient has a documented intolerance to generic famciclovir. **Sitavig:** patient has a diagnosis of recurrent herpes labialis (cold sores). AND patient is immunocompetent AND patient has a documented side effect or treatment failure with acyclovir AND valacyclovir. **Valtrex:** patient has a documented intolerance to generic valacyclovir
INFLUENZA MEDICATIONS		
Preferred After Clinical Criteria Are Met OSELTAMIVIR (compare to Tamiflu®) QL=10 capsules/30 days (45 mg & 75 mg caps) 20 capsules / 30 days (30 mg caps) 180 ml (6 mg/ml) / 30 days (suspension) RELENZA® (zanamivir) *QL= 20 blisters / 30 days* TAMIFLU® (oseltamivir) *QL=10 capsules/30 days(45 mg & 75 mg caps) 20 capsules / 30 days (30 mg caps) 180 ml (6 mg/ml) / 30 days (suspension)*	Xofluza™ (baloxavir marboxil) QL=2 tablets/30 days	**Oseltamivir, Tamiflu, Relenza:** Tamiflu and Relenza will NOT require prior-authorization at this time when prescribed within the following quantity limits: **Relenza:** 20 blisters per 30 days **Oseltamivir/Tamiflu:** 75mg or 45mg: 10 caps per 30 day **Oseltamivir/Tamiflu:** 30mg: 20 caps per 30 days **Oseltamivir/Tamiflu:** Suspension (6mg/ml): 180ml (3 bottles) per 30 days **Xofluza:** Patient is ≥ 12 years of age AND there is a clinical, patient-specific reason the patient cannot use a preferred agent. **Note:** A maximum of one single dose per 30 days will be approved based on the patient's body weight: 40mg (2 x 20mg tablets) for patients weighing between 40kg and 80kg or 80mg (2 x 40mg tablets) for patients weighing at least 80kg. **Limitations:** Amantadine, Flumadine and rimantadine are not CDC recommended for use in influenza treatment or chemoprophylaxis at this time and are not covered for this indication. For information regarding amantadine see "Parkinsons Medications".
CYTOMEGALOVIRUS (CMV) INFECTION MEDICATIONS		
Valganciclovir (compare to Valctye®) tablet	Prevymis® (letermovir) Valcyte® tablets, solution Valganciclovir (compare to Valcyte®) solution	**Prevymis:** Indication is for the prophylaxis of cytomegalovirus (CMV) infection in adult CMV-seropositive recipients [R+] of an allogenic hematopoietic stem cell transplant AND therapy is initiated between day 0 and day 28 post-transplantation AND therapy will continue through day 100 post-transplantation AND for approval of injection, the patient must be unable to take oral medications. **Valcyte:** the patient has a documented intolerance to generic valganciclovir AND for approval of solution, the patient has a medical necessity for a non-solid oral dosage form. **Valganciclovir solution:** the patient has a medical necessity for a non-solid oral dosage form.
INFLUENZA VACCINES		
SEASONAL Influenza Vaccine INJECTION **Inactivated Influenza Vaccine, Trivalent (IIV3),**	**Adjuvanted Inactivated Influenza Vaccine, Trivalent (IIV3), Standard Dose (egg based)** Fluad™ Injection	**Flucelvax Quadrivalent:** Prescriber provides clinical rationale why one of the preferred influenza vaccines cannot be used. **Flublok:** Patient must have a documented severe reaction to egg based influenza

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
Standard Dose (egg based) AFLURIA® Injection **Inactivated Influenza Vaccine, Quadrivalent (IIV4),** **Standard Dose (egg based)** AFLURIA® QUADRIVALENT Injection FLUARIX® QUADRIVALENT Injection FLULAVAL® QUADRIVALENT Injection FLUZONE® QUADRIVALENT Injection	**Inactivated Influenza Vaccine, Trivalent (IIV3), High Dose (egg based)** Fluzone High-Dose® Injection **Recombinant Influenza Vaccine, Quadrivalent (RIV4) (egg FREE)** Flublok® Injection **Inactivated Influenza Vaccine, Quadrivalent (ccIIV4), Standard Dose (cell culture based) (NOT egg free)** Flucelvax Quadrivalent® Injection **Live Attenuated Influenza Vaccine, Quadrivalent (LAIV4) (egg based)** Flumist® Quadrivalent Intranasal	vaccine. **Flumist:** Flumist is being requested for influenza prophylaxis during flu season AND The patient is between the ages of 19 and 49 years old, AND Prescriber provides documentation of a contraindication to an intramuscular injection (e.g., currently on warfarin; history of thrombocytopenia) or other compelling information to support the use of this dosage form. **Fluzone High Dose, Fluad:** 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.
VACCINES - OTHER		
Preferred after Age Limit is met Gardasil Shingrix Zostavax		**Gardasil**: Covered for 19 years old to 45 years old (those under 19 should be referred to their pediatrician or PCP for state-supplied vaccine) **Shingrix**: Covered if ≥ 50 years of age **Zostavax:** Covered if ≥ 60 years of age Vaccines on the Advisory Committee on Immunization Practices (ACIP) list of recommended vaccines for children ≤ 18 years of age are supplied through the Vaccines for Children program administered by the Vermont Department of Health, and are not available through DVHA's pharmacy programs • Vaccines on the ACIP list of recommended vaccines for adults ≥ 19 years of age are available at many primary care provider offices and through the pharmacy programs. Vaccines are subject to the same limitations as the ACIP guideline recommendations. Providers who participate in the Blueprint for Health initiative must enroll in the Vaccines for Adults program administered by the Vermont Department of Health. The ACIP guidelines and information about enrollment in these programs can be found at

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		http://healthvermont.gov/hc/imm/provider.aspx•Vaccines not on the recommended list may require Prior Authorization.
ANTI-MIGRAINE AGENTS		
Calcitonin gene-related peptide (CGRP) Inhibitors: Initial approval is 6 months; renewals are 1 year		
Preferred After Clinical Criteria are Met Emgality® (galcanezumab-gnlm) *(Qty Limit = 240mg (2 injections) for the first 30 days followed by 120 mg (1 injection) per 30 days)*	Aimovig™ (erenumab-aooe) *(Qty limit = 140mg per 30 days)* Ajovy® (fremanezumab-vfrm) *(Qty Limit = 225mg (1 injection) per 30 days or 675mg (3 injections) every 90 days*	**All agents :** 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 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 **Aimovig, Ajovy additional criteria:** The patient must have a documented side effect, allergy, or treatment failure to Emgality. **Note:** Aimovig approvals for 140mg dose(s) must use "140DOSE" package (containing 2 x 70mg syringes or auto-injectors). Approval will not be granted for 2 separate 70mg packages.
TRIPTANS		
Single Agent **ORAL** SUMATRIPTAN (compare to Imitrex®) *Quantity Limit = 18 tablets/30 days (25 mg), 9 tablets/month (50 mg, 100 mg)* RELPAX® (eletriptan) 20 mg, 40 mg *Quantity Limit = 12 tablets/30 days* RIZATRIPTAN (compare to Maxalt®) *Quantity Limit = 12 tablets/30 days* RIZATRIPTAN ODT (compare to Maxalt-MLT®) *Quantity Limit = 12 tablets/30 days*	Almotriptan 6.25mg, 12.5mg *Quantity Limit = 12 tablets/30 days* Amerge® (naratriptan) 1 mg, 2.5 mg *Quantity Limit = 9 tablets/ 30 days* Eletriptan (compare to Relpax®) *Quantity Limit = 12 tablets/30 days* Frova® (frovatriptan) 2.5 mg *Quantity Limit = 9 tablets/ 30 days* Frovatriptan (compare to Frova®) 2.5mg *Quantity Limit = 9 tablets/30 days* Imitrex®* (sumatriptan) *Quantity Limit = 18 tablets/ 30 days (25 mg), 9 tablets/ 30 days (50 mg, 100 mg),* Maxalt® (rizatriptan) 5 mg, 10 mg tablet *Quantity Limit = 12 tablets/ 30 days*	**Almotriptan, Amerge, Eletriptan, Frova, Frovatriptan, Imitrex, Maxalt, Maxalt MLT, Naratriptan, Zomig, Zomig ZMT, Zolmitriptan, Zolmitriptan ODT:** 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. **Treximet:** patient had a documented side effect, allergy or treatment failure with 2 preferred Triptans, AND patient is unable to take the individual components (sumatriptan and naproxen) separately. **Zomig Nasal Spray, Imitrex Nasal Spray, Onzetra Xsail:** patient has had a documented side effect, allergy or treatment failure with Sumatriptan Nasal Spray **Imitrex, Sumavel Dose Pro Injections, Zembrace**: patient has had a documented intolerance to generic sumatriptan injection.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Maxalt-MLT® (rizatriptan ODT) *Quantity Limit = 12 tablets/ 30 days* NARATRIPTAN (compare to Amerge®) (*Quantity Limit = 9 tablets/ 30 days)* Zomig® (zolmitriptan) tablets *Quantity Limit = 12 tablets/ 30 days (2.5 mg), 6 tablets/ 30 days (5 mg)* Zomig® ZMT (zolmitriptan ODT) *Quantity Limit = 12 tablets/ 30 days (2.5 mg), 6 tablets/ 30 days (5 mg)* Zolmitriptan (compare to Zomig®) tablets *Quantity Limit = 12 tablets/ 30 days (2.5 mg), 6 tablets/ 30 days (5 mg)* Zolmitriptan ODT (compare to Zomig® ZMT) *Quantity Limit = 12 tablets/ 30 days (2.5 mg), 6 tablets/ 30 days (5 mg)*	**To exceed quantity limits:** patient is taking a medication for migraine prophylaxis.
NASAL SPRAY SUMATRIPTAN (compare to Imitrex®) *Quantity Limit =12 units/ 30 days (5 mg nasal spray),* *6 units/ 30 days (20 mg nasal spray)*	Imitrex® (sumatriptan) *Quantity Limit =12 units/ 30 days (5 mg nasal spray),* *6 units/ 30 days (20 mg nasal spray)* Zomig® (zolmitriptan) *Quantity Limit = 12 units/ 30 days (2.5 or 5 mg nasal spray)*	
NASAL POWDER All products require PA.	Onzetra Xsail® (sumatriptan succinate) *Quantity Limit = 8 doses/30 days*	
INJECTABLE SUMATRIPTAN (compare to Imitrex®) *Quantity Limit =8 injections (4ml)/ 30 days (4 or 6 mg injection)*	Imitrex® (sumatriptan) *Quantity Limit =8 injections/ 30 days (4ml)(4 or 6 mg injection)* Sumavel DosePro® (sumatriptan) 6 mg/0.5ml, 4 mg/0.5 ml *Quantity Limit =4 injections/ 30 days*	

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Zembrace® SymTouch (sumatriptan) 3mg/5ml *Quantity Limit =4 injections/ 30 days*	
Combination Product (Oral)	Treximet® (sumatriptan/naproxen) *Quantity Limit = 9 tablets/ 30 days*	
ANTI-PSYCHOTIC ATYPICAL & COMBINATIONS (CHILDREN < 18 YEARS OLD)		
Preferred After Clinical Criteria Are Met **TABLETS/CAPSULES** ARIPIPRAZOLE (compare to Abilify®) FDA maximum recommended dose=30mgday, QL = 1.5 tabs/day (5mg, 10mg, & 15mg) OLANZAPINE (compare to Zyprexa®) *FDA maximum recommended dose = 20 mg/day,* *Quantity limit = 1.5 tabs/day (2.5 mg, 5 mg, 7.5 mg & 10 mg tabs)* RISPERIDONE (compare to Risperdal®) *FDA maximum recommended dose = 16 mg/day* QUETIAPINE (compare to Seroquel®) *FDA maximum recommended dose = 800 mg/day* ZIPRASIDONE (compare to Geodon®) *FDA maximum recommended dose = 160 mg/day* ***Preferred After Clinical Criteria Are Met***	Abilify® (aripiprazole) *FDA maximum recommended dose = 30 mg/day,* *Quantity limit = 1.5 tabs/day (5 mg, 10 mg & 15 mg tabs)* Clozapine (compare to Clozaril®) *FDA maximum recommended dose = 900 mg/day* Clozaril® *(clozapine)* *FDA maximum recommended dose = 900 mg/day* Geodon® (ziprasidone) *FDA maximum recommended dose = 160 mg/day* Invega® (paliperidone) *FDA maximum recommended dose = 12 mg/day* *Quantity limit = 1 tab/day (3mg, 9mg), 2 tabs/day (6mg)* Latuda® (lurasidone) *FDA maximum recommended dose = 80mg/day* *Quantity limit = 1 tab/day* Paliperidone (compare to Invega®) FDA maximum recommended dose = 12 mg/day Quantity limit = 1 tab/day (3mg, 9mg), 2 tabs/day (6mg) Risperdal® (risperidone) *FDA maximum recommended dose = 16 mg/day* Seroquel® (quetiapine) *FDA maximum recommended dose = 800 mg/day* Saphris® (asenapine) *FDA maximum recommended dose = 20mg/day QL = 2 tabs/ day*	**Target symptoms or Diagnosis that will be accepted for approval:** Target Symptoms - Grandiosity/euphoria/mania; Obsessions/compulsions; Psychotic symptoms; Tics (motor or vocal). Diagnosis- Autism with Aggression and/or irritability; Disruptive Mood Dysregulation Disorder; Bipolar Disorder; Intellectual Disability with Aggression and/or Irritability; Major Depressive Disorder with psychotic features; Obsessive Compulsive Disorder; Schizophrenia/Schizoaffective Disorder; Tourette's Syndrome. **Criteria for approval of ALL drugs:** Medication is being requested for one of the target symptoms or diagnoses listed above AND the patient is started and stabilized on the requested medication (Note: samples are not considered adequate justification for stabilization) OR patient meets additional criteria outlined below. Note: all requests for patients < 5 years will be reviewed by the DVHA medical director. **Invega, Paliperidone, Saphris:** 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. **Abilify, Clozaril, Geodon, Risperdal, Seroquel, Zyprexa:** patient has a documented intolerance to the generic equivalent. **Clozapine:** patient has had a documented side effect, allergy or treatment failure with at least three other antipsychotic medications (typical or atypical antipsychotics), two of which must be preferred agents. **Latuda:** *Indication for use is schizophrenia:* 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. *Indication for use is Bipolar 1 depression:* patient is ≥ 10 years of age or older AND

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Seroquel XR® (quetiapine XR) *FDA maximum recommended dose = 800 mg/day* *Quantity Limit = 1 tab/day* *(150 mg & 200 mg tablet strengths), 2 tabs/day (50 mg strength)* Zyprexa® (olanzapine) *FDA maximum recommended dose = 20 mg/day,* *Quantity limit = 1.5 tabs/day (2.5 mg, 5 mg, 7.5 mg & 10 mg tabs)*	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. **Seroquel XR:** patient has not been able to be adherent to a twice daily dosing schedule of quetiapine immediate release resulting in a significant clinical impact.
ORAL SOLUTIONS RISPERIDONE (compare to Risperdal®) oral solution *FDA maximum recommended dose = 16 mg/day*	Abilify® (aripiprazole) oral solution *FDA maximum recommended dose = 25 mg/day* Risperdal® (risperidone) oral solution *FDA maximum recommended dose = 16 mg/day* Versacloz® (clozapine) Oral Suspension *FDA maximum recommended dose = 900 mg/day* *Quantity limit = 18 ml/day*	**Abilify Oral Solution:** patient has had a documented side effect, allergy or treatment failure with risperidone oral solution OR prescriber feels that risperidone would not be an appropriate alternative for the patient because of pre-existing medical conditions such as obesity or diabetes. **Versacloz Oral Solution:** AND patient has had a documented side effect, allergy or treatment failure with at least three other antipsychotic medications (typical or atypical antipsychotics). AND patient is unable to use clozapine orally disintegrating tablets.
ORALLY DISINTEGRATING TABLETS All products require PA	Abilify® Discmelt (aripiprazole) *FDA maximum recommended dose = 30 mg/day,* *Quantity limit = 2 tabs/day (10 mg & 15 mg tabs)* clozapine orally disintegrating tablets (Compare to FazaClo®) *FDA maximum recommended dose = 900 mg/day* FazaClo® (clozapine orally disintegrating tablets) *FDA maximum recommended dose = 900 mg/day* Olanzapine orally disintegrating tablets (compare to Zyprexa Zydis®) *FDA maximum recommended dose = 20 mg/day,* *Quantity limit = 1.5 tabs/day (5 mg & 10 mg tabs)* Risperdal® M-Tab (risperidone orally disintegrating tablets) *FDA maximum recommended dose = 16 mg/day* Risperidone ODT (compare to Risperdal® M-Tab) *FDA maximum recommended dose = 16 mg/day* Zyprexa Zydis® (olanzapine orally disintegrating tablets) *FDA maximum recommended dose = 20 mg/day,* *Quantity limit = 1.5 tabs/day (5mg&10mg)*	**Olanzapine ODT, Risperdal M-Tabs, Risperidone ODT, Zyprexa Zydis:** patient meets clinical criteria for non-orally disintegrating oral dosage forms of the same medication AND Medical necessity for a specialty dosage form has been provided AND if the request is for Risperdal M-tabs or Zyprexa Zydis, the patient has a documented intolerance to the generic equivalent. **Clozapine ODT, FazaClo:** Medical necessity for a specialty dosage form has been provided AND patient has had a documented side effect, allergy or treatment failure with at least three other antipsychotic medications (typical or atypical antipsychotics) If the request is for Fazaclo, the patient has a documented intolerance to the generic equivalent. **Abilify Discmelt** 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 **Limitations:** Approval for use in Children < 18 years old will not be granted for the following medications or dosage forms due to no FDA approval for use in children and little or no literature to support their use in this population. Exceptions will be made for patients who have been started and stabilized on the requested medication or dosage form (Note: samples are not considered adequate justification for stabilization): Fanapt, Rexulti, Vraylar, Geodon Im, Abilify IM, Olanzapine IM, Zyprexa IM, Abilify Maintena, Invega Sustenna, Invega Trinza, Risperdal Consta, Zyprexa Relprevv, Symbyax,

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		Olanzapine/fluoxetine.
ANTI-PSYCHOTIC ATYPICAL & COMBINATIONS (ADULTS ≥ 18 YEARS OLD)		
TABLETS/CAPSULES ARIPIPRAZOLE (compare to Abilify®) *FDA maximum recommended dose=30mg/day, QL = 1.5 tabs/day (5mg, 10mg, & 15mg)* CLOZAPINE (compare to Clozaril®) *FDA maximum recommended dose = 900 mg/day* OLANZAPINE (compare to Zyprexa®) *FDA maximum recommended dose = 20 mg/day, Quantity limit = 1.5 tabs/day (2.5 mg, 5 mg, 7.5 mg & 10 mg tabs)* RISPERIDONE (compare to Risperdal®) *FDA maximum recommended dose = 16 mg/day* QUETIAPINE (compare to Seroquel®) > 50 mg/day *FDA maximum recommended dose = 800 mg/day* ZIPRASIDONE (compare to Geodon®) *FDA maximum recommended dose = 160 mg/day*	Abilify® (aripiprazole) *FDA maximum recommended dose = 30 mg/day, Quantity limit = 1.5 tabs/day (5 mg, 10 mg & 15 mg tabs)* Abilify® Mycite (aripiprazole tablets with sensor) *FDA maximum recommended dose=30mg/day, Quantity limit=1tab/day)* Clozaril®* *(clozapine)* *FDA maximum recommended dose = 900 mg/day* Fanapt® (iloperidone) *FDA maximum recommended dose = 24 mg/day* *Quantity limit = 2 tablets/day* Geodon®* (ziprasidone) *FDA maximum recommended dose = 160 mg/day* Invega® (paliperidone) *FDA maximum recommended dose = 12 mg/day* *Quantity limit = 1 tab/day (3mg, 9mg), 2tabs/day(6mg)* Latuda® (lurasidone) *FDA maximum recommended dose = 160 mg/day* *Quantity limit = 1 tablet/day all strengths except 80 mg = 2 tablets/day* Nuplazid™ (primavaserin) *FDA maximum recommended dose = 34mg, Quantity Limit = 2/tablets/day* Quetiapine (compare to Seroquel®) <50mg/day (adults >18 years old) Quetiapine ER (compare to Seroquel® XR) Rexulti® (brexpiprazole) *FDA maximum recommended dose = 3mg (adjunct of MDD) or 5mg (schizophrenia)* Risperdal®* (risperidone) *FDA maximum recommended dose = 16 mg/day* Saphris® (asenapine) sublingual tablet *FDA maximum recommended dose = 20 mg/day* Seroquel® (quetiapine) *FDA maximum recommended dose = 800 mg/day*	**Criteria for approval of ALL non-preferred drugs:** patient has been started and stabilized on the requested medication (Note: samples are not considered adequate justification for stabilization.) OR patient meets additional criteria outlined below. **Note**: Trazodone dosed at < 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. **Fanapt. Vraylar:** The indication for use is the treatment of schizophrenia/schizoaffective disorder or bipolar disorder. AND The patient has had a documented side effect, allergy or treatment failure with at least three preferred products (typical or atypical antipsychotics). **Invega, Saphris:** 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. Note: Prior therapy with injectable Invega Sustenna® is not considered to be started and stabilized for oral Invega. Patients transferring to oral therapy from Invega Sustenna® should transition to oral risperidone (unless patient previously failed such treatment). **Abilify, Clozaril, Geodon, Risperdal, and Zyprexa:** patient has a documented intolerance to the generic equivalent. **Abilify Mycite:** The patient has not been able to be adherent to aripiprazole tablets resulting in significant clinical impact (documentation of measures aimed at improving compliance is required) AND thre 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. **Latuda:** *Indication for use is schizophrenia/schizoaffective disorder or Bipolar I depression:* The patient is pregnant OR *Indication for use is schizophrenia/schizoaffective disorder:* the patient has had a documented side effect, allergy or treatment failure with two preferred products (typical or atypical antipsychotics) OR *Indication for use is Bipolar I depression:* the patient has had a documented side

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ORAL SOLUTIONS RISPERIDONE (compare to Risperdal®) oral solution *FDA maximum recommended dose = 16 mg/day* **SHORT-ACTING INJECTABLE PRODUCTS** GEODON® IM (ziprasidone intramuscular injection) *FDA maximum recommended dose = 40 mg/day* **LONG-ACTING INJECTABLE PRODUCTS** Abilify Maintena® (aripiprazole monohydrate) *FDA maximum recommended dose = 400 mg/month* *Quantity limit = 1 vial/28 days* Aristada® (aripiprazole lauroxil) *Quantity Limit = 1 syringe/28 days (441mg, 662mg, 882mg strengths)* *Quantity Limit=1 syringe/60 days (1064mg)* Aristada Initio™ (aripiprazole lauroxil) Invega Sustenna® (paliperidone palmitate) *FDA maximum recommended dose = 234 mg/month* Risperdal® Consta (risperdone microspheres) *FDA maximum recommended dose = 50 mg/14 days*	Seroquel XR® (quetiapine XR) *FDA maximum recommended dose = 800 mg/day* *Quantity Limit = 1 tab/day* *(150 mg & 200 mg tablet strengths), 2 tabs/day (50 mg strength)* Vraylar® (cariprazine) *FDA maximum recommended dose = 6mg/day,* *Quantity limit = 1 capsule/day* ZYPREXA®* (olanzapine) *FDA maximum recommended dose = 20 mg/day,* *Quantity limit = 1.5 tabs/day (2.5 mg, 5 mg, 7.5 mg & 10 mg tabs)* Abilify® (aripiprazole) oral solution *FDA maximum recommended dose = 25 mg/day* Risperdal® (risperidone) oral solution *FDA maximum recommended dose = 16 mg/day* Versacloz® (clozapine) Oral Suspension *FDA maximum recommended dose = 900 mg/day* *Quantity limit = 18 ml/day* 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* Perseris® (risperidone) *FDA maximum recommended dose = 120mg/month* *Quantity Limit = 1 syringe/28 days* Zyprexa Relprevv® (olanzapine pamoate) *FDA maximum recommended dose = 600 mg/month* *Quantity limit = 1 vial/28 days (405 mg) or 2 vials/month (210 or 300 mg)*	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. **Nuplazid**: The diagnosis or indication is the treatment of hallucinations/delusions associated with Parkinson's Disease psychosis. **Rexulti:** *Indication for use is schizophrenia:* the patient has had a documented side effect, allergy or treatment failure with at least three preferred products, one being Abilify (typical or atypical antipsychotics) OR *Indication for use is adjunct treatment of Major Depressive Disorder (MDD)*: the patient has had a documented inadequate response to at least 3 different antidepressants from two different classes AND the patient has had a documented side effect, allergy or treatment failure with two preferred atypical antipsychotic product being used as adjunctive therapy, one of which must be aripiprazole **Quetiapine/Seroquel < or = 50mg/day:** The patient is being prescribed > 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 *Indication for use is Adjunct treatment of Major Depressive Disorder (MDD):* the patient has had a documented inadequate response to at least 3 different antidepressants from 2 different classes OR *Indication for use is Adjunct treatment of any anxiety disorder (panic, agoraphobia, social phobia, obsessive-compulsive disorder, PTSD, Acute Stress Disorder, Generalized Anxiety Disorder):* the patient has had a documented inadequate response to at least 3 different antidepressants from 2 different classes If the request if for brand Seroquel, the patient has a documented intolerance to generic quetiapine. **NOTE:** Quetiapine in doses of < 50 mg/day will not be approved for indications of insomnia, for sleep or as a hypnotic. **Quetiapine ER, Seroquel XR:** *Indication for use is schizophrenia/schizoaffective disorder or bipolar disorder (bipolar mania, bipolar depression, and bipolar maintenance:* 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 OR *Indication for use is Adjunct treatment of Major Depressive Disorder (MDD):*the patient has had a documented inadequate response to at least 3 different antidepressants from 2 different classes AND the patient has had a documented treatment failure with quetiapine immediate release being used as adjunctive

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
Preferred After Clinical Criteria are Met Invega Trinza® (paliperidone palmitate) *FDA maximum recommended dose = 819mg/3months* **ORALLY DISINTEGRATING TABLETS** **All products require PA** **COMBINATION PRODUCTS** **All products require PA**	Abilify® Discmelt (aripiprazole) *FDA maximum recommended dose = 30 mg/day, Quantity limit = 2 tabs/day (10 mg & 15 mg tabs)* clozapine orally disintegrating tablets (Compare to FazaClo®) *FDA maximum recommended dose = 900 mg/day* FazaClo® (clozapine orally disintegrating tablets) *FDA maximum recommended dose = 900 mg/day* Olanzapine orally disintegrating tablets (compare to Zyprexa Zydis®) *FDA maximum recommended dose = 20 mg/day, Quantity limit = 1.5 tabs/day (5 mg & 10 mg tabs)* Risperdal® M-Tab (risperidone orally disintegrating tablets) *FDA maximum recommended dose = 16 mg/day* Risperidone ODT (compare to Risperdal® M-Tab) *FDA maximum recommended dose = 16 mg/day* Zyprexa Zydis® (olanzapine orally disintegrating tablets) *FDA maximum recommended dose = 20 mg/day, Quantity limit = 1.5 tabs/day (5 mg & 10 mg tabs)* olanzapine/fluoxetine (compare to Symbyax®) *FDA maximum recommended dose = 18 mg/75 mg (per day)* Symbyax® (olanzapine/fluoxetine) *FDA maximum recommended dose = 18 mg/75 mg (per day)*	therapy. *Indication for use is Adjunct treatment of any anxiety disorder (panic, agoraphobia, social phobia, obsessive-compulsive disorder, PTSD, Acute Stress Disorder, Generalized Anxiety Disorder):* the patient has had a documented inadequate response to at least 3 different antidepressants from 2 different classes or at least 2 antidepressants and buspirone AND the patient has had a documented treatment failure with quetiapine immediate release being used as adjunctive therapy. **Abilify Oral Solutions:** the patient has had a documented side effect, allergy or treatment failure with preferred risperidone oral solution. **Risperdal Oral Solution:** The patient has a documented intolerance to the generic product risperidone. **Versacloz Oral Solution**: The patient has a medical necessity for a non-solid oral dosage form and is unable to use clozapine orally disintegrating tablets. **NON-PREFERRED SHORT-ACTING INJECTABLE PRODUCTS**: Medical necessity for a specialty dosage form has been provided. AND The patient has had a documented side effect, allergy, or treatment failure with Geodon IM. In addition, for approval of Zyprexa® IM, the patient must have had a documented intolerance to generic olanzapine IM. **Invega Trinza**: The patient is started and stabilized on the medication OR tolerability has been established with Invega Sustenna for at least 4 months. **Note:** This is processed via automated (electronic) step therapy. **Perseris:** Medical necessity for a specialty dosage form has been provided (e.g. non-compliance with oral medications) AND tolerability has been established previously with oral risperidone AND the patient is unable to tolerate Risperdal Consta. **Zyprexa Relprevv:** Medical necessity for a specialty dosage form has been provided (non-compliance with oral medications) AND Tolerability has been established previously with oral olanzapine AND the patient is unable to tolerate a preferred long-acting injectable product. **ORALLY DISINTEGRATING TABLETS:** Medical necessity for a specialty dosage form has been provided. AND If the request is for FazaClo, Risperdal M-Tab or Zyprexa Zydis, the patient has a documented intolerance to the generic equivalent. **COMBINATION PRODUCTS:** The patient has had a documented side effect, allergy or treatment failure with two preferred products (ziprasidone, risperidone, and quetiapine). OR The prescriber provides a clinically valid reason for the use of the requested medication. AND If the request is for brand product, the patient has a documented intolerance to the generic product.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ANTI-PSYCHOTIC: TYPICALS		
ORAL HALOPERIDOL (compare to Haldol®) LOXAPINE (compare to Loxitane®) PERPHENAZINE PIMOZIDE TRIFLUOPERAZINE **LONG ACTING INJECTABLE PRODUCTS** FLUPHENAZINE DECANOATE HALOPERIDOL DECANOATE (compare to Haldol® decanoate)	Chlorpromazine Fluphenazine Haldol®* (haloperidol) Loxitane®* (loxapine) Thioridazine Thiothixene Haldol® decanoate* (haloperidol decanoate)	**Chlorpromazine:** patient has a diagnosis of acute intermittent porphyria or intractable hiccups OR patient has had a documented side effect, allergy or treatment failure with at least three preferred products (may be typical or atypical anti-psychotics). **Fluphenazine Oral Solution:** patient has a requirement for an oral liquid dosage form (i.e. swallowing disorder, inability to take oral medications) **Fluphenazine tablets:** patient is transitioning to the decanoate formulation or requires supplemental oral dosing in addition to decanoate OR patient has had a documented side effect, allergy or treatment failure with at least three preferred products (may be typical or atypical anti-psychotics). **All other oral medications:** patient has had a documented side effect, allergy or treatment failure with at least three preferred products (may be typical or atypical anti-psychotics). If a product has an AB rated generic, one trial must be the generic. **Long Acting Injectable Products:** for approval of haldol decanoate, the patient has a documented intolerance to the generic product.
ANTIRETROVIRAL THERAPY HUMAN IMMUNODEFICIENCY VIRUS (HIV)		
Integrase Strand Transfer Inhibitors ISENTRESS® (raltegravir potassium) TIVICAY® (dolutegravir sodium) **Nucleoside Reverse Transcriptase Inhibitors (NRTI)** ABACAVIR SULFATE DIDANOSINE DR EMTRIVA® (emtricitabine) EPIVIR® (lamivudine) RETROVIR® (zidovudine) STAVUDINE (compare to ZERIT®) VIDEX EC (didanosine) VIDEX SOLUTION (didanosene) VIREAD® (tenofovir disoproxil fumarate) ZERIT® (stavudine) ZIAGEN® (abacavir sulfate)		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ZIDOVUDINE (compare to Retrovir®) **Non-nucleoside Reverse Transcriptase Inhibitors (NNRTI)** EDURANT® (rilpivirine) INTELENCE® (etravirine) NEVIRAPINE (compare to Viramune®) NEVIRAPINE ER (compare to Viramune® ER) RESCRIPTOR® (delavirdine mesylate) SUSTIVA® (efavirenz) VIRAMUNE® (nevirapine) VIRAMUNE® ER (nevirapine ER) **Pharmacoenhancer-Cytochrome P450 Inhibitor** TYBOST® (cobicistat) **Protease Inhibitors** APTIVUS® tipranavir) ATAZANAVIR (compare to Reyataz) CRIXIVAN® (indinavir) EVOTAZ® (atazanavir/cobicistat) FOSEMPRENAVIR (compare to Lexiva®) INVIRASE® (saquinavir mesylate) LEXIVA® (fosemprenavir) NORVIR® (ritonavir) PREZCOBIX® (darunavir/cobicistat) PREZISTA® (darunavir ethanolate) REYATAZ® (atazanavir) VIRACEPT® (nelfinavir) **Entry Inhibitors** FUZEON® (enfuvirtide) SELZENTRY® (maraviroc) **Combination Products - NRTIs** ABACAVIR/LAMIVUDINE (compare to Epzicom®) ABACAVIR/LAMIVUDINE/ZIDOVUDINE (compare to Trizivir®) COMBIVIR® (lamivudine/zidovudine) EPZICOM® (abacavir/lamivudine)		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
LAMIVUDINE/ZIDOVUDINE (compare to Combivir®) TRIZIVIR® (abacavir/lamivudine/zidovudine) **Combination Products – Nucleoside & Nucleotide Analog RTIs** CIMDUO™ (lamivudine/tenofovir) DESCOVY® (emtricitabine/tenofovir AF) TRUVADA® (emtricitabine/tenofovir) **Combination Products - Nucleoside & Nucleotide Analogs & Integrase Inhibitors** BIKTARVY® (bictegravir/emtricabine/tenofovir AF) GENVOYA® (elvitegravir/cobicistat/ emtricitabine/tenofovir AF) STRIBILD® (elvitegravir/cobicistat/ emtricitabine/tenofovir) TRIUMEQ® (abacavir/lamivudine/dolutegravir) **Combination Products - Nucleoside & Nucleotide Analogs & NNRTIs** ATRIPLA® (efavirenz/emtricitabine/tenofovir) COMPLERA® (emtricitabine/relpivirine/tenofovir) ODEFSEY® (emtricitabine/relpivirine/ tenofovir AF) SYMFI™ (efavirenz/lamivudine/tenofovir) SYMFI™ LO (efavirenz/lamivudine/tenofovir) **Combination Products – NNRTI & Integrase Inhibitors** JULUCA® (dolutegravir/rilpivirine) **Combination Products – Protease Inhibitors** KALETRA® (lopinavir/ritonavir) LOPINAVIR/RITONAVIR (compare to Kaletra®)		
Immunologic Therapies Trogarzo™ (ibalizumab-uiyk) QL = 10 vials (2000mg) x 1 dose then 4 vials (800mg) every 14 days thereafter		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
BILE SALTS AND BILIARY AGENTS		
URSODIOL tablet, capsule	Actigall® (ursodiol) Chenodal® (chendiol) Cholbam® (cholic acid) Ocaliva® (obeticholic acid) Urso® (Urosiol) Urso® Forte (ursodiol)	**Chenodal:** The indication for use is with radiolucent stones in well-opacifying gallbladders, in whom selective surgery would be undertaken except for the presence of increased surgical risk due to systemic disease or age AND the patient does not have any of the following contraindications to therapy: women who are pregnanat or may become pregnant, known hepatocyte dysfunction or bile ductal abnormalities such as intrahepatic cholestasis, primary biliary cirrhosis or sclerosing cholangitis. **Cholbam:** The indication for use is the treatment of bile acid synthesis disorders due to single enzyme defects OR for the adjunctive treatment of peroxisomal disorders, including Zellweger spectrum disorders, AND the patient exhibits manifestations of liver disease, steatorrhea, or complications from decreased fat soluble vitamin absorption AND the prescriber is hepatologist or gastroenterologist. Initial approval will be granted for 3 months. For re-approval after 3 months, there must be documented clinical benefit. **Ocaliva:** The indication for use is the treatment of primary biliary cholangitis (PBC) AND the patient has had an inadequate response or is unable to tolerate ursodiol. **Urso, Urso Forte, Actigall:** The patient must have a documented treatment limiting side effect to generic ursodiol.
BONE RESORPTION INHIBITORS		
<u>ORAL BISPHOSPHONATES</u> **TABLETS/CAPSULES** ALENDRONATE (compare to Fosamax®) tablets BINOSTO® (alendronate) 70 mg effervescent tablet *(Quantity Limit=4 tablets/28 days)*	Actonel® (risedronate) Alendronate oral solution Atelvia (risedronate) Delayed Release Tablet *(Quantity Limit = 4 tablets/28 days)* Boniva® (ibandronate) *(Quantity Limit = 150 mg tablet/1 tablet per 28 days)* Etidronate Fosamax®* (alendronate) Fosamax Plus D® (alendronate/vitamin D) Ibandronate (compare to Boniva®) *(Quantity Limit = 150 mg tablet/1 tablet per 28 days)* Risedronate (compare to Actonel®) Boniva® Injection (ibandronate) *(QL = 3 mg/3 months (four doses)/year)*	**Actonel, Atelvia, Risedronate:** patient has a diagnosis/indication of Paget's Disease, postmenopausal osteoporosis, osteoporosis in men or glucocorticoid induced osteoporosis AND 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 Actonel, the patient has also had a documented intolerance to generic risedronate **Alendronate Oral Solution:** prescriber provides documentation of medical necessity for the specialty dosage form (i.e. inability to swallow tablets, dysphagia) AND the patient has a documented intolerance to Binosto. **Boniva Oral, Ibandronate:** patient has a diagnosis/indication of postmenopausal osteoporosis AND patient has had a documented side effect, allergy or treatment failure** to generic alendronate tablets. AND if the request if for brand Boniva oral, the patient has also had a documented intolerance to generic Ibandronate **Calcitonin Nasal Spray (generic), Miacalcin Nasal Spray:** patient is started and

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
INJECTABLE BISPHOSPHONATES All products require PA **ESTROGEN AGONIST/ANTAGONIST** RALOXIFENE (compare to Evista®) Tablet *(QL=1 tablet/day)* **INJECTABLE RANKL INHIBITOR** All products require PA **CALCITONIN NASAL SPRAY** All products require PA **CALCITONIN INJECTION** All products require PA **PARATHYROID HORMONE INJECTION** All products require PA	ibandronate Injection (compare to Boniva®) *(QL=3 mg/3 months (four doses)/year)* Reclast® Injection (zoledronic acid) *(Quantity Limit = 5 mg (one dose)/year)* Zoledronic Acid Injection (compare to Reclast®) 5mg/100ml*(QL=5 mg (one dose)/year)* Zometa® (zoledronic acid) Injection 4mg/100ml or conc. 4mg/5ml Evista® (raloxifene) Tablet *(QL = 1 tablet/day)* Prolia® Injection (denosumab) *(QL=60 mg/6 months (two doses)/year)* Xgeva® (denosumab) *(QL=120 mg/28 days)* Calcitonin Nasal Spray (compare to Miacalcin®) Miacalcin® (calcitonin) Nasal Spray Miacalcin® (calcitonin) Injection Forteo® (teriparatide) *(Quantity Limit = 1 pen (2.4ml/30 days)* *(Lifetime max duration of treatment = 2 years)* Tymlos™ (abaloparatide) injection (*Quantity Limit = 1 pen (1.56ml)/30 days) (Lifetime max duration of treatment = 2 years)*	stabilized on the requested medication. If the request is for generic Calcitonin Nasal Spray, the patient has had a documented intolerance to brand Miacalcin. Note: Calcitonin Nasal Spray (brand and generic) no longer recommended for osteoporosis. **Miacalcin Injection:** patient has a diagnosis/indication of Paget's Disease **Evista Tablets:** patient has had a documented intolerance to generic raloxifene. **Fosamax Tablets:** patient has had a documented intolerance to generic alendronate tablets. **Fosamax Plus D:** there is a clinical reason why the patient is unable to take generic alendronate tablets and vitamin D separately. **Etidronate:** 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 **Forteo:** patient has a diagnosis/indication of postmenopausal osteoporosis in females, primary or hypogoandal osteoporosis in males or glucocorticoid induced osteoporosis AND patient has had a documented side effect, allergy, or treatment failure** to an oral bisphosphonate. AND prescriber has verified that the patient has been counseled about osteosarcoma risk **Tymlos:** 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. **Boniva Injection, Ibandronate Injection:** patient has a diagnosis/indication of postmenopausal osteoporosis AND patient has had a documented side effect or treatment failure** to a preferred bisphosphonate. **Prolia Injection:** 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.. **Reclast Injection, Zoledronic Acid Injection (5mg):** 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.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		Zometa Injection, Zoledronic Acid Injection (4mg): Diagnosis or indication is bone metastases from solid tumors, multiple myeloma, osteopenia or treatment of hypercalcemia of malignancy **Xgeva Injection:** diagnosis or indication is bone metastases from solid tumors (e.g. prostate, breast, thyroid, non-small lung cancer), hypercalcemia of malignancy, or giant cell tumor of bone. **Treatment failure is defined as documented continued bone loss or fracture after one or more years despite treatment with an oral bisphosphonate.
BOTULINUM TOXINS		
	Botox® (onabotulinumtoxinA) Myobloc® (rimabotulinumtoxinB) Dysport® (abobotulinumtoxinA) Xeomin® (incobotulinumtoxinA)	**BOTOX (onabotulinumtoxinA):** The indication for use is: o Strabismus and blepharospasm associated with dystonia, including essential blepharospasm, VII cranial nerve disorders/hemifacial spasm or Focal dystonias, including cervical dystonia, spasmodic dystonia, oromandibular dystonia OR Limb spasticity (e.g., due to cerebral palsy, multiple sclerosis, or other demyelinating CNS diseases) OR Focal spasticity (e.g., due to hemorrhagic stroke, anoxia, traumatic brain injury) OR Severe Axillary Hyperhidrosis (if member has failed an adequate trial of topical therapy) OR Overactive bladder or detrusor overactivity (if member has failed an adequate trial of at least TWO urinary antispasmodics (either short- or long-acting formulations) OR Chronic migraine (≥15 headache days per month, of which ≥ 8 are migraine days, for at least 3 months) and the member has failed or has a contraindication to an adequate trial of at least TWO medications for migraine prophylaxis from at least two different classes (tricyclic antidepressants, SNRI's, beta-blockers, calcium channel blockers or anticonvulsants). For re-approval after 3 months, the patient must have had an improvement in symptoms. AND The patient is >12 years of age if for blepharospasm or strabismus, >16 years of age for cervical dystonia, and >18 years of age for upper or lower limb spasticity, hyperhidrosis, chronic migraine or overactive bladder/detrusor overactivity. **Dysport (abobotulinumtoxinA):** The patient has a diagnosis of cervical dystonia or upper limb spasiticity AND The patient is ≥18 years of age OR the patient has a diagnosis of lower limb spasticity and is 2 years of age or older. **Myobloc (rimabotulinumtoxinB):** The patient has a diagnosis of focal dystonia, including cervical dystonia, spasmodic dystonia, oromandibular dystonia AND The patient is >16 years of age **Xeomin (incobotulinumtoxinA):** The patient has a diagnosis of cervical dystonia, upper limb spasticity, or blepharospasm OR the patient has a diagnosis of chronic sialorrhea and has a documented side effect, allergy, treatment failure,

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		or contraindication to at least two anticholinergic agents (e.g. scopolamine, glycopyrrolate). AND The patient is ≥18 years of age **LIMITATIONS:** Coverage of botulinum toxins will not be approved for cosmetic use (e.g., glabellar lines, vertical glabellar eyebrow furrows, facial rhytides, horizontal neck rhytides, etc.). (BOTOX Cosmetic (onabotulinumtoxinA) is not covered) **IMPORTANT NOTE:** Botulinum neurotoxins are used to treat various disorders of focal muscle spasm and excessive muscle contractions, such as focal dystonias. When injected intramuscularly, botulinum neurotoxins produce a presynaptic neuromuscular blockade by preventing the release of acetylcholine from the nerve endings. As a consequence of the chemistry and clinical pharmacology of each botulinum neurotoxin product, botulinum neurotoxins are not terchangeable, even among same sterotype products. Units of biological activity are unique to each preparation and cannot be compared or converted into units of another. It is important that providers recognize there is no safe dose conversion ratio—i.e., one unit of BOTOX (onabotulinumtoxinA, formerly type A) does not equal one unit of Myobloc (rimabotulinumtoxinB, formerly type B) does not equal one unit of Dysport (abobotulinumtoxinA) does not equal one unit of Xeomin (incobotulinumtoxinA). Failure to understand the unique characteristics of each formulation of botulinum neurotoxin can result in under or over dosage. It is expected that use of these products will be based on each product's individual dosing, efficacy and safety profiles.
BPH AGENTS		
ALPHA BLOCKERS ALFUZOSIN ER (compare to Uroxatral®) *Quanitity Limit = 1 tablet/day* DOXAZOSIN (compare to Cardura®) TAMSULOSIN (compare to Flomax®) *Quantity Limit = 2 capsules/day* TERAZOSIN (formerly Hytrin®)	Cardura®* (doxazosin) Cardura XL® (doxazosin) *Quantity Limit = 1 tablet/day* Flomax®* (tamsulosin) *Quantity Limit = 2 capsules/day* Rapaflo® (silodosin) *Quantity Limit = 1 capsule/day* Uroxatral® (alfuzosin) *Quantity Limit = 1 tablet/day*	**Cardura, Cardura XL:** The patient has had a documented side effect, allergy or treatment failure with two alpha blockers, one of which must be generic doxazosin. **Flomax:** The patient has had a documented side effect, allergy or treatment failure with two preferred alpha blockers, one of which must be generic tamsulosin. **Rapaflo, Uroxatral:** The patient has had a documented side effect, allergy or treatment failure with two preferred alpha blockers. In addition, for approval of Uroxatral, the patient must have a documented intolerance to generic alfuzosin ER.
ANDROGEN HORMONE INHIBITORS	Avodart® (dutasteride) (*QL = 1 capsule/day)* Dutaseride (compare to Avodart®) *QL = 1 capsule/day* finasteride (compare to Proscar®) females; males age <	**Avodart, dutasteride, Proscar:** The patient has a diagnosis of BPH (benign prostatic hypertrophy) AND the patient has a documented side effect, allergy or treatment failure to generic finasteride AND for approval of brand Avodart, the patient must have a documented intolerance to generic dutasteride. **Finasteride for males age < 45:** The patient has a diagnosis of BPH (benign

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
FINASTERIDE (compare to Proscar®) *(QL = 1 tablet/day)* **COMBINATION PRODUCT**	45 *(QL = 1 tablet/day)* Proscar® *(finasteride) *(QL = 1 tablet/day)* Dutasteride/tamsulosin (compare to Jalyn®) (*QL=1 capsule/day)* Jalyn® (dutasteride/tamsulosin) (*QL = 1 capsule/day)*	prostatic hypertrophy) **Dutasteride/tamsulosin, Jalyn:** The patient has a diagnosis of BPH (benign prostatic hypertrophy) AND the patient has a documented treatment failure/inadequate response to combination therapy with generic tamsulosin and finasteride AND is unable to take tamsulosin and dutasteride as the individual separate agents AND for approval of Jayln, the patient must have a documented intolerance to generic dutasteride/tamsulosin. **LIMITATIONS:** Coverage of androgen hormone inhibitors will not be approved for cosmetic use in men or women (male-pattern baldness/alopecia or hirsutism). (This includes Propecia (finasteride) 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.
BULK POWDERS		
http://dvha.vermont.gov/for-providers/covered-bulk-powders-dvha-weblist.pdf		
CARDIAC GLYCOSIDES		
DIGOXIN DIGOXIN Oral Solution LANOXIN® (digoxin)		
CHEMICAL DEPENDENCY		
ALCOHOL DEPENDENCY		
ACAMPROSATE DISULFIRAM 250 mg, 500 mg tab (compare to Antabuse®) NALTREXONE oral **Preferred Agent after Clinical Criteria are Met** Vivitrol® (naltexone for extended-release injectable suspension)	Antabuse®* (disulfiram)	**Antabuse**: The patient has had a documented intolerance to the generic equivalent product

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
(QL = 1 injection (380 mg) per 30 days)		
OPIATE DEPENDENCY		
NALTREXONE oral SUBOXONE® sublingual FILM (buprenorphine/naloxone) *QL = 2 films per day (8 mg strength), or* *1 film per day (4 mg and 12 mg strengths)* *(Maximum daily Dose = 16 mg/day, PA required for over 16mg)* ***Maximum days supply for Suboxone is 14 days*** Note: Methadone for opiate dependency can only be prescribed through a Methadone Maintenance Clinic Vivitrol® (naltrexone for extended-release injectable suspension) (QL = 1 injection (380 mg) per 30 days)	buprenorphine sublingual TABLET (formerly Subutex®) *QL = 3 tablets per day (2 mg strength) or 2 tablets/day (8 mg strength)* *(Maximum Daily Dose = 16 mg/day)* buprenorphine/naloxone (formerly Suboxone®) sublingual TABLET *QL = 2 tablets per day (8 mg strength) or 3 tablets per day (2 mg strength)* *(Maximum daily Dose = 16 mg/day)* Bunavail® (*QL= 1film per day(2.1/0.3mg, 6.1/1mg), 2films per day (4.2/0.7mg)* Zubsolv® *(QL=1 film per day of all strengths)* **Maximum days supply for oral buprenorphine/naloxone or buprenorphine is 14 days** Probuphine® (buprenorphine) subdermal implant *(QL = 4 implants per 6 months) Maximum length of therapy=1 year* Sublocade® (buprenorphine extended-release) injection *Maximum 30 day supply*	**CLINICAL CONSIDERATIONS:** 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. **Buprenorphine/naloxone:** FDA Medwatch form has been submitted documenting a provider-observed reaction to Suboxone films severe enough to require discontinuation (documentation of measures tried to mitigate/manage symptoms is required). **Bunavail, Zubsolv:** FDA Medwatch form has been submitted documenting 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). **Buprenorphine:** 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. **Requests to exceed quantity limits or maximum daily dose:** documentation must be submitted detailing medical necessity for requested dosage regimen. **Probuphine:** 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 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. **Note:** 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). **Sublocade:** 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

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		provided detailing why the member cannot use a more cost effective buprenorphine formulation. **Note:** 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. **Vivitrol:** There must be a documented trial of oral naltrexone to establish tolerability AND Patient should be opiate free for > 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.
OPIATE WITHDRAWAL TREATMENT		
Central Alpha Agonists Clonidine IR tablets (compare to Catapres®) **Note:** Methadone for opiate dependency or withdrawal can only be prescribed through a Methadone Maintenance Clinic	Lucemyra® (lofexidine) Maximum length of therapy = 14 days	**Lucemyra:** Indication for use is the mitigation of opioid withdrawal symptoms to facilitate abrupt opioid discontinuation AND the patient is ≥ 18 years of age AND the patient is unable to tolerate clonidine due to significant side effects.
OVERDOSE TREATMENT		
NALOXONE HCL Prefilled luer-lock needleless syringe plus intranasal mucosal atomizing device (Rescue kit) NARCAN® (naloxone hcl) Nasal Spray Quantity Limit = 4 single-use sprays/28days		**Limitations: Effective 4/1/17, Evzio® is not classified as a covered outpatient drug and is therefore not covered by Vermont Medicaid.**

GASTROINTESTINAL AGENTS: CONSTIPATION/DIARRHEA, IRRITABLE BOWEL SYNDROME-CONSTRIPATION (IBS-C), IRRITABLE BOWEL SYNDROME-DIARRHEA (IBS-D), SHORT BOWEL SYNDROME, OPIOID INDUCED CONSTIPATION

Preferred Agents (No PA Required)	**Non-preferred Agents (PA Required)**	**Criteria**
Constipation: Chronic, IBS_C, or Opioid-Induced (Length of approval for non-preferred agents: Initial PA of 3 months and & 12 months thereafter		
Bulk-Producing Laxatives PSYLLIUM **Osmotic Laxatives** LACTULOSE	Linzess® (linaclotide) 72mcg *(Qty limit = 1 capsule/day)* Relistor® (methylnaltrexone) tablets (*Qty Limit = 3*	**Linzess 72mcg:** The patient is 18 years of age or older. AND The patient has a diagnosis of chronic idiopathic constipation (CIC) AND the patient is unable to tolerate the 145 mcg dose

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
POLYETHYLENE GLYCOL 3350 (PEG) (**Stimulant Laxative** BISACODYL SENNA **Stool Softener** DOCUSATE **Miscellaneous** DICYCLOMINE **Guanylate Cyclase-C Agonists** LINZESS® (linaclotide) 145mcg and 290mcg *(Qty limit = 1 capsule/day)* **CIC-2 Chloride Channel Activators** AMITIZA® (lubiprostone) *(Qty Limit = 2 capsules/day)* **Opioid Antagonists** MOVANTIK® (naloxegol) *(Qty limit=1 tablet/day)*	*tabs/day)* Relistor® (methylnatrexone) injection Symproic® (naldemedine) (Qty limit=1 tablet/day) Trulance (plecanatide) (Qty limit=1 tablet/day)	**Relistor Tablets, Symproic:** 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. **Relistor Injection:** The patient must have documented opioid-induced constipation and be receiving palliative care AND the patient must have had documented treatment failure to a 1 week trial of 2 preferred laxatives from 2 different laxative classes used in combination. **Trulance:** 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.
Short Bowel Syndrome (SBS) (length of approval: 6 Months)		
	Gattex® (teduglutide) Vials Maximum days' supply = 30 days	**Gattex:** Patient has a diagnosis of short bowel syndrome AND Patient is receiving specialized nutritional support administered intravenously (i.e. parenteral nutrition) AND Patient is 18 years of age or older AND Patient does not have an active gastrointestinal malignancy (gastrointestinal tract, hepatobiliary, pancreatic), colorectal cancer, or small bowel cancer. Note: Re-approval requires evidence of decreased parenteral nutrition support from baseline.
Antidiarrheal: HIV/AIDs (length of approval: initial approval 3 months, subsequent 1 year)		
DIPHENOXYLATE/ATROPINE LOPERAMIDE	Mytesi® (crofelemer) 125 mg DR Tablets *QL = 2 tablets/day*	**Mytesi:** Patient has HIV/AIDS and is receiving anti-retroviral therapy AND Patient is at least 18 years of age AND Patient requires symptomatic relief of noninfectious diarrhea AND Infectious diarrhea (e.g. cryptosporidiosis, c. difficile, etc.) has been ruled out AND Patient has tried and failed at least one anti-diarrheal medication (i.e. loperamide or atropine/diphenoxylate)
Antidiarrheal: IBS-D (length of approval: initial approval 3 months, subsequent 1 year)		
All products require PA	Alosetron (compare to Lotronex®) Lotronex® (alosetron) Viberzi® (eluxadoline) Xermelo™ (telotristat ethyl) (QL=3 tablets/day)	**Lotronex/alosetron:** The patient is a woman and has a diagnosis of severe diarrhea-predominant irritable bowel syndrome (IBS) with symptoms lasting 6 months or longer AND has had anatomic or biochemical abnormalities of the GI tract excluded AND has not responded adequately to conventional therapies loperamide, cholestyramine, and TCA's. For approval of generic alosetron, the patient must

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		have documented intolerance to brand Lotronex. **Viberzi:** The patient has a diagnosis of IBS-D AND does not have any of the following contraindications to therapy A) known or suspected biliary duct obstruction, or sphincter of Oddi disease or dysfunction B) alcoholism, alcohol abuse, alcohol addiction, or drink more than 3 alcoholic beverages/day C) a history of pancreatitis; structural diseases of the pancreas D) severe hepatic impairment (Child-Pugh Class C) AND has not responded adequately to conventional therapies loperamide, cholestyramine, and TCA's. **Xermelo:** The patient has a diagnosis of carcinoid syndrome diarrhea AND had an inadequeate treatment response (defined as 4 or more bowel movements per day) despite use of a long-acting somatostatin analog for at least 3 consecutive montths AND the medication will be used in combination with a long-acting somatostatin analog therapy. For reauthorization, documentation showing a decrease in the number of bowel movements per day is required. **Note:** Xermelo will not be approved in treatment naïve patients or as monotherapy.
CONTRACEPTIVES		
SELECT PRODUCTS (length of approval: 1 year) **MONOPHASIC AGENTS:**		
Due to the extensive list of products, any monophasic BCP not listed as non-preferred is considered preferred.	Blisovi FE 24 (norethindrone/ethinyl estradiol/FE) Brevicon-28 (norethindrone/ethinyl estradiol) Drospirenone/ethinyl estradiol/levomefol Gildesse fe (norethindrone/ ethinyl estradiol/FE) Junel FE 24 (norethindrone/ethinyl estradiol/FE) Lo-Estrin (norethindrone/ethinyl estradiol) Lo-Estrin FE (norethindrone/ ethinyl estradiol/FE) LoMedia FE (norethindrone/ ethinyl estradiol/FE) Microgestin FE (norethindrone/ethinyl estradiol/FE) Norinyl 1/35 (norethindrone/ethinyl estradiol) Ogestrel (norgestrel/ethinyl estradiol) Ortho-Cyclen-28 (norgestimate/ethinyl estradiol) Ovcon-35/28 (norethindrone/ethinyl estradiol) Rajani (drospirenone/ethinyl estradiol/levomefol) Taytulla (norethindrone/ethinyl estradiol/FE) Yaz (drospirenone/ ethinyl estradiol) Yasmin 28 (drospirenone/ ethinyl estradiol)	**Non-preferred agents:** Trial with at least three preferred contraceptive products including the preferred formulation of the requested non-preferred agent

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Zenchent FE (norethindrone/ethinyl estradiol/FE) Zovia 1-50(ethynodiol D/ ethinyl estradiol)	
BIPHASIC AGENTS		
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) VIORELE (desogestrel/ ethinyl estradiol)	Azurette (desogestrel/ ethinyl estradiol) Lo Loestrin FE(norethindrone/ ethinyl estradiol/FE) Mircette (desogestrel/ ethinyl estradiol) Necon 10/11-28 (norethindrone/ ethinyl estradiol)	**Non-preferred agents:** Trial with at least three preferred contraceptive products including the preferred formulation of the requested non-preferred agent
TRIPHASIC AGENTS		
ALYACEN (norethindrone ethinyl estradiol) ARANELLE (norethindrone/ethinyl estradiol) CAZIANT (desogestrel/ ethinyl estradiol) CYCLAFEM (norethindrone/ethinyl estradiol) DASETTA (norethindrone/ethinyl estradiol) ENPRESSE (levonorgestrel/ ethinyl estradiol) LEENA (norethindrone/ethinyl estradiol) LEVONEST (levonorgestrel/ ethinyl estradiol)) MYZILRA (levonorgestrel/ ethinyl estradiol) NATAZIA (dienogest/estradiol valerate) NECON 7/7/7 (norethindrone/ethinyl estradiol) Norgestimate ethinyl estradiol NORTREL 7/7/7 (norethindrone/ethinyl estradiol) PIRMELLA (norethindrone/ethinyl estradiol) TILIA FE (norethindrone/ethinyl estradiol/FE) TRI-ESTARYLLA (norgestimate/ ethinyl estradiol) TRI-LEGEST FE (norethindrone/ethinyl estradiol/FE) TRI-LINYAH (norgestimate/ ethinyl estradiol) TRI-LO-ESTARYLLA (norgestimate/ethinyl estradiol) TRI-LO-MARZIA (norgestimate/ethinyl estradiol) TRI-LO-SPRINTEC (norgestimate/ethinyl estradiol) TRINESSA (norgestimate/ ethinyl estradiol) TRINESSA LO (norgestimate/ethinyl estradiol) TRI-PREVIFEM (norgestimate/ ethinyl estradiol) TRI-SPRINTEC (norgestimate/ ethinyl estradiol) TRIVORA (levonorgestrel/ ethinyl estradiol) VELIVET (desogestrel/ ethinyl estradiol)	Cyclessa (desogestrel/ ethinyl estradiol) Estrostep FE (norethindrone/ethinyl estradiol/FE) Ortho-Novum 7/7/7 (norethindrone/ethinyl estradiol) Ortho Tri-Cyclen (norgestimate/ ethinyl estradiol) Ortho Tri-Cyclen LO (norgestimate/ ethinyl estradiol) Tri-Norinyl (norethindrone/ethinyl estradiol)	**Non-preferred agents:** Trial with at least three preferred contraceptive products including the preferred formulation of the requested non-preferred agent
EXTENDED CYCLE		
AMETHIA LO (levonorgestrel/ ethinyl estradiol) AMETHYST (levonorgestrel/ ethinyl estradiol)	Amethia (levonorgestrel/ ethinyl estradiol) Daysee (levonorgestrel/ ethinyl estradiol)	**Non-preferred agents:** 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
ASHLYNA (levonorgestrel/ ethinyl estradiol) CAMRESE (levonorgestrel/ ethinyl estradiol) CAMRESE LO (levonorgestrel/ ethinyl estradiol) INTROVALE (levonorgestrel/ ethinyl estradiol 3MTH) JOLESSA (levonorgestrel/ ethinyl estradiol 3MTH) LEVONORGESTREL ETHINYL ESTRADIOL TBDSPK 3 month LO-SEASONIQUE (levonorgestrel/ ethinyl estradiol) QUASENSE (levonorgestrel/ ethinyl estradiol 3MTH) SEASONIQUE (levonorgestrel/ ethinyl estradiol)	Fayosim (levonorgestrel/ ethinyl estradiol) Quartette (levonorgestrel/ ethinyl estradiol) Rivelsa (levonorgestrel/ ethinyl estradiol)	
PROGESTIN ONLY CONTRACEPTIVES		
CAMILA (norethindrone) DEBLITANE (norethindrone) ERRIN (norethindrone) HEATHER (norethindrone) JENCYCLA (norethindrone) JOLIVETTE(norethindrone) LYZA (norethindrone) NORA-BE (norethindrone) NORETHINDRONE 0.35MG SHAROBEL (norethindrone)	Ortho Micronor (norethindrone)	**Non-preferred agents:** Trial with at least three preferred contraceptive products including the preferred formulation of the requested non-preferred agent
INJECTABLE CONTRACEPTIVES		
MEDROXYPROGESTERONE ACETATE 150MG (IM) VIAL/SYRINGE DEPO-PROVERA 104 (SUB-Q) SYRINGE (medroxyprogesterone acetate)	Depo-Provera (IM) (medroxyprogesterone acetate) 150mg Susp vial/syringe	
VAGINAL RING		
NUVARING® (etonogestrel/ethinyl estradiol vaginal ring)		
LONG ACTING REVERSIBLE CONTRACEPTIVES (LARCs)		
KYLEENA (levonorgestrel) IUD LILETTA (levonorgestrel) IUD MIRENA (levonorgestrel) IUD PARAGARD (copper) IUD SKYLA (levonorgestrel) IUD NEXPLANON (etonogestrel) Implant		
TOPICAL CONTRACEPTIVES		
XULANE PATCH (norelgestromin/ ethinyl estradiol)		
EMERGENCY CONTRACEPTIVES		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
AFTERA (levonorgestrel) ECONTRA EZ (levonorgestrel) FALLBACK SOLO (levonorgestrel) LEVONORGESTREL MY WAY (levonorgestrel) NEXT CHOICE (levonorgestrel) OPCICON ONE-STEP (levonorgestrel) OPTION 2 (levonorgestrel) REACT (levonorgestrel) TAKE ACTION (levonorgestrel) ELLA (ulipristal)		
CORONARY VASODILATORS/ANTIANGINALS/SINUS NODE INHIBITORS		
ORAL		
ISOSORBIDE DINITRATE tablet (compare to Isordil®) ISOSORBIDE DINITRATE ER tablet ISOSORBIDE MONONITRATE tablet ISOSORBIDE MONONITRATE ER tablet NITROGLYCERIN SPRAY LINGUAL (compare to Nitrolingual Pump Spray®) NITROMIST® Lingual Spray NITROSTAT® (nitroglycerin SL tablet)	Dilatrate-SR® (isosorbide dinitrate SR capsule) Isosorbide dinitrate SL tablet Isordil®* (isosorbide dinitrate tablet) Nitrolingual Pump Spray® BiDil® (isosorbide dinitrate/hydralazine) Ranexa® (ranolazine) *(Quantity Limit = 3 tablets/day (500 mg), 2 tablets/day (1000 mg)))* Ranolazine tablet (compare to Ranexa®) *(Qty Limit = 3 tablets/day (500 mg), 2 tablets/day (1000 mg))*	**Dilatrate-SR, Isosorbide dinitrate SL tablet, Isordil:** the patient has had a side effect, allergy, or treatment failure to at least two preferred agents. **Nitrolingual Pump Spray:** the patient has had a side effect, allergy, or treatment failure to Nitroglycerin spray lingual. **Bidil:** The prescriber provides a clinically valid reason why the patient cannot use isosorbide dinitrate and hydralazine as separate agents. **Ranexa, Ranolazine:** The patient has had a diagnosis/indication of chronic angina. AND The patient has had a documented side effect, allergy, or treatment failure with at least one medication from two of the following classes: beta-blockers, maintenance nitrates, or calcium channel blockers. AND The patient does not have any of the following conditions: Hepatic insufficiency, Concurrent use of medications which may interact with Ranexa: CYP450 3A4 inducers (rifampin, rifabutin, rifapentin, phenobarbital, phenytoin, carbamazepine, St.John's wort) CYP450 3A4 inhibitors (diltiazem, verapamil, ketoconazole, protease inhibitors, grapefruit juice, macrolide antibiotics) Note: doses of digoxin or drugs metabolized by CYP450 2D6 (TCAs, some antipsychotics) may need to be adjusted if used with Ranexa. AND The dose requested does not exceed 3 tablets/day (500 mg) or 2 tablets/day (1000 mg).
TOPICAL		
NITRO-BID® (nitroglycerin ointment) NITROGLYCERIN TRANSDERMAL PATCHES (compare to Nitro-Dur®)	Nitro-Dur®* (nitroglycerin transdermal patch)	**Nitro-Dur:** patient has had a side effect, allergy, or treatment failure to generic nitroglycerin transdermal patches.
SINUS NODE INHIBITORS		
	Corlanor® (ivabradine) (QL=60 tabs/30 days)	**Corlanor Clinical Criteria:**

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		• Diagnosis of stable, symptomatic heart failure AND • Left ventricular ejection fraction of ≤ 35% AND • Resting heart rate ≥ 70 bpm AND • In sinus rhythm AND • Persisting symptoms despite maximally tolerated doses of beta blockers or who have contraindication to beta blocker therapy
CORTICOSTEROIDS: ORAL		
CORTISONE ACETATE tablets DEXAMETHASONE tablets, elixir, intensol, solution DEXPAK® tabs (dexamethasone taper pack) HYDROCORTISONE tab (compare to Cortef®) MEDROL® (methylprednisolone) 2mg tablets METHYLPREDNISOLONE (compare to Medrol®) tabs METHYLPREDNISOLONE DOSE PACK (compare to Medrol Dose Pack®) tabs ORAPRED® ODT (prednisolone sod phosphate) (age < 12 yrs) PREDNISOLONE 3 mg/ml oral solution, syrup (compare to Prelone®) PREDNISOLONE SODIUM PHOSPHATE 3 mg/ml oral solution (compare to Orapred®) PREDNISOLONE SOD PHOSPHATE ORAL SOLUTION 6.7mg/5ml (5mg/5ml base) (compare to Pediapred®) PREDNISONE intensol, solution, tablets	Celestone® (betamethasone) oral solution Cortef®* (hydrocortisone) tablets Flo-Pred® (prednisolone acetate) oral suspension Medrol®* (methylprednisolone) tablets Medrol Dose Pak®* (methylprednisolone) tabs Millipred® (prednisolone) tablets Millipred® (prednisolone sodium phos) oral solution Millipred DP® (prednisolone) dose pack tablets Orapred®* oral solution* (prednisolone sod phos) Orapred® ODT (prednisolone sod phos) (age ≥ 12 yrs) Pediapred®* (prednisolone sod phosphate) oral solution prednisolone sodium phosphate oral solution 25 mg/5ml Rayos® (prednisone) Delayed Release Tablet *(Quantity limit = 1 tablet/day)* Veripred® 20 oral solution (prednisolone sodium phosphate)	**Rayos:** The patient has had a trial of generic immediate release prednisone and has documented side effects that are associated with the later onset of activity of immediate release prednisone taken in the morning. **All Others:** The patient has been started and stabilized on the requested medication. OR The patient has a documented side effect, allergy, or treatment failure to at least two preferred medications. If a product has an AB rated generic, one trial must be the generic formulation.
COUGH AND COLD PREPARATIONS		
All generics MUCINEX ® (guaifenesin)	Hydrocodone/chlorpheniramine (compare to Tussionex®) *(QL = 60 ml/RX)* Tussionex® (hydrocodone/chlorpheniramine) *(QL = 60 ml/RX)*	**Tussionex, TussiCaps, Hydrocodone/chlorpheniramine suspension (generic):** The patient has had a documented side effect, allergy, or treatment failure to two of the following generically available cough or cough/cold products: hydrocodone/homatropine (compare to Hycodan), promethazine/codeine (previously Phenergan with Codeine), guaifenesin/codeine (Cheratussin AC) or

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	TussiCaps® (hydrocodone/chlorpheniramine) *(QL = 12 capsules/RX)* All other brands	benzonatate. AND patient is 6 years old of age or greater. AND The quantity requested does not exceed 60 ml (Tussionex) or 12 capsules (TussiCaps). AND If the request is for Tussionex, the patient has a documented intolerance to generic hydrocodone/chlorpheniramine suspension. **All Other Brands:** The prescriber must provide a clinically valid reason for the use of the requested medication including reasons why any of the generically available preparations would not be a suitable alternative.
CYSTIC FIBROSIS MEDICATIONS		
Preferred After Clinical Criteria Are Met: BETHKIS® (tobramycin) inhalation solution (Quantity Limit = 56 vials/56 days; maximum days' supply = 56 days) (2 vials/day for 28 days, then 28 days off) KITABIS® (tobramycin sol) (*QL= 56vials/56days; maximum days' supply = 56 days; 2 vials/day for 28 days, then 28 days off)* TOBI® (tobramycin PODHaler capsules for inhalation) (*QL = 224 capsules/56 days; maximum days' supply = 56 days) (4 capsules twice daily for 28 days, then 28 days off)*	Cayston® (aztreonam) inhalation solution (Quantity Limit = 84 vials/56 days; maximum days supply = 56 days) (3 vials/day for 28 days, then 28 days off) Kalydeco® (ivacaftor) tablets (Quantity Limit = 2 tablets/day, maximum days' supply = 30 days) Kalydeco® (ivacaftor) packets (Quantity Limit = 2 packets/day, maximum days' supply = 30 days) Orkambi® (lumacaftor/ivacaftor) (Quantity Limit= 120/30 days; max days supply=30 days) Pulmozyme® (dornase alfa) inhalation solution (Quantity Limit =60/30 days; maximum days supply=30 days) Symdeko® (tezacaftor/ivacaftor and ivacaftor) (Quantity Limit =56/28 days; maximum days supply = 28 days) TOBI® (tobramycin) inhalation solution (Quantity Limit = 56 vials/56 days; maximum days supply = 56 days) (2 vials/day for 28 days, then 28 days off) Tobramycin inhalation solution (compare to Tobi®) (Quantity Limit = 56 vials/56 days; maximum days' supply = 56 days)(2	**Bethkis, Kitabis, Pulmozyme:** diagnosis or indication is cystic fibrosis **TOBI, tobramycin inhalation solutions:** Diagnosis or indication is cystic fibrosis and the patient has a documented failure or intolerance to Kitabis and Bethkis. **Cayston:** diagnosis or indication is cystic fibrosis and the patient has had a documented failure, intolerance or inadequate response to inhaled tobramycin therapy alone **Kalydeco:** The patient has a diagnosis of Cystic Fibrosis AND Patient has a mutation on at least one allele in the cystic fibrosis transmembrane conductance regulator gene(CFTR gene) shown to be responsive to Kayldeco per FDA approval (documentation provided). AND The patient is ≥1 year old. Note: Renewal of Prior Authorization will require documentation of member response. **TOBI PODHALER:** allowed after a trial of another form of inhaled tobramycin **Orkambi/Symdeko:** The patient has a diagnosis of Cystic Fibrosis AND Initial Criteria • ≥ 2 years of age for Orkambi or ≥ 12 years of age for Symdeko • Patient must be determined to be homozygous for the *F508del* mutation in the CFTR gene as confirmed by an FDA-approved CF mutation test (Orkambi and Symdeko) OR Patient has a mutation on at least one allele in the CFTR gene shown to be responsive to tezacaftor/ivacaftor per FDA approval (Symdeko only) • If the patient is under the age of 18, they must have undergone a baseline ophthalmic examination to monitor for lens opacities/cataracts • Prescriber is a CF specialist or pulmonologist Ongoing Approval Criteria • Patient has stable or improved FEV1 • Patient has LFTs/bilirubin monitored every 3 months for the first year of therapy and annually after the first year • ALT or AST ≤ 5 X the upper limit of normal or ALT/AST ≤ 3 X the upper limits of normal and bilirubin is ≤ 2 X the upper limit of normal • For patients under the age of 18, have follow up ophthalmic exam at least annually

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	vials/day for 28 days, then 28 days off)	
DERMATOLOGICAL AGENTS		
ACTINIC KERATOSIS THERAPY		
IMIQUIMOD 5% Cream EFUDEX®* (fluorouracil) 5% cream CARAC® (fluorouracil) 0.5% cream *C=cream, F=foam, G=gel, L=lotion, O=ointment, S=solution*	Aldara® (imiquimod) 5 % Cream Diclofenac Sodium 3 % Gel (compare to Solaraze®) *Qty Limit = 1 tube/30 days* Fluorouracil (compare to Efudex®) 5% cream 5%, 2% solution Fluorouracil (compare to CARAC®) 0.5% cream Picato® (ingenol mebutate) 0.015 % Gel *Qty Limit = 3 tubes* Picato® (ingenol mebutate) 0.05 % Gel *Qty Limit = 2 tubes* Tolak® (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 cm2 on the face or scalp. AND The patient has had a documented side effect, allergy, or treatment failure with 5-fluorouracil.
ANTIOBIOTICS TOPICAL		
Single Agent BACITRACIN MUPIROCIN OINTMENT (compare to Bactroban®) **Combination Products** BACITRACIN-POLYMYXIN NEOMYCIN-BACITRACIN-POLYMYXIN *C=cream, F=foam, G=gel, L=lotion, O=ointment, S=solution*	Centany® Ointment (mupirocin) Gentamicin Cream or Ointment Mupirocin cream (compare to Bactroban®) Cortisporin® Cream (neomycin-polymyxin-hydrocortisone) Cortisporin® Ointment(bacitracin-neomycin-polymyxin-hydrocortisone) **All other branded products**	**mupirocin cream, Centany Ointment:** 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
ANTIFUNGALS: ONYCHOMYCOSIS		
CICLOPIROX 8 % solution (compare to Penlac®	Ciclodan® (ciclopirox 8% solution)	**Ciclodan, Jublia, Kerydin, Penlac Sol:** The patient meets at least 1 of the

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
Nail Lacquer) QL =6.6 ml/90 days	Penlac® Nail Lacquer (ciclopirox 8 % solution) QL = 6.6 ml/90 Kerydin® Jublia® QL=48 weeks treatment	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. **LIMITATIONS:** Coverage of Onychomycosis agents will NOT be approved solely for cosmetic purposes. Kits with multiple drug products or non-drug items not covered.
ANTIFUNGALS: TOPICAL		
Single Agent 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 **Combination Products** CLOTRIMAZOLE W/BETAMETHASONE (compare to Lotrisone®) C, L *C=cream, F=foam, G=gel, L=lotion, P=powder, S=solution, Sh=shampoo, Sp=spray, Sus=suspension*	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 Luzu® (luliconazole) 1% Cream Mentax®) 1% C Naftin® (naftifine) 1% & 2% C, 1%, 2% G Nizoral®* (ketoconazole) 2% Sh Nystatin w/triamcinolone C, O Nystop®, Nyamyc®* (nystatin) P Oxistat® (oxiconazole) 1% C Lotrisone®* (clotrimazole w/betamethasone) C Vusion® (miconazole w/zinc oxide) O *(QL=50 g/30 days)* **All other branded products** **Note**: Please refer to "Dermatological: Antifungals: Onychomycosis" for ciclopirox solution and Penlac® Nail Lacquer	**All Non-Preferred Agents (except Vusion):** The patient has had a documented side effect, allergy, or treatment failure to at least TWO different preferred generic topical antifungal agents. (If a product has an AB rated generic, one trial must be the generic equivalent of the requested product.) OR The patient has a contraindication that supports the need for a specific product or dosage form of a brand topical antifungal. **Vusion:** The patient has a diagnosis of diaper dermatitis complicated by documented candidiasis AND The patient is at least 4 weeks of age.AND The patient has had two trials (with two different preferred antifungal agents) used in combination with a zinc oxide diaper rash product resulting in documented side effects, allergy, or treatment failures.
ANTIVIRALS: TOPICAL		
ABREVA OTC (docosanol) 10% C *C=cream, O=ointment* Note: See Anti-Infectives: Antivirals: Herpes: Oral for Sitavig®	Acyclovir (compare to Zovirax®) 5 % O Denavir® (penciclovir) 1% C Zovirax® (acyclovir) 5% C, O Xerese® (acyclovir 5%/hydrocortisone 1%) C	**Acyclovir, Denavir, Xerese, Zovirax:** 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. ** Topical antiviral therapy offers minimal clinical benefit in the treatment of genital herpes and its use is discouraged by the CDC so topical antiviral therapy will not be approved for this indication. **
CORTICOSTEROIDS: LOW POTENCY		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ALCLOMETASONE 0.05% C, O FLUOCINOLONE 0.01% C, S, oil (compare to Derma-Smoothe, Synalar®) HYDROCORTISONE 0.5%, 1%, 2.5% C; 1%, 2.5% L, 0.5%, 1%, 2.5% O *C=cream, F=foam, G=gel, L=lotion, O=ointment, S=solution*	Capex® (fluocinolone) 0.01% shampoo Derma-Smoothe®* (fluocinolone 0.01%) oil Desonate® (desonide) 0.05% G Desonide 0.05% C,L,O (compare to DesOwen®) DesOwen®* (desonide) 0.05% C, L Synalar®* (fluocinolone) 0.01% S **All other brands**	**CRITERIA FOR APPROVAL (NON-PREFERRED AGENTS):** The patient has a documented side effect, allergy, or treatment failure to at least two different preferred agents of similar potency. (If a product has an AB rated generic, one trial must be the generic.)
CORTICOSTEROIDS: MEDIUM POTENCY		
BETAMETHASONE DIPROPIONATE 0.05% C, L, O BETAMETHASONE VALERATE 0.1% C, L, O BETAMETHASONE VALERATE 0.12% (compare to Luxiq®) F FLUOCINOLONE 0.025% C, O (compare to Synalar®) FLUTICASONE 0.05% C; 0.005% O (compare to Cutivate®) MOMETASONE FUROATE 0.1% C, L, O, S (compare to Elocon®) TRIAMCINOLONE ACETONIDE 0.025%, 0.1% C, L, O	Clocortolone 0.1% C (compare to Cloderm®) Cloderm® (clocortolone) 0.1% C Cordran® (all products) Cutivate®(fluticasone) 0.05% L desoximetasone 0.05% C, O (compare to Topicort®) Elocon®* (all products) Flurandrenolide (compare to Cordran®) C, L, O Fluticasone (compare to Cutivate®) 0.05%, L Hydrocortisone Butyrate 0.1% C, O, S Hydrocortisone Valerate 0.2% C,O Kenalog® (triamcinolone) Aerosol Spray Luxiq® (betamethasone valerate) F prednicarbate (compare to Dermatop®) 0.1% C, O 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 **All other brands**	**CRITERIA FOR APPROVAL (NON-PREFERRED AGENTS):** The patient has a documented side effect, allergy, or treatment failure to at least two different preferred agents of similar potency. (If a product has an AB rated generic, one trial must be the generic.)
CORTICOSTEROIDS: HIGH POTENCY		
AUGMENTED BETAMETHASONE 0.05% C, L (compare to Diprolene® AF) BETAMETHASONE VALERATE 0.1% C, O DESOXIMETASONE 0.05% C, G, O; 0.25% C, O (compare to Topicort®) FLUOCINONIDE 0.05% C, G, O, TRIAMCINOLONE ACETONIDE 0.5% C, O *C=cream, F=foam, G=gel, L=lotion, O=ointment, S=solution*	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 Halog® (halcinonide) all products Topicort®* (desoximetasone) 0.05% G; 0.25% C, O, Spray **All other brands**	**CRITERIA FOR APPROVAL (NON-PREFERRED AGENTS):** The patient has a documented side effect, allergy, or treatment failure to at least two different preferred agents of similar potency. (If a product has an AB rated generic, one trial must be the generic.)
CORTICOSTEROIDS: VERY HIGH POTENCY		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
AUGMENTED BETAMETHASONE 0.05% C,L, O (compare to Diprolene®) 0.05% G CLOBETASOL PROPIONATE (compare to Temovate®/Cormax®) 0.05%, C, G, O, S HALOBETASOL PROPRIONATE (compare to Ultravate®) *C=cream, F=foam, G=gel, L=lotion, O=ointment, S=solution*	Bryhali® (halobetasol propionate) L Clobetasol propionate (compare to Clobex®) 0.05% L, Sh, Spray clobetasol 0.05% F (compare to Oulux®) clobetasol propionate emulsion (compare to Olux E®) 0.05% F Clobex® (clobetasol propionate) 0.05% L, shampoo, spray Diprolene®* (augmented betamethasone) 0.05% L, O Diprolene®AF 0.05% C fluocinonide (compare to Vanos®)0.1% C Olux® * /Olux E® (clobetasol propionate) 0.05% F Temovate®* (clobetasol propionate) 0.05% C, , O, Vanos® (fluocinonide) 0.1% C Ultravate®* (halobetasol propionate) 0.05% C, O **All other brands**	**CRITERIA FOR APPROVAL (NON-PREFERRED AGENTS)**: The patient has a documented side effect, allergy, or treatment failure to at least two different preferred agents of similar potency. (If a product has an AB rated generic, one trial must be the generic.)
GENITAL WART THERAPY		
IMIQUIMOD 5 % (compare to Aldara®) cream PODOFILOX SOLUTION (compare to Condylox®)	Aldara® (imiquimod) 5% cream Condylox® Gel (podofilox gel) Condylox®* solution (podofilox solution) Veregan® (sinecatechins ointment) (Quantity limit = 15 grams (1 tube)/per 30 days) Zyclara® (imiquimod 3.75%) Cream (Quantity limit = 56 packets)/per 8 weeks) Zyclara® (imiquimod 3.75%) Cream Pump (Quantity limit = 2 pumps/per 8 weeks)	**Condylox gel, Veregan:** The patient has had a documented side effect, allergy, or treatment failure with imiquimod. **Condylox Solution:** The patient has had a documented intolerance to generic podofilox solution. **Aldara cream:** The patient has had a documented intolerance to generic imiquimod
IMMUNOMODULATORS		
Preferred after Clinical Criteria are Met ELIDEL® (pimecrolimus) PROTOPIC® (tacrolimus) ***Note:*** please refer to *Dermatological Agents: Corticosteroids* category for preferred topical corticosteroids.	Dupixent® (dupilumab) Eucrisa® (crisaborole) Ointment Pimecrolimus cream (compare to Elidel®) Tacrolimis Ointment (compare to Protopic®)	**Criteria for Approval (topical medications)** : The patient is ≥ 2 years of age AND 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. **Note:** Use in children less than 2 years of age is not indicated. Protopic oinment 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

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		months, the prescriber must submit documentation of clinical improvement in symptoms. Renewals may be granted for up to 1 year. **Pimecrolimus, Elidel, Protopic, Tacrolimus additional criteria:** The quantity requested does not exceed 30 grams/fill and 90 grams/6 months. AND If the request is for generic pimecrolimus or tacrolimus ointment, the patient has a documented intolerance to the brand name equivalent. **Eucrisa additional criteria**: 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. **Dupixent**: • The patient is ≥ 18 years of age AND • The patient has a diagnosis of moderate to severe atopic dermatitis AND • The prescription is initiated in consultation with a dermatologist, allergist, or immunologist AND • At least 10% of the body's surface area is involved AND • The patient has had a documented side effect, allergy, or treatment failure (defined as daily treatment for at least one month) with at least one moderate to high potency topical corticosteroid and one preferred topical calcineurin inhibitor within the last 6 months AND • 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 • 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.
SCABICIDES AND PEDICULOCIDES		
SCABICIDES PERMETHRIN 5 % (compare to Elimite®) *C* **PEDICULICIDES (lice treatment)** PERMETHRIN 1 % *CR, L* PIPERONYL BUTOXIDE AND PYRETHRINS *G, S, Sh* NATROBA® (spinosad 0.9 %) *Ss* SKLICE® (Ivermectin 0.5 %) *L* *C=cream, CR=crème rinse, G=gel, L=lotion, S=solution, Sh=shampoo, Sp=spray, Ss=suspension*	Elimite™ (permethrin 5%) C Eurax® (crotamiton 10 %) *C, L* Lindane *L* Lindane *Sh* Malathion †*L* (compare to Ovide®) Ovide® (malathion) *L* Spinosad (compare to Natroba) *Ss* All other brand and generic Scabicides and Pediculicides	**Non-preferred Scabicides:** The patient has had a documented side effect or allergy to permethrin cream or treatment failure with two treatments of permethrin cream. **Non-Preferred Pediculicides:** The patient has had a documented side effect or allergy to OTC permethrin and piperonyl butoxide and pyrethrins and one treatment of Natroba or Sklice OR treatment failure with two treatments of OTC permethrin and/or piperonyl butoxide and pyrethrins and one treatment of Natroba or Sklice. For approval of Ovide® Lotion, the patient must also have a documented intolerance to the generic equivalent product.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
DESMOPRESSIN: INTRANASAL/ORAL		
Intranasal All products Require PA **Oral** DESMOPRESSIN	DDAVP® (desmopressin) Nasal Solution or Spray 0.01% Desmopressin Nasal Solution or Spray 0.01 % (compare to DDAVP®) Nocdurna® (desmopressin) SL tablets Qty limit=1 tablet/day Noctiva™ (desmopressin) Nasal Spray Stimate® (desmopressin) Nasal Solution 1.5 mg/ml DDAVP®* (desmopressin) tablets	**CRITERIA FOR APPROVAL:** **Intranasal (except as indicated below):** The diagnosis or indication for the requested medication is (1) Diabetes Insipidus, (2) hemophilia type A, or (3) Von Willebrand disease AND If the request is for brand DDAVP, the patient has a documented intolerance to generic desmopressin spray or solution. **Oral**: The diagnosis or indication for the requested medication is (1) Diabetes Insipidus and/or (2) primary nocturnal enuresis AND The patient has had a documented intolerance to generic desmopressin tablets **Nocdurna, Noctiva:** Patient is ≥18 years of age (Nocdurna) or ≥ 50 years of age (Noctiva) AND the indication for use is the treatment of nocturia due to nocturnal polyuria (defined as nighttime urine production exceeding 1/3 of the 24-hour urine production) causing patient to awaken more than 2 times per night to void for at least 6 months AND patient has eGFR > 50ml/min/1.73m2 AND patient does not have increased risk of severe hyponatremia (e.g. concomitant use of loop diuretics or corticosteroids, diagnosis of CHF, or uncontrolled hypertension) AND serum sodium concentrations are normal before starting therapy AND patient has had a documented intolerance to generic desmopressin tablets. **LIMITATIONS:** Desmopressin intranasal formulations will not be approved for the treatment of primary nocturnal enuresis (PNE) due to safety risks of hyponatremia. Oral tablets may be prescribed for this indication.
DIABETIC TESTING SUPPLIES		
MONITORS/METERS		
Please refer to the DVHA website for covered Diabetic testing supplies. http://dvha.vermont.gov/for-providers/vermont-pdsl-january-2019.pdf		**CRITERIA FOR APPROVAL:** The prescriber demonstrates that the patient has a medical necessity for clinically significant features that are not available on any of the preferred meters/test strips. **LIMITATIONS:** Talking monitors are not covered under the pharmacy benefit.
TEST STRIPS/LANCETS		
DIABETIC TEST STRIPS Please refer to the DVHA website for covered Diabetic testing supplies.		**CRITERIA FOR APPROVAL:** The prescriber demonstrates that the patient has a medical necessity for clinically significant features that are not available on any of the preferred meters/test strips. **LIMITATIONS:** Talking monitors are not covered under the pharmacy benefit.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
LANCETS All brands and store brands		
ENDOMETRIOSIS AGENTS		
Lupaneta Pack™ (leuprolide acetate for depot suspension and norethindrone acetate tablets) QL = 3.75 mg kit/month or 11.25 mg kit/3 months Lupron Depot® (leuprolide acetate for depot suspension) QL = 3.75 mg kit/month or 11.25 mg kit/3 months Synarel® (nafarelin acetate) nasal solution Zoladex® (goserelin acetate) implant QL = 3.6 mg/month	Orilissa® (elagolix) tablets	**Orilissa:** Patient has a diagnosis of moderate-severe endometriosis pain and has a documented side effect, allergy, or treatment failure to at least TWO medications from at least 2 different classes (oral contraceptives, NSAIDs, progestins, and GnRH agonists). **Note:** 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. Initial approval will be granted for 6 months. For re-approval, the patient must have documentation of clinical improvement and lipid and bone mineral density (BMD) monitoring. Maximum length of therapy 2 years.
EPINEPHRINE: AUTO-INJECTOR		
EPINEPHRINE INJ (compare to Epipen-Jr®) (authorized generic, Mylan labeler code 49502 is the only preferred form) 0.15mg (epinephrine 0.15mg/0.15ml (1:000)) EPINEPHRINE INJ (compare to Epipen®) (authorized generic, Mylan labeler code 49502 is the only preferred form) 0.3mg (epinephrine 0.3mg/0.3ml (1:000))	Epinephrine Inj 0.15mg (epinephrine 0.15mg/0.15ml (1:1000)) Epinephrine Inj 0.3mg (epinephrine 0.3mg/0.3ml (1:1000)) Epipen® 2-PAK inj 0.3mg (epinephrine 0.3mg/0.3ml (1:1000)) Epipen-Jr® 2-PAK inj 0.15mg (epinephrine 0.15mg/0.3ml (1:1000))	**Epipen, non-authorized generics:** The patient must have a documented intolerance to the authorized generic epinephrine. **Limitations:** Auvi-Q® is not classified as a covered outpatient drug and is therefore not covered by Vermont Medicaid
ESTROGENS: VAGINAL		
Estradiol ESTRACE VAGINAL® Cream ESTRING® Vaginal Ring VAGIFEM® Vaginal Tablets **Conjugated Estrogens** PREMARIN VAGINAL® Cream		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
Estradiol Acetate FEMRING® Vaginal Ring		
GASTROINTESTINAL		
INFLAMMATORY BOWEL DISEASE INJECTABLES (Initial approval is 3 months; renewals are 1 year)		
Preferred After Clinical Criteria Are Met HUMIRA® (adalimumab) *Quantity limit = 6 syringes/28 days for the first month (Crohn's starter kit);2 syringes/28 days subsequently* REMICADE® (infliximab)	Cimzia® (certolizumab pegol) *Quantity limit = 1 kit/28 days* Inflectra® (infliximab-dyyb) biosimilar to Remicade® Entyvio® (vedolizumab) *Quantity limit = 300mgX 3/42 days, 300mg X 1 every 56 days thereafter* Renflexis™ (infliximab-abda) biosimilar to Remicade® Simponi® (golimumab) SC *3 of 100mg prefilled syringe or autoinjector X 1, then 100mg/28days* Stelara® (ustekinumab) Tysabri® (natalizumab)	**Clinical Criteria (Crohn's Disease)** **Humira, Remicade, Cimzia, Tysabri, Entyvio, Inflectra, Renflexis, Stelara:** • Patient has a diagnosis of Crohn's disease and has already been stabilized on the medication. OR • Diagnosis is moderate to severe Crohn's disease and at least 2 of the following drug classes resulted in an adverse effect, allergic reaction, inadequate response, or treatment failure (i.e. resistant or intolerant to steroids or immunosuppressants): aminosalicylates, antibiotics, corticosteroids, and immunomodulators such as azathioprine, 6-mercaptopurine, or methotrexate. Note: Humira and Cimzia have been shown to be effective in patients who have been treated with infliximab but have lost response to therapy. **Cimzia additional criteria:** • Patient age > 18 years AND • The prescriber must provide a clinically valid reason why Humira cannot be used. **Inflectra/Renflexis additional criteria:** • The prescriber must provide a clinically valid reason why Humira and Remicade cannot be used. **Tysabri additional criteria:** • The patient has a documented side effect, allergy, treatment failure, or contraindication to BOTH, Remicade and Humira. **Entyvio, Stelara additional criteria:** • Patient age > 18 years AND • The patient has a documented side effect, allergy, treatment failure (including corticosteroid dependence despite therapy), or contraindication to BOTH Remicade and Humira • Note: Initial IV dose for Stelara will be approved through the medical benefit. All subsequent subcutaneous doses may be approved through the pharmacy benefit with quantity limit of 90mg every 8 weeks **Clinical Criteria (Ulcerative Colitis)** **Humira, Remicade:**

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		• Patient has a diagnosis of Ulcerative Colitis and has already been stabilized on the medication. OR • The patient has a diagnosis of Ulcerative Colitis and has had a documented side effect, allergy or treatment failure with at least 2 of the following 3 agents: aminosalicylates (e.g. sulfasalazine, mesalamine, etc), corticosteroids, or immunomodulators (e.g. azathioprine, 6-mercaptopurine, cyclosporine, etc.). **Entyvio, Simponi:** • Patient has a diagnosis of ulcerative colitis and has already been stabilized on the drug OR • Age > 18 years AND a diagnosis of ulcerative colitis AND • has demonstrated corticosteroid dependence or has had an inadequate response to or failed to tolerate oral aminosalicylates, oral corticosteroids, azathioprine, or 6-mercaptopurine AND the prescriber must provide a clinically valid reason why Humira and Remicade cannot be used. **Inflectra/Renflexis:** • The patient has a diagnosis of Ulcerative Colitis and has had a documented side effect, allergy or treatment failure with at least 2 of the following 3 agents: aminosalicylates (e.g. sulfasalazine, mesalamine, etc), corticosteroids, or immunomodulators (e.g. azathioprine, 6-mercaptopurine, cyclosporine, etc.) AND the prescriber must provide a clinically valid reason why Humira and Remicade cannot be used.
H.PYLORI COMBINATION THERAPY		
Lansoprazole, amoxicillin, clarithromycin (compare to Prevpac®) *(Quantity limit = 112 caps & tabs/14 days)*	Omeclamox-Pak® (omeprazole, clarithromycin, amoxicillin) *(Quantity limit = 80 caps & tabs/10 days)* Prevpac® (lansoprazole, amoxicillin, clarithromycin) *(Quantity limit = 112 caps & tabs/14 days)* Pylera® (bismuth subcitrate, metronidazole, tetracycline) capsules *(Quantity limit=120 capsules/10 days)*	**CRITERIA FOR APPROVAL:** The patient has a documented treatment failure with Lansoprazole, amoxicillin, clarithromycin combo package.
H-2 BLOCKERS		
FAMOTIDINE (compare to Pepcid®) tablet RANITIDINE (compare to Zantac®) tablet	Cimetidine (compare to Tagamet®) tablet Pepcid®* (famotidine) tablet ranitidine capsule	**Nizatidine capsule, Pepcid tablet, ranitidine capsule, Zantac tablets:** The patient has had a documented side effect, allergy, or treatment failure to at least

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
SYRUPS AND SPECIAL DOSAGE FORMS CIMETIDINE ORAL SOLUTION RANITIDNE syrup (compare to Zantac®)	Zantac®* (ranitidine) tablet famotidine (compare to Pepcid®) oral suspension Nizatidine †Oral Solution (compare to Axid®) Pepcid® (famotidine) Oral Suspension	one preferred medication. If a medication has an AB rated generic, the trial must be the generic formulation. For approval of ranitidine capsules, the patient must have had a trial of ranitidine tablets. **Famotidine Oral Suspension, Nizatidine Oral Solution, Pepcid Oral Suspension:** The patient has had a documented side effect, allergy, or treatment failure to ranitidine syrup or cimetidine oral solution. If a medication has an AB rated generic, there must have been a trial of the generic formulation. **Cimetidine tablet** current users as of 05/29/2015 would be grandfathered
INFLAMMATORY BOWEL AGENTS (ORAL & RECTAL PRODUCTS)		
MESALAMINE PRODUCTS **Oral** APRISO® (mesalamine capsule extended release) DELZICOL;® (mesalamine capsule delayed-release) *(QL = 6 capsules/day)* LIALDA® (mesalamine tablet extended-release) PENTASA ER ® 250mg (mesalamine cap CR) **Rectal** CANASA® (mesalamine suppository) MESALAMINE ENEMA (compare to Rowasa®)	Asacol HD® (mesalamine tablet delayed release) Pentasa ER ® (mesalamine cap CR) 500mg Sfrowasa® (mesalamine enema sulfite free)	**Azulfidine, Colazal:** patient has had a documented intolerance to the generic equivalent of the requested medication. **Asacol HD:** The patient has had a documented side effect, allergy, or treatment failure 2 preferred oral mesalamine products. **Entocort EC/Uceris ER tab:** The patient had a documented intolerance to the generic budesonide 24 hr capsules. **Giazo:** The diagnosis is ulcerative colitis AND The patient is male and > 18 years old. AND The patient has a documented intolerance to generic balsalazide. **Pentasa 500mg :** The patient must be unable to adhere to a dosing regimen comprised of Pentasa 250mg capsules resulting in significant clinical impact. **Sfrowasa:** The patient has had a documented intolerance to mesalamine enema. **LIMITATIONS:** Kits with non-drug products are not covered.
CORTICOSTEROIDS **ORAL** BUDESONIDE 24HR (compare to Entocort EC®) *QL = 3 capsules/day* **RECTAL** UCERIS RECTAL FOAM (budesonide) **OTHER** BALSALAZIDE (compare to Colazal®) DIPENTUM® (olsalazine) SULFAZINE SULFAZINE EC SULFASALAZINE (compare to Azulfidine®) SULFASALAZINE DR	Entocort EC®* (budesonide 24 hr cap) *QL = 3 capsules/day* Uceris® (budesonide) ER Tablet *QL = 1 tablet/day* Azulfidine®* (sulfasalazine) Colazal®* (balsalazide) Giazo® (balsalazide disodium) tablet *QL = 6 tablets/day*	
PROKINETIC AGENTS		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
Tablets METOCLOPRAMIDE tabs (compare to Reglan®) **Oral Solution** METOCLOPRAMIDE (formerly Reglan®) oral sol **Orally Disintegrating Tablets**	Reglan®* (metoclopramide)	**Reglan:** The patient has had a documented intolerance to generic metoclopramide tablets.
PROTON PUMP INHIBITORS		
ORAL CAPULES/TABLETS OMEPRAZOLE RX capsules (compare to Prilosec®) *(Quantity limit = 1 capsule/day)* PANTOPRAZOLE tablets (compare to Protonix®) *(Quantity limit=1 tab/day)* LANSOPRAZOLE generic RX capsules (compare to Prevacid®) *(Quantity limit = 1 cap/day)* **SUSPENSION & SPECIAL DOSAGE FORMS** Nexium® (esomeprazole) powder for suspension (age < 12 years)	Aciphex® (rabeprazole) tablets *(Quantity limit=1 tab/day)* Dexilant® (dexlansoprazole) capsules *(Quantity limit=1 cap/day)* Esomeprazole (compare to Nexium®) *(Quantity limit = 1 cap/day)* Nexium® (esomeprazole) capsules *(Quantity limit=1 cap/day)* omeprazole generic OTC tablets *(Quantity limit=1 tab/day)* omeprazole magnesium generic OTC 20 mg capsules *(Quantity limit=1 cap/day)* omeprazole/sodium bicarb capsules RX (compare to Zegerid®) *(Quantity limit=1 cap/day)* Prevacid® RX (lansoprazole) capsules *(Quantity limit=1 cap/day)* Prevacid® 24 hr OTC (lansoprazole) capsules *(Quantity limit=1 cap/day)* Prilosec OTC® 20mg (omeprazole magnesium) tablets *(Quantity limit = 1 tablet/day)* Prilosec®* RX (brand) (omeprazole) capsules *(Quantity limit=1 cap/day)* Protonix®* (pantoprazole) tablets *(Quantity limit=1 tab/day)* rabeprazole (compare to Aciphex®) tablets *(Quantity limit = 1 tab/day)* Zegerid RX ® (omeprazole/sodium bicarb) caps, oral, suspension *(Quantity limit=1 cap/day)* Aciphex® Sprinkle (rabeprazole) DR Capsule	**Nexium powder for suspension (for patients ≥ 12 years old):** The patient has a requirement for a non-solid oral dosage form (e.g. an oral liquid, dissolving tablet or sprinkle). **Prevacid Solutabs, Prilosec packet, and Protonix packet:** The patient has a requirement for a non-solid oral dosage form (e.g. an oral liquid, dissolving tablet or sprinkle). AND the member has had a documented side effect, allergy or treatment failure to Nexium powder for suspension. **Aciphex Sprinkle:** The patient has a requirement for a non-solid oral dosage form AND The member has had a documented side effect, allergy, or treatment failure to omeprazole capsule opened and sprinkled omeprazole or lansoprazole suspension or Prevacid solutab. **Other non-preferred medications:** The member has had a documented side effect, allergy, or treatment failure to Omeprazole RX generic capsules, Lansoprazole RX generic capsules, and Pantoprazole generic tablets. If the request is for Prevacid 24 hr OTC or Prevacid RX, the patient must also have a documented intolerance to lansoprazole generic RX capsules. If the request is for brand Zegerid RX capsules, the patient must also have a documented intolerance to the generic equivalent. **CRITERIA FOR APPROVAL (twice daily dosing):** **Gastroesophageal Reflux Disease (GERD)** – If member has had an adequate trial (e.g. 8 weeks) of standard once daily dosing for GERD, twice daily dosing may be approved. **Note:** Approval of twice daily dosing for GERD is limited to 12 weeks. For continuation after 12 weeks, there must be a documented attempt to taper to once daily dosing of a PPI with an adjunctive H2 Blocker. The dosing of long-term PPI's should be periodically re-evaluated so that the lowest effective dose can be prescribed to manage the condition. **Zollinger-Ellison (ZE) syndrome** – Up to triple dose PPI may be approved. **Hypersecretory conditions (endocrine adenomas or systemic mastocytosis)** – Double dose PPI may be approved. **Erosive Esophagitis, Esophageal stricture, Barrett's esophagitis (complicated GERD)** – Double dose PPI may be approved.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
(Quantity limit=1 packet/day)	*(Quantity limit=1 cap/day)* Nexium® (esomeprazole) powder for suspension (age ≥ 12 years) *(Quantity limit=1 packet/day)* Prevacid Solutabs® (lansoprazole) *(Quantity limit=1 tab/day)* Prilosec® (omeprazole magnesium) packet *(Quantity limit=2 packets/day)* Protonix® (pantoprazole) packet *(Quantity limit=1 packet/day)*	**Treatment of ulcers caused by H. Pylori** – Double dose PPI may be approved for up to 2 weeks. **Laryngopharyngeal reflux** – Double dose PPI may be approved. **LIMITATIONS:** First-Lansoprazole® and First-Omeprazole Suspension Kits are not covered as Federal Rebate is no longer offered. Nexium 24HR OTC (esomeprazole) capsules OTC Plan Exclusion - these products are not covered.
GAUCHER'S DISEASE MEDICATIONS		

	Cerdelga *(Quantity limit=2 caps/day)*
	Cerezyme® (imiglucerase for injection)
	Elelyso® (taliglucerase alfa for injection)
	Vpriv® (velaglucerase alfa for injection)
	Miglustat (compare to Zavesca®)
	(QL = max 3 caps/daily)
	Zavesca® (miglustat) (*QL = max 3 caps/daily)*
	
	****Maximum days supply per fill for all drugs is 14 days****
		CRITERIA FOR APPROVAL: The diagnosis or indication is Gaucher disease (GD) type I. AND The diagnosis has been confirmed by molecular or enzymatic testing.
		<u>Age Limits</u>
		Elelyso, Vpriv: for patients ≥ 4 years old
		Cerezyme: for patients ≥ 2 years old
		Cerdelga, Miglustat, Zavesca: for patients ≥ 18 years old
		
		Cerezyme/Vpriv additional criteria: Failure, intolerance or other contraindication to enzyme replacement therapy with Elelyso
		
		Cerdelga additional criteria:
		• Testing to verify if CYP2D6 extensive metabolizer (EM), intermediate metabolizer (IM), poor metabolizer (PM), or if CYP2D6 genotype cannot be determined
		  ○ Dose max: 84mg twice/day if EM or IM
		  ○ Dose max: 84mg/day if PM
		  ○ Case by case determination if CYP2D6 cannot be determined
		
		Miglustat, Zavesca additional criteria:
		• For whom enzyme replacement therapy is not a therapeutic option (e.g. due to allergy, hypersensitivity, or poor venous access)

GOUT AGENTS		
COLCHICINE CAPSULES PROBENECID	Colcrys® (colchicine) tablet *QL = 3 tablets/day (gout) or 4 tablets/day (FMF)*	**Colcrys, colchicine tablets:** *Diagnosis or indication is Familial Mediterranean Fever (FMF) or Diagnosis* OR *Diagnosis or indication is acute treatment of gout flares:* The patient has had a

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ALLOPURINOL (compare to Zyloprim®) COLCHICINE/PROBENECID	Colchicine tablets (compare to Colcrys®) Duzallo® (lesinurad/allopurinol) Mitigare® (colchicine) capsule QL= 2 capsule/day Zyloprim®* (allopurinol) Zurampic® (lesinurad) Uloric® (febuxostat) *QL (40 mg tablets) = 1 tablet/day*	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 form the NSAID class due to one of the following: • The patient is 60 years of ager or older • The patient has a history of GI bleed • The patient is currently taking an anticoagulant (warfarin or heparin), an oral corticosteroid, or methotrexate. OR *Diagnosis or indication is prophylaxis of gout flares in adults:* the patient must have a documented intolerance to colchicinecapsules. **Duzallo:** The diagnosis or indication is treatment of symptomatic hyperuricemia associated with gout AND the patient has not achieved target serum uric acid levels (< 6mg/dl) with an allopurinol dose of at least 300mg or febuxostat 80mg AND patient is unable to take Zurampic and allopurinol as athe individual separate agents. **Mitigare capsules:** the diagnosis or indication is prophylaxis of gout flares in adults AND the patient must have a documented intolerance to colchicine capsules. **Uloric:** The diagnosis or indication is treatment of gout AND The patient has had a documented side effect, allergy, treatment failure or a contraindication to allopurinol. NOTE: Treatment failure is defined as inability to reduce serum uric acid levels to < 6 mg/dl with allopurinol doses of 600 mg/day taken consistently. Additionally, renal impairment is not considered a contraindication to allopurinol use. **Zurampic:** The diagnosis or indication is treatment of symptomatic hyperuricemia associated with gout AND the patient has not achieved target serum uric acid levels (< 6 mg/dl) with an allopurinol dose of at least 300mg or febuxostat 80mg AND the medication is being used in combination with a xanthine oxidase inhibitor (Zurampic is not recommended for use as monotherapy). **Zyloprim:** The patient has had a documented intolerance to generic allopurinol
GROWTH STIMULATING AGENTS		
GENOTROPIN® NORDITROPIN®	Humatrope® Nutropin® AQ Omnitrope® Saizen® Zomacton® **<u>Specialized Indications – See Specific Criteria</u>** Increlex® (mecasermin) Serostim®	**Criteria for Approval Pediatric:** 1) The patient must have one of the following indications for growth hormone: □ Turner syndrome confirmed by genetic testing. □ Prader-Willi Syndrome confirmed by genetic testing. □ Growth deficiency due to chronic renal failure. □ Patient who is Small for Gestational Age (SGA) due to Intrauterine Growth Retardation (IUGR)and catch up growth not achieved by age 2 (Birth weight less than 2500g at gestational age of <37 weeks or a birth weight or length below the 3rd percentile for gestational age). OR □ Pediatric Growth Hormone Deficiency confirmed by results of two

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Zorbtive®	provocative growth hormone stimulation tests (insulin, arginine, levodopa, propranolol, clonidine, or glucagon) showing results (peak level) <10ng/ml. 2) The requested medication must be prescribed by a pediatric endocrinologist (or pediatric nephrologist if prescribed for growth deficiency due to chronic renal failure). 3) Confirmation of non-closure of epiphyseal plates (x-ray determining bone age) must be provided for females > age 12 and males > age 14. 4) Initial requests can be approved for 6 months. Subsequent requests can be approved for up to 1 year with documentation of positive response to treatment with growth hormone. **Criteria for Approval Adult:** The patient must have one of the following indications for growth hormone: Panhypopituitarism due to surgical or radiological eradication of the pituitary. OR Adult Growth Hormone Deficiency confirmed by one growth hormone stimulation test (insulin, arginine, levodopa, propranolol, clonidine, or glucagon) showing results (peak level) <5ng/ml. Growth hormone deficient children must be retested after completion of growth. **LIMITATIONS:** Coverage of Growth Hormone products will not be approved for patients who have Idiopathic Short Stature. **HUMATROPE, NUTROPIN AQ, OMNITROPE, SAIZEN, ZOMACTON:** The patient has a documented side effect, allergy, or treatment failure to both preferred agents. **Increlex:** Member has growth hormone gene deletion AND neutralizing antibodies to growth hormone, OR primary insulin-like growth factor (IGF-1) deficiency (IGFD), defined by the following: o Height standard deviation score < -3 AND Basal IGF-1 standard deviation score < -3 AND Normal or elevated growth hormone level Member is ≥ 2 years old (safety and efficacy has not been established in patients younger than 2), AND Member has open epiphysis, AND Member is under the care of an endocrinologist or other specialist trained to diagnose and treat growth disorders. **Serostim:** A diagnosis of AIDS associated wasting/anorexia **Zorbtive:** A diagnosis of short bowel syndrome. Concomitant use of specialized nutritional support (specialty TPN) Prescription must be issued by gastroenterologist (specialist)
HEMATOPOIETICS		
Colony Stimulating Factors		
Fulphila™ (pegfilgrastim-jmdb) Syringe Granix® (tbo-filgrastim) Syringe Neupogen® (filgrastim) Vial	Leukine® (sargramostim) Vial Neulasta® (pegfilgrastim) Syringe Neupogen® (filgrastim) Syringe	**Leukine, Neulasta, Neupogen syringe, Nivestym, Zarxio syringe:** 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

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
Udenyca™ (pegfilgrastim-cbqv)	Nivestym™ (figrastim-aafi) Vial, Syringe Zarxio® (filgrastim-sndz) Syringe	alternatives.
Erythropoietic Stimulating Agents		
Preferred After Clinical Criteria are Met EPOGEN® (epoetin alpha) PROCRIT® (epoetin alpha) RETACRIT® (epoetin alpha-epbx)	Aranesp® (darbepoetin alfa) Mircera® (methoxypolyethylene glycolepoetin beta)	**Aranesp, Procrit, Epogen, Retacrit:** diagnosis or indication for the requested medication is anemia due to one of the following: Chronic kidney disease/renal failure, Post-renal transplant, use of zidovudine for the treatment of human immunodeficiency virus (HIV) (other causes of anemia, such as iron/folate/vitamin B12 deficiency have been eliminated), Surgery patients at high risk for perioperative blood loss, Cancer chemotherapy, Use of ribavirin or interferon therapy for Hepatitis C, Myelodysplastic syndrome. Hemoglobin level at initiation of therapy is <10 g/dL OR for patients currently maintained on therapy, hemoglobin level is < 11 g/dL in dialysis patients with chronic kidney disease, < 10 g/dL in non-dialysis patients with chronic kidney disease, or < 12 g/dL in patients treated for other indications AND for approval of Aranesp the patient has had a documented side effect, allergy, or treatment failure to the preferred agents. **Mircera:** The diagnosis or indication for the requested medication is anemia due to chronic kidney disease/renal failure AND Hemoglobin level at initiation of therapy is <10g/dl OR For patients currently maintained on therapy, hemoglobin level is ≤11 g/dL in dialysis patients with chronic kidney disease, ≤10 g/dL in non-dialysis patients with chronic kidney disease AND The patient has had a documented side effect, allergy, or treatment failure to the preferred agents.
HEMOPHILIA FACTORS		
AHF-Factor VII		
	Novoseven® RT	**Novoseven RT:** Medication is being used for the treatment of acute bleeding episodes in a patient with Hemophilia A or B with inhibitors OR Patient has congenital Factor VII deficiency.
AHF-Factor VIII		
ADVATE® HELIXATE FS® HEMOFIL® M KOATE®-DVI KOGENATE FS® MONOCLATE-P® NOVOEIGHT® NUWIQ® OBIZUR® XYNTHA®	Adynovate® Afstyla® Eloctate® Hemlibra® Jivi® Kovaltry® Recombinate®	**All Non-Preferred Products (except Hemlibra):** 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. **Hemlibra:** Patient has Hemophilia A with factor VIII inhibitors OR patient has Hemophilia A without factor VIII inhibitors and the prescriber provides a clinically compelling reason for use including reasons why any of the preferred products would not be suitable alternatives. **Note:** Hemlibra will not be approved for breakthrough bleeding.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
AHF-Factor IX		
ALPHANINE® SD ALPROLIX® BEBULIN® BENEFIX® MONONINE®	Idelvion® Ixinity® Kcentra® Profilnine® Rebinyn® Rixubis®	**All Non-Preferred Products:** The prescriber must provide a clinically compelling reason for the use of the requested medication including reasons why any of the preferred products would not be suitable alternatives.
AHF-Von Willebrand Factor		
ALPHANATE® HUMATE-P® WILATE®	Vonvendi®	**All Non-Preferred Products:** The prescriber must provide a clinically compelling reason for the use of the requested medication including reasons why any of the preferred products would not be suitable alternatives.
AHF-Anti-Inhibitor Coagulation Complex		
	Feiba®	**Feiba:** medication is being used for the treatment of acute bleeding episodes or routine prophylaxis in a patient with Hemophilia A or B with inhibitors.
HEPATITIS B AGENTS		
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)	**Adefovir, Hepsera, Lamivudine HBV, Epivir-HBV:** The prescriber must provide a clinically compelling reason for the use of the requested medication including reasons why any of the preferred products would not be suitable alternatives AND for approval of brand Hepsera or Epivir-HBV, the patient has a documented intolerance to the generic. **Note:** AASLD and WHO guidelines recommend these not be utilized first line due to potential for the development of resistance. **Baraclude tabs:** the patient has a documented intolerance to generic entecavir. **Baraclude suspension:** the patient has a medical necessity for a non-solid oral dosage form. **Vemlidy:** the patient must have a diagnosis of osteoporosis, renal insufficiency (CrCl < 60ml/min), or other contraindication to Viread such as chronic steroid use.
HEPATITIS C AGENTS		
Initial PA: 3 months; subsequent maximum 3 months		
<u>RIBAVIRIN PRODUCTS</u> RIBASPHERE 200 mg tabs RIBAVIRINn 200 mg tablets	Moderiba® tablets Dose Pak (ribavirin) Rebetol Oral Solution® (ribavirin 40 mg/ml) Ribapak Dose Pack® (ribavirin) ribavirin 200 mg capsules Ribasphere 400 and 600 mg tabs(ribavirin) Pegasys® (peginterferon alfa-2a)*(QL=4 vials/28 days)*	**Non-preferred Ribavirin Brands/strengths:** The patient is unable to use generic ribavirin 200 mg tablets

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
PEGINTERFERON PRODUCTS PEG-INTRON/PEG-INTRON REDIPEN (peginterferon alfa-2b) *(QL= I kit (4 pens per) 28 days)* PEG-INTRON REDIPEN PAK 4 (peginterferon alfa-2b) *(QL= I kit (4 pens per) 28 days)*	Pegasys Convenience PAK®(peg-interferon alfa-2a)*(QL=1 kit/28 days)* Pegasys Proclick (peginterferon alfa-2a)	**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*** EPCLUSA® (sofosbuvir/velpatasvir) MAVYRET™ (glecaprevir/pibrentasvir)	Daklinza® (daclatasvir) Harvoni® (ledipasvir/sofosbuvir) Ledipasvir/sofosbuvir (compare to Harvoni®) Sofosbuvir/velpatasvir (compare to Epclusa®) Sovaldi® (sofosbuvir) Viekira PAK® (ombitasvir, paritaprevir, ritonavir tablet with dasabuvir tablet) Vosevi® (sofosbuvir/velpatasvir/voxilaprevir) Zepatier® (elbasvir/grazoprevir)	**Direct Acting Agents: Daklinza, 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, and HIV negative. • 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		
Preferred After Clinical Criteria are Met Berinert® (human C1 inhibitor) Haegarda® (human C1 inhibitor)	Cinryze® (human C1 inhibitor) *(QL =20 vials/30days)* Firazyr® (icatibant) *(QL = 3 syringes (9 ml)/fill)* Kalbitor® (escallantide) *(QL = 6 vials (2 packs) per fill)* Ruconest® (recombinant C1 esterase inhibitor) *(QL = 4 vials/fill)* Takhzyro™ (lanadelumab-flyo) *(QL = 2 vials/28 days)*	**Berinert:** The diagnosis or indication is treatment of an acute Hereditary Angioedema (HAE) attack. (Approval may be granted so that 2 doses may be kept on hand. **Firazyr, Kalbitor, Ruconest:** The diagnosis or indication is treatment of an acute Hereditary Angioedema (HAE) attack AND the patient has a documented side effect, allergy, treatment failure or contraindication to Berinert (Approval may be granted so that 2 doses may be kept on had for Kalbitor or Ruconest and 3 doses for Firazyr.) **Haegarda:** The diagnosis or indication is prophylaxis of Hereditary Angioedema (HAE) attacks. **Cinryze, Takhzyro:** The diagnosis or indication is prophylaxis of Hereditary Angioedema (HAE) attacks AND the patient has a documented side effect, allergy, treatment failure or contraindication to Haegarda OR the request is for

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		Cinryze in a patient between the ages of 6-11.
HYPERKALEMIA AGENTS		
Kionex® (sodium polystyrene sulfonate) powder, suspension SPS® (sodium polystyrene sulfonate) suspension	Lokelma™ (sodium zirconium cyclosilicate) Veltassa® (patiromer sorbitex calcium) powder packets (*QL = 1 packet/day)*	**Lokelma, Veltassa:** The patient requires therapy for the treatment of non-emergent hyperkalemia and has a side effect, allergy, or contraindication to one preferred sodium polystyrene sulfonate product.
IDIOPATHIC PULMONARY FIBROSIS (IPF)		

	Esbriet® (pirfenidone) (*QL =267mg tablets= 270 tabs/month, 801mg tablets=90 tabs/month)*
	Ofev® (nintedanib) (*QL = 60 tabs/month)*
		Clinical Criteria: Esbriet, Ofev
		○ Age ≥ 18
		○ Diagnosis of idiopathic pulmonary fibrosis (IPF-ICD-9 Code 516.31 or ICD-10 code J84.112) as well as exclusion of other known causes of Interstitial Lung Disease.
		○ May not be used in combination with Ofev® or Esbriet® respectively.
		○ The prescriber is a pulmonologist.
		○ Clinical documentation that the member is a non-smoker or has not smoked in 6 weeks.
		○ FVC≥ 50% of predicted
		○ AND one of the following
		  ○ High-resolution computed tomography (HRCT) revealing IPF or probable IPF.
		  ○ Surgical lung biopsy consistent with IPF or probable IPF.
		Reauthorization Criteria:
		○ Documentation the patient is receiving clinical benefit to Esbrit® or Ofev® therapy as evidenced by < 10% decline in percent predicted FVC of < 200mL decrease in FVC AND
		○ There is clinical documentation that the member has remained tobacco-free.

IMMUNOLOGIC THERAPIES FOR ASTHMA		
(Initial 3 months, Renewal 1 year)		
	Cinqair® (reslizumab) Intravenous injection Fasenra® (benralizumab) subcutaneous injection *Quantity limit = 1 syringe every 28 days for 3 doses then 1 syringe every 56 days* Nucala® (mepolizumab) subcutaneous injection	**Xolair®:** *Diagnosis of moderate to severe persistent asthma:* • The patient must be 6 years of age or older AND • The patient has had a therapeutic failure or contraindication to an inhaled corticosteroid (with or without chronic oral corticosteroid therapy), a

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Quantity limit = 1 vial every 28 days Xolair® (omalizumab) subcutaneous injection vial *Quantity limit = 6 vials every 28 days*	leukotriene receptor antagonist, and a long-acting beta-agonist AND • The prescriber is a pulmonologist, allergist, or immunologist AND • Patient has tested positive to at least one perennial aerollergen by skin or blood test (i.e.: RAST, CAP, intracutaneous test) AND • Patient has a 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. *Diagnosis of chronic idiopathic urticaria:* • The patient must be 12 years of age or older AND • The patient has a therapeutic failure or contraindication to an H1 antihistamine (e.g. cetirizine, fexofenadine) at double the daily dose AND • The patient has therapeutic failure or contraindication to a leukotriene receptor antagonist. **Limitations:** Xolair use will not be approved if requested for prevention of peanut related allergic reaction or in patients with a diagnosis of moderate to severe persistent asthma who are currently smoking. **Fasenra, Nucala, Cinqair:** • The patient must be 12 years of age or older for Fasenra/Nucala or 18 years of age or older for Cinqair AND • The patient must have a diagnosis of severe persistent asthma with an eosinophilic phenotype as defined by pre-treatment blood eosinophil count of ≥ 150 cells per mcL within the previous 6 weeks or ≥ 300 cells per mcL within 12 months prior to initiation of therapy AND • The patient has a history of 2 or more exacerbations in the previous year despite regular use of high dose inhaled corticosteroids (ICS) AND inadequate symptom control when given in combination with another controller medication (long-acting beta agonist {LABA} or leukotriene receptor antagonist {LTRA}) for a minimum of 3 consecutive months, with or without oral corticosteroids. Pharmacy claims will be evaluated to assess compliance with therapy. AND • The patient has a pre-treatment FEV_1 < 80% predicted AND • The prescriber is an allergist, immunologist, or pulmonologist. AND For continuation of therapy after the initial 3 month authorization, the patient must continue to receive therapy with both an ICS and a controller medication (LABA or LTRA) 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 FEV_1 from baseline. **Limitations:** Fasenra®, Nucala® and Cinqair® will not be considered in patients

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		who are currently smoking, in combination with omalizumab, OR for treatment of other eosinophilic conditions.
IMMUNOSUPPRESANTS, ORAL		
AZATHIOPRINE tablet CYCLOSPORINE capsule CYCLOSPORINE MODIFIED MYCOPHENOLATE MOFETIL tablet, capsule, suspension MYCOPHENOLIC ACID delayed release tablet SIROLIMUS tablet TACROLIMUS capsule ZORTRESS® (everolimus) tablet	Astagraf® XL (tacrolimus) capsule Azasan® (azathioprine) tablet Cellcept® (mycophenolate mofetil) tablet, capsule, suspension Envarsus® XR (tacrolimus) tablet Gengraf® (cyclosporine modified) capsule, solution Imuran® (azathioprine) tablet Myfortic® (mycophenolic acid) delayed release tablet Neoral® (cyclosporine modified) capsule, solution Prograf® (tacrolimus) capsule Rapamune® (sirolimus) tablet, solution Sandimmune® (cyclosporine) capsule, solution	**Criteria:** The patient has been started and stabilized on the requested product OR the patient has a documented side effect, allergy, or treatment failure to a preferred agent (if a product has and AB rated generic, there must be a trial of the generic formulation).
INTERLEUKIN (IL)-1 RECEPTOR BLOCKERS		
Preferred After Clinical Criteria Are Met ILARIS® (canakinumab)	Arcalyst® (rilonacept) *(QL = 2 vials for loading dose, then 1 vial per week)*	**Ilaris:** The diagnosis is Cryopyrin-Associated Periodic Syndrome (CAPS) OR The diagnosis is Familial Cold Autoinflammatory Syndrome (FCAS), Familial Mediterranean Fever (FMF), Hyper-IgD periodic fever syndrome (HIDS), Muckle-Wells Syndrome (MWS), or Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS) AND The patient is > 4 years old OR The diagnosis is systemic juvenile idiopathic arthritis (sJIA) with active systemic features and varying degrees of synovitis with continued disease activity after initial therapy (Initial therapy defined as 1 month of anakinra (Kineret), 2 weeks of glucocorticoid monotherapy (oral or IV) or one month of NSAIDs). AND patient is > 2 years of age. **Arcalyst:** The diagnosis is Cryopyrin-Associated Periodic Syndrome (CAPS) OR The diagnosis is Familial Cold Autoinflammatory Syndrome (FCAS) OR The diagnosis is Muckle-Wells Syndrome (MWS) AND The patient is > 12 years old AND The patient must have a documented side effect, allergy, treatment failure or a contraindication to Ilaris (canakinumab) **Note:** Medical Records to support the above diagnosis must accompany the Prior Authorization request. Authorization for continued use shall be reviewed at least every 12 months to confirm patient has experienced disease stability or improvement while on therapy.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
IRON CHELATING AGENTS		
EXJADE® (deferasirox) FERRIPROX®(deferiprone)	Jadenu®(deferasirox)	**Jandenu®:** patient has had a documented side effect allergy or treatment failure to Exjade®; Jadenu®will not be approved without compelling clinical reason why Exjade® cannot be used as they are different forms of the same medication
LIPOTROPICS		
BILE ACID SEQUESTRANTS		
CHOLESTYRAMINE powder (compare to Questran®) CHOLESTYRAMINE LIGHT powder (compare to Questran Light®) PREVALITE powder (cholestyramine light) COLESTIPOL tablets, granules (compare to Colestid®) WELCHOL® (colesevelam) tablets, powder packets	Colesevelam (compare to Welchol®) Colestid® tablets, granules (colestipol) Questran® powder (cholestyramine) Questran Light® powder (cholestyramine light)	**Colesevelam:** The patient has had a documented intolerance to the brand name equivalent. **Questran, Questran Light, Colestid:** The patient has had a documented intolerance to the preferred generic formulation.
FIBRIC ACID DERIVATIVES		
GEMFIBROZIL (compare to Lopid®) 600 mg FENOFIBRATE NANOCRYSTALIZED (compare to Tricor®) 48 mg, 145 mg tablets *Quantity Limit = 1 tablet/day*	Antara® (fenofibrate micronized) 43 mg, 30 mg, 90 mg, 130 mg fenofibrate tablets (compare to Lofibra® tablets) 54 mg, 160 mg fenofibrate capsule (compare to (Lipofen®) 50 mg, 150 mg fenofibrate micronized capsule (compare to Lofibra® capsules) 67 mg, 134 mg, 200 mg fenofibrate micronized (compare to Antara®) 43 mg, 130 mg fenofibric acid (compare to Trilipix) 45mg, 135mg delayed release capsule fenofibric acid 35 mg, 105 mg *Quantity Limit = 1 capsule/day* Fenoglide® (fenofibrate MeltDose) 40 mg, 120 mg Fibricor® (fenofibric acid) 35 mg, 105 mg	**Lopid:** The patient has had a documented intolerance to generic gemfibrozil. **Antara, fenofibrate, fenofibrate micronized, fenofibric acid (all strengths), Fenoglide,Fibricor, Lipofen, Tricor, Triglide, and Trilipix:** The patient is taking a statin 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.)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Lipofen® (fenofibrate) 50 mg, 150 mg Lopid® (gemfibrozil) 600 mg Tricor® (fenofibrate nanocrystallized) 48 mg, 145 mg Triglide® (fenofibrate) 50 mg, 160 mg Trilipix (fenofibric acid) 45 mg, 135 mg delayed release capsule	
HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMA (HoFH) AGENTS		
All products require a PA	Juxtapid® (lomitapide) Capsule *QL = 5 and 10 mg caps (1 per day), 20 mg cap (3 per day)* *QL = 4 syringes(4 ml)/28 days* Maximum days' supply per fill for all drugs is 28 days	**CRITERIA FOR APPROVAL:** Patient has a diagnosis of homozygous familial hypercholesterolemia (HoFH) AND Medication will be used as adjunct to a low-fat diet and other lipid-lowering treatments AND Patient does not have any of the following contraindications to therapy: ▪ Pregnancy ▪ Concomitant use with strong or moderate CYP3A4 inhibitors ▪ Moderate or severe hepatic impairment or active liver disease including unexplained persistent abnormal liver function tests AND Patient has tried and had an inadequate response, intolerance or contraindication to BOTH atorvastatin and rosuvastatin. Note: Re-approval requires confirmation that the patient has responded to therapy (i.e. decreased LDL levels) AND the patient does not have any contraindications to therapy.
NICOTINIC ACID DERIVATIVES		
NIACIN NIASPAN® (niacin extended release)	Niacin extended release (compare to Niaspan®)	**CRITERIA FOR APPROVAL:** The patient has a documented intolerance to the branded product.
STATINS		
ATORVASTATIN (compare to Lipitor®) CRESTOR® (rosuvastin) LOVASTATIN PRAVASTAIN (compare to Pravachol®) ROSUVASTATIN (compare to Crestor®) SIMVASTATIN (compare to Zocor®) **Note:** All preferred agents have a quantity limit of 1 tablet/day	Altoprev® (lovastatin SR) Fluvastatin Fluvastatin ER (compare to Lescol® XL) Lescol® XL (fluvastatin ER) Lipitor® (atorvastatin) Livalo® (pitavastatin) Pravachol® (pravastatin) Zocor® (simvastatin) Zypitamag™ (pitavastatin) **Note:** All non-preferred agents have a quantity limit of 1 tablet/day except fluvastatin IR which has a quantity limit of 2 tablets/day.	**Non-preferred agents (except as noted below):** The patient must have a documented side effect, allergy, or treatment failure to 3 preferred statins. If the product has an AB rated generic, one trial must be the generic formulation. **Zypitamag:** The patient must have a documented side effect, allergy, or treatment failure to 3 preferred statins AND clinical justification is provided documenting why the patient is unable to use Livalo. **LIMITATIONS: Simvastatin 80 mg:** initiation of simvastatin 80 mg or titration to 80 mg is not recommended by the FDA due to the increased risk of myopathy, including rhabdomyolysis. Patients may only continue on this dose when new to Medicaid if the patient has been taking this dose for 12 or more months without evidence of muscle toxicity. If the request is for Zocor 80 mg, the patient must have met the prior treatment length requirement and have a documented intolerance to the generic equivalent
MISCELLANEOUS/COMBOS		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
Ezetimibe (compare to Zetia®) *(Qty Limit = 1 tablet/day)*	Lovaza® (omega-3-acid ethyl esters) Omega-3-acid ethyl esters (compare to Lovaza®) Vascepa® (icosapent ethyl) *(QL = 4 capsules/day)* Zetia® (ezetimibe) *(Qty Limit = 1 tablet/day)* Ezetimibe/simvastatin (compare to Vytorin®) Vytorin® (ezetimibe/simvastatin) *(QL = 1 tablet/day)* Amlodipine/atorvastatin (compare to Caduet®) *(Qty Limit = 1 tablet/day)* Caduet® (atorvastatin/amlodipine) *(Qty Limit = 1 tablet/day)*	**Zetia:** patient must have a documented intolerance to the generic equivalent. **Lovaza, Vascepa, Omega-3-acid ethyl esters:** The patient has been started and stabilized on this medication (Note: samples are not considered adequate justification for stabilization.) OR The patient has triglyceride levels > 500 mg/dL AND The patient has a documented contraindication, side effect, allergy, or treatment failure to a fibric acid derivative and niacin. AND If the request is for brand Lovaza, the patient has a documented intolerance to the generic equivalent. **Amlodipine/atorvastatin, Caduet:** The 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. **Vytorin, ezetimibe/simvastatin:** The patient has had an inadequate response to atorvastatin or rosuvastatin. 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.
PCSK9 INHIBITORS		

Preferred After Clinical Criteria are Met
 	
PRALUENT® (alirocumab)
QL = 2ml (75mg injection every 2 weeks or 300mg every month)/ 28 days; Max 28-day supply
	Repatha® (evolocumab) Sureclick, prefilled syringe
	QL = 2ml (2 injections)/ 28 days; Max 28-day supply
	Repatha® (evolocumab) Pushtronix™
	QL = 3.5ml (One single-use infusor and prefilled cartridge)/ 28 days; Max 28-day supply
		Criteria for approval:
		• Age > 18 years of age **or** > 13 and dx of homozygous familial hypercholesterolemia (HoFH)
		• Concurrent use with statin therapy
		• Documented adherence to prescribed lipid lowering medications for the previous 90 days
		• Recommended or prescribed by a lipidologist or cardiologist
		• 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
		Additional criteria for the diagnosis of heterozygous familial hypercholesterolemia (HeFH): (both are required)
		• Total cholesterol > 290 mg/dL OR LDL-C > 190 mg/dL AND one of the following
		  ○ Presence of tendon xanthomas **OR**
		  ○ In 1st or 2nd degree relative-documented tendon xanthomas, MI at age ≤ 60 years or TC > 290 mg/dL
		• For approval of Repatha, the patient must have a documented side effect, allergy, or treatment failure with Praluent.
		
		Additional criteria for the diagnosis of clinical atherosclerotic cardiovascular disease:
		• History of MI, angina, coronary or other arterial revascularization, stroke, TIA, or PVD of atherosclerotic origin
		• For approval of Repatha, the patient must have a documented side effect, allergy, or treatment failure with Praluent.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		Additional criteria for the diagnosis of homozygous familial hypercholesterolemia (Repatha only): • Total cholesterol and LDL-C > 600 mg/dL and TG within reference range **OR** • Confirmation of diagnosis by gene testing
MISCELLANEOUS		
GLYCOPYRROLATE 1 mg, 2 mg tablets (compare to Robinul®, Robinul Forte®) KUVAN® (sapropterin) PYRIDOSTIGMINE BROMIDE (Compare to Mestinon) RILUZOLE (Compare to Rilutek®) ***PREFERRED AFTER CLINICAL CRITERIA ARE MET*** CARBAGLU® dispersible tablets (carglumic acid) *(Maximum days supply per fill = 14 days)* CRYSVITA® (burosumab-twza) FABRAZYME (agalsidase beta) IV	Mestinon® Benlysta® (belimumab) *(Maximum days supply per fill = 28 days)* Brineura™ (cerliponase alfa) (QL=1 package per 14 days (Brineura Injhection, 2 vials of 150mg/5ml, and Intraventriculsr Electrolytes Injection, 1 vial of 5ml)) Elaprase® (idursulfase) *(QL = calculated dose/week)* Cuvposa® oral solution (glycopyrrolate)* Maximum days supply per fill is 30 days Galafold™ (migalastat) Qty Limit=14 caps/28 days; Maximum days' supply=28 days Hetlioz® (tasimelteon) 20 mg oral capsule *Quantity limit =1 capsule/day* * Maximum days supply per fill is 30 days* Hydroxyprogesterone caproate 250mg/ml vial (intramuscular injection) Korlym® tablets (mifepristone) *Quantity limit = 4 tablets/day* Luxturna® (voretigine neparvovec-rzyl) suspension for subretinal injection *(Quantity Limit = one injection per eye per lifetime)* Otrexup® or Rasuvo® Single-dose auto-injector for subcutaneous use (methotrexate) *(Quantity Limit = 4 syringes/28 days)* Myalept® (metreleptin) vial for subcutaneous injection *QL = one vial/day (Maximum days' supply per fill = 30 days)* Radicava® (edaravone) IV injection Rilutek® (riluzole)	**Benylsta:** The diagnosis or indication is active systemic lupus erythematosus (SLE) AND The patient is positive for autoantibodies (anti-nuclear antibody (ANA) and/or anti-double-stranded DNA (anti-dsDNA). AND The patient has had a documented inadequate response or intolerance to at least TWO of the following agents: NSAIDs, hydroxychloroquine, prednisone, azathioprine, methotrexate, mycophenolate. **Note:** The efficacy of Benlysta® has not been evaluated in patients with severe active lupus nephritis or severe active central nervous system lupus. Benlysta has not been studied in combination with other biologics or intravenous cyclophosphamide. Use of Benlysta is not recommended in these situations. Initial approval will be granted for 3 months. For therapy continuation, clinical documentation must be submitted documenting stable disease activity OR reduction in disease activity or corticosteroid dose. **Brineura:** • Patient is 3 years of age or older AND • The diagnosis or indication is late infantile neuronal ceroid lipofuscinosis type 2 (CLN2), confirmed by deficiency of the lysosomal enzyme tripeptidyl peptidase-1 (TPP1) (results of genetic testing must be submitted AND • The prescriber is a neurologist or other physician specializing in intraventricular administration **Note:** Bineura will be approved as a medical benefit ONLY and will NOT be approved if billed through pharmacy point of sale. Initial approval will be granted for 3 months. Renewal may be granted for up to 12 months. For therapy continuation, clinical documentation must be submitted documenting improvement or maintenance of motor ability OR slower progression of disease than would otherwise be expected AND a 12-lead ECG evaluation is performed every 6 months. **Carbaglu:** 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

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Signifor® (pasireotide) Ampules *QL (all strengths) = 2 ml (2 amps)/day* Maximum days' supply = 30 days Soliris® (eculizumab) *(Quantity Limit = 12 vials(360 ml) /28 days) Maximum days' supply per fill = 28 days* Somatuline® Depot Injection (lanreotide) *(Quantity Limit = 0.2 ml/28 days (60 mg syringe), 0.3 ml/28 days (90 mg syringe) and 0.5 ml/28 days (120 mg syringe))* Tiglutik™ (riluzole) suspension Lysteda® tablets (tranexamic acid) *Quantity limit = 30 tablets/28 days tranexamic acid (compare to Lysteda®)* *Quantity limit = 30 tablets/28 days* Palynziq™ (pegvaliase-pqpz) Spinraza (nusinersen) injection 12mg/5ml single-dose vial Xatmep™ (methotrexate) oral solution Zinplava™ (Bezlotoxumab) injection	geneticist) or prescriber is in consultation with a specialist **Crysvita:** • Patient is ≥ 1 year of age AND • Patient has a diagnosis of X-linked hypophosphatemia AND • Medication is prescribed by or in consultation with an endocrinologist or nephrologist AND • Patient has not received oral phosphate or vitamin D analogs within 1 week prior to starting therapy AND • Baseline fasting serum phosphorous level is below the lower limit of the laboratory normal reference range AND • Patient does not have severe renal impairment, defined as a GFR of < 30mL/min AND • Dose does not exceed 90mg every 14 days (pediatrics) or 90mg every 28 days (adults) **Note:** Initial approval will be granted for 6 months. Renewal may be granted for up to 1 year. For therapy continuation, patient must have disease response as indicated by one of the following: • Increased serum phosphate levels, not exceeding the upper limit of the laboratory normal range. • A reduction in serum total alkaline phosphatase activity. • Improvement in symptoms (e.g. skeletal pain, linear growth, etc.). • Improvement in radiographic imaging of Rickets/osteomalacia. **Elaprase (Hunter's Syndrome Injectable**): The diagnosis or indication for the requested medication is Hunter's Syndrome **Cuvposa:** The diagnosis or indication for the requested medication is Sialorrhea or a neurologic condition associated with excessive drooling (e.g. cerebral palsy, mental retardation, Parkinson's disease). AND The dose cannot be obtained from the tablet formulation. AND (For patients >18 years of age) The patient has had a documented side effect, allergy, treatment failure, or a contraindication to scopolamine patches. **Fabrazyme:** Diagnosis or indication is Fabry Disease. **Galafold:** Patient is ≥ 18 years of age AND Diagnosis or indication is Fabry Disease with an amenable galactosidase alpha (GLA) gene variant for treatment (results must be submitted) AND enzyme replacement therapy is not a therapeutic option (e.g. due to allergy, hypersensitivity, or poor venous access). **Hetlioz:** Patient has documentation of Non-24-Hour Sleep-Wake Disorder (Non-24) AND Patient has documentation of total blindness AND Patient has had a documented side effect, allergy or treatment failure with Rozerem and at least one OTC melatonin product. **Korlym:** Patient is ≥18 years of age AND Patient has a diagnosis of endogenous Cushing's syndrome AND Patient is diagnosed with type 2 diabetes mellitus

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		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 (eg. ketoconazole, etomidate) AND Patient does not have any of the following contraindications to Korlym: Pregnancy (pregnancy must be excluded before the initiation of therapy or if treatment is interrupted for >14 days in females of reproductive potential. Nonhormonal contraceptives should be used during and one month after stopping treatment in all women of reproductive potential) OR Patient requires concomitant treatment with systemic corticosteroids for serious medical conditions/illnesses (immunosuppression for organ transplant) OR Patient has a history of unexplained vaginal bleeding OR Patient has endometrial hyperplasia with atypia or endometrial carcinoma OR Patient is concomitantly taking simvastatin, lovastatin, or a CYP3A substrate with a narrow therapeutic index (e.g., cyclosporine, dihydroergotamine, ergotamine, fentanyl, pimozide, quinidine, sirolimus, or tacrolimus). **Luxturna:** patient must have inherited retinal dystrophy due to mutations in both copies of the RPE65 gene (results of genetic testing must be submitted) AND patient has sufficient viable retinal cells as determined by the treating physician(s) AND Luxturna will be administered by a retinal specialist;/surgeon experienced in performing intraocular surgery and associated with an Ocular Gene Therapy Treatment Center. **Otrexup, Rasuvo:** The patient has a diagnosis of rheumatoid arthritis (RA), polyarticular juvenile idiopathic arthritis (pJIA) or psoriasis. AND The patient has been intolerant to oral methotrexate AND The patient has been unable to be compliant with a non-auto-injector form of injectable methotrexate (includes difficulty with manual dexterity). **Myalept:** Patient has a diagnosis of congenital or acquired generalized lipodystrophy AND Patient has one or more of the following metabolic abnormalities AND is refractory to current standards of care for lipid and diabetic management: Insulin resistance (defined as requiring > 200 units per day), Hypertriglyceridemia, Diabetes AND Prescription is written by or in consultation with an endocrinologist AND The prescriber is registered in the MYALEPT REMS program. Reauthorization for continued use criteria: Patient has experienced an objective response to therapy • Sustained reduction in hemoglobin A1c (HbA1c) level from baseline OR • Sustained reduction in triglyceride (TG) levels from baseline **Palynziq:** Patient is 18 years of age or older AND has a diagnosis of phenylketonuria AND has uncontrolled blood phenylalanine (PHE) concentrations (> 600 micromol/L) on existing management, including restricting dietary phenylalanine

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		and protein intake and treatment with sapropterin. For re-approval, the patient must have achieved at least a 20% reduction in PHE concentration from pre-treatment baseline or a PHE ≤ 600 micromol/L after 16 weeks of continuous treatment with the maximum dosage of 40mg daily. **Note:** Palynziq has a black box warning for anaphylaxis which can occur at any time during treatment. Patients, pharmacies, and physicians must be enrolled in the Palynziq REMS program AND concurrent auto-injectable epinephrine must be prescribed. **Radicava:** • The diagnosis is amyotrophic lateral sclerosis (ALS) AND • Disease duration is ≤ 2 years AND • Patient has functionally retained most activities of daily living AND • Patient has normal respiratory function (defined as a % predicted forced vital capacity of ≥ 80%) AND • Patient does not have a sulfite allergy AND • Initial approval will be granted for 14 doses/28 days and all subsequent approvals will be for 10 doses/28 days **Rilutek:** patient must have a documented intolerance with riluzole **Signifor:** Patient has a diagnosis of (pituitary) Cushing's disease AND Patient is 18 years of age or older AND Pituitary surgery is not an option or has not been curative Note: Re-approval requires confirmation that the patient has experienced an objective response to therapy (i.e., clinically meaningful reduction in 24-hour urinary free cortisol levels and/or improvement in signs or symptoms of the disease). **Soliris:** The patient has a diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) documented by flow cytometry. AND The patient has received the meningococcal vaccine at least 2 weeks prior to therapy initiation. OR The patient has a diagnosis of atypical hemolytic uremic syndrome (aHUS). AND The patient has received the meningococcal vaccine at least 2 weeks prior to therapy initiation. Authorization for continued use shall be reviewed to confirm that the patient has experienced an objective response to the therapy. **Somatuline:** The diagnosis or indication for the requested medication is Acromegaly. **Tiglutik:** patient must be unable to take whole or crushed riluzole tablets **Lysteda, Tranexamic acid:** The diagnosis or indication is clinically significant heavy menstrual bleeding AND The patient has been started and stabilized on oral tranexamic acid within the previous 360 days OR The patient does not have a contraindication to therapy with oral tranexamic acid (i.e., active thrombotic disease, history of thrombosis/thromboembolism, or an intrinsic risk of thrombosis/thromboembolism), and if oral tranexamic acid is to be used concomitantly with an estrogen containing hormonal contraceptive product, the

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

		risks of combination therapy have been discussed with the patient. AND The patient has had a documented side effect, allergy, contraindication, or an inadequate response with at least one oral contraceptive or progestin containing product despite an adequate trial of at least 90 days, or a rationale for why these products cannot be used (e.g. actively attempting to conceive). AND The patient has had a documented side effect, allergy, contraindication, or an inadequate response with at least one 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.
		Xatmep: The patient has a diagnosis of polyarticular juvenile idiopathic arthritis or acute lymphoblastic leukemia (ALL) AND patient has a requirement for an oral liquid dosage form (i.e. swallowing disorder, inability to take oral medications)
		Spinraza:
		• The diagnosis is spinal muscular atrophy (SMA) type 1,2, or 3 (results of genetic testing must be submitted) AND
		• The patient has at least 2 copies of the SMN2 gene AND
		• The prescriber is a neurologist, pulmonologist, or other physician with expertise in treating SMA AND
		• The need for invasive or noninvasive ventiliation (if applicable) does not exceed more than 6 hours per 24 hour period AND
		• Baseline motor ability has been established using one of the following exams:
		  ○ Hammersmith Infant Neurological Exam (HINE)
		  ○ Hammersmith Functional Motor Scale Expanded (HFMSE)
		  ○ Upper Limb Module Test (non-ambulitory)
		  ○ Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND) AND
		• Prior to starting therapy, and prior to each dose, the following laboroatory tests will be conducted: Platelet count, prothrombin time (PT), activated partial thromboplastin time (aPTT), and quantitative spot urine protein
		Note: Initial approval will be granted for 4 loading doses (the first 3 loading doses should be administered at 14-day intervals; the 4th loading dose should be administered 30 days after the 3rd dose). Renewal may be granted for up to 12 months with a maximum of 3 doses approved per year (12mg(5ml) every 4 months). For therapy continuation, clinical documentation must be submitted documenting improvement or maintenance of motor ability OR slower progression of disease than would otherwise be expected.
		Zinplava:

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

		• The patient is 18 years of age or older AND
		• The patient has a diagnosis of *Clostridium difficile* infection (CDI) confirmed by a positive stool test collected within the past 7 days AND
		• The patient is or will receive concomitant Standard of Care antibacterial therapy for CDI (e.g. metronidazole, vancomycin, or fidaxomicin) AND
		• The patient is at high risk for recurrence based on at least one of the following:
		  ○ Age ≥ 65 years
		  ○ Two or more episodes of CDI within the past 6 months
		  ○ The patient is immunocompromised
		  ○ The patient has clinically severe CDI (e.g. fever, abdominal tenderness, WBC ≥ 15,000 cells/mm^3, albumin <30g/L, or renal failure)
		Note: A single-dose of 10mg/kg will be approved per active CDI. A repeat dose will not be approved for recurrence of the same active infection.

MOOD STABILIZERS		
LITHIUM CARBONATE (formerly Eskalith®) LITHIUM CARBONATE SR (compare to Lithobid®, formerly Eskalith CR®) LITHIUM CITRATE SYRUP	Equetro® (carbamazepine SR) Lithobid®* (lithium carbonate SR)	**Lithobid:** The patient has had a documented side effect, allergy, or treatment failure with the generic equivalent of the requested medication. **Equetro:** The patient has had a documented side effect, allergy, or treatment failure with a carbamazepine product from the anticonvulsant therapeutic drug category
MOVEMENT DISORDERS		
Preferred After Clinical Criteria are Met XENAZINE® tablets (tetrabenazine) *(Maximum 1 month supply per fill)* *Quantity limit = 50 mg/day at initial approval (12.5 mg tablets ONLY), up to100 mg/day at subsequent approvals (12.5 mg or 25 mg tablets)*	Austedo® (deutetrabenazine) tablets (Maximum 1 month supply per fill) Quantity limit = 48mg/day Ingrezza® (valbenazine tosylate) capsules (Maximum 1 month supply per fill) Quantity limit =80mg/day) Tetrabenzaine (compare to Xenazine®) (Maximum 1 month supply per fill) Quantity limit = 50mg/day at initial approval (12.5mg tablets ONLY), up to 100mg/day at subsequent approvals (12.5mg or 25mg tablets)	**Austedo:** The diagnosis or indication for the requested medication is Huntington's Disease (HD) with chorea or Tardive Dyskinesia (TD) AND the patient is ≥18 years of age AND the patient has a documented side effect, allergy, contraindication or treatment failure with Xenazine. **Ingrezza:** The diagnosis or indication for the requested medication is Tardive Dyskinesia (TD) AND the patient patient is ≥18 years of age AND the patient has a documented side effect, allergy, contraindication or treatment failure with Xenazine. **Tetrabenazine:** The patient must have a documented intolerance to brand Xenazine. **Xenazine:** The diagnosis or indication for use is Tourette Syndrome OR the

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		diagnosis or indication for use is Huntington's Disease (HD) with Chorea or Tardive Dyskinesia (TD) AND the patient is ≥18 years of age. **Note:** Austedo, Tetrabenazine, and Xenazine are contraindicated in patients who are suicidal, and in patients with untreated or inadequately treated depression.
MUCOSAL COATING AGENTS		
ALUMINUM HYDROXIDE†(formerly Amphojel®) EPISIL® (wound barrier) GELCLAIR® (povidone sodium hyaluronate glycyrrhetinic acid gel) MYLANTA/DIPHENYDRAMINE/LIDOCAINE VISCOUS (aka "Magic Mouthwash") Or other similar single or combination products	MuGard® (mucoadhesive oral wound rinse) *(QL = 4 bottles/month)*	**MuGard:** Patient is receiving radiation and/or chemotherapy. AND The patient has had a documented side effect, allergy or treatment failure with at least one oral mucosal coating agent (e.g. aluminum hydroxide suspension, Mylanta) or a topical anesthetic (e.g. viscous lidocaine or diphenhydramine solutions) or combinations of similar agents. **Additional criteria for viscous lidocaine:** • Due to a FDA safety alert, viscous lidocaine will require prior authorization for children ≤3 years of age.
MULTIPLE SCLEROSIS MEDICATIONS		
INJECTABLES **Interferons** AVONEX® (interferon *B*-1a) BETASERON® (interferon *B*-1b) REBIF® (interferon *B*-1a) REBIF® REBIDOSE (interferon *B*-1a) **Other** COPAXONE® 20 mg (glatiramer acetate) *(QL = 1 kit/30 days)* **ORAL**	Extavia® (interferon beta-1b) Copaxone® 40 mg (glatiramer)*(QL = 12 syringes(12 ml)/28 days)* Glatiramer Acetate (compare to Copaxone®)20mg (QL=1kit/30days) Glatiramer Acetate (compare to Copaxone®) 40mg (QL = 12 syringes (12 ml)/28 days) Glatopa® 20mg (glatiramer acetate) (QL=1 carton (30 syringes/30 days) Glatopa® 40 mg (glatiramer) (QL = 12 syringes (12 ml)/28 days) Ocrevus® (ocrelizumab) (QL=300mgx2doses then 600mg every 6 months thereafter) Plegridy® (peginterferon beta-1a) Tecfidera® (dimethyl fumarate) *(QL = 2 capsules/day, maximum 30 day supply per fill)*	**Copaxone 40 mg Syringe:** Patient has a diagnosis of multiple sclerosis. AND The patient has a documented side effect, allergy, treatment failure, or contraindication to at least one preferred drug (not Copaxone 20 mg). AND The patient is unable to tolerate or be compliant with Copaxone 20 mg daily dosing. **Extavia:** Patient has a diagnosis of multiple sclerosis. AND The provider provides a clinical reason why Betaseron cannot be prescribed. **Glatiramer, Glatopa:** Patient is ≥ 18 years AND diagnosis of relapsing forms of Multiple Sclerosis AND the provider provides a clinical reason why Copaxone cannot be prescribed. **Ocrevus:** Patient is ≥18 years AND has a diagnosis of relapsing multiple sclerosis AND has a documented side effect, allergy, treatment failure or contraindication to at least two preferred drugs and Tysabri, OR Diagnosis of relapsing multiple sclerosis and the patient has a documented side effect, allergy, treatment failure, or contraindication to two preferred drugs and has

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
AMPYRA® (dalfampridine) tablet *(QL = 2 tablets/day, maximum 30 day supply per fill)* AUBAGIO® (teriflunamide) tablet *(QL = 1 tablet/day, maximum 28 day supply per fill)* GILENYA® (fingolimod) capsule *(QL = 1 capsule/day, maximum 30 day supply per fill)*	Tysabri® (natalizumab)	tested positive for anti-JVC antibodies. OR Patient is ≥18 years AND has a diasnosis of primary progressive multiple sclerosis. **Plegridy:** 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. **Tecfidera:** The patient is started and stabilized on the requested medication (Note: samples are not considered adequate justification for stabilization.) OR 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. **Tysabri:** Patient has a diagnosis of relapsing multiple sclerosis and has already been stabilized on Tysabri OR Diagnosis is relapsing multiple sclerosis and the patient has a documented side effect, allergy, treatment failure, or contraindication to at least two preferred drugs.
MUSCLE RELAXANTS, SKELETAL		
Musculoskeletal Agents **Single Agent** CHLORZOXAZONE tablets *(Quantity limit = 4 tablets/day)* CYCLOBENZAPRINE†5 mg, 10 mg tablets (compare to Flexeril®) *(Quantity limit = 6 tablets/day (5 mg), 3 tablets/day (10 mg))* METHOCARBAMOL tablets (compare to Robaxin®) *(Quantity limit = 8 tablets/day)* ORPHENADRINE CITRATE ER 100 mg tablet *(Quantity limit = 2 tablets/day)*	Amrix®(cyclobenzaprine sustained-release) capsule *(Quantity limit = 1 capsule/day)* carisoprodol tablets *(Quantity limit = 4 tablets/day)* cyclobenzaprine 7.5 mg tab (compare to Fexmid®) *(Quantity limit = 3 tablets/day)* Fexmid® (cyclobenzaprine) 7.5 mg tablet *(Quantity limit = 3 tablets/day)* Lorzone® (chlorzoxazone) tablets *(Quantity limit = 4 tablets/day)* metaxalone (compare to Skelaxin®) tablets *(Quantity limit = 4 tablets/day)* Robaxin®* (methocarbamol) tablets *(Quantity limit = 8 tablets/day)* Skelaxin® (metaxalone) tablets *(Quantity limit = 4 tablets/day)* Soma® (carisoprodol) tablets *(Quantity limit = 4 tablets/day)* carisoprodol, ASA (previously Soma Compound®) *(Quantity limit = 4 tablets/day)* carisoprodol, ASA, codeine *(Quantity limit = 4 tablets/day)*	**Amrix, cyclobenzaprine 7.5 mg, Fexmid**: The prescriber must provide a clinically valid reason why a preferred generic cyclobenzaprine cannot be used. For approval of Fexmid, the patient must also have a documented intolerance to the generic equivalent. **Brand skeletal muscle relaxants with generics available (Flexeril, Robaxin):** The patient has had a documented side effect, allergy or treatment failure with two different preferred musculoskeletal agents (One trial must be the AB rated generic). **carisoprodol, carisoprodol/ASA, carisoprodol/ASA/codeine, Lorzone, Soma, metaxolone, Skelaxin:** The patient has had a documented side effect, allergy or treatment failure with two different preferred musculoskeletal agents. Additionally, if a brand name product is requested where an AB rated generic exists, the patient must also have had a documented intolerance to the generic product. **Dantrium, Zanaflex tablets:** The patient must have a documented intolerance with the AB rated generic product. **Tizanadine capsules, Zanaflex capsules:** The prescriber must provide a clinically valid reason why generic tizanidine tablets cannot be used. AND If the request is for Zanaflex capsules, the patient must have a documented intolerance to generic tizanadine capsules

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
<u>Combination Product</u> All products require PA *ASA = aspirin* **Maximum duration of therapy all musculoskeletal agents = 90 days** **<u>Antispasticity Agents</u>** BACLOFEN DANTROLENE (compare to Dantrium®) TIZANIDINE (compare to Zanaflex®) tablets	Dantrium®* (dantrolene) tizanidine (compare to Zanaflex®) capsules Zanaflex® (tizanidine) capsules Zanaflex®* (tizanidine) tablets	
MUSCULAR DYSTROPHY AGENTS		
	Emflaza™ (deflazacort) *(Maximum 30 day supply per fill)* Exondys 51™ (eteplirsen)	**Emflaza:** • The patient must be ≥ 5 years of age AND • The patient must have a diagnosis of Duchenne MuscularDystrophy AND • There is documented improvement in muscle function or strength with use of prednisone, but the patient has experienced weight gain >10% of body weight withing 3 months or >25% within 1 year. **Exondys:** • 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 (results of genetic testing must be submitted) AND • The prescriber is, or has consulted with, a neuromuscular disorder specialist AND • The dose does not exceed 30mg/kg once weekly AND • The patient is currently on a stable corticosteroid dose for at least 6 months. • 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.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
NEUROGENIC ORTHOSTATIC HYPOTENSION		
FLUDROCORTISONE† MIDODRINE†	Northera®	**Quantity Limits:** • Initial 2 weeks approval • Continued therapy approvals based on documentation of continued benefit clinically and as evidenced by positional blood pressure readings **Clinical Criteria:** • diagnosis of neurogenic orthostatic hypotension caused by primary autonomic failure (Parkinson's disease, multiple system atrophy, or pure autonomic failure), dopamine beta-hydroxylase deficiency, or non-diabetic autonomic neuropathy, AND • the presentation of symptoms including dizziness, lightheadedness, and the feeling of "blacking out" AND • Failure of multiple non-pharmacologic measures as appropriate (e.g. removal of offending medications, compression stockings, increased fluid and salt intake) AND • Failure, intolerance or contra-indication to fludrocortisone AND midodrine
NEUROPATHIC PAIN & FIBROMYALGIA AGENTS		
Oral		
Duloxetine (compare to Cymbalta®) Quantity limit = 2 capsules/day Lyrica® (pregabalin) capsules Quantity Limit = 3 capsules/day	Cymbalta® (duloxetine) Gralise® (gabapentin) tablet, starter pack Quantity Limit = 3 tablets/day (Maximum 30 day supply per fill) Horizant® (gabapentin enacarbil) ER Tablet FDA maximum recommended dose = 1200mg/day Lyrica® CR (pregabalin, extended release) FDA maximum recommended dose = 330mg/day (DPN), 660MG/day (PHN) Lyrica® (pregabalin) solution Savella® (milnacipran) tablet, titration pack Quantity Limit = 2 tablets/day	**Cymbalta:** the patient has had a documented intolerance with generic duloxetine. **Gralise, Horizant:** The patient has a diagnosis of post-herpetic neuralgia (PHN) AND The patient has had a documented side effect, allergy, contraindication or treatment failure with at least one drug from the tricyclic antidepressant class AND The patient has had an inadequate response to the generic gabapentin immediate-release. **Lyrica CR:** 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 Lyrica immediate release resulting in a significant clinical impact. **Note:** The efficacy of Lyrica® CR has not been established for the management of fibromyalgia or as adjunctive therapy for adult patients with partial onset seizures. **Lyrica solution:** the patient is unable to use Lyrica capsules (e.g. Swallowing disorder) **Savella:** The diagnosis or indication is treatment of fibromyalgia AND The patient has had a documented side effect, allergy, or treatment failure to TWO drugs from the following: gabapentin, tricyclic antidepressant, SSRI antidepressant, SNRI antidepressant, miscellaneous antidepressant, cyclobenzaprine or Lyrica.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
NUTRITIONALS, LIQUID ORAL SUPPLEMENTS		
	ALL Note: Nutritional supplements administered via tube feeds may be provided through the Medical Benefit	**EleCare, EleCare Jr:** The patient is an infant or child who needs an amino acid-based medical food or who cannot tolerate intact or hydrolyzed protein. AND The product is being requested for the dietary management of protein maldigestion, malabsorption, severe food allergies, short-bowel syndrome, eosinophilic GI disorders, GI-tract impairment, or other conditions for which an amino acid-based diet is required. **All Others:** Requested nutritional supplement will be administered via tube feeding. OR Patient has one of the following conditions where feeding is difficult or malabsorption or maldigestion occurs: AIDS, Cancer, Celiac Disease, Cerebral Palsy, Chronic Diarrhea, Cognitive Impairment, Cystic Fibrosis, Dementia (includes Alzheimer's), Developmental Delays, Difficulty with chewing/swallowing food, Inflammatory Bowel Disease, Parkinson's, Short Gut. OR Patient has experienced unplanned weight loss or is extremely low weight (see further definitions below) OR Patient has demonstrated nutritional deficiency identified by low serum protein levels (albumin or pre-albumin levels to be provided) (albumin <3.5 g/dL /pre-albumin <15 mg/dL) **Unplanned Weight Loss/Low Weight Table:** **Adult:** □ Involuntary loss of > 10 % of body weight within 6 months □ Involuntary loss of > 5% of body weight within 1 month □ Loss of > 2% of body weight within one week □ BMI of < 18.5 kg/m2 **Elderly:** (>65): □ Involuntary loss of > 10 % of body weight within 6 months □ Involuntary loss of > 5 % of body weight within 3 months □ Loss of > 2 % of body weight within one month □ BMI of < 18.5 kg/m2 **Children:** □ < 80 % of expected weight-for-height □ < 90 % of expected height-for-age □ Mid-upper arm circumference/head circumference ratio < 0.25 **Limitations:** Infant formulas are not covered under the pharmacy benefit. Please contact WIC.
ONCOLOGY: ORAL (select)		
See Oncology: Oral order form for details of		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
medication that must be obtained through a DVHA enrolled specialty pharmacy provider. A current list of approved providers may be found at http://dvha.vermont.gov/for-providers/1dvha-enrolled-specialty-pharmacies.pdf		
OPHTHALMICS		
ANTIBIOTICS		
QUINOLONES BESIVANCE® (besifloxacin) suspension CILOXAN® ointment CIPROFLOXACIN HCL (compare to Ciloxan®) solution MOXEZA® (moxifloxacin 0.5%) (preservative free) solution MOXIFLOXACIN 0.5% solution (compare to Vigamox) (authorized generic, labeler code 00781 is the only preferred form)	Ciloxan® (ciprofloxacin) solution gatifloxacin 0.5% solution (compare to Zymaxid®) levofloxacin 0.5 % solution moxifloxacin 0.5% solution (compare to Vigamox®) (non-authorized generic forms) Ocuflox®*(ofloxacin) solution Ofloxacin (compare to Ocuflox®) solution Vigamox® (moxifloxacin 0.5%) (preservative free) solution Zymaxid® (gatifloxacin 0.5%) solution	**Single and Combination Agents (except noted below):** 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.) **Vigamox and non-authorized moxifloxacin generics:** 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 Moxeza or the authorized generic (labeler 00781) moxifloxacin.
MACROLIDES ERYTHROMYCIN ointment	Azasite®(azithromycin) solution All other brands	
AMINOGLYCOSIDES **Single Agent** AK-TOB (tobramycin) solution GARAMYCIN® (gentamicin) ointment, solution GENTAK (gentamicin) ointment, solution GENTAMICIN ointment, solution TOBRAMYCIN solution (compare to Tobrex®)	Tobramycin w/Dexamethasone (compare to Tobradex®) suspension Tobradex ST®(tobramycin/dexamethasone) suspension Tobrex® ointment, solution (tobramycin) Pred-G® S.O.P. (gentamicin/prednisolone) ointment	
Combination PRED-G® (gentamicin/prednisolone) ointment, suspension TOBRADEX®* (tobramycin/dexamethasone) suspension , ointment	Bacitracin ointment Bleph-10®* (sulfacetamide) solution Sulfacetamide sodium (compare to Bleph-10®) solution Sulfacetamide sodium ointment	

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ZYLET® (tobramycin/loteprednol) suspension **MISCELLANEOUS** **Single Agent** All products require PA **Combination** BACITRACIN ZINC W/POLYMYXIN B ointment NEOMYCIN/BACITRACIN/POLYMYXIN ointment NEOMYCIN/POLYMYXIN W/DEXAMETHASONE (compare to Maxitrol®) ointment, suspension NEOMYCIN/POLYMYXIN/BACITRACIN/ HYDROCORTISONE ointment POLYMYXIN B W/TRIMETHOPRIM (compare to Polytrim®) solution SULFACETAMIDE W/PREDNISOLONE SOD PHOSPHATE solution	Blephamide® (sulfacetamide/prednisolone acetate) suspension Blephamide® S.O.P. (sulfacetamide/prednisolone acetate) ointment Maxitrol®* (neomycin/polymyxin/dexamethasone) suspension, ointment Neomycin/Polymyxin W/Gramicidin solution Neomycin/Polymyxin w/Hydrocortisone ointment, suspension Polytrim®* (polymyxin B/trimethoprim) soln	
ANTIHISTAMINES		
AZELASTINE (compare to Optivar®) *(QL = 1 bottle/month)* KETOTIFEN 0.025 % (eg. Alaway®, Zaditor® OTC, others) *(QL=1 bottle/month)* OLOPATADINE 0.1% (compare to Patanol®) *(QL=1 bottle/month)* PAZEO® (olopatadine 0.7%) *(QL= 1 bottle/month)*	Bepreve® (bepotastine besilate) *(QL = 1 bottle/month)* Elestat® (epinastine) *(Quantity Limit = 1 bottle/month)* Epinastine (compare to Elestat®) *(QL = 1 bottle/month)* Emadine® (emedastine) *(Quantity Limit = 2 bottles/month)* Lastacaft® (alcaftadine) *(QL = 1 bottle/month)* Olopatadine 0.2% (compare to Pataday®) *(Quantity limit = 1 bottle/month)* Pataday® (olopatadine 0.2%) *(Quantity Limit = 1 bottle/month)* Patanol® (olopatadine 0.1%) *(Quantity Limit = 1 bottle/month)*	**Bepreve, Elestat, Epinastine, Olopatadine 0.2%, Patanol, Pataday:** The patient has had a documented side effect, allergy, or treatment failure to Olopatadine 0.1% or Pazeo. For approved of Elestat the patient must also have had a documented intolerance to the generic equivalent. **Lastacaft, Emadine:** The patient is pregnant and the diagnosis is allergic conjunctivitis OR The patient has had a documented side effect, allergy, or treatment failure to ketotifen. AND The patient has had a documented side effect, allergy, or treatment failure to a preferred olopatadine product.
CORTICOSTEROIDS: TOPICAL		
ALREX® (loteprednol) 0.2% suspension DUREZOL® (difluprednate) 0.05% emulsion FLAREX® (fluorometholone acetate) 0.1% suspension FLUOROMETHOLONE 0.1% suspension	Dexamethasone sodium phosphate 0.1% solution FML Forte® (fluorometholone) 0.25% suspension FML Liquifilm® (fluorometholone) 0.1% suspension Inveltys™ (loteprednol) suspension Lotemax® (loteprednol) 0.5% gel	**Non-preferred agents:** The patient has had a documented side effect, allergy, or treatment failure with TWO preferred ophthalmic corticosteroid. (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
FML® (fluorometholone) 0.1% ointment LOTEMAX® (loteprednol) 0.5% suspension, ointment MAXIDEX® (dexamethasone) suspension PRED MILD® (prednisolone acetate) 0.12% suspension PREDNISOLONE ACETATE 1%suspensionS PREDNISOLONE SODIUM PHOSPHATE 1% solution *E=emulsion, G=gel,O=ointment, S=suspension, Sol=solution*	Pred Forte®/Omnipred® (prednisolone acetate) 1% suspension All other brands	
CYSTARAN		
	Cystaran® (cysteamine) 0.44% ophthalmic solution *(QL=4 bottles (60 ml)/ 28 days)* *Maximum days' supply/RX = 28 days*	**Cystaran:** The indication for use is corneal cystine accumulation in patients with cystinosis.
DRY EYE SYNDROME		
Ocular Lubricants 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 **Immunomodulators** RESTASIS® (cyclosporine ophthalmic emulsion) 0.05% droperette (NDC 00023916330 and 00023916360 are the only preferred NDC's) QL=180 vials per 90days	Cequa™ (cyclosporine ophthalmic solution) 0.09% Restasis® (cyclosporine ophthalmic emulsion) 0.05% Multidose bottle (*QL= 1 bottle (5.5ml) per 25 days.* Xiidra® (lifitegrast) solution (*QL = 60 vials per 30 days)*	**Restasis Multidose:** Both package sizes of the droperettes must be on a long-term backorder and unavailable from the manufacturer. **Cequa, Xiidra:** The patient has a diagnosis of Dry Eye Disease AND has a documented side effect, allergy or treatment failure to Restasis.
GLAUCOMA AGENTS/MIOTICS		
ALPHA-2 ADRENERGIC **Single Agent** ALPHAGAN P® 0.1 %, 0.15 % (brimonidine tartrate) BRIMONIDINE TARTRATE 0.2 % **Combination** COMBIGAN® (brimonidine tartrate/timolol maleate) SIMBRINZA®	apraclonidine (compare to Iopidine®) brimonidine tartrate 0.15 % (compare to Alphagan P®) Iopidine® (apraclonidine)	**ALPHA 2 ADRENERGIC AGENTS:** Single Agent: The patient has had a documented side effect, allergy or treatment failure with at least one preferred ophthalmic alpha 2 adrenergic agent. If the request is for brimonidine tartrate 0.15%, the patient must have a documented intolerance of brand name Alphagan P 0.15%. **BETA BLOCKERS:** The patient has had a documented side effect, allergy or

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
(brinzolamide 1% and brimonidine 0.2%) Suspension **BETA BLOCKER** CARTEOLOL HCL LEVOBUNOLOL HCL (compare to Betagan®) TIMOLOL MALEATE (compare to Timoptic®) **PROSTAGLANDIN INHIBITORS** LATANOPROST (compare to Xalatan®) LUMIGAN®(bimatoprost) TRAVATAN Z® (travoprost) (BAK free) **RHO KINASE INHIBITORS** RHOPRESSA® (netarsudil) **CARBONIC ANHYDRASE INHIBITOR** **Single Agent** DORZOLAMIDE 2 % (compare to Trusopt®) **Combination** DORZOLAMIDE w/TIMOLOL (compare to Cosopt®) **MISCELLANEOUS** ISOPTO® CARPINE (pilocarpine) PILOCARPINE HCL PHOSPHOLINE IODIDE® (echothiophate)	Betagan®* (levobunolol) Betoptic S® (betaxolol suspension) Istalol®* (timolol) Timoptic®* (timolol maleate) Timoptic XE®* (timolol maleate gel) Timolol maleate gel (compare to Timotic XE®) Bimatoprost 0.03% (Lumigan®) Vyzulta® (latanoprostene bunod) Xelpros® (latanoprost) (BAK free) Zioptan® (tafluprost) Azopt® (brinzolamide 1%) Trusopt®* (dorzolamide 2 %) Cosopt®* (dorzolamide w/timolol) Cosopt PF® (dorzolamide w/timolol) (pres-free) Miochol-E® (acetylcholine)	treatment failure with at least one preferred ophthalmic beta blocker. **PROSTAGLANDIN INHIBITORS** **Bimatoprost, Vyzulta, Xalatan, Xelpros, Zioptan:** The patient has had a documented side effect, allergy or treatment failure with at least 2 preferred prostaglandin inhibitors. **CARBONIC ANHYDRASE INHIBITORS** **Single Agent:** The patient has had a documented side effect, allergy or treatment failure with a preferred carbonic anhydrase inhibitor. **Combination Product:** **Cosopt:** The patient has had a documented intolerance to the generic equivalent product. **Cosopt PF:** The patient has had a documented intolerance to the preservatives in the generic combination product. **Miscellaneous:** The patient has had a documented side effect, allergy or treatment failure with a preferred miscellaneous ophthalmic agent. If a product has an AB rated generic, there must have also been a trial of the generic formulation)
MAST CELL STABILIZERS		
CROMOLYN SODIUM (formerly Crolom®)	Alocril® (nedocromil sodium) Alomide® (lodoxamide)	**Criteria for Approval:** The patient has had a documented side effect, allergy, or treatment failure with generic cromolyn sodium
NON-STEROIDAL ANTI-INFLAMMATORY DRUGS (NSAIDs)		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
FLURBIPROFEN 0.03% ophthalmic solution ILEVRO® ophthalmic suspension (nepafenac 0.3%) KETOROLAC 0.4 % ophthalmic solution (compare to Acular LS®) KETOROLAC 0.5 % ophthalmic solution (compare to Acular®)	Acular® (ketorolac 0.5% ophthalmic solution) Acular LS ® (ketorolac 0.4% ophthalmic solution) Acuvail (ketorolac 0.45 %) Ophthalmic Solution *(Quantity Limit = 30 unit dose packets/15 days)* Bromfenac 0.09 % ophthalmic solution BromSite™ (bromfenac 0.075%) solution Diclofenac 0.1% ophthalmic solution Nevanac® ophthalmic suspension (nepafenac 0.1%) Ocufen®* ophthalmic solution (flurbiprofen 0.03%) Prolensa® ophthalmic solution (bromfenac 0.07%)	**Acuvail:** The patient has had a documented side effect, allergy, or treatment failure to Acular OR ketorolac 0.5% OR The patient has a documented hypersensitivity to the preservative benzalkonium chloride. **Acular, Acular LS, Bromfenac, BromSite, Diclofenac, Ocufen, Prolensa,:** 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.
OTIC ANTI-INFECTIVES		
Anti-infective Single Agent OFLOXACIN 0.3% Otic solution (formerly Floxin®) **Anti-infective/Corticosteroid Combination** CIPRODEX® (ciprofloxacin 0.3%/dexamethasone 0.1%) otic suspension CIPRO-HC® (ciprofloxacin 0.2%/hydrocortisone 1%) otic suspension NEOMYCIN/POLYMYXIN B SULFATE/HYDROCORTISONE SOLUTION **Miscellaneous Agents** ACETIC ACID Otic solution	Ciprofloxacin 0.2% (compare to Cetraxal®) otic solution *(Qty limit = 14 unit dose packages/ 7 days)* Otiprio® (ciprofloxacin 6%) otic suspension Floxin® (ofloxacin) otic solution Coly-Mycin S®(neomycin/colistin/thonzium/hydrocortisone) Neomycin/Polymixin B Sulfate/Hydrocortisone Suspension Otovel® (ciprofloxacin 0.3%/fluocinolone 0.025%) otic solution QL = 28 unit dose packages/7days Acetasol HC (acetic acid 2%/hydrocortisone 1% otic solution) Acetic Acid/Hydrocortisone Otic Solution	**All non-preferred products :** The patient has had a documented side effect, allergy, or treatment failure to two preferred products.
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. http://dvha.vermont.gov/for-providers/drug-coverage-lists-1		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
PANCREATIC ENZYME PRODUCTS		
CREON® DR Capsule ZENPEP® DR Capsule	Pancreaze® DR Capsule Pertzye® DR Capsule Viokace® DR Capsule	**Pancreaze, Pertzye, Viokace:** The patient has been started and stabilized on the requested product. OR The patient has had treatment failure or documented intolerance with both Creon and Zenpep.
PARATHYROID AGENTS		
CALCITRIOL (compare to Rocaltrol®) DOXERCALCIFEROL (compare to Hectoral®) ERGOCALCIFEROL (compare to Drisdol®) PARICALCITOL (compare to Zemplar®) SENSIPAR® (cinacalcet)	Drisdol® (ergocalciferol) Hectoral® (doxercalciferol) Natpara® (parathyroid hormone) (max dosage = 2 cartridges per 28 days) Parsabiv™ (etelcalcetide) Rayaldee® (calcifediol ER) Rocaltrol® (calcitriol) Zemplar® (paricalcitol)	**Drisdol/Hectoral:** The patient must have a documented side effect, allergy, or treatment failure to two preferred agents. If a product has an AB rated generic, one trial must be the generic formulation. **Natpara clinical criteria** ▪ Natpara: diagnosis of hypocalcemia secondary to hypoparathyroidism (but NOT acute post-surgical hypoparathyroidism within 6 months of surgery) **AND** ▪ Natpara PA form must be completed and clinical and lab documentation supplied **AND** ▪ Must be prescribed by an endocrinologist **AND** ▪ Must be documented by **ALL** of the following: ○History of hypoparathyroidism >18 months **AND** ○Biochemical evidence of hypocalcemia **AND** ○Concomitant serum intact parathyroid hormone (PTH) concentrations below the lower limit of the normal laboratory reference range on 2 test dates at least 21 days apart within the past 12 months **AND** ▪ No history of the following: ○mutation in CaSR gene **OR** ○pseudohypoparathyroidism **OR** ○a condition with an increased risk of osteosarcoma **AND** ▪ Hypocalcemia is not corrected by calcium supplements and preferred active forms of vitamin D alone **AND** ▪ Patients must be taking vitamin D metabolite/analog therapy with calcitriol ≥0.25 µg per day OR equivalent **AND** ▪ Must be taking supplemental oral calcium treatment ≥ 1000 mg per day over and above normal dietary calcium intake **AND** ▪ Serum calcium must be ≥ 7.5 mg/dl prior to starting Natpara **AND** ▪ Serum thyroid function tests and serum magnesium levels must be within normal limits **AND** ▪ Documentation of creatinine clearance > 30 mL/min on two separate measurements **OR** creatinine clearance > 60 mL/min AND serum creatinine < 1.5 mg/dL **Parsabiv:** indication is for the treatment of secondary hyperparathyroidism in a

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		patient with Chronic Kidney Disease (CKD) receiving hemodialysis AND the patient has a documented side effect, allergy, or treatment failure with Sensipar. Note: treatment failure is defined as < 30% reduction from baseline in mean pre-dialysis PTH concentrations.
PARKINSON'S MEDICATIONS		
DOPAMINE PRECURSOR CARBIDOPA/LEVODOPA (compare to Sinemet®) CARBIDOPA/LEVODOPA ER (compare to Sinemet® CR) CARBIDOPA/LEVODOPA ODT **DOPAMINE AGONISTS (ORAL)** BROMOCRIPTINE (compare to Parlodel®) PRAMIPEXOLE (compare to Mirapex®) ROPINIROLE (compare to Requip®) **DOPAMINE AGONISTS (TRANSDERMAL)** NEUPRO® (rotigotine) transdermal patch *(Quantity Limit = 1 patch/day)* *(2mg, 4 mg, 6 mg and 8 mg patches)* **COMT INHIBITORS** COMTAN® (entacapone) ENTACAPONE (compare to Comtan®) **MAO-B INHIBITORS** SELEGILINE	Rytary® (carbidopa/levodopa ER caps) Sinemet®* (carbidopa/levodopa) Sinemet CR®*(carbidopa/levodopa ER) Mirapex®* (pramipexole) Mirapex ER® (pramipexole ER) *QL = 1 tab/day* Pramipexole ER (compare to Mirapex ER®) Requip®* (ropinirole) Requip XL® (ropinirole XL) *QL = 1 tab/day (all strengths except 12 mg), QL = 2 tabs/day (12 mg)* ropinirole XL (compare to Requip XL®) *QL = 1 tab/day (all strengths except 12 mg), QL = 2 tabs/day (12 mg)* Tasmar® (tolcapone) Tolcapone (compare to Tasmar®) Azilect® (rasagiline) (QL = 1 mg/day) Rasagiline (compare to Azilect®) (QL = 1mg/day) Xadago® (safinamide) (QL=1 tab/day)	**Sinemet, Sinemet CR, Mirapex, Parlodel, Requip:** The patient has had a documented intolerance to the generic product. **Rytary:** The patient has a diagnosis of Parkinson's disease, post-encephalitic parkinsonism, or parkinsonism following intoxication from carbon monoxide or manganese AND the prescriber is a neurologist AND the patient is having breakthrough symptoms despite a combination of concurrent IR and ER formulations of carbidopa/levodopa **Azilect, rasagiline:** The diagnosis or indication is Parkinson's disease. AND The patient has had a documented side effect, allergy, or treatment failure with selegiline. AND The dose requested does not exceed 1 mg/day **carbidopa/levodopa/entacapone**: The patient has had a documented intolerance to brand Stalevo. **Gocovri**: diagnosis or indication is for the treatment of dyskinesia in a patient with Parkinson's Disease AND the patient is currently receiving levodopa-based therapy (with or without concomitant dopaminergic medications) AND the patient has a documented side effect, allergy, or treatment failure with immediate release amantadine. **Note:** treatment failure is defined by a decrease in effectivemess despite attempts to increase dosage to 300mg/day or by temporarily discontinuing amantadine for several weeks and restarting therapy. **Mirapex ER, pramipexole ER, Requip XL, ropinirole XL:** The diagnosis or indication is Parkinson's disease. Requests will not be approved for Restless Leg Syndrome (RLS) AND The patient has had an inadequate response (i.e. wearing off effect or "off" time) with the immediate release product. OR The patient has not been able to be adherent to a three times daily dosing schedule of the immediate release product resulting in a significant clinical impact. AND If the requested product has an AB rated generic, the patient has a documented intolerance to the generic product. **Osmolex ER:** patient has not been able to be adherent to the dosing schedule of amantadine immediate release resulting in a significant clinical impact. **Tasmar, Tolcapone:** The diagnosis or indication is Parkinson's disease. AND The patient has had a documented side effect, allergy, or treatment failure with Comtan or entacapone. For approval of brand Tasmar, the patient must have documented intolerance to the generic equivalent.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
OTHER AMANTADINE syrup AMANTADINE capsules, tablets (PA required for ≤ 10 day supply) STALEVO® (carbidopa/levodopa/entacapone)	Zelapar® (selegiline ODT) *(QL = 2.5 mg/day)* carbidopa/levodopa/entacapone (compare to Stalevo®) Gocovri™ (amantadine extended release) QL = 2 tabs/day) Osmolex® ER (amantadine extended-release) QL = 1 tablet/strength/day	**Xadago:** The diagnosis or indication is Parkinson's disease AND The patient is on current therapy with levodopa/carbidopa AND The patient has had a documented side effect, allergy, or treatment failure with selegiline. Note: Xadago will no be approved for monotherapy. **Zelapar:** The diagnosis or indication is Parkinson's disease. AND The patient is on current therapy with levodopa/carbidopa. AND Medical necessity for disintegrating tablet administration is provided (i.e. inability to swallow tablets or drug interaction with oral selegiline). AND the dose requested does not exceed 2.5mg/day **Limitations:** To prevent the use of amantadine in influenza treatment/prophylaxis, days supply < 10 days will require PA.
PHOSPHODIESTERASE-4 (PDE-4) INHIBITORS		
	Daliresp® tablet (roflumilast) *Quantity limit = 1 tablet/day* Otezla® tablet (apremilast) *(Starter pack – Quantity limit = 55 tablets/28 days)* *(30 mg tablets – Quantity limit = 2 tablets/day)* *** Maximum days' supply per fill = 30)**	**Daliresp:** The indication for the requested medication is treatment to reduce the risk of COPD exacerbations in patients with severe COPD associated with chronic bronchitis and a history of exacerbations. AND The patient has had a documented side effect, allergy, treatment failure, or a contraindication to at least one inhaled long-acting anticholinergic AND at least one inhaled long-acting beta-agonist AND at least one inhaled corticosteroid. **Otezla:** The patient is 18 years of age or older AND The patient has a diagnosis of psoriatic arthritis AND The patient has had inadequate response to, intolerance to, or contraindication to methotrexate OR The patient has a diagnosis of moderate to severe plaque psoriasis affecting > 10% of the body surface area (BSA) and/or has involvement of the palms, soles, head and neck, or genitalia and has had a documented side effect, allergy, inadequate treatment response, or treatment failure to at least 2 topical agents and at least 1 oral systemic agent, unless otherwise contraindicated.
PHOSPHODIESTERASE-5 (PDE-5) INHIBITORS		
Effective 7/1/06, phosphodiesterase-5 (PDE-5) inhibitors are no longer a covered benefit for all Vermont Pharmacy Programs for the treatment of erectile dysfunction. This change is resultant from changes set into effect January 1, 2006 and as detailed in Section 1903 (i)(21)(K) of the Social Security Act (the Act), precluding Medicaid Federal Funding for outpatient drugs used for the treatment of sexual or erectile dysfunction. Sildenafil will remain available for coverage via prior-authorization for the treatment of Pulmonary Arterial Hypertension.		
Preferred After Clinical Criteria are Met SILDENAFIL CITRATE (compare to Revatio®) tablet	Adcirca® (tadalafil) *(Quantity Limit = 2 tablets/day)* Revatio® (sildenafil) Tabs (*Quantity Limit = 3*	**Sildenafil:** Clinical Diagnosis of Pulmonary Hypertension **Adcirca (tadalafil) 20 mg, Revatio (sildenafil citrate) 20 mg:** Clinical diagnosis of pulmonary hypertension AND No concomitant use of organic nitrate-

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
(Quantity Limit = 3 tablets/day)	*tablets/day)* Revatio® (sildenafil citrate) suspension Revatio® (sildenafil citrate) vial *(Quantity Limit = 3 vials/day, maximum 14 days supply per fill)*	containing products AND patient has a documented intolerance to generic sildenafil. **Revatio Suspension:** Clinical diagnosis of pulmonary hypertension AND medical necessity for a liquid formulation is provided OR the patient is unable to tolerate a 20mg dose. **Revatio IV:** Clinical diagnosis of pulmonary hypertension AND No concomitant use of organic nitrate-containing products AND The patient has a requirement for an injectable dosage form. AND Arrangements have been made for IV bolus administration outside of an inpatient hospital setting.
PLATELET INHIBITORS		
AGGREGATION INHIBITORS BRILINTA® (ticagrelor) Tablet *QL = 2 tablets/day* CILOSTAZOL CLOPIDOGREL†75 mg (compare to Plavix®) PRASUGREL (compare to Effient®) TICLOPIDINE (formerly Ticlid®) **OTHER** AGGRENOX® (dipyridamole/Aspirin) ANAGRELIDE (compare to Agrylin®) ASPIRIN DIPYRIDAMOLE	Effient® (prasugrel) Tablet *QL = 1 tablet/day* Plavix®* 75 mg (clopidogrel bisulfate) Zontivity® (vorapaxar) Tablet *QL = 1 tablet/day* Agrylin®* (anagrelide) Dipyridamole/Aspirin (compare to Aggrenox®) Durlaza® (asprin extended release) capsules Yosprala® (aspirin and omeprazole)	**Agrylin, Effient, Plavix:** The patient has had a documented intolerance to the generic formulation of the medication. **Dipyridamole/Aspirin:** The patient has had a documented intolerance to the brand formulation of the medication. **Durlaza:** The patient is ≥ 18 years of age AND the indication for use is to reduce the risk of death and myocardial infarction (MI) in patients with chronic coronary artery disease (history of MI, unstable angina pectoris, or chronic stable angina) OR to reduce the risk of death and recurrent stroke in patients who have had an ischemic stroke or transient ischemic attack AND the patient is unable to use at least 4 preferred products, one of which must be enteric coated aspirin. **Yosprala:** The patient must be at risk for developing aspirin-associated gastric ulcers (history of gastric ulcers or age ≥ 60) AND the patient must have a documented side effect, allergy, or contraindication to 3 preferred PPI's (one of which must omeprazole) used in combination with aspirin. **Zontivity:** The patient is started and stabilized on the medication. (Note: samples are not considered adequate justification for stabilization.) OR The patient has a history of myocardial infarction (MI) or peripheral arterial disease (PAD) AND The indication for use is reduction of thrombotic cardiovascular events. AND The medication is being prescribed in combination with aspirin and/or clopidogrel. **Limitations:** Plavix/clopidogrel 300mg is not an outpatient dose and is not covered in the pharmacy benefit.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
PSEUDOBULBAR AFFECT AGENTS		
All products require PA	Nuedexta® capsules (dextromethorphan/quinidine) Quantity limit = 2 capsules/day	**Nuedexta:** The patient must have a diagnosis of pseudobulbar affect (PBA) secondary to a neurological condition AND the patient has had a trial and therapy failure at a therapeutic dose with a tricyclic antidepressant (TCA) or an SSRI AND the patient has documentation of a current EKG (within the past 3 months) without QT prolongation AND initial authorizations will be approved for 6 months with a baseline Center for Neurologic Studies Lability Scale (CNS-LS) questionnaire AND subsequent prior authorizations will be considered at 6 month intervals with documented efficacy as seen in an improvement in the CNS-LS questionnaire
PROGESTATIONAL AGENTS		
Preferred After Clinical Criteria are Met MAKENA® (hydroxyprogesterone caproate) 250mg/ml vial (intramuscular injections) Maximum fill = 35 day supply MAKENA® (hydroxyprogesterone caproate) 275mg/1.1ml auto-injector (subcutaneous injection) Maximum fill = 28 day supply	Hydroxyprogesterone caproate 250mg/ml vial (intramuscular injection)	**Hydroxyprogesterone caproate:** 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 endogenous estrogen production, or production and desquamation of secretory endometrium OR for prophylaxis of preterm labor, the patient must meet criteria outlined above for Makena AND the patient must be unable to use both formulations of Makena. **Makena:** Patient is 16 years of age or older AND Patient has a history of singleton spontaneous preterm birth AND Patient is having a singleton (single offspring) pregnancy AND Therapy will be started between 16 weeks, 0 days and 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.
PLATELET STIMULATING AGENTS		
	Doptelet® (avatrombopag) Maximum 5 days' supply per procedure Mulpleta® (lusutrombopag) Maximum 7 days' supply per procedure Nplate® (romiplostim) Promacta® (eltrombopag) Tavalisse™ (fostamatinib disodium hexahydrate)	**Doptelet, Mulpleta:** The patient is at least 18 years of age AND the diagnosis is thrombocytopenia in a patient with chronic liver disease scheduled to undergo an elective surgical or dental procedure AND the patient's platelet count is less than 50,000/µL (< 50 x 10^9/L) **NPlate:** The diagnosis or indication is chronic immune (idiopathic) thrombocytopenic purpura (ITP). AND The patient's platelet count is less than 30,000/µL (< 30 x 10^9/L) or the patient is actively bleeding. AND The patient has an insufficient response or documented intolerance to corticosteroids, immunoglobulins, or splenectomy AND Promacta. **Promacta:**

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		Indication for use is chronic immune thrombocytopenia (ITP): The patient's platelet count is less than than 30,000/µL (< 30 x 10^9/L) or the patient is actively bleeding, AND the patient has had an insufficient response or documented intolerance to corticosteroids, immunoglobulins, or splenectomy. ***Indication for use is chronic Hepatitis-C associated thrombocytopenia:*** The patient is at least 18 years of age AND medication is used to initiate or maintain interferon-based therapy. ***Indication for use is Severe Aplastic Anemia:*** patient has had an inadequate response to standard immunosuppressive therapy (e.g. cyclosporine). **Tavalisse:** The patient is at least 18 years of age AND The diagnosis is chronic immune thrombocytopenia (ITP) AND The patient's platelet count is less than < 30 x 10^9/L AND The patient has had a documented side effect, allergy, treatment failure or a contraindication to therapy with corticosteroids AND the patient has failed at least one of the following additional treatments: immunoglobulins, rituximab, splenectomy, or a thrombopoietin receptor agonist (e.g. eltrombopag, romiplostim, etc.). **Note:** Initial approval will be granted for 12 weeks. For therapy continuation, the patient must have achieved and maintained a platelet count of at least 50 x 10^9/L and/or have a documented decrease in rescue treatment(s) with platelet transfusions.
PSORIASIS		
INJECTABLES (Initial approval is 3 months, renewals are 1 year)		
Preferred After Clinical Criteria Are Met COSENTYX® (secukinumab) ENBREL® (etanercept) *Quantity limit = 8 syringes/28 days for the first 3 months; then 4 syringes/28 days(50 mg) or 8 syringes/28 days (25 mg) subsequently* HUMIRA® (adalimumab) *Quantity limit = 4 syringes/28 days for one month; 2 syringes/28 days subsequently*	Ilumya™ (tildrakizumab-asmn) (Quantity Limit = 2 ml (2 syringes) for the first month then 1 ml (1 syringe)/84 days subsequently) Inflectra® (infliximab-dyyb) biosimilar to Remicade® Remicade® (infliximab) Renflexis™ (infliximab-abda) biosimilar to Remicade® Siliq™ (brodalumab) injection (Quantity limit = 6 ml (4 syringes) for the first month then 3 ml (syringes)/28 days subsequently) Stelara® (ustekinumab) *(Quantity limit = 45 mg (0.5 ml) or 90 mg (1 ml) per dose) (90mg dose only permitted if patient weight > 100kg)* *(90 mg dose only permitted if pt weight > 100 kg)* Taltz® (ixekizumab) (*Quantity limit = 3 syringes/28 days for the first month, 2 syringes/28 days months 2 and 3 and 1 syringe/28 days subsequently)* Tremfya® (guselkumab) (*Quantity limit = 2 syringes/28 days for the first month, then 1 syringe ever 56 days thereafter)*	**Clinical Criteria:** **For all drugs:** The prescription must be written by a dermatologist or rheumatologist AND The patient has a documented diagnosis of moderate to severe plaque psoriasis and has already been stabilized on the drug being requested OR The prescription must be written by a dermatologist or rheumatologist AND The patient has a documented diagnosis of moderate to severe plaque psoriasis affecting > 10% of the body surface area (BSA) and/or has involvement of the palms, soles, head and neck, or genitalia and has had a documented side effect, allergy, inadequate treatment response, or treatment failure to at least 2 different categories of therapy [i.e. at least 2 topical agents and at least 1 oral systemic agent, (unless otherwise contraindicated)] from the following categories: Topical agents: emollients, keratolytics, corticosteroids, calcipotriene, tazarotene, etc. Systemic agents: methotrexate, sulfasalazine, azathioprine, cyclosporine, tacrolimus, mycophenolate mofetil, etc. Phototherapy: ultraviolet A and topical psoralens (topical PUVA), ultraviolet A and oral psoralens (systemic PUVA, narrow band ultraviolet B (NUVA), etc. **Additional Criteria for Cosentyx:** The prescriber must provide evidence of a

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		trial and failure or contraindication to Humira®. **Note:** Cosentyx approvals for 300mg dose(s) must use "300DOSE" package (containing 2 x 150mg pens or syringes). Approval will not be granted for 2 separate 150mg packages. **Additional Criteria for Ilumya, Remicade, Siliq, Stelara, Taltz, Tremfya:** The prescriber must provide a clinically valid reason why both Humira® and Cosentyx® cannot be used. **Note:** Siliq is contraindicated in patients with Crohn's disease. **Additional Criteria for Inflectra, Renflexis:** The prescriber must provide a clinically valid reason why Humira®, Cosentyx®, and Remicade® cannot be used.
NON-BIOLOGICS		
ORAL ACITRETIN (compare to Soriatane®) capsules CYCLOSPORINE (generic) METHOTREXATE (generic) **TOPICAL** CALCIPOTRIENE Ointment, Solution DOVONEX® CREAM (calcipotriene) TAZORAC® (tazarotene cream, gel)	Oxsoralen-Ultra® (methoxsalen) Soriatane® (acitretin) capsules Calcitrene® (calcipotriene) ointment calcitriol (compare to Vectical®) Ointment *(Quantity Limit = 200 g (2 tubes)/week)* Calcipotriene Cream (compare to Dovonex®) Calcipotriene/betamethasone ointment (compare to Taclonex®) *(QL for initial fill = 60 grams)* Enstilar® (calcipotriene/betamethasone) foam Sorilux® (calcipotriene) foam Methoxsalen (compare to Oxsoralen-Ultra®) Taclonex® (calcipotriene/betamethasone ointment/scalp suspension) *(QL for initial fill = 60 grams)* Tazarotene Cream Vectical® Ointment (calcitriol) *(Quantity Limit = 200 g (2 tubes)/week)*	**Calcitrene, Soriatane:** The patient has a documented intolerance to the generic equivalent. **Calcipotriene cream:** The patient has a documented intolerance to Brand Dovonex cream. **Tazarotene:** The patient has a documented intolerance to brand Tazorac. **Enstilar, Taclonex or calcipotriene/betamethasone diproprionate Ointment or Scalp Suspension:** The patient has had an inadequate response to a 24 month trial of a betamethasone dipropionate product and Dovonex (or generic calcipotriene), simultaneously. AND The patient has had a documented side effect, allergy, or treatment failure with Tazorac 0.05% or 0.1% cream or gel. Note: If approved, initial fill of Taclonex® or calcipotriene/betamethasone diproprionate will be limited to 60 grams. **Vectical Ointment, Calcitriol Ointment:** The patient ≥ 18 years of age AND The patient has a diagnosis of mild-to-moderate plaque psoriasis AND The patient has demonstrated inadequate response, adverse reaction or contraindication to calcipotriene. **Sorilux:** The patient ≥ 18 years of age AND The patient has a diagnosis of plaque psoriasis AND The patient has demonstrated inadequate response or intolerance to other dosage forms of calcipotriene (brand or generic) **Methoxsalen, Oxsoralen Ultra:** The patient has a documented diagnosis of moderate to severe psoriasis affecting > 10% of the body surface area (BSA) and/or has involvement of the palms, soles, head and neck, or genitalia and has had a documented side effect, allergy, inadequate treatment response, or treatment failure to at least 2 topical agents and at least 1 oral systemic agent, unless otherwise contraindicated. **Limitations:** Kits with non-drug or combinations of 2 drug products are not covered.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
PULMONARY AGENTS		
ANTICOLINERGICS: INHALED		
SHORT-ACTING BRONCHODILATORS ATROVENT HFA® (ipratropium) IPRATROPIUM NEBULIZER SOLN IPRATROPIUM/ALBUTEROL NEBULIZER SOLN **LONG-ACTING BRONCHODILATORS (LAMA)** SPIRIVA® HANDIHALER (tiotropium) Quantity Limit = 1 capsule/day TUDORZA® PRESSAIR® (aclidinium bromide) Quantity Limit = 3 inhalers/90 days **COMBINATION LONG-ACTING BRONCHODILATORS (LAMA & LABA)** ANORO® ELLIPTA (umeclidinium/vilanterol) Quantity Limit = 3 inhalers (180 blisters)/90 days BEVESPI AEROSPHERE® (glycopyrrolate/formoterol) Quantity Limit = 3 inhalers/90 days **LAMA/LABA/ICS COMBINATION** All agents require PA	Combivent® Respimat (ipratropium/albuterol) Quantity Limit = 1 inhaler (4 grams)/30 days Incruse Ellipta® (umeclidinium bromide) (Quantity Limit= 1 inhaler/30 days) Lonhala® Magnair (glycopyrollate) inhalation solution Quantity Limit = 60 vials/30 days Seebri Neohaler® (glycopyrrolate) Spiriva® Respimat (tiotropium) QL = 1 inhaler/30days Stiolto® Respimat (tiotropium/olodaterol) Quantity Limit = 3 inhalers/ 90 days Utibron™ Neohaler® (indaceterol/glycopyrrolate) Quantity Limit = 1 inhaler (60 blisters) 30 days Trelegy® Ellipta (fluticasone/umeclidinium/vilanterol) Quantity Limit = 1 inhaler (60 blisters)/30 days	**Combivent Respimat:** clinical justification must be provided detailing why the patient cannot use a combination of Atrovent HFA and the preferred albuterol formulation. **Note:** Per 2018 GOLD Guidelines, Long-acting bronchodilator use is recommended for Groups B-D. **Incruse Ellipta/Seebri Neohaler:** The patient has had documented side effect, allergy or treatment failure to BOTH preferred LAMA's (Spiriva® and Tudorza). **Stiolto Respimat/Utibron Neohaler:** The patient has a documented side effect, allergy, or treatment failure to BOTH preferred LAMA/LABA combinations (Bevespi Aerosphere and Anoro Ellipta). **Lonhala Magnair:** patient has a diagnosis of COPD (not FDA approved for asthma) AND has a failure of nebulized ipratropium solution AND at least 3 inhaled LAMA's. **Trelegy Ellipta:** patient has a diagnosis of COPD (not FDA approved for asthma) AND has a failure of at least 2 different combinations of a preferred Inhaled Corticosteroid, LABA, and LAMA used in combination. **Spiriva Respimat:** patient has a diagnosis of COPD and a compelling clinical reason why they cannot use Spiriva Handihaler OR patient has a diagnosis of asthma and has a side effect, allergy, or treatment failure despite maximized dose of a preferred ICS/LABA combination product.
ANTIHISTAMINES: INTRANASAL		
	SINGLE AGENT Astelin® (azelastine) Nasal Spray *Quantity Limit = 1 bottle (30 ml)/30 days* Astepro® (azelastine 0.15 %) Nasal Spray *Quantity Limit = 1 bottle (30 ml)/30 days* azelastine (compare to Astelin®) Nasal Spray *Quantity Limit = 1 bottle (30 ml)/30 days* azelastine 0.15 % (compare to Astepro®) Nasal Spray	**ASTELIN, ASTEPRO, AZELASTINE, DYMISTA, OLOPATADINE,** **PATANASE:** The diagnosis or indication for the requested medication is allergic rhinitis. AND The patient has had a documented side effect, allergy, or treatment failure to loratadine (OTC) OR cetirizine (OTC) AND a preferred nasal corticosteroid used in combination. AND If the request is for Astepro, the patient has a documented intolerance to the generic equivalent.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Quantity Limit = 1 bottle (30 ml)/30 days Olopatadine 0.6% (compare to Patanase®) Nasal Spray *Quantity Limit = 1 bottle (31 gm)/30 days* Patanase® (olopatadine 0.6%) Nasal Spray *Quantity Limit = 1 bottle (31 gm)/30 day* COMBO WITH CORTICOSTEROID Dymista® (azelastine/fluticasone) Nasal Spray *Quantity Limit = 1 bottle (23 gm)/30 days*	
ANTIHISTAMINES: 1ST GENERATION		
All generic antihistamines All generic antihistamine/decongestant combinations	All brand antihistamines (example: Benadryl®) All brand antihistamine/decongestant combinations (example: Deconamine SR®, Rynatan®, Ryna-12®)	**CRITERIA FOR APPROVAL:** The prescriber must provide a clinically valid reason for the use of the requested medication including reasons why any of the generically available products would not be a suitable alternative.
ANTIHISTAMINES: 2ND GENERATION		
SINGLE AGENT TABLET LORATADINE (OTC) (Allergy Relief®, Alavert®) CETIRIZINE OTC (formerly Zyrtec®) 5 mg, 10 mg tablets **After loratadine OTC and cetirizine OTC trials** FEXOFENADINE 60 mg, 180 mg (OTC) tablets (formerly Allegra®) **COMBINATION WITH PSEUDOEPHEDRINE** LORATADINE/PSEUDOEPHEDRINE SR 12hr 5 mg/120 MG (OTC) (Alavert Allergy/Sinus®) LORATADINE/PSEUDOEPHEDRINE SR 24hr 10 mg/240 MG †(OTC) **SINGLE AGENT ORAL LIQUID** LORATADINE (OTC) syrup (Allergy Relief®) CETIRIZINE (OTC, RX) syrup	Clarinex® (desloratadine) 5 mg tablet desloratadine (compare to Clarinex®) 5 mg tablet Levocetirizine (compare to Xyzal®) 5 mg tablet Xyzal® (levocetirizine) 5 mg tablet All other brands Cetirizine/Pseudoephedrine SR 12hr 5 mg/120 mg OTC Clarinex-D® 12 hr (desloratadine/pseudoephedrine 2.5 mg/120 mg) Clarinex Syrup® (desloratadine) Levocetirizine (compare to Xyzal®) Solution Xyzal® (levocetirizine) Solution	**FEXOFENADINE 60MG/180 MG TABLETS** The patient has had a documented side effect, allergy, or treatment failure to loratadine (OTC) AND cetirizine (OTC). **CLARINEX TABLETS, DESLORATADINE TABLETS, LEVOCETIRIZINE TABLETS, XYZALTABLETS** The patient has had a documented side effect, allergy, or treatment failure to loratadine (OTC) AND cetirizine (OTC) AND fexofenadine. AND If the request is for Clarinex or Xyzal, the patient must also have a documented intolerance to the generic equivalent tablets. **CERTIRIZINE CHEWABLE TABLETS, CLARINEX REDITABS, DESLORATADINE ODT:** The patient has had a documented side effect, allergy, or treatment failure to loratadine (OTC) rapidly disintegrating tablets and a preferred oral liquid. AND If the request is for Clarinex Reditabs, the patient must also have a documented intolerance to the generic equivalent tablets **CLARINEX SYRUP, LEVOCETIRIZINE SOLUTION, XYZAL SOLUTION ORAL LIQUID:** the patient has had a documented side effect, allergy, or treatment failure to loratadine syrup AND cetirizine syrup. AND If the request is for Xyzal, the patient must also have a documented intolerance to levocetirizine solution. **CETIRIZINE D, CLARINEX-D:** The patient has had a documented side effect, allergy, or treatment failure to loratadine-D (OTC). **LIMITATIONS:** Many Allegra® and Zyrtec® brand products as well as Claritin capsules are not covered as no Federal Rebate is offered. Fexofenadine

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
CHEWABLE/ORALLY DISINTEGRATING TABLET LORATADINE (OTC) (Allergy Relief®, Alavert®) rapidly disintegrating tablet (RDT) (compare to Claritin®) 10 mg	Certirizine OTC Chewable Tablets 5 mg, 10 mg Clarinex Reditabs® (desloratadine) 2.5 mg, 5 mg Desloratadine ODT (compare to Clarinex Reditabs®) 2.5 mg, 5 mg All other brands	suspension not covered as no Federal Rebate is offered. Fexofenadine/pseudoephedrine combination products) (brand and generic) are not covered – individual components may be prescribed separately.
BETA-ADRENERGIC AGENTS		
METERED-DOSE INHALERS (SHORT-ACTING) PROAIR® HFA (albuterol) PROAIR® Respiclick (albuterol) PROVENTIL® HFA (albuterol) **METERED-DOSE INHALERS (LONG-ACTING) (*Preferred after clinical criteria are met)*** SEREVENT® DISKUS (salmeterol xinafoate) *Quantity Limit = 60 blisters/30 days* **NEBULIZER SOLUTIONS (SHORT-ACTING)** ALBUTEROL neb solution (all strengths) LEVALBUTEROL neb solution (age ≤ 12 years) **NEBULIZER SOLUTIONS (LONG-ACTING)** All products require a PA **TABLETS/SYRUP (SHORT-ACTING)** ALBUTEROL tablets/syrup **TABLETS (LONG-ACTING)** ALBUTEROL ER tablets	Levalbuterol Aerosol (compare to Xopenex ® HFA) Ventolin® HFA (albuterol) Xopenex® HFA (levalbuterol) Arcapta® Neohaler (indacaterol) *Quantity Limit = 1 capsule/day* Striverdi Respimat® (olodaterol) Levalbuterol neb solution (compare to Xopenex®) (age > 12 years) Xopenex® neb solution (all ages) Brovana® (arformoterol) *QL = 2 vial/day* Perforomist® (formoterol) *QL = 2 vial/day* metaproterenol tablets/syrup terbutaline tablets Vospire ER®* (albuterol)	**Levalbuterol (aerosol), Ventolin HFA, Xopenex HFA**: 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. **Serevent**: The patient has a diagnosis of asthma and is prescribed an inhaled corticosteroid (pharmacy claims will be evaluated to assess compliance with long term controller therapy) OR the patient has a diagnosis of COPD. **Arcapta, Striverdi:** The patient has a diagnosis of COPD (not FDA approved for asthma). AND The patient has a documented side effect, allergy, or treatment failure to Serevent. **Levalbuterol, Xopenex nebulizer solution (age > 12 years):** 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. **Xopenex (age <12 years):** The patient must have a documented intolerance to generic levalbuterol nebulizer solution **Brovana or Perforomist Nebulizer Solution:** The patient must have a diagnosis of COPD. AND The patient must be unable to use a non-nebulized long-acting bronchodilator or anticholinergic (Serevent or Spiriva) due to a physical limitation **Metaproterenol tablets/syrup:** The patient has had a documented side effect, allergy or treatment failure with generic albuterol tablets/syrup. **Terbutaline tablets:** The medication is not being prescribed for the prevention/treatment of preterm labor. **Vospire ER tablets:** The patient must have had a documented side effect, allergy, or treatment failure to generic albuterol ER tablets.
CORTICOSTEROIDS/COMBINATIONS: INHALED		
METERED DOSE INHALERS (SINGLE AGENT) ASMANEX® (mometasone furoate) (QL = 3 inhalers/90 days)	Aerospan® (flunisolide HFA) *(QL = 6 inhalers (53.4 gm)/90 days)* Alvesco® (ciclesonide)	**Metered-dose inhalers (single agent):** The patient has had a documented side effect, allergy, or treatment failure to at least two preferred agents AND for approval of Asmanex HFA, there must be a clinically compelling reason the

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
FLOVENT® DISKUS (fluticasone propionate) *(QL = 3 inhalers/90 days)* FLOVENT® HFA (fluticasone propionate) *(QL = 36 gm(3 inhalers)/90 days)* PULMICORT FLEXHALER® (budesonide) *(QL = 6 inhalers/90 days)* QVAR® REDIHALER™ 40mcg/inh *(QL = 21.2 gm (2 inhalers)/90 days)* QVAR® REDIHALER™ 80mcg/inh *(QL = 31.8 gm (3 inhalers/90 days)*	*(QL = 18.3 gm (3 inhalers)/90 days)) (80 mcg/inh)* *(QL =36.6 gm (6 inhalers)/90 days)) (160 mcg/inh)* Armonair Respiclick® (fluticasone propionate) (QL = 3 inhalers/90 days) Arnuity Ellipta 100 or 200mcg/inh (fluticasone furoate) (QL= 90 blisters/90 days) Asmanex® (mometasone furoate) HFA QL = 39 gm (3 inhalers)/90 days)	patient is unable to use Asmanex. **AirDuo Respiclick, Breo Ellipta, Fluticasone Salmeterol** The patient has had a documented side effect, allergy, or treatment failure to any 2 of the following: Advair, Dulera, or Symbicort. **Budesonide Inh Suspension:** The patient requires a nebulizer formulation AND if the dose is 1mg, the patient must be unable to use two 0.5mg vials **Pulmicort Respules:** The patient requires a nebulizer formulation AND if the dose is 1mg, the patient must be unable to use two 0.5mg vials AND the patient has a documented intolerance to the generic.
METERED DOSE INHALERS (COMBINATION PRODUCT) ADVAIR® HFA (fluticasone/salmeterol) *(QL = 36 gm (3 inhalers)/90 days)* ADVAIR® DISKUS (fluticasone/salmeterol) *(QL = 3 inhalers/90 days)* DULERA® (mometasone/formoterol) *(QL = 39 gm (3 inhalers)/90 days)* SYMBICORT® (budesonide/formoterol) *(QL = 30.6 gm (3 inhalers)/90 days)*	AirDuo Respiclick® (fluticasones/almeterol) (*QL=3 inhalers/90 days)* Breo Ellipta® (fluticasone furoate/vilanterol) *(QL = 180 blisters(3 inhalers)/90 days)* Fluticasone/salmeterol (comopare to AirDuo Respiclick®) *QL=3 inhalers/90 days)*	
NEBULIZER SOLUTIONS BUDESONIDE INH SUSPENSION 0.25mg, 0.5mg Age ≤ 12 yrs)	Budesonide Inh Suspension 1mg (all ages), 0.25mg and 0.5mg (age >12 years) Pulmicort Respules® (budesonide)	
CORTICOSTEROIDS: INTRANASAL		
<u>SINGLE AGENT</u> BUDESONIDE QL = 8.43 ml (1 inhaler)/30 days FLUTICASONE Propionate *QL = 16 gm (1 inhaler)/30 days* TRIAMCINOLONE	Beconase AQ® (beclomethasone) *QL =50 gm (2 inhalers)/30 days* flunisolide 25 mcg/spray (formerly Nasalide®) *QL = 50 ml (2 inhalers)/30 days* Mometasone (compare to Nasonex®) QL = 17gm (1 inhaler)/30 days	**Beconase AQ, Flunisolide 25 mcg/spray, Nasonex, Mometasone, QNASL:** The patient has had a documented side effect, allergy, or treatment failure of two preferred nasal glucocorticoids. If a product has an AB rated generic, one trial must be the generic. **Dymista:** The diagnosis or indication is allergic rhinitis. AND The patient has had a documented side effect, allergy, or treatment failure to loratadine (OTC) OR

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
QL = 16.9 ml (1 inhaler)/30 days OMNARIS® (ciclesonide) *QL = 12.5 gm (1 inhaler)/30 days* ZETONNA® (ciclesonide) *QL = 6.1 gm (1 inhaler)/30 days*	NASONEX® (mometasone) *QL = 17 gm (1 inhaler)/30 days* QNASL® (beclomethasone diproprionate) HFA *QL = 10.6 gm (1 inhaler)/30 days* Xhance™ (fluticasone propionate) *QL=16ml (1 inhaler)/30 days* **COMBINATION WITH ANTIHISTAMINE** Dymista® (azelastine/fluticasone) *QL = 23 gm (1 inhaler)/30 days*	cetirizine (OTC) AND a preferred nasal corticosteroid used in combination. **Xhance:** The patient has had a documented side effect, allergy, or treatment failure of three preferred nasal glucocorticoids, one of which must be fluticasone. **Limitations:** Nasacort Allergy OTC and Flonase are not covered as no Federal Rebate is offered.
LEUKOTRIENE MODIFIERS		
Preferred After Age Criteria Are Met MONTELUKAST SODIUM (compare to Singulair®) tablets MONTELUKAST SODIUM (compare to Singulair®) chews 4mg for ages 2-5, 5mg for age 6-14 MONTELUKAST SODIUM (compare to Singulair®) granules ages 6months-23months	Accolate® (zafirlukast) *Quantity Limit = 2 tablets/day* Singulair® (montelukast sodium) tablets, chew tabs, granules *Quantity Limit = 1 tablet or packet per day* zafirlukast (compare to Accolate®) Zileuton ER (compare to Zyflo CR®) *Quantity Limit = 4 tablets/day* Zyflo (zileuton) *Quantity Limit = 4 tablets/day* Zyflo CR® (zileuton SR) *Quantity Limit = 4 tablets/day*	**Montelukast:** Clinical rationale must be provided for prescribing a dose and formulation that differs from age recommendations AND If the request is for brand Singulair, the patient has a documented intolerance to the generic equivalent montelukast preparation. **Zafirlukast, Accolate:** The diagnosis or indication for the requested medication is asthma. AND If the request is for Accolate, the patient has a documented intolerance to generic zafirlukast. **Zileuton ER, Zyflo/Zyflo CR:** The diagnosis or indication for the requested medication is asthma. AND The patient has had a documented side effect, allergy, or treatment failure to Accolate or Singulair/Montelukast AND if the request is for Zileuton ER, the patient must have a documented intolerance to brand Zyflo CR.
SYNAGIS		
	SYNAGIS® (palivizumab) *Quantity Limit = 1 vial/month (50 mg) or 2 vials/month (100 mg)*	**CRITERIA FOR APPROVAL:** Infants born at 28 weeks of gestation or earlier (i.e., ≤ 28 weeks, 6 days) and under twelve months of age at the start of the RSV season (maximum 5 doses). Infants born at 29-32 weeks (i.e., between 29 weeks, 0 days and 31 weeks, 6 days) of gestation and under 1 year of age at the start of the RSV season who develop chronic lung disease of prematurity defined as a requirement for >21% oxygen for at least the first 28 days after birth (maximum 5 doses). Children under 24 months of age with chronic lung disease of prematurity defined as born at 31 weeks, 6 days or less who required >21% oxygen for at least the first 28 days after birth and continue to require medical support (chronic corticosteroid therapy, diuretic therapy, or supplemental oxygen) during the 6-month period before the start of the second RSV season

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		(maximum 5 doses). Children under 12 months of age with hemodynamically significant congenital heart disease (CHD) (dosing continues in the RSV season through the end of the month the infant reaches 12 months old -maximum 5 doses): Acyanotic heart disease and receiving medication to control congestive heart failure and will require cardiac surgical procedures, Moderate to severe pulmonary hypertension , Cyanotic heart disease and recommended for Synagis therapy by Pediatric Cardiologist Infants under 12 months of age with either: (dosing continues in the RSV season through the end of the month the infant reaches 12 months old -maximum 5 doses) Congenital abnormalities of the airways that impairs the ability to clear secretions from the upper airway because of ineffective cough, Neuromuscular condition that impairs the ability to clear secretions from the upper airway because of ineffective cough Infants and children less than 24 months of age who will undergo a heart transplant during the RSV season Infants and children less than 24 months of age who are profoundly immunocompromised during the RSV season (e.g. undergoing organ or stem cell transplant or receiving chemotherapy). **EXCLUDED FROM APPROVAL:** Infants and children with hemodynamically insignificant heart disease. Infants with cardiac lesions adequately corrected by surgery, unless they continue to require medication for congestive heart failure. Infants with mild cardiomyopathy who are not receiving medical therapy. Breakthrough hospitalization for RSV disease (Synagis therapy should be discontinued for the season once hospitalization for RSV has occurred). Infants and children with Down syndrome unless other indications above are present. Infants and children with cystic fibrosis unless other specific conditions are present This drug must be obtained and billed through 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.
PULMONARY ARTERIAL HYPERTENSION MEDICATIONS		
ENDOTHELAN RECEPTOR ANTAGONISTS	Letairis® (ambrisentan) Tablet	**Adempas:** The patient has a diagnosis of pulmonary arterial hypertension (PAH) with New York Heart Association (NYHA) Functional Class II or III. OR The patient has a diagnosis of chronic thromboembolic pulmonary hypertension

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
TRACLEER® (bosentan) Tablet (62.5mg, 125mg) *Quantity Limit = 2 tablets/day* **PROSTACYCLIN AGONISTS** **Injection** EPOPROSTENOL (compare to Flolan®) REMODULIN® (treprostinil sodium injection) VELETRI® (epoprostinil) **Inhalation** TYVASO® (treprostinil inhalation solution) VENTAVIS® (iloprost inhalation solution) **Oral** ORENITRAM® (treprostinil) ER Tablet **sGC STIMULATOR** All products require a PA ****Maximum days supply for all drugs is 30 days****	*Quantity Limit = one tablet/day* Opsumit® (macitentan) Tablet *Quantity Limit = one tablet/day* Tracleer® tablets for oral suspension (32mg) Flolan®* (epoprostenol) Uptravi® (selexipag) tablets *200mcg strength, QL = 140 tablets/30 days for the first 2 months then 2 tablets/day subsequently. All other strengths, QL = 2 tablets/day* Adempas® (riociguat) Tablets *Quantity Limit = 3 tablets/day*	(CTEPH, WHO Group 4) AND the patient has persistent or recurrent disease after surgical treatment (e.g., pulmonary endarterectomy) or has CTEPH that is inoperable AND The patient is 18 years of age or older AND The patient will not use Adempas concomitantly with the following: Nitrates or nitric oxide donors (such as amyl nitrate) in any form. Phosphodiesterase (PDE) inhibitors, including specific PDE-5 inhibitors (such as sildenafil, tadalafil, or vardenafil) or non-specific PDE inhibitors (such as dipyridamole or theophylline) AND The patient is not pregnant AND Female patients are enrolled in the Adempas REMS Program **Tracleer tablets for oral suspension:** Patient has a diagnosis of PAH with NYHA Functional ClassII or III AND patient is ≤ 12 years of age and <40kg. **Flolan:** Clinical diagnosis of pulmonary hypertension AND The patient has had a documented intolerance to the generic epoprostenol. **Letairis, Opsumit:** Patient has a diagnosis of PAH with NYHA Functional Class II or III AND Patient is not pregnant AND Female patients have been enrolled in the REMS Program AND the patient has a documented side effect, allergy, or treatment failure with Tracleer. **Uptravi:** 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
RENAL DISEASE: PHOSPHATE BINDERS		
CALCIUM ACETATE (compare to Phos Lo®) capsule CALCIUM ACETATE (compare to Eliphos®) tablet FOSRENOL® (lanthanum carbonate) RENAGEL® (sevelamer) **ORAL SOLUTIONS** PHOSLYRA® (calcium acetate) oral solution	Auryxia® (ferric citrate) *(QL= 12/day)* Eliphos® (calcium acetate) tablet Lanthanum carbonate (compare to Fosrenol) Renvela® (sevelamer carbonate) Oral Suspension Packet *(QL = 2 packs/day (0.8 g strength only)* Renvela® (sevelamer carbonate) tablets sevelamer carbonate Oral Suspension Packet (compare to Renvela®) *(QL = 2 packs/day (0.8 g strength only)* Sevelamer carbonate tablets (compare to Renvela®) Velphoro® (sucroferric oxyhydroxide) Chew Tablet	**Eliphos:** The patient must have a documented intolerance to the generic equivalent calcium acetate tablet or capsule. **Renvela Oral Suspension Packet, Sevelamer Packet:** The patient has a requirement for a liquid dosage form. **Auryxia, lanthanum carbonate, Renvela tablets, sevelamer carbonate tablets, Velphoro Chew Tablet:** The patient must have a documented side effect, allergy, or inadequate response to one preferred phosphate binder.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
RESTLESS LEG SYNDROME MEDICATIONS		
DOPAMINE AGONISTS (ORAL) PRAMIPEXOLE (compare to Mirapex®) ROPINIROLE (compare to Requip®) **DOPAMINE AGONISTS (TRANSDERMAL)** NEUPRO® (rotigotine) transdermal patch *(Quantity Limit = 1 patch/day)* *(1mg, 2 mg and 3 mg patches ONLY)* **GAMMA-AMINOBUTYRIC ACID ANALOG** GABAPENTIN IR	Mirapex®* (pramipexole) Requip®* (ropinirole) Horizant® (gabapentin enacarbil) ER Tablet *(Quantity Limit = 1 tablet/day)*	**Mirapex, Requip:** The patient has had a documented intolerance to the generic product. **Horizant:** The patient has a diagnosis of restless legs syndrome (RLS). AND The patient has had a documented side effect, allergy, contraindication or treatment failure to two preferred dopamine agonists (pramipexole IR, ropinirole IR, Neupro) AND gabapentin IR. **Limitations:** Requests for Mirapex ER and Requip XL will not be approved for Restless Leg Syndrome (RLS).
RHEUMATOID, JUVENILE & PSORIATIC ARTHRITIS: IMMUNOMODULATORS		
Preferred After Clinical Criteria Are Met **Injectable** COSENTYX® (secukinumab) ENBREL® (etanercept) *(Quantity limit = 4 syringes/28 days(50 mg) and 8 syringes/28 days (25 mg))* HUMIRA® (adalimumab) (*Quantity limit = 4 syringes/28 days)*	Actemra® (tocilizumab) Intravenous Infusion *(Qty limit = 4 vials/28 days (80 mg vial), 3 vials/28 days (200 mg vial) or 2 vials/28 days (400 mg vial))* Actemra® (tocilizumab) Subcutaneous *(Qty limit = 4 prefilled syringes (3.6ml)/28 days)* Cimzia® (certolizumab pegol) *(Quantity limit = 1 kit/28 days)* Inflectra® (Infliximab-dyyb) biosimilar to Remicade® Kevzara® (sarilumab) (*Quantity limit = 2 syringes/28 days)* Kineret® (anakinra) *(Quantity limit = 1 syringe/day)* Olumiant® (baricitinib) tablets (Qty limit = 1 tablet/day) Maximum 30 days supply Orencia® (abatacept) Subcutaneous Injection *(Quantity limit = 4 syringes/28 days)* Orencia® (abatacept) Intravenous Infusion Remicade® (infliximab) Renflexis™ (Infliximab-abda) biosimilar to Remicade®	**Clinical Criteria for all drugs:** Patient has a diagnosis of rheumatoid arthritis (RA), juvenile idiopathic arthritis* or psoriatic arthritis and has already been stabilized on the drug being requested OR Diagnosis is RA, juvenile idiopathic arthritis or psoriatic arthritis, and methotrexate therapy resulted in an adverse effect, allergic reaction, inadequate response, or treatment failure. If methotrexate is contraindicated, another DMARD should be tried prior to approving therapy. Other DMARDs include leflunomide, sulfasalazine, gold, antimalarials, minocycline, D-penicillamine, azathioprine, cyclophosphamide and cyclosporine. Additional note for Humira: Approval should be granted in cases where patients have been treated with infliximab but have lost response to therapy. **Cosentyx additional criteria:** patient must be ≥ 18 years of age AND the prescriber must provide evidence of a trial and failure or contraindication to Humira. **Note:** Cosentyx approvals for 300mg dose(s) must use "300DOSE" package (containing 2x150mg pens or syringes). Approval will not be granted for 2 separate 150mg packages. **Actemra, Cimzia, Kevzara, Remicade, Simponi (subcutaneous), and Stelara additional criteria:** The prescriber must provide clinically valid reason why both Humira and Enbrel cannot be used.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
Oral All products require PA.	Simponi® (golimumab) Subcutaneous *Qty Limit = 1 of 50 mg prefilled syringe or autoinjector/28 days)* Simponi Aria® (golimumab) 50 mg/4 ml Vial for Intravenous Infusion Stelara® (ustekinumab) *(Quantity limit = 45 mg (0.5 ml) or 90 mg (1 ml) per dose)* *(90 mg dose only permitted for pt weight > 100 kg)* Xeljanz® (tofacitinib) tablet *(Qty limit = 2 tablets/day)* *Maximum 30 days supply* Xeljanz® XR (tofacitinib) tablet (*Qty limit = 1tablet/day)*	**Inflectra, Renflexis additional criteria:** The prescriber must provide a clinically valid reason why both Humira and Enbrel cannot be used AND the patient must be unable to use Remicade. **Simponi Aria additional criteria:** The patient has not responded adequately to Simponi subcutaneous. AND The prescriber must provide a clinically valid reason why both Humira and Enbrel cannot be used. **Kineret, Orencia additional criteria:** Note: Kineret or Orencia may be used as monotherapy or concomitantly with DMARDs, other than TNF antagonists. Kineret or Orencia should not be administered concomitantly with any TNF antagonists (i.e. Enbrel, Humira, or Remicade). AND The prescriber must provide a clinically valid reason why both Humira and Enbrel cannot be used. **Xeljanz, Xeljanz XR additional criteria** The patient must be ≥ 18 years of age AND The prescriber must provide a clinically valid reason why both Humira and Enbrel cannot be used. For approval of Xeljanz XR, patient has not been able to tolerate or adhere to twice daily dosing of immediate release Xeljanz, resulting in significant clinical impact. **Olumiant additional criteria:** 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. **Note: Patients with systemic juvenile arthritis (SJRA/SJIA) and fever** are not required to have a trial of a DMARD, including methotrexate. Patients with systemic juvenile arthritis without fever should have a trial of methotrexate, but a trial of another DMARD in the case of a contraindication to methotrexate is not required before Enbrel, Humira, Actemra, or Orencia is approved. * Patients with psoriatic arthritis with a documented diagnosis of active axial involvement should have a trial of NSAID therapy, but a trial with DMARD is not required before a TNF-blocker is approved. If no active axial skeletal involvement, then an NSAID trial and a DMARD trial are required (unless otherwise contraindicated) prior to receiving Humira, Enbrel, Remicade, Cimzia, Stelara or Simponi
SICKLE CELL DISEASE THERAPIES		
DROXIA® (hydroxyurea) 200mg, 300mg, 400mg cap HYDROXYUREA (compare to Hydrea®) 500mg cap	Endari (L-glutamine powder for oral solution) QL=maximum of 30 day supply Hydrea® (hydroxyurea) 500mg cap Nutrestore (L-glutamine powder or oral solution) QL=168 packets/28 days Siklos® (hydroxyurea) 100mg, 1000mg tablet	**Endari:** Indication for use is to reduce the acute complication of Sickle Cell Anemia AND the patient has had a documented intolerance to Nutrestore **Hydrea:** Patient has had a documented intolerance to the generic equivalent. **Nutrestore:** *Indication or use is Short Bowel Syndrome (SBS):* the medication is administered as co-therapy with recombinant growth hormone AND duration of treatment does not exceed 16 weeks. *Indication for use is Sickle Cell Anemia (SCA*): medication will be approved with

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		quantity limits based on patient weight (< 30kg = 2 packets/day, 30-65 kg = 4 packets/day, > 65kg = 6 packets/day **Siklos:** Patient has a diagnosis of Sickle Cell Anemia with recurrent moderate to severe pain crises AND the required dose is < 200mg OR Patient has a diagnosis of Sickle Cell Anemia with recurrent moderate to severe pain crises AND has a documented intolerance to a preferred hydroxyurea formulation. For re-approval, the patient must have a documented decrease in vaso-occlusive episodes, acute chest syndrome, SCD related hospitalizations, or blood transfusions.
SALIVA STIMULANTS		
PILOCARPINE (compare to Salagen®) CEVIMELINE (compare to Evoxac®) EVOXAC® (cevimeline)	Salagen®* (pilocarpine)	Salagen: The patient has had a documented side effect, allergy, or treatment failure to generic pilocarpine
SEDATIVE/HYPNOTICS		
BENZODIAZEPINE		
ESTAZOLAM TEMAZEPAM 15 mg, 30 mg (compare to Restoril®)	flurazepam (formerly Dalmane®) Halcion® (triazolam) Restoril®* (temazepam) temazepam 7.5 mg, 22.5 mg (compare to Restoril®) triazolam (compare to Halcion®)	**Criteria for Approval:** The patient has had a documented side effect, allergy, or treatment failure with two preferred benzodiazepine sedative/hypnotics. If a product has an AB rated generic, one trial must be the generic.
NON BENZODIAZEPINE, NON BARBITURATE		
ZOLPIDEM (compare to Ambien®)*(Quantity Limit = 1 tab/day)* ZALEPLON (compare to Sonata®) *(Quantity Limit = 1 cap/day (5 mg) or 2 caps/day (10 mg))*	Ambien®* (zolpidem) *(Quantity Limit = 1 tab/day)* Ambien CR® (zolpidem) *(Quantity Limit = 1 tab/day)* Belsomra® (suvorexant) *(Quantity Limit = 1 tab/day)* Edluar® (zolpidem) sublingual tablet *(Quantity Limit = 1 tab/day)* eszopiclone (compare to Lunesta®) *(Quantity Limit = 1 tab/day)* Intermezzo® (zolpidem) Sublingual Tablet *(Quantity Limit = 1 tab/day)* Lunesta® (eszopiclone) *(Quantity Limit = 1 tab/day)* Rozerem® (ramelteon) *(Quantity Limit = 1 tab/day)* Silenor® (doxepin) *(Quantity limit = 1 tab/day)* Sonata®* (zaleplon) *(Quantity Limit = 1 cap/day (5 mg) or 2 caps/day (10 mg))* Zolpidem CR (compare to Ambien CR®) *(Quantity Limit*	**Ambien, Sonata:** The patient has had a documented intolerance to the generic equivalent. **Ambien CR, Belsomra, Lunesta, eszopiclone, Zolpidem CR:** The patient has had a documented side effect, allergy or treatment failure to generic zolpidem. If the request is for brand Ambien CR, there has also been a documented intolerance to the generic. Belsomra will be available to the few patients who are unable to tolerate or who have failed on preferred medications. **Edluar:** The patient has a medical necessity for a disintegrating tablet formulation (i.e. swallowing disorder). **Intermezzo:** The patient has insomnia characterized by middle-of-the night awakening followed by difficulty returning to sleep AND The patient has had a documented inadequate response to zolpidem IR AND zaleplon. **Rozerem:** The patient has had a documented side effect, allergy, contraindication or treatment failure to generic zolpidem. OR There is a question of substance

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	= 1 tab/day)	abuse with the patient or family of the patient. **Silenor:** The patient has had a documented side effect, allergy, contraindication or treatment failure to generic zolpidem AND The patient has had a documented intolerance with generic doxepin or there is another clinically valid reason why a generic doxepin (capsule or oral solution) cannot be used.
SMOKING CESSATION THERAPIES		
NICOTINE REPLACEMENT: maximum duration is 16 weeks (2 x 8 weeks)/365 days for non-preferred. For approval of therapy beyond the established maximum duration, the prescriber must provide evidence that the patient is engaged in a smoking cessation counseling program.		
NICOTINE GUM NICOTINE LOZENGE NICOTINE PATCH OTC **ORAL THERAPY** BUPROPION SR (compare to Zyban®) CHANTIX® (varenicline) (Limited to 18 years and older, Quantity Limit = 2 tabs/day, max duration 24 weeks (2x12 weeks)/365 days)	Nicoderm CQ Patch® Nicorette Gum® Nicorette Lozenge Nicotrol Inhaler® Nicotrol Nasal Spray® Zyban®* (bupropion SR) (maximum duration 24 weeks (2 x 12 weeks)/365 days)	**Nicoderm CQ patch:** The patient has had a documented intolerance to generic nicotine patch. **Nicorette gum:** The patient has had a documented intolerance to generic nicotine gum. **Nicorette Lozenge:** The patient has had a documented intolerance to generic nicotine lozenge. **Nicotrol Inhaler:** The patient has had a documented treatment failure with BOTH generic nicotine patch and generic nicotine gum. **Nicotrol Nasal Spray:** The prescriber must provide a clinically valid reason for the use of the requested medication. **Zyban:** The patient has had a documented intolerance to generic bupropion SR. *Smoking Cessation Counseling is encouraged with the use of smoking cessation therapies* *The combined prescribing of long acting (patch) and faster acting (gum or lozenge) nicotine replacement therapy is encouraged for greater likelihood of quit success. **Vermont QUIT LINE** (available free to all patients) 1-800-QUIT-NOW (1-800-784-8669) **GETQUIT™** Support Plan available free to all Chantix® patients 1-877-CHANTIX (242-6849) **Limitations:** Nicotine System Kit® not covered – prescribe multiple strengths separately
TESTOSTERONE REPLACEMENT THERAPY		
Nasal		
All products require PA	Natesto® (testosterone) nasal (QL = 1 pump/30 days)	**Natesto:** The patient has had a documented side effect, allergy, or treatment failure to AndroGel® Gel and Androderm.
Topical		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ANDRODERM® Transdermal 2mg, 4 mg (testosterone patch) *Quantity limit = 1 patch/day/strength* ANDROGEL® GEL (testosterone 1% gel packets) *Quantity limit = 2.5 gm packet (1 packet/day)* *5 gm packet (2 packets/day)* ANDROGEL® GEL (testosterone 1.62% gel packets) *Quantity limit = 1.25 gm packet (1.62%) (1 packet/day)* *2.5 gm packet (1.62%) (2 packets/day)* ANDROGEL® PUMP (testosterone pump bottles) *Quantity limit = 1.62% (2 bottles/30 days)*	Axiron (testosterone 2% solution) 90 ml Pump Bottle *Quantity limit = 2 bottles/30 days* Fortesta® (testosterone 2 % Gel) 60 gm Pump Bottle *Quantity limit = 2 bottles/30 days* Testim® Gel 5 gm (testosterone 1% gel tube) *Quantity limit = 2 tubes/day* Testosterone 1% Gel Packets (compare to Androgel®, Vogelxo®) *Quantity Limit = 2.5gm packet (1 packet/day)* *Quantity Limit= 5gm packet (2 packets/day)* Testosterone 1% gel tube (compare to Testim® Gel 5 gm, Vogelxo®, Androgel®) *Quantity limit = 2 tubes/day* Testosterone 1% Gel Pump (compare to Androgel®, Vogelxo®) *Quantity limit = 4 bottles/30 days* Testosterone 2% gel 60 gm pump bottle (compare to Fortesta®) *Quantity limit = 2 bottles/30 days* Testosterone 2% solution 90ml Pump Bottle (compare to Axiron®) *Quantity limit = 2 bottles/30 days* Vogelxo® 1% (testosterone 1%) gel, pump *Quantity limit = 2 tubes/day (5 gm gel tubes)* *Quantity limit = 4 bottles/30 days (gel pump bottle)*	**Axiron, Fortesta, Testim Testosterone Gel 1%, Testosterone Gel 2 %:** The patient has had a documented side effect, allergy, or treatment failure to Androgel and Androderm.
Oral		
Methitest (methyltesterone) Tablet 10mg	Android (methyltestoterone) capsule 10mg Methyltestosterone capsule 10mg Striant® Sr (testosterone) 30mg Testred (methyltestosterone) capsule 10mg *Maximum day supply all products is 30 days*	**Android, Striant, Methyltesterone, Testred**: patient has a documented side effect, allergy, or treatment failure to Methitest
Injectable		
TESTOSTERONE CYPIONATE IM (compare to Depo®-Testosterone) TESTOSTERONE ENANTHATE IM	Aveed® (testosterone undecanote) IM Depo®-Testosterone (testosterone cypionate) IM Testopel® (testosterone) implant pellets Xyosted™ (testosterone enanthate) SC	**Depo-Testosterone:** The patient has a documented intolerance to generic testosterone cypionate. Aveed, Testopel, Xyosted**: The patient has had a documented side effect, allergy,** or treatment failure to TWO preferred testosterone products, one of which must be an injectable formulation.
URINARY ANTISPASMODICS		
SHORT-ACTING AGENTS OXYBUTYNIN	Flavoxate	Please note: Patients <21 years of age are exempt from all ORAL

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
LONG-ACTING AGENTS ***(Qty Limit = 1 per day)*** OXYBUTYNIN XL (compare to Ditropan® XL) TOVIAZ® (fesoterodine) **Transdermal/Topical** All products require PA **BETA-3 ADRENERGIC AGONISTS** All products require PA	Detrol® (tolterodine) tolterodine (compare to Detrol®) trospium Detrol LA® (tolterodine SR) Ditropan XL® (oxybutynin XL) Enablex® (darifenacin) tolterodine SR (compare to Detrol LA®) trospium ER Vesicare® (solifenacin) Gelnique 3%® (oxybutynin topical gel) *(Qty limit = 1 pump bottle (92gm)per 30 days)* Gelnique 10%® (oxybutynin topical gel) *(Qty limit = 1 sachet/day)* Oxytrol® (oxybutinin transdermal) *(Qty Limit = 8 patches/28 days)* Myrbetriq® (mirabegron) ER Tablet *(Qty limit = 1 tablet/day)*	ANTIMUSCARINIC Urinary Antispasmodics PA requirements **Detrol, Detrol LA, Ditropan XL, Enablex, tolterodine (generic), tolterodine SR (generic), trospium (generic), trospium ER (generic), Vesicare:** The patient has had a documented side effect, allergy, or treatment failure with one preferred long-acting agent. If a medication has an AB rated generic, there must have also been a trial of the generic formulation. **Gelnique 3%, 10%, Oxytrol:** The patient is unable to swallow a solid oral formulation (e.g. patients with dysphagia) OR The patient is unable to be compliant with solid oral dosage forms. **Myrbetriq:** The patient has had a documented side effect, allergy, treatment failure, or contraindication with one preferred long-acting urinary antimuscarinic agent. **Limitations:** Oxytrol (for Women) OTC not covered. Oxytrol RX is available but subject to prior authorization.
VAGINAL ANTI-INFECTIVES		
CLINDAMYCIN CLEOCIN® Vaginal Ovules (clindamycin vaginal suppositories) CLINDAMYCIN VAGINAL (clindamycin vaginal cream 2%) CLINDESSE® (clindamycin vaginal cream 2%) **METRONIDAZOLE** METRONIDAZOLE VAGINAL GEL 0.75% VANDAZOLE (metronidazole vaginal 0.75%) **SECNIDAZOLE** All products require PA	Cleocin®* (clindamycin vaginal cream 2%) Metrogel Vaginal®* (metronidazole vaginal gel 0.75%) Nuvessa Vaginal® (metronidazole vaginal gel 1.3%) (1 pre-filled applicator/30 days) Solosec™ (secnidazole) oral granules packet	**Cleocin:** The patient has had a documented side effect, allergy, or treatment failure to a preferred clindamycin vaginal cream. **Metrogel Vaginal, Nuvessa Vaginal:** The patient has had a documented side effect, allergy, or treatment failure to generic metronidazole vaginal gel 0.75 % or Vandazole. **Solosec:** The patient has had a documented side effect, allergy, or treatment failure to a preferred topical anti-infective and oral metronidazole.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
VASOPRESSIN RECEPTOR ANTAGONIST		
	Jynarque® tablets (tolvaptan) Quantity Limit = 56 tablets/28 days Samsca® tablets (tolvaptan) Quantity limit = 15 mg tablets (1 tablet/day), 30 mg tablets (2 tablets/day)	**Samsca:** The agent is being used for the treatment of euvolemic or hypervolemic hyponatremia AND Despite optimal fluid restriction, the patient's serum sodium < 120 mEq/L or the patient is symptomatic with a serum sodium < 125 mEq/L. AND The treatment will be initiated or is being reinitiated in a hospital setting where serum sodium can be monitored **Jynarque:** The patient must be ≥ 18 years of age AND the patient is at risk of rapidly progressing Autosomal Polycystic Kidney Disease (ADPKD) AND the patient has normal serum sodium concentrations before starting the medication (results must be submitted) AND the patient and provider are enrolled in the Jynarque® REMS program
VITAMINS: PRENATAL MULTIVITAMINS		
COMPLETE NATAL DHA CONCEPT OB CONCEPT DHA NIVA-PLUS O-CAL-FA O-CAL PRENATAL PRENATAL PLUS IRON PRENATAL VITAMINS PLUS PREPLUS PRETAB TRINATAL RX 1 VOL-NATE VOL-PLUS	All others	**All Non-Preferred:** The prescriber must provide a clinically valid reason for the use of the requested medication including reasons why any of the preferred products would not be a suitable alternative.