EFFECTIVE
Version
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Department of Vermont Health Access
Pharmacy Benefit Management Program

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

The Commissioner for Office of Vermont Health Access shall establish a pharmacy best practices and cost control program designed to reduce the cost of providing prescription drugs, while maintaining high quality in prescription drug therapies. The program shall include:

"A preferred list of covered prescription drugs that identifies preferred choices within therapeutic classes for particular diseases and conditions, including generic alternatives"

From Act 127 passed in 2002

The following pages contain:

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

Therapeutic class criteria are listed alphabetically. Within each category the Preferred Drugs are noted in the left-hand columns. Representative non-preferred agents have been included and are listed in the right-hand column. Any drug not listed as preferred in any of the included categories requires Prior Authorization. Approval of non-preferred brand name products may require trial and failure of at least 2 different generic manufacturers.

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

Drugs highlighted in yellow denote a change in PDL status.

To search the PDL, press CTRL + F

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

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
TOPICAL - RETINOIDS		
AVITA® (tretinoin) DIFFERIN® (adapalene) 0.1% C, G; L 0.3% G RETIN-A® (tretinoin) 0.025%, 0.05%, 0.1% C; 0.01%, 0.025% G C= *cream*, G=*gel*, L=*lotion*	Adapalene (compare to Differin®) 0.1% C, G, 0.3% G Adapalene/Benzoyl Peroxide (compare to Epiduo) 0.1-2.5% G Aklief® (trifarotene) 0.005% C Altreno™ (tretinoin) 0.05% L Arazlo® (tazarotene) 0.045% L Atralin® (tretinoin) 0.05% G Clindamycin/tretinoin 1.2-0.025% G Epiduo Forte (adapalene/benzoyl peroxide) 0.3-2.5% G Fabior® (tazarotene) 0.1% F Plixda® (adapalene) 0.1% swabs Retin-A Micro® (tretinoin microsphere) 0.04%, 0.06%, 0.08%, 0.1% G Tazarotene (compare to Tazorac ®) 0.1%C Tretinoin (compare to Retin-A®) 0.025%, 0.05%, 0.1% C; 0.01%, 0.025% G Tretinoin microsphere (compare to Retin-A Micro®) 0.1%, 0.04%	**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 the brand name equivalent. **Aklief, Arazlo, Fabior, Tazarotene:** patient has had a documented side effect or treatment failure with a preferred topical tretinoin product and Differin. **Adapalene/benzoyl peroxide gel, Clindamycin/tretinoin gel, Epiduo Forte:** patient has had a documented side effect or treatment failure on combination therapy with the separate ingredients of the combination product **Plixda:** patient has had a documented side effect, allergy, or treatment failure with brand Differin AND a generic adapalene product. **Limitations:** Coverage of topical retinoid products will not be approved for cosmetic use (wrinkles age spots, etc.) (i.e. Avage, Renova, Tri-Luma).
TOPICAL - ROSACEA		
FINACEA® (azelaic acid) 15% *G*, F METRONIDAZOLE 0.75% *C, G, L* *C=cream, F=Foam, G=gel, L=lotion*	All brand metronidazole products (MetroCream® 0.75% *C*, Metrogel® 1% *G*, MetroLotion® 0.75% *L*, Noritate® 1% *C* etc.) Metronidazole 1% *G* Soolantra® (ivermectin) Zilxi® (minocycline) 1.5% F	**Brand name metronidazole products, metronidazole 1% gel (generic), and Soolantra**: diagnosis or indication is rosacea AND patient has had a documented side effect, allergy or treatment failure with a preferred generic topical metronidazole product. If a product has an AB rated generic, there must have also been a trial of the generic formulation. **Zilxi:** diagnosis or indication is rosacea AND patient has had a documented side effect, allergy, or treatment failure with a preferred generic topical metronidazole product and Finacea. **Limitations**: The use of Mirvaso (brimonidine topical gel) for treating skin redness is considered cosmetic. Medications used for cosmetic purposes are excluded from coverage. Mirvaso topical gel has not been shown to improve any other symptom of rosacea (e.g. pustules, papules, flushing, etc.) or to alter the course of the disease.
ADHD AND NARCOLEPSY CATAPLEXY MEDICATIONS		
SHORT/INTERMEDIATE ACTING STIMULANTS		
AMPHETAMINE/DETROAMPHETAMINE (compare to Adderall®)	Adderall® (amphetamine/dextroamphetamine)	**Clinical Criteria for ALL non-preferred drugs:** patient has a diagnosis of ADD, ADHD or narcolepsy AND patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
DEXMETHYLPHENIDATE (compare to Focalin®) METHYLIN® (compare to Ritalin®) solution METHYLPHENIDATE (compare to Ritalin®) tablets, solution METHYLPHENIDATE SR (compare to Ritalin® SR) PROCENTRA® (dextroamphetamine sulfate) 1 mg/ml oral solution	Amphetamine Sulfate (compare to Evekeo) Desoxyn® (methamphetamine) Dextroamphetamine sulfate 1 mg/ml oral solution Dextroamphetamine IR (Zenzedi 5 or 10 mg, formerly Dexedrine®) Evekeo® (amphetamine sulfate) Evekeo® ODT (amphetamine sulfate) Focalin® (dexmethylphenidate) Methamphetamine (compare to Desoxyn®) Methylphenidate (compare to Ritalin ®) chewable tablets Ritalin® (methylphenidate) Zenzedi® (dextroamphetamine IR) 2.5 mg, 7.5 mg, 15 mg, 20 mg, 30 mg tablets	for stabilization.) OR patient meets additional clinical criteria outlined below. **Focalin, Adderall, Ritalin:** the patient must have had a documented intolerance to the preferred generic equivalent. **Methamphetamine and Desoxyn:** Given the high abuse potential of methamphetamine and Desoxyn, the patient must have a diagnosis of ADD, ADHD or narcolepsy and have failed all preferred treatment alternatives. In addition, for approval of brand name Desoxyn, the patient must have had a documented intolerance to generic methamphetamine. **Methylphenidate chewable tablets:** patient has a documented intolerance to methylphenidate and Methylin solution. **Evekeo ODT, Dextroamphetamine oral solution:** patient has a medical necessity for a non-solid oral dosage form. (e.g. swallowing disorder). AND the patient has a documented intolerance Procentra oral solution. **Amphetamine Sulfate, Dextroamphetamine IR, Zenzedi, Evekeo:** the patient has had a documented side-effect, allergy, or treatment failure of at least 2 preferred agents (If a product has an AB rated generic, there must have been a trial of the generic.)
LONG ACTING STIMULANTS		
METHYLPHENIDATE PRODUCTS **ORAL** CONCERTA® (methylphenidate SA OSM IR/ER, 22:78%) DEXMETHYLPHENIDATE SR 24 HR IR/ER, 50:50% (compare to Focalin XR®) FOCALIN® XR (dexmethylphenidate SR 24 HR IR/ER, 50:50%) METHYLPHENIDATE SR 24 HR, IR/ER, 50:50% (compare to Ritalin LA®) QUILLICHEW ER ™ (methylphenidate IR/ER, 30:70%) chewable tablets RITALIN LA® (methylphenidate SR 24 HR, IR/ER, 50:50%) **ORAL SUSPENSION** QUILLIVANT XR® (methylphenidate IR/ER, 20:80%) *QTY LIMIT:* 1 bottle (60ml, 120ml, 150ml)/30days 2 bottles (180ml)/30days	Adhansia ® XR (methylphenidate IR/ER 20:80%) *QTY LIMIT:* 1 capsule/day Aptensio® XR (methylphenidate DR 24HR IR/ER, 40:60%) Cotempla® XR (methylphenidate IR/ER 25:75%) ODT Jornay PM™ (methylphenidate ER) capsules *QTY LIMIT:* 1 capsule/day Methylphenidate CR, IR/ER, 30:70% (compare to Metadate CD®) Methylphenidate SA OSM IR/ER, 22:78% (compare to Concerta®)	**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. **Methylphenidate CR:** patient has had a documented side-effect, allergy, or treatment failure on one preferred long-acting Methylphenidate product. **Adhasia XR, Cotempla XR ODT, Jornay PM:** patient has had a documented side-effect, allergy, or treatment failure on 3 preferred long-acting Methylphenidate products. **Aptensio XR:** patient has had a documented side effect, allergy, or treatment failure on two preferred long-acting Methylphenidate products. **Methylphenidate SA OSM:** the patient must have a documented intolerance to brand Concerta.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
TRANSDERMAL All products require PA	Daytrana® (methylphenidate patch) *QTY LIMIT:* 1 patch/day	**Daytrana patch:** patient has a documented medical necessity for a specialty non-oral dosage form.
AMPHETAMINE PRODUCTS **ORAL** ADDERALL XR® (amphetamine/dextroamphetamine SR 24 HR, IR/ER, 50:50%) AMPHETAMINE/DEXTROAMPHETAMINE SR 24 HR, IR/ER, 50:50% (compare to Adderall XR®) VYVANSE® (lisdexamfetamine) capsule *QTY LIMIT:* 1 cap /day	Adzenys XR® ODT (amphetamine SR 24 HR, IR/ER, 50:50%) *QTY LIMIT:* 1 cap/day Adzenys ER™ suspension (amphetamine SR 24 HR, IR/ER, 50:50%) Dyanavel ™ suspension (amphetamine/dextroamphetamine SR) *QTY LIMIT*: 240ml/30days Dexedrine CR® (dextroamphetamine 24 HR SR) Dextroamphetamine 24 HR SR (compare to Dexedrine CR®) Mydayis® (mixed amphetamine salts) extended-release capsules Vyvanse® (lisdexamfetamine) chewable tablet *QTY LIMIT*: 1 tab/day	**Adzenys XR ODT, Adzenys ER suspension, Dyanavel XR suspension, Vyvanse Chew:** patient must be unable to tolerate Adderall XR sprinkled onto applesauce or Vyvanse mixed with yogurt, water, or orange juice. **Dexedrine CR, Dextroamphetamine SR, Mydayis:** patient must have a documented intolerance to two preferred amphetamine products. For approval of brand Dexedrine CR, the patient must also have a documented intolerance to the generic equivalent.
MISCELLANEOUS		
ARMODAFINIL (compare to Nuvigil®) *QTY LIMIT:* 50 mg = 2 tabs/day 150 mg/200 mg/250 mg = 1 tab/day, Max days supply = 30 days ATOMOXETINE (compare to Strattera®) *QTY LIMIT:* 10, 18, 25 and 40 mg = 2 capsules/day 60, 80 and 100 mg = 1 capsule/day FDA maximum recommended dose = 100 mg/day CLONIDINE ER *QTY LIMIT:* 4 tabs/day GUANFACINE ER (Intuniv®) MODAFINIL (compare to Provigil®) *QTY LIMIT:* 100 mg = 1.5 tablets/day; 200 mg = 2 tablets/day Maximum Daily Dose = 400 mg, Max day supply = 30 days	Intuniv® (guanfacine extended release) Tablet *QTY LIMIT:* 1 tablet/day Nuvigil® (armodafinil) *QTY LIMIT:* 50 mg = 2 tablets/day; 150 mg/200 mg/250 mg = 1 tablet/day, Max days supply = 30 days Provigil® (modafinil) *QTY LIMIT:* 100 mg = 1.5 tablets/day; 200 mg = 2 tablets/day Maximum Daily Dose = 400 mg, Max day supply = 30 days Qelbree™ (viloxazine hydrochloride) ER capsule *QTY LIMIT:* 100 mg = 1 capsule/day 150 mg/200 mg = 2 capsules/day FDA maximum recommended dose = 400 mg/day Strattera® (atomoxetine) *QTY LIMIT:* 10, 18, 25 and 40 mg = 2 capsules/day 60, 80 and 100 mg = 1 capsule/day FDA maximum recommended dose = 100 mg/day	**Intuniv, Nuvigil, Provigil, Strattera:** patient must have a documented intolerance to the generic equivalent. **Qelbree:** The patient has had a documented side effect, allergy, contraindication, or treatment failure to one preferred stimulant or there is a history of substance abuse with the patient or family of the patient AND the patient has had a documented side effect, allergy, or treatment failure to atomoxetine. **Sunosi:** patient has had a documented side effect, allergy, or treatment failure to 2 preferred agents (may be stimulant or non-stimulant) **Wakix:** indication for use is the treatment of excessive daytime sleepiness in narcolepsy AND patient has no known risk factors for increased QT prolongation (e.g. cardiac arrhythmias, symptomatic bradycardia, hypokalemia, or congenital prolongation of the QT interval) AND medication is not being used in combination with other drugs known to prolong the QT interval (e.g. antipsychotics, erythromycin, tricyclic antidepressants) AND patient has had a documented side effect, allergy, or treatment failure to at least 3 agents (may be preferred or non-preferred; may be stimulant or non-stimulant), one of which must be Sunosi. **Xyrem, Xywav** patient has had a documented side effect, allergy, or treatment failure to 2 preferred agents (may be stimulant or non-stimulant) and Sunosi AND patient has been enrolled in the REMS program AND for approval of Xywav, the patient

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Sunosi® (solriamfetol) tablet *QTY LIMIT:* 1 tablet/day FDA maximum recommended dose = 150 mg/day Wakix® (pitolisant) tablet *QTY LIMIT:* 2 tablets/day FDA maximum recommended dose = 35.6 mg/day Xyrem® (sodium oxybate) oral solution *QTY LIMIT:* 540 ml/30 days Xywav™ (calcium, magnesium, potassium, and sodium oxybates) solution QTY LIMIT: 9 g (18 mL)/day	must have a documented intolerance to Xyrem.
ALLERGEN IMMUNOTHERAPY		
	Oralair® *QTY LIMIT:* 1 tablet/day Palforzia® (peanut allergen powder-dnfp)	**Oralair:** • 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 **Palforzia:** • Patient age ≥ 4 years and ≤ 17 years for initial dose escalation or ≥ 4 years for up-dosing and maintenance • The prescriber is an allergist or immunologist • Prescriber must provide the testing to show that the patient is allergic to peanuts • Patient must not have a recent history of uncontrolled asthma, eosinophilic esophagitis, or other eosinophilic GI disease. • Prescriber, pharmacy, and patient must be registered with the REMS program • Patient must have an auto-injectable epinephrine on-hand • Initial approval will be granted for 6 months and includes approval for initial dose escalation and Up Dosing. Approval for Up Dosing may be extended if the patient was unable to tolerate all the dose levels at 2-week intervals. • For approval of Maintenance Dosing (300mg daily), pharmacy records will be evaluated to assess compliance with once daily therapy and ensure no level was missed during Up Dosing. Documentation must be provided

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		attesting that the patient has not experienced any treatment restricting adverse events (e.g. systemic allergic reactions, severe anaphylaxis).
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 5 mg and 10 mg *QTY LIMIT:* 1 tablet/day GALANTAMINE tablet RIVASTIGMINE (compare to Exelon®) capsule *QTY LIMIT:* 2 capsules/day	Aricept® (donepezil) Tablet *QTY LIMIT:* 1 tablet/day Donepezil (compare to Aricept ®) Tablet 23 mg Donepezil ODT (compare to Aricept® ODT) *QTY LIMIT:* 1 tablet/day Galantamine ER capsule (compare to Razadyne® ER) Razadyne ER® (galantamine) capsule	**Donepezil 23mg Tablet, Galantamine ER Capsule, Razadyne ER Capsule:** the patient has been started and stabilized on the requested medication (Note: samples are not considered adequate justification for stabilization) OR patient had a documented side effect, allergy or treatment failure to a preferred cholinesterase inhibitor. **Aricept:** the patient has a documented intolerance to the generic product. **Donepezil ODT, Galantamine Oral Solution, Rivastigmine patch:** medical necessity for a specialty dosage form has been provided. AND for approval of rivastigmine patch the patient has a documented intolerance to brand Exelon patch.
SOLUTION All products require PA	Galantamine (compare to Razadyne®) Oral Solution	
TRANSDERMAL EXELON® (rivastigmine transdermal) Patch *QTY LIMIT*: 1 patch/day	Rivastigmine (compare to Exelon®) patch *QTY LIMIT:* 1 patch/day	
NMDA RECEPTOR ANTAGONIST		
MEMANTINE Tablets	Memantine oral solution Memantine XR (compare to Namenda® XR) Oral	**Namenda:** Patient has a documented intolerance to the generic. **Memantine XR, Namenda XR:** Patient has not been able to tolerate twice daily

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	capsule *QTY LIMIT:* 1 capsule/day Namenda® (memantine) tablet Namenda® XR (memantine ER) Oral Capsule *QTY LIMIT:* 1 capsule/day	dosing of immediate release memantine, resulting in significant clinical impact. **Memantine Oral Solution:** medical necessity for a specialty dosage form has been provided.
CHOLINESTERASE INHIBITOR/NMDA COMBINATION		
All products require PA	Namzaric® (donepezil/memantine) Capsule *QTY LIMIT:* 1 capsule/day	**Namzaric:** Clinically compelling reason why the individual ingredients of donepezil and memantine cannot be used.
ANALGESICS		
MISCELLANEOUS: TOPICAL AND TRANSDERMAL PATCH		
LIDOCAINE 3% Cream LIDOCAINE 4% OTC Patch LIDOCAINE 4% cream LIDODERM® Patch (lidocaine 5%) *QTY LIMIT:* 3 patches/day LIDOCAINE 5% Ointment, Cream LIDOCAINE/PRILOCAINE 2.5-2.5% Cream SYNERA® (lidocaine/tetracaine) Patch	Lidocaine 5% patch (compare to Lidoderm®) *QTY LIMIT:* 3 patches/day Qutenza® Patch (capsaicin 8 %) *QTY LIMIT:* 4 patches/90 days Ztlido™ Patch (lidocaine 1.8%) *QTY LIMIT:* 3 patches/day (Note: Please refer to Analgesics: COX IIs and NSAIDs for topical NSAIDS)	**Lidocaine 5% patch:** the patient has had a documented intolerance to brand Lidoderm. **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 Lidoderm patch. OR patient has a medical necessity for transdermal formulation (ex. dysphagia, inability to take oral medications) AND patient has had a documented side effect, allergy, treatment failure or contraindication to Lidoderm patch.
OPIOIDS: SHORT ACTING		
ACETAMINOPHEN W/CODEINE (compare to Tylenol® w/codeine) (age >12 years) BUTALBITAL COMP. W/CODEINE (compare to Fiorinal® w/codeine) (age >12 years) CODEINE SULFATE (age >12 years) ENDOCET® (oxycodone w/ acetaminophen) HYDROCODONE (plain, w/acetaminophen, or w/ibuprofen) (some exceptions apply) *QTY LIMIT:* Hydrocodone/APAP = 12 tablets/day HYDROMORPHONE tablets (compare to Dilaudid®) MORPHINE SULFATE OXYCODONE (plain)	Acetaminophen w/hydrocodone: *all branded products* *QTY LIMIT:* = 12 tablets/day Acetaminophen w/oxycodone: *all branded products* *QTY LIMIT:* = 12 tablets/day Actiq® (fentanyl lozenge on a stick: 200 mcg, 400 mcg, 600 mcg, 800 mcg, 1200 mcg, 1600 mcg) Apadaz® (benzhydrocodone/APAP) *QTY LIMIT:* 12 tablets/day Benzhydrocodone/APAP (compare to Apadaz®) *QTY LIMIT:* 12 tablets/day Butorphanol Nasal Spray *QTY LIMIT:* 2 bottles/month Demerol (meperidine) Dilaudid®(hydromorphone) tablets Dilaudid-5®(hydromorphone) oral solution	**Note:** The initial fill for all short-acting opiates will be limited to 50 Morphine Milligram Equivalents (MME) and 7-day supply for patients ≥ 18 years of age OR 24 MME and 3-day supply for patients ≤ 17 years of age. **Butorphanol Nasal Spray:** documented site effect, allergy, treatment failure, or contraindication to codeine, hydrocodone, morphine, & oxycodone (all 4 generic entities) as single or combination products. OR is unable to use tablet or liquid formulations. **Actiq, Fentanyl transmucosal, Fentora:** indication of cancer breakthrough pain AND patient is opioid tolerant AND is on a long acting opioid formulation AND is 18 years of age or older (Actiq 16 years of age or older) AND prescriber is registered in the Transmucosal Immediate Release Fentanyl (TIRF) Risk Evaluation and Mitigation Strategy (REMS) Access program AND member has had a documented treatment failure with or intolerance to 2 of the following 3 immediate release treatment options: morphine, hydromorphone or oxycodone. OR is unable to use tablet or liquid formulations AND if the request is for brand name Actiq, member has a

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
OXYCODONE (w/acetaminophen, w/aspirin or w/ibuprofen) *QTY LIMIT:* Oxycodone/APAP = 12 tablets/day TRAMADOL (compare to Ultram®) *QTY LIMIT:* 8 tablets/day (Age ≥ 16) TRAMADOL/APAP (compare to Ultracet®) *QTY LIMIT:* 8 tablets/day (Age ≥18) ****NOTE: As of 5/1/21, a completed safety checklist must be submitted for new patients exceeding 90 MME per day, and existing patients exceeding 120 MME per day (applies to any combination of short and/or long acting opiates)**** **Note:** The FDA restricts the use of prescription codeine pain and cough medicines in children. Prior authorization is required for patients <12 years of age.	Fentanyl citrate transmucosal (compare to Actiq®) Fentora® (fentanyl citrate buccal tablets) Hydrocodone-Acetaminophen solution 10-325 Mg/15ml Hydromorphone oral solution (compare to Dilaudid-5®) Meperidine *QTY LIMIT*: 30 tablets/5-day supply per 30 days Nucynta® (tapentadol) Oxycodone (plain) capsules Oxymorphone (compare to Opana®) Pentazocine w/acetaminophen Pentazocine w/naloxone Qdolo® (tramadol) oral solution Ultracet® (tramadol w/ acetaminophen) *QTY LIMIT:* 8 tablets/day	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. **Qdolo:** The patient is ≥ 18 years of age AND medical necessity has been provided for a liquid formulation AND the patient has had a documented side effect, allergy or treatment failure with oxycodone oral solution and morphine oral solution **Ultracet:** member has a documented intolerance to the generic formulation **Other Short acting Opioids:** member has had a documented side effect, allergy, or treatment failure to at least 3 medications not requiring prior approval. (If a product has an AB rated generic, one trial must be the generic.) **PA requests to exceed daily cumulative MME limits:** • Non-Opioid alternatives (up to a maximum dose recommended by the FDA) and Non-Pharmacological Treatments have been considered, and any appropriate treatments are documented in the patient's medical records. Such treatments may include, but are not limited to: NSAIDs, Acetaminophen, Acupuncture, Chiropractic, Physical Therapy. • Vermont Prescription Monitoring System (VPMS) has been queried. • Patient education and informed consent have been obtained, and a Controlled Substance Treatment Agreement is included in the patient's medical record. • A reevaluation of the effectiveness and safety of the patient's pain management plan, including an assessment of the patient's adherence to the treatment regimen is completed no less than once every 90 days. • Patient has a valid prescription for or states they are in possession of naloxone. • Patients in nursing homes, receiving or eligible for hospice services, or those with chronic pain associated with cancer or cancer treatment are exempt from these requirements. **Limitations:** APAP containing products: daily doses that result in > 4 grams of acetaminophen/day will reject for PA; Meperidine 75 mg/ml injection no longer available – 25 mg/ml, 50 mg/ml and 100 mg/ml available. Brand name Demerol 75 mg/ml and 100 mg/2ml not covered - no generic equivalents. `
OPIOIDS: LONG ACTING		
<u>TRANSDERMAL</u> BUTRANS (buprenorphine) TRANSDERMAL SYSTEM *QTY LIMIT:* 4 patches/28 days (Maximum 28-day fill) FENTANYL PATCH (compare to Duragesic®)	Buprenorphine patch (compare to Butrans®) *QTY LIMIT:* 4 patches/28 days) (Maximum 28-day Fill) Fentanyl patch 37.5 mcg/hr, 62.5 mcg/hr, 87.5 mcg/hr	**CLINICAL CONSIDERATIONS:** Long acting opioid dosage forms are intended for use in opioid tolerant patients only. These tablet/capsule/topical medication strengths may cause fatal respiratory depression when administered to patients not previously exposed to opioids. LA opioids should be prescribed for patients with a diagnosis or condition that requires a continuous, around-the-clock analgesic. LA opioids should be reserved for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
QTY LIMIT: 12 mcg/hr, 25 mcg/hr, 50 mcg/hr = 15 patches/30 days, 75 mcg/hr, 100 mcg/hr = 30 patches/30 days **BUCCAL** All products require PA **ORAL** MORPHINE SULFATE CR 12 hr tablet (compare to MS Contin®) *QTY LIMIT:* 90 tablets/strength/30 days	Belbuca® (buprenorphine hcl buccal film) *QTY LIMIT:* 56 films/28 days (Maximum 28-day fill) Conzip® (tramadol ER biphasic release) capsule *QTY LIMIT:* 1 capsule/day Hydromorphone XR tablet *QTY LIMIT:* 30 tablets/30 days (8 mg, 12 mg, 16 mg tabs) Methadone5 mg, 10 mg tablets Methadone oral solution (no PA required for patient less than 1 year old) Methadone oral concentrate 10 mg/ml Morphine sulfate SR 24hr capsule (compare to Kadian®) *QTY LIMIT:* 60 capsules/strength/30 days Morphine sulfate SR beads 24hr capsule *QTY LIMIT:* 30 capsules/strength/30 days MS Contin® (morphine sulfate CR 12 hr) tablets *QTY LIMIT:* 90 tablets/strength/30 days Oxymorphone ER *QTY LIMIT:* 60 tablets/strength/30 days Nucynta ER® (tapentadol ER) *QTY LIMIT:* 2 tablets/day Tramadol SR (compare to Ultram ER®) *QTY LIMIT:* 1 tablet/day Tramadol ER biphasic-release® capsule *QTY LIMIT:* 150 mg = 1 capsule/day Tramadol ER biphasic-release tablet (formerly Ryzolt®) *QTY LIMIT:* 1 tablet/day Zohydro ER® (hydrocodone bitartrate)	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 **Fentanyl patches 37.5mcg/hr, 62.5mcg/hr, 87.5mcg/hr:** provider must submit clinical rationale detailing why the patient is unable to use a combination of the preferred strengths. **Methadone Tablet:** patient has had a documented side effect, allergy, or treatment failure to morphine sulfate CR 12 hr tablets AND the initial methadone daily dose does not exceed 30mg (Note: Methadone products, when used for treatment of opioid addiction in detoxification or maintenance programs, shall be dispensed ONLY by certified opioid treatment programs as stipulated in 42 CFR 8.12, NOT retail pharmacy.) **Methadone Liquid:** Patient must have a medical necessity for an oral liquid (i.e. swallowing disorder, inability to take oral medications) AND the initial daily dose does not exceed 30mg OR patient has been started and stabilized on the requested oral liquid medication. (Note: Methadone products, when used for treatment of opioid addiction in detoxification or maintenance programs, shall be dispensed ONLY by certified opioid treatment programs as stipulated in 42 CFR 8.12, NOT retail pharmacy.) **Conzip, Tramadol ER biphasic-release Capsule, Tramadol ER biphasic-release Tablet, Tramadol ER/SR:** member has had a documented treatment failure to a preferred short-acting tramadol product. In addition, for approval of tramadol ER biphasic-release capsule or tablet or the patient must have a documented intolerance to generic tramadol ER/SR. **Oral Non-Preferred (except methadone & tramadol containing products):** the patient has had a documented side effect, allergy, or treatment failure to morphine sulfate CR 12hr tablet (generic) AND generic fentanyl patch. (If a product has an AB rated generic, there must have been a trial of the generic). AND the patient must have a documented side effect, allergy, or treatment failure to the preferred abuse deterrent formulation (Xtampza ER) before OxyContin will be approved. **Hysingla ER/Zohydro ER:** Available with PA for those unable to tolerate any preferred medications. All requests will go to the DVHA Medical Director for approval. **PA requests to exceed daily cumulative MME limits:** • Non-Opioid alternatives (up to a maximum dose recommended by the FDA) and Non-Pharmacological Treatments have been considered, and

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ORAL, ABUSE-DETERRENT FORMULATIONS XTAMPZA ER® (oxycodone ER) *QTY LIMIT:* 60 caps/strength/30days ****NOTE: As of 5/1/21, a completed safety checklist must be submitted for new patients exceeding 90 MME per day, and existing patients exceeding 120 MME per day (applies to any combination of short and/or long acting opiates)****	Hysingla ER® (hydrocodone bitartrate) *QTY LIMIT:* 1 tablet/ day Oxycodone ER (compare to OxyContin®) *QTY LIMIT:* 90 tablets/strength/30 days OxyContin® (Oxycodone ER) *QTY LIMIT:* 90 tablets/strength/30 days	any appropriate treatments are documented in the patient's medical records. Such treatments may include, but are not limited to: NSAIDs, Acetaminophen, Acupuncture, Chiropractic, Physical Therapy. • Vermont Prescription Monitoring System (VPMS) has been queried. • Patient education and informed consent have been obtained, and a Controlled Substance Treatment Agreement is included in the patient's medical record. • A reevaluation of the effectiveness and safety of the patient's pain management plan, including an assessment of the patient's adherence to the treatment regimen is completed no less than once every 90 days. • Patient has a valid prescription for or states they are in possession of naloxone. • Patients in nursing homes, receiving or eligible for hospice services, or those with chronic pain associated with cancer or cancer treatment are exempt from these requirements. **Limitations:** Methadone 40mg dispersible tablet not approved for retail dispensing.
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®) *QTY LIMIT:* 20 doses/5 day supply every 90 day MECLOFENAMATE SODIUM MELOXICAM tabs (compare to Mobic®) NABUMETONE NAPROXEN (compare to Naprosyn®) 250 mg, 375 mg, 500 mg NAPROXEN ENTERIC COATED (compare to EC-Naprosyn®) 375 mg, 500 mg NAPROXEN SODIUM OTC 220 mg OXAPROZIN (compare to Daypro®)	Cambia® (diclofenac potassium) packet for oral solution *QTY LIMIT:* 9 packets/month Daypro® (oxaprozin) EC-Naprosyn® (naproxen sodium enteric coated) Etodolac ER Feldene® (piroxicam) Fenoprofen 400 mg 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 oral suspension Naproxen Sodium 275 mg and 550 mg (compare to Anaprox, Anaprox DS®) Naproxen sodium ER Qmiiz (meloxicam) ODT™ Relafen® DS (nabumetone)	**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. **Celebrex**: patient has had a documented intolerance to generic celecoxib. **Pennsaid:** patient has had a documented side effect or inadequate response to Diclofenac gel or topical solution. **Diclofenac Patch, Licart:** patient has had a documented side effect or inadequate response to Diclofenac gel or topical solution AND patient has a documented intolerance to brand Flector Patch. **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

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
PIROXICAM (compare to Feldene®) SULINDAC **ORAL** **COX-II Selective** CELECOXIB *QTY LIMIT*: 2 caps/day **INJECTABLE** KETOROLAC Injection (formerly Toradol®) *QTY LIMIT:* 1 dose per fill **NASAL SPRAY** All products require PA **TOPICAL** DICLOFENAC (compare to Voltaren®) gel 1% DICLOFENAC 1.5 % Topical Solution **TRANSDERMAL** Flector® (diclofenac) 1.3 % Patch *QTY LIMIT:* 2 patches/day **NSAID/ANTI-ULCER** All products require PA Note: Please refer to "Dermatological: Actinic Keratosis Therapy" for Solaraze® or Diclofenac 3% Gel	Tivorbex (indomethacin) capsules *QTY LIMIT:* 3 caps/day Vivlodex® (meloxicam) capsules Zipsor® (diclofenac potassium) Zorvolex® (diclofenac) Capsules *QTY LIMIT: 3 capsules/day* Sprix® (ketorolac) Nasal Spray *QTY LIMIT:* 5 bottles/5 days – once every 90 days Pennsaid® (diclofenac) 2% Topical Solution Diclofenac (compare to Flector®) 1.3% Patch *QTY LIMIT:* 2 patches/day Licart® (diclofenac epolamine) 1.3% Patch QTY LIMIT: 1 patch/day Arthrotec® (diclofenac sodium w/misoprostol) Diclofenac sodium w/misoprostol (compare to Arthrotec®) Duexis® (ibuprofen/famotidine) *QTY LIMIT:* 3 tablets/day Vimovo® (naproxen/esomeprazole) *QTY LIMIT:* 2 tablets/day	form (i.e. inability to take medication orally (NPO)). **Relafen DS:** patient has had a documented side effect, allergy, or treatment failure to 4 or more preferred generic NSAIDs, including generic nabumetone. **Tivorbex:** patient has had a documented side effect, allergy, or treatment failure to 4 or more preferred generic NSAIDs, including generic indomethacin. **Qmiiz, Vivlodex:** patient has had a documented side effect, allergy, or treatment failure to 4 or more preferred generic NSAIDs, including generic meloxicam. **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 generic NSAIDs due to one of the following: Patient is 60 years of age or older, Patient has a history of GI bleed, Patient is currently taking an oral corticosteroid, Patient is currently taking methotrexate AND patient is unable to take naproxen and a preferred proton pump inhibitor, separately. **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 AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
Preferred After Clinical Criteria Are Met ENBREL® (etanercept) *QTY LIMIT*:50 mg = 4 syringes/28 days, 25 mg = 8 syringes/28 days HUMIRA® (adalimumab) *QTY LIMIT*:2 syringes/28 days TALTZ® (ixekizumab) *QTY LIMIT*: 80 mg prefilled syringe or autoinjector = 2/28 days for the first month and 1/28 days subsequently	Avsola® (infliximab-axxq) biosimilar to Remicade® Cimzia® (certolizumab pegol) *QTY LIMIT:* 1 kit/28 days (starter X 1, then regular) Cosentyx® (secukinumab) Subcutaneous Inflectra® (infliximab-dyyb) biosimilar to Remicade® Remicade® (infliximab) Renflexis™ (infliximab-abda) biosimilar to Remicade® Simponi® (golimumab) Subcutaneous *QTY LIMIT:* 50 mg prefilled syringe or autoinjector = 1/28 days	**Clinical Criteria:** **For all drugs:** patient has a diagnosis of ankylosing spondylitis (AS) and has already been stabilized on the medication being requested. OR patient has a confirmed diagnosis of AS, and conventional NSAID treatment and DMARD therapy (e.g. methotrexate therapy) resulted in an adverse effect, allergic reaction, inadequate response, or treatment failure. If methotrexate is contraindicated, another DMARD should be tried. **Additional criteria for Taltz:** the patient had a trial and failure or contraindication to Humira. **Additional criteria for Cimzia, Remicade, Renflexis, Simponi:** the prescriber must provide a clinically valid reason why at least 2 preferred agents cannot be used. **Note:** Patient must be ≥ 18 years of age for Simponi approval as safety and efficacy has not been established in pediatric patients. **Additional criteria for Avsola, Inflectra:** the prescriber must provide a clinically valid reason why at least 2 preferred agents cannot be used, and the patient must be unable to use Remicade or Renflexis. * Patients with documented diagnosis of active axial involvement should have a trial with two NSAIDs, but a trial with DMARD is not required. If no active axial skeletal involvement, then NSAID trial and a DMARD trial are required (unless otherwise contraindicated).
ANTI-ANXIETY: ANXIOLYTICS		
BENZODIAZEPINE		
CHLORDIAZEPOXIDE (formerly Librium®) CLONAZEPAM (compare to Klonopin®) *QTY LIMIT:* 4 tabs/day except 2 mg. 2 mg = 3 tabs/day CLONAZEPAM ODT (formerly Klonopin Wafers®) *QTY LIMIT:* 4 tabs/day except 2 mg. 2 mg = 3 tabs/day DIAZEPAM (compare to Valium®) LORAZEPAM (compare to Ativan®) *QTY LIMIT:* 4 tablets/day OXAZEPAM (formerly Serax®)	Alprazolam (compare to Xanax®) *QTY LIMIT:* 4 tablets/day Alprazolam ER, alprazolam XR® (compare to Xanax XR®) *QTY LIMIT:* 2 tablets/day Alprazolam ODT (compare to Niravam®) *QTY LIMIT:* 3 tablets/day Alprazolam Intensol® (alprazolam concentrate) Ativan® (lorazepam) *QTY LIMIT:* 4 tablets/day Clorazepate tabs (compare to Tranxene T®) Diazepam Intensol® (diazepam concentrate) Klonopin® (clonazepam) *QTY LIMIT:* 4 tabs/day except 2 mg. 2 mg = 3 tabs/day Lorazepam Intensol® (lorazepam concentrate)	**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 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.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Niravam® (alprazolam ODT) *QTY LIMIT:* 3 tablets/day Tranxene T® (clorazepate tablets) Valium® (diazepam) Xanax® (alprazolam) *QTY LIMIT: 4* tablets/day Xanax XR® (alprazolam XR) *QTY LIMIT:* 2 tablets/day	
NON-BENZODIAZEPINE		
BUSPIRONE (formerly Buspar®) HYDROXYZINE HYDROCHLORIDE (formerly Atarax®) HYDROXYZINE PAMOATE (compare to Vistaril®) (all strengths except 100 mg) MEPROBAMATE	Hydroxyzine Pamoate (100 mg strength ONLY) (compare to Vistaril®) Vistaril® (hydroxyzine pamoate)	**Hydroxyzine Pamote 100mg strength ONLY:** patient is unable to use generic 50 mg capsules. **Vistaril:** patient has a documented intolerance to the generic formulation.
ANTICOAGULANTS		
ORAL		
VITAMIN K ANTAGONIST WARFARIN (compare to Coumadin®) **DIRECT THROMBIN INHIBITOR** PRADAXA® (dabigatran etexilate) *QTY LIMIT:* 2 capsules/day **FACTOR XA INHIBITOR** ELIQUIS® (apixaban) *QTY LIMIT:* 2 tablets/day *QTY LIMIT:* 5mg = 4 tablets/day for 7 days if indication is treatment of DVT or PE (followed by 5 mg twice daily) XARELTO® (rivaroxaban) *QTY LIMIT:* 10 mg = 1 tablet/day *QTY LIMIT:* 15 mg and 20 mg = 1 tablet/day *QTY LIMIT:* 15 mg = 2 tablets/day for 21 days if indication is treatment of DVT or PE (followed by 20mg once daily) *QTY LIMIT:* Starter Pack (15 mg/20 mg) = 51 tablets/30days	Savaysa® (edoxaban) *QTY LIMIT:* 1 tablet/daily	**Savaysa:** creatinine clearance is documented to be < 95 ml/min AND prescriber has provided another clinically valid reason why generic warfarin, Pradaxa, Xarelto or Eliquis cannot be used. A yearly creatinine clearance is required with renewal of PA request

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
Preferred After Clinical Criteria Are Met XARELTO® (rivaroxaban) 2.5 mg *QTY LIMIT:* 2 tablets/day)		**Xarelto 2.5 mg:** Patient has a diagnosis of chronic coronary artery disease (CAD) or peripheral artery disease (PAD) AND medication is being used concurrently with aspirin.
INJECTABLE		
UNFRACTIONATED HEPARIN INJECTABLE HEPARIN **LOW MOLECULAR WEIGHT HEPARINS INJECTABLE** ENOXAPARIN (compare to Lovenox®) *QTY LIMIT:* 2 syringes/day calculated in ml volume **SELECTIVE FACTOR XA INHIBITON INJECTABLE** All products require PA	Fragmin® (dalteparin) Lovenox® (enoxaparin) *QTY LIMIT:* 2 syringes/day calculated in ml volume Arixtra® (fondaparinux) Fondaparinux (compare to Arixtra®)	**Arixtra, Fondaparinux, Lovenox and Fragmin**: patient has a documented intolerance to generic enoxaparin AND if the request is for brand Arixtra, the patient must also have a documented intolerance to generic fondaparinux.
ANTICONVULSANTS		
ORAL		
CARBAMAZEPINE tablets (compare to Tegretol®) CARBAMAZEPINE capsules (compare to Carbatrol®) CARBAMAZEPINE extended release (compare to Tegretol XR®) CELONTIN® (methsuxamide) CLOBAZAM (compare to Onfi®) *QTY LIMIT:* 10 mg = 3 tabs/day, 20 mg = 2 tabs/day CLONAZEPAM (compare to Klonopin®) *QTY LIMIT:* 4 tablets/day CLONAZEPAM ODT (formerly Klonopin Wafers®) *QTY LIMIT:* 4 tablets/day DIAZEPAM (compare to Valium®) DILVALPROEX SODIUM capsules (compare to Depakote Sprinkles®) DIVALPROEX SODIUM (compare to Depakote®) DIVALPROEX SODIUM ER (compare to Depakote	Aptiom® (eslicarbazepine acetate) *QTY LIMIT:*200, 400, and 800 mg = 1 tab/day 600 mg = 2 tabs/day Banzel® (rufinamide) *QTY LIMIT:* 400 mg = 8 tabs/day, 200 mg = 16 tabs/day Banzel® (rufinamide) oral suspension *QTY LIMIT:* 80 ml/day (3,200 mg/day) Briviact® (brivaracetam) tablets, oral suspension Carbatrol® (carbamazepine) capsules Clorazepate (compare to Tranxene-T®) tablets Depakote® (divalproex sodium) Depakote ER® (divalproex sodium) Depakote Sprinkles® (divalproex sodium caps) Diacomit® (stiripentol) Dilantin® (phenytoin) chewable tablets, capsules, 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. **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). **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, Depakote, Depakote ER, Depakote Sprinkles, Dilantin, Keppra tablets or oral solution, Klonopin, Klonopin Wafers, Lamictal tablets or chew tablets, Lyrica, Mysoline, Neurontin capsules, tablets, solution, Onfi,**

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
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 solution (compare to Keppra® oral solution) OXCARBAZEPINE tablets (compare to Trileptal®) OXCARBAZEPINE oral suspension (compare to Trileptal®) PEGANONE® (ethotoin) PHENYTOIN (compare to Dilantin®) PHENYTOIN EX cap (compare to Phenytek®) PREGABALIN capsules (compare to Lyrica) *QTY LIMIT:*3 capsules/day PRIMIDONE (compare to Mysoline®) TEGRETOL® (carbamazepine) suspension TEGRETOL XR® (carbamazepine) 100 mg ONLY TOPIRAMATE ER TOPIRAMATE tabs (compare to Topamax® tabs) TOPIRAMATE sprinkle caps (compare to Topamax® Sprinkles) VALPROIC ACID ZONISAMIDE	Elepsia™ (levetiracetam) extended release Epidiolex® (cannabidiol) oral solution *QTY LIMIT:* 20 mg/kg/day (LGS or DA indication) or 25mg/kg/day (TSC indication) Felbamate (compare to Felbatol®) Fintepla® (fenfluramine) oral solution Felbatol® (felbamate) Fycompa® (perampanel) tablets *QTY LIMIT:* 1 tablet/day Keppra®* (levetiracetam) tablets, oral solution Keppra XR® (levetiracetam extended release) Klonopin® (clonazepam) *QTY LIMIT:* 4 tablets/day Lamictal® tabs (lamotrigine tabs) Lamictal® chew tabs (lamotrigine chew tabs) Lamictal ODT® (lamotrigine orally disintegrating tablets) Lamictal XR® tablets (lamotrigine extended release) Lamotrigine ER (compare to Lamictal XR®) Lamotrigine ODT (compare to Lamictal ODT®) Levetiracetam ER (compare to Keppra XR®) Lyrica® (pregabalin) capsules *QTY LIMIT:* 3 capsules/day Lyrica® (pregabalin) oral solution Mysoline® (primidone) Neurontin® (gabapentin) capsules, tablets and solution Onfi® (clobazam) Oral Suspension 2.5 mg/ml *QTY LIMIT:* 16 ml/day Onfi® (clobazam) Tablets *QTY LIMIT:* 10 mg = 3 tabs/day, 20 mg = 2 tabs/day Oxtellar® XR (oxcarbazapine ER) tablet Pregabalin oral solution (compare to Lyrica®) Qudexy® XR (topiramate) capsules Sabril® (vigabatrin) Spritam® (levetiracetam) tablets for oral suspension Sympazan® (clobazam) films Tegretol® (carbamazepine) tablets Tegretol XR® (carbamazepine) (200 and 400 mg strengths)	**Phenytek, Tegretol tablets, Tegretol XR (200 mg & 400 mg), Topamax tabs, Topamax sprinkles, Trileptal tablets, Trileptal oral suspension, Zarontin:** patient has had a documented intolerance to the generic equivalent of the requested medication. **Clorazepate, Fycompa, Tranxene-T:** diagnosis is adjunctive therapy of partial-onset seizures OR diagnosis is adjunctive therapy for primary generalized tonic-clonic seizures (Fycompa only) AND the patient has had a documented side effect, allergy, treatment failure, inadequate response, or a contraindication to at least TWO preferred anticonvulsants. AND for approval of Tranxene-T the patient must have a documented intolerance to the generic equivalent. **Diacomit:** Diagnosis or indication is treatment of Dravet Syndrome AND neutrophil and platelet counts have been obtained prior to starting therapy and are monitored periodically thereafter AND Patient is unable to tolerate or has had an inadequate response to valproate and clobazam AND medication will used concurrently with clobazam. **Note:** There are no clinical data to support the use of Diacomit as monotherapy. **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 *Diagnosis or indication is Tuberous Sclerosis Complex:* 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 or vigabatrin. **Felbamate, Felbatol:** patient information/consent describing aplastic anemia and liver injury has been completed AND diagnosis is adjunctive therapy of partial-onset seizures or Lennox-Gastaut seizures and the patient has had a documented side effect, allergy, treatment failure/inadequate response or a contraindication to at least THREE preferred anticonvulsants. Additionally, if brand is requested, the patient has a documented intolerance to the generic product. **Fintepla:** Diagnosis or indication is treatment of Dravet Syndrome AND patient has had a documented side effect, allergy, treatment failure/inadequate response or contraindication to at least two preferred anticonvulsants and Epidiolex AND prescriber, pharmacy and patient are registered with the REMS

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	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 *QTY LIMIT*:200 mg = 2 caps/day, all other strengths = 1 cap/day Vigabatrin (compare to Sabril®) Vimpat® (lacosamide) tablets, oral solution Xcopri® (cenobamate) tablets *QTY LIMIT*:200 mg = 2 tabs/day, all other strengths = 1 tab/day Zarontin® (ethosuximide)	programs AND for reapproval, the patient must have a documented decrease from baseline in seizure frequency per 28 days. **Elepsia XR, Keppra XR, Lamictal XR, Lamotrigine ER, 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 Elepsia XR, 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 approval of brand Lamictal ODT, the patient must have a documented intolerance to the generic equivalent. **Lyrica oral solution, Pregabalin oral solution:** the patient is unable to use pregabalin capsules (i.e. swallowing disorder). For approval of brand Lyrica oral solution, the patient must have a documented intolerance to the generic equivalent. **Qudexy XR, Trokendi XR:** patient has failed treatment with topiramate ER. **Spritam**: medical necessity for a specialty dosage form has been provided AND patient must have a documented intolerance to levetiracetam oral solution. **Sympazan:** diagnosis or indication is adjunctive treatment of refractory epilepsy (may include different types of epilepsy) AND patient has had a documented side effect, allergy, treatment failure, inadequate response or a contraindication to at least TWO preferred anticonvulsants AND prescriber must provide a clinically compelling reason why the patient is unable to use Clobazam tablets AND Clobazam suspension **Tiagabine generic:** patient has had a documented intolerance to the brand name product. **Sabril, Vigabatrin:** prescriber and patient are registered with the REMS program AND diagnosis is infantile spasms OR patient is > 16 years old and the indication is adjunctive therapy in refractory complex partial seizures and failure of THREE other preferred anticonvulsants. **Vimpat:** diagnosis is monotherapy or adjunctive therapy of partial-onset seizures and the patient has had a documented side effect, allergy, treatment failure/inadequate response or a contraindication to at least TWO preferred anticonvulsants AND if the request is for the oral solution, the patient is unable to use Vimpat tables (e.g. swallowing disorder). **Xcopri: t**he diagnosis is adjunctive therapy of partial-onset seizures AND the patient is ≥ 18 years of age AND the patient has had a documented side effect, allergy, treatment failure/inadequate response or a contraindication to at least TWO preferred anticonvulsants AND for reapproval, the patient must have a documented decrease from baseline in seizure frequency per 28 days. **PA Requests to Exceed *QTY LIMIT* for clonazepam/clonazepam ODT or Klonopin**: all requests will be referred to the DVHA Medical Director for review unless the patient has been started and stabilized on the requested quantity for treatment of a seizure disorder.
NASAL		
NAYZILAM® (midazolam) nasal spray (age ≥ 12		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
years) *QTY LIMIT:* 10 units/30 days VALTOCO® (diazepam) nasal spray (age ≥ 6 years) *QTY LIMIT:* 20 units/30 days		
RECTAL		
DIAZEPAM (compare to Diastat®) rectal gel	Diastat® (diazepam) rectal gel	**Diastat:** patient has had a documented intolerance to the generic equivalent
ANTIDEPRESSANTS		
MAO INHIBITORS		
PHENELZINE SULFATE (compare to Nardil®) FDA maximum recommended dose = 90 mg/day TRANYLCYPROMINE FDA maximum recommended dose = 60 mg/day	Emsam® (selegiline) *QTY LIMIT:* 1 patch/day Marplan® (isocarboxazid) Nardil® (phenylzine) FDA maximum recommended dose = 90 mg/day	**Marplan:** patient has been started and stabilized on the requested medication (Note: samples are not considered adequate justification for stabilization). OR patient has had a documented side effect, allergy, or treatment failure to phenelzine and tranylcypromine. **Nardil:** patient has had a documented intolerance to generic equivalent product. **Emsam:** patient has had a documented side effect, allergy, or treatment failure with at least 3 antidepressants from 2 of the major antidepressant classes (Miscellaneous, SNRIs, SSRIs, and Tricyclic Antidepressants). OR patient is unable to tolerate oral medication.
MISCELLANEOUS		
BUPROPION SR (compare to Wellbutrin SR®) FDA maximum recommended dose = 400mg/day BUPROPION XL (compare to Wellbutrin XL®) 150 mg, 300 mg FDA maximum recommended dose = 450 mg/day BUPROPION FDA maximum recommended dose = 450 mg/day MAPROTILINE FDA maximum recommended dose = 225 mg/day MIRTAZAPINE (compare to Remeron®) FDA maximum recommended dose = 45 mg/day MIRTAZAPINE RDT (compare to Remeron Sol-Tab®) FDA maximum recommended dose = 45 mg/day TRAZODONE HCL (formerly Desyrel®) FDA maximum recommended dose = 600 mg/day	Aplenzin® (bupropion hydrobromide) ER tablets *QTY LIMIT:* 1 tablet/day Bupropion XL 450mg (compare to Forfivo XL®) *QTY LIMIT:* 1 tablet/day FDA maximum recommended dose = 450 mg/day Forfivo XL® (bupropion SR 24hr) 450 mg tablet *QTY LIMIT:*1 tablet/day FDA maximum recommended dose = 450 mg/day Nefazodone FDA maximum recommended dose = 600 mg/day Remeron® (mirtazapine) FDA maximum recommended dose = 45 mg/day Remeron Sol Tab® (mirtazapine RDT) FDA maximum recommended dose = 45 mg/day Spravato® (esketamine) nasal spray *QTY LIMIT:* not to exceed FDA recommended dose and frequency for corresponding timeframe Trintellix® (vortioxetine) Tablet	**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 inadequate response to at least 3 different antidepressants from the SSRI, SNRI and/or Miscellaneous Antidepressant categories (may be preferred or non-preferred), one of which must be bupropion XL. **Bupropion XL 450mg, Forfivo XL**: The patient is unable to take the equivalent dose as generic bupropion XL (150mg & 300mg) AND for approval of brand, the patient must have a documented intolerance to the generic equivalent. **Nefazodone:** The patient 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. **Spravato**: the patient has a diagnosis of treatment resistant depression AND the patient is ≥ 18 years of age AND medication is being used as adjunct treatment

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	QTY LIMIT: 1 tablet/day Viibryd® (vilazodone) Tablet *QTY LIMIT:* 1 tablet/day Wellbutrin SR® (bupropion SR) FDA maximum recommended dose = 400 mg/day Wellbutrin XL® (bupropion XL) FDA maximum recommended dose = 450 mg/day Zulresso™ (brexanolone) intravenous solution	with an oral antidepressant AND the patient has a documented treatment failure (defined by at least 8 weeks of therapy) with at least 2 different antidepressants from the SSRI, SNRI, and/or Miscellaneous Antidepressant categories (may be preferred or nonpreferred) AND the healthcare site and patient are enrolled in the Spravato® REMS program. Initial approval will be granted for 3 months. For re-approval after 3 months, the patient must have documented improvement in symptoms. **Note:** Spravato® will be approved as a medical benefit ONLY and will NOT be approved if billed through pharmacy point of sale. **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 8 weeks of therapy) to at least 2 different antidepressants from the SSRI, SNRI, and/or Miscellaneous Antidepressant categories (may be preferred or non-preferred). **Zulresso:** Patient is ≥ 18 years of age and ≤ 6 months postpartum AND patient has a diagnosis of postpartum depression (PPD) with documented onset of symptoms occurring in the third trimester or within 4 weeks of delivery AND the patient has a documented treatment failure (defined by at least 8 weeks of therapy) with two different oral antidepressants unless contraindicated or documentation shows that the severity of depression would place the health of the mother or infant at significant risk AND the pharmacy, patient, and healthcare facility are enrolled in the REMS program. Note: Zulresso™ will be approved as a medical benefit ONLY and will NOT be approved if billed through pharmacy point of sale. **Note:** After a 4-month lapse in use of a non-preferred agent for a mental health indication, or if there is a change in therapy, a lookback through claims information will identify the need to re-initiate therapy following the PDL and clinical criteria.
SNRI		
DULOXETINE (compare to Cymbalta®) capsule *QTY LIMIT:* 2 capsules/day FDA maximum recommended dose = 120 mg/day (MDD and GAD), 60 mg/day all others VENLAFAXINE ER capsule (compare to Effexor XR®) *QTY LIMIT:* 37.5 mg and 75 mg = 1 capsule/day FDA maximum recommended dose = 225 mg/day VENLAFAXINE IR tablet FDA maximum recommended dose = 225 mg/day	Cymbalta® (duloxetine) capsule *QTY LIMIT:* 2 capsules/day FDA maximum recommended dose = 120 mg/day (MDD and GAD), 60 mg/day all others Desvenlafaxine base SR *QTY LIMIT:* 50 mg tablet only = 1 tablet/day FDA maximum recommended dose = 400 mg/day Desvenlafaxine succinate ER (compare to Pristiq®) *QTY LIMIT:* 50 mg tablet only = 1 tablet/day FDA maximum recommended dose = 400 mg/day Drizalma® (duloxetine) sprinkle capsule QTY LIMIT: 2 capsules/day FDA maximum recommended dose = 120 mg/day (MDD and GAD), 60 mg/day all others	**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 ER tablet (generic), Effexor XR Capsule (brand), Desvenlafaxine ER succinate, Pristiq:** The patient has had a documented intolerance to generic venlafaxine ER caps AND if the request is for Pristiq, the patient has a documented intolerance to the generic. **Desvenlafaxine SR (base), Fetzima:** The patient has had a documented side effect, allergy, or inadequate response to at least 2 different antidepressants AND The patient has had a documented intolerance with generic desvenlafaxine succinate ER. **Cymbalta, Drizalma:** There must be a clinically compelling reason why the dosing needs cannot be accomplished with generic duloxetine. **Note:** After a 4-month lapse in use of a non-preferred agent for a mental health

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Effexor XR® (venlafaxine XR) capsule *QTY LIMIT:* 37.5 mg and 75 mg = 1 capsule/day FDA maximum recommended dose = 225 mg/day Fetzima® (levomilnacipran ER) capsule *QTY LIMIT:* 1 capsule/day FDA maximum recommended dose = 120 mg/day Fetzima® (levomilnacipran ER) capsule titration pack *QTY LIMIT:* 1 pack per lifetime FDA maximum recommended dose = 120 mg/day Pristiq® (desvenlafaxine succinate SR) *QTY LIMIT:* 50 mg tablet only = 1 tablet/day FDA maximum recommended dose = 400 mg/day Venlafaxine ER® tablet *QTY LIMIT:* 37.5 mg and 75 mg = 1 tablet/day FDA maximum recommended dose = 225 mg/day	indication, or if there is a change in therapy, a lookback through claims information will identify the need to re-initiate therapy following the PDL and clinical criteria.
SSRIs		
CITALOPRAM (compare to Celexa®) tablets, solution FDA maximum recommended dose = 40 mg/day ESCITALOPRAM (compare to Lexapro®) tablets FDA maximum recommended dose = 20mg/day FLUOXETINE (compare to Prozac®) capsules, tablets, solution FDA maximum recommended dose = 80 mg/day FLUVOXAMINE FDA maximum recommended dose = 300 mg/day PAROXETINE hydrochloride tablet (compare to Paxil®) FDA maximum recommended dose = 60 mg/day SERTRALINE (compare to Zoloft®) tablet, solution FDA maximum recommended dose = 200 mg/day,	Brisdelle® (paroxetine mesylate) *QTY LIMIT:* 1 capsule/day Celexa® (citalopram) FDA maximum recommended dose = 40 mg/day Escitalopram solution FDA maximum recommended dose = 20 mg/day Fluoxetine 90 mg FDA maximum recommended dose = 90 mg/week Fluvoxamine CR *QTY LIMIT:* 2 capsules/day FDA maximum recommended dose = 300 mg/day Lexapro® (escitalopram) *QTY LIMIT*:5 mg and 10 mg tablets = 1.5 tabs/day FDA maximum recommended dose = 20mg/day Paroxetine mesylate (compare to Brisdelle®) *QTY LIMIT:* 1 capsule/day 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	**Celexa, Fluvoxamine CR, Lexapro, Paxil tablet, Pexva, Paroxetine CR, Paxil CR, Prozac, Zoloft:** The patient had a documented side effect, allergy, or treatment failure with 2 preferred SSRIs. One trial must be the generic formulation or IR formulation if CR formulation requested. **Brisdelle, Paroxetine mesylate:** The indication for use is moderate to severe vasomotor symptoms (VMS) associated with menopause. AND The patient has tried and failed generic paroxetine hydrochloride. **Paxil suspension, Escitalopram solution:** The patient has a requirement for an oral liquid dosage form. AND The patient had a documented side effect, allergy, or treatment failure with 2 preferred liquid SSRI formulations. **Fluoxetine 90mg:** The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR The patient failed and is not a candidate for daily fluoxetine. AND The prescriber provides clinically compelling rationale for once-weekly dosing. **Sertraline capsules:** Prescriber must provide a clinically compelling reason why the patient is unable to use tablets. **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.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Pexeva® (paroxetine) FDA maximum recommended dose = 60 mg/day Prozac® (fluoxetine) FDA maximum recommended dose = 80 mg/day Sertraline capsule 150 mg, 200 mg *QTY LIMIT:* 1 capsule/day Zoloft® (sertraline) *QTY LIMIT:* 25 mg and 50 mg tablets = 1.5 tabs/day FDA maximum recommended dose = 200 mg/day	
TRICYCLICS		
AMITRIPTYLINE FDA maximum recommended dose = 300 mg/day AMOXAPINE DOXEPIN IMIPRAMINE FDA maximum recommended dose = 300 mg/day NORTRIPTYLINE (compare to Pamelor®) NORTRIPTYLINE Oral Solution	Anafranil® (clomipramine) Clomipramine (compare to Anafranil®) Imipramine Pamoate capsules Desipramine (compare to Norpramin®) Norpramin® (desipramine) Pamelor® (nortriptyline) Protriptyline Trimipramine (compare to Surmontil®)	**Criteria for approval of ALL non-preferred drugs:** patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR the patient meets additional criteria as outlined below. **Imipramine Pamoate:** The patient has had a documented side effect, allergy, or treatment failure to 3 preferred TCAs, one of which must be imipramine tablets. **Desipramine:** The patient has had a documented side effect, allergy, or treatment failure to nortriptyline. **Clomipramine:** The patient has had a documented side effect, allergy, or treatment failure to 2 or more preferred TCAs OR patient has a diagnosis of obsessive-compulsive disorder AND has had a documented side effect, allergy, or treatment failure to 2 SSRIs. **All other non-preferred agents:** The patient has had a documented side effect, allergy, or treatment failure to 2 or more preferred TCAs. One trial must be the AB rated generic formulation if available **Limitation:** Chlordiazepoxide/amitriptyline and amitriptyline/perphenazine combinations are not covered. Generic agents may be prescribed separately.
ANTI-DIABETICS		
ALPHA-GLUCOSIDASE INHIBITORS		
ACARBOSE (compare to Precose®) MIGLITOL	Precose® (acarbose)	**Precose:** patient must have a documented intolerance to generic acarbose
BIGUANIDES & COMBINATIONS		
SINGLE AGENT METFORMIN (compare to Glucophage®) METFORMIN XR (compare to Glucophage XR®)	Fortamet® (metformin ER Osmotic) Glumetza® (metformin ER modified release) Metformin ER modified release (compare to Glumetza)	**Fortamet, Glumetza, Metformin ER mod release, Metformin ER osmotic:** patient has had a documented intolerance to generic metformin XR (if product has an AB rated generic, there must have been a trial of the generic) **Metformin oral solution, Riomet:** prescriber provides documentation of medical

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
COMBINATION GLIPIZIDE/METFORMIN GLYBURIDE/METFORMIN	Metformin oral solution (compare to Riomet®) Metformin ER Osmotic (compare to Fortamet®) Riomet® (metformin oral solution)	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) *QTY LIMIT:* 1 tab/day TRADJENTA® *(linagliptin)* *QTY LIMIT:*1 tab/day **COMBINATION** JANUMET® (sitagliptin/metformin) *QTY LIMIT:* 2 tabs/day JANUMET XR® (sitagliptin/metformin ER) *QTY LIMIT:* 50/500 and 100/1000 mg = 1 tab/day, 50/1000 mg = 2 tabs/day JENTADUETO® (linagliptin/metformin) *QTY LIMIT:* 2 tabs/day	***Non-Preferred After Clinical Criteria Are Met*** Alogliptan (compare to Nesina®) *QTY LIMIT:* 1 tab/day Nesina® (alogliptin) *QTY LIMIT:* 1 tab/day Onglyza® (saxagliptin) *QTY LIMIT:* 1 tab/day Jentadueto XR (linagliptan/metformin ER) *QTY LIMIT:* 1 tab/day Kazano® (alogliptin/metformin) *QTY LIMIT:* 1 tab/day Kombiglyze XR® (saxagliptin/metformin ER) *QTY LIMIT:* 1 tab/day Oseni® (alogliptin/pioglitazone) *QTY LIMIT:* 1 tab/day	**Januvia, Tradjenta:** patient has had a documented side effect, allergy, contraindication OR treatment failure with metformin **Alogliptan, 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)
HYPOGLYCEMIA TREATMENTS		
GLUCAGEN® HYPOKIT® (glucagon for injection) 1mg GLUCAGON EMERGENCY KIT (glucagon for injection) 1mg (Lilly labeler code 00002 is the only preferred form)	Baqsimi® (glucagon nasal powder) 3mg Glucagon emergency kit (all other labelers) Gvoke™ (glucagon SC injection) prefilled syringe, auto-injector 0.5mg, 1mg Zegalogue® (dasiglucagon SC injection) 0.6 mg	**Baqsimi, Gvoke, Zegalogue:** The patient's age is FDA approved for the given medication AND Patient has recurrent episodes of symptomatic or severe hypoglycemia (<55 mg/dL) requiring the assistance of another individual AND caregiver(s) is unable to reconstitute and administer IM glucagon (e.g. difficulty with manual dexterity). Convenience is not adequate justification for inability to use Glucagon IM. **Glucagon Emergency Kit (non-preferred manufacturers):** Labeler 00002 must be on backorder and unavailable from the manufactuer.
INSULINS		
RAPID-ACTING INJECTABLE HUMALOG® (insulin lispro) INSULIN ASPART (compare to Novolog®	Admelog® (insulin lispro) Afrezza ® Inhaled (insulin human) Apidra® (insulin glulisine)	**Admelog, Fiasp, Insulin Lispro, Lyumjev:** Both Humalog and Novolog must be on a long-term backorder and unavailable from the manufacturer. **Apidra, Humulin R (U-100), Novolin R:** patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
NOVOLOG® (insulin aspart) **SHORT-ACTING INJECTABLE** HUMULIN R® U-500 **INTERMEDIATE-ACTING INJECTABLE** All products require PA **LONG-ACTING ANALOGS INJECTABLE** LANTUS® (insulin glargine) LEVEMIR® (insulin detemir) TOUJEO® (insulin glargine) TRESIBA® (insulin degludec) **MIXED INSULINS INJECTABLE** NOVOLOG MIX 70/30® (Protamine/Aspart) HUMALOG MIX 50/50® (Protamine/Lispro) HUMALOG MIX 75/25® (Protamine/Lispro)	Fiasp® (insulin aspart) Insulin Aspart (compare to Novolog®) Insulin Lispro (compare to Humalog®) Lyumjev® (insulin lispro-aabc) Humulin R® (Regular) U-100 Novolin R® (Regular) U-100 Humulin N® (NPH) Novolin N® (NPH) Basaglar® (insulin glargine) Semglee® (insulin glargine) Toujeo® Max (insulin glargine) Insulin Aspart Protamine/Aspart 70/30 (compare to Novolog Mix 70/30®) Humulin 70/30® (NPH/Regular) Novolin 70/30® (NPH/Regular)	for stabilization.) OR patient has had a documented side effect, allergy OR treatment failure to Novolog or Humalog. **Humulin N, Novolin N:** patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR patient has a documented treatment failure to at least one preferred long-acting agent (Lantus or Levemir). **Humulin 70/30, Insulin Aspart Protamine/Aspart 70/30, Novolin 70/30:** patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR patient has had a documented side effect, allergy or treatment failure to Novolog Mix or Humalog Mix. **Toujeo Max:** The patient is currently using insulin glargine 300 units/mL AND the dose exceeds 160 units. **Basaglar, Semglee:** Diagnosis of diabetes mellitus AND Lantus must be on a long-term backorder and unavailable from the manufacturer. **AFREZZA INHALED INSULIN:** • Baseline PFT with FEV1 ≥ 70 % predicted • Patient does not have underlying lung disease (Asthma, COPD) • Patient is a non-smoker or has stopped smoking more than six months prior to starting Afrezza • Patient is currently using a long-acting insulin • Patient has failed to achieve HbA1c goal (defined as ≤ 7%) on a short-acting insulin in combination with a long-acting insulin • Initial approval is for 3 months and improved glycemic control must be documented for further approvals
MEGLITINIDES		
SINGLE AGENT NATEGLINIDE REPAGLINIDE		
PEPTIDE HORMONES: GLP-1 RECEPTOR AGONISTS		
SINGLE AGENTS TRULICITY® (dulaglutide) *QTY LIMIT: 12 pens/84 days* VICTOZA® (liraglutide) *QTY LIMIT:* 9 pens/90 days	Adlyxin® (lixisenatide) Bydureon® BCise™ (exenatide extended-release) *QTY LIMIT:* 12 pens/84 days Byetta® (exenatide) *QTY LIMIT:* 3 pens/90 days Ozempic® (semaglutide) *QTY LIMIT: 9mL/84 days* Rybelsus® (semaglutide) tablets *QTY LIMIT: 1 tablet/day*	**Adlyxin/Byetta/Bydureon BCise:** patient has a documented side effect, allergy, contraindication, or treatment failure with at least one preferred GLP-1 Receptor Agonist. **Ozempic:** patient has a documented side effect, allergy, contraindication, or treatment failure with Trulicity. **Rybelsus:** 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,

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
COMBINATION AGENTS All products require PA **AMYLINOMIMETICS** All products require PA	Soliqua® (insulin glargine/lixisenatide) *QTY LIMIT:* 3 pens/25 days Xultophy® (insulin degludec/liraglutide) Symlin® (pramlintide)	allergy, contraindication, or treatment failure with one preferred SGLT2 inhibitor AND patient has a documented side effect, allergy, contraindication, or treatment failure with at least one preferred GLP-1 Receptor Agonist or has a clinically valid reason for being unable to administer an injection (e.g. visual impairment, impaired dexterity). **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		
SINGLE AGENTS FARXIGA® (dapagliflozin) *QTY LIMIT:* 1 tab/day INVOKANA® (canagliflozin) *QTY LIMIT:* 1 tab/day JARDIANCE (empagliflozin) *QTY LIMIT:* 1 tab/day **COMBINATIONS AGENTS** INVOKAMET® (canagliflozin/metformin) *QTY LIMIT:* 1 tab/day SYNJARDY® (empagliflozin/metformin) *QTY LIMIT:* 2 tabs/day XIGDUO XR® (dapagliflozin & metformin ER) *QTY LIMIT: 5/1000 mg = 2/day, all other strengths = 1/day*	Steglatro® (ertugliflozin) *QTY LIMIT:* 1 tab/day Glyxambi® (empagliflozin/ linagliptin) *QTY LIMIT:* 1 tab/day Invokamet® XR (canagliflozin/metformin ER) Qtern® (dapagliflozin/saxagliptin) Segluromet® (ertugliflozin/metformin) *QTY LIMIT:* 2 tabs/day Steglujan® (ertugliflozin/sitagliptin) *QTY LIMIT:* 1 tab/day Synjardy® XR (empagliflozin/metformin ER) *QTY LIMIT:* 1 tab/day Trijardy® XR (empagliflozin/linagliptin/metformin ER)	**Steglatro:** Patient has a documented side effect, allergy, or contraindication to two preferred SGLT2 inhibitors. **Invokamet XR/Segluromet/ Synjardy XR additional criteria:** The patient has documentation of a failure of therapy with a preferred SGLT2 inhibitor used in combination 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 **Trijardy XR:** patient has documentation of a failure of therapy with a preferred SGLT2 inhibitor, a preferred DDP-4 inhibitor and metformin/metformin XR used in combination.
SULFONYLUREAS 2ND GENERATION		
GLIMEPIRIDE (compare to Amaryl®) GLIPIZIDE (compare to Glucotrol®) GLIPIZIDE ER (compare to Glucotrol XL®) GLYBURIDE GLYBURIDE MICRONIZED	Amaryl® (glimepiride) Glucotrol® (glipizide) Glucotrol XL® (glipizide ER) Glynase® (glyburide micronized)	**Criteria for Approval:** Patient must have a documented side effect, allergy or treatment failure to two preferred sulfonylureas. If a product has an AB rated generic, one trial must be the generic.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
THIAZOLIDINEDIONES & COMBINATIONS		
Preferred After Clinical Criteria Are Met PIOGLITAZONE (compare to Actos®) **COMBINATION** All products require PA	Actos® (pioglitazone) Actoplus Met® (pioglitazone/metformin) Duetact® (pioglitazone/glimepiride) *QTY LIMIT:* 1 tablet/day Pioglitazone/Glimepiride (compare to Duetact®) *QTY LIMIT:* 1 tablet/day Pioglitazone/Metformin (Compare to Actoplus Met)	**Actos, Pioglitazone:** Patient has been started and stabilized on the requested medication OR patient has had a documented side effect, allergy, contraindication OR treatment failure with metformin AND for approval of Actos, the patient has a documented intolerance to the generic equivalent. **Actoplus Met, Duetact, Pioglitazone/Metformin, Pioglitazone/Glimepiride:** patient is unable to take as the individual separate agents AND if the request is for Actoplus Met or Duetact, the patient has had a documented intolerance to the generic equivalent.
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 *QTY LIMIT:* 3 tabs/day, maximum of 30 days per fill ONDANSETRON ODT *QTY LIMIT:* 3 tabs/day, maximum of 30 days per fill ONDANSETRON oral solution 4mg/5mL	Akynzeo® (nutupitant/palonosetron) Granisetron 1 mg *QTY LIMIT:* 6 tabs/28 days Granisetron injectable Sancuso® 3.1 mg/24 hr transdermal patch (granisetron) *QTY LIMIT:* 4 patches/28 days Sustol® (granisetron) injection 10 mg/0.4ml *QTY LIMIT:* 4 injections/28 days Zofran® (ondansetron) oral tablets *QTY LIMIT:* 4 mg = 12 tabs/28 days Zuplenz® (ondansetron) oral soluble film *QTY LIMIT:* 4 mg = 12 films/28 days, 8 mg = 6 films/28 days	**Akynzeo:** Has a diagnosis of nausea and vomiting associated with cancer chemotherapy AND patient has a documented side effect, allergy, or treatment failure of a regimen consisting of a 5-HT3 antagonist, an NK1 antagonist, and dexamethasone **Granisetron:** 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 generic formulation. **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 *QTY LIMIT:*** **Zuplenz:** For nausea and vomiting associated with chemotherapy or radiation

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		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. **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 is not considered an outpatient medication and is not covered in the pharmacy benefit.
MISCELLANEOUS (PREGNANCY)		
DICLEGIS® (10 mg doxylamine succinate and 10 mg pyridoxine hydrochloride) DR tablet QTY LIMIT: 4 tablets/day	Bonjesta® (20 mg doxylamine succinate and 20 mg pyridoxine hydrochloride ER tablet) *QTY LIMIT:* 2 tablets/day Doxylamine succinate/pyridoxine hydrochloride DR tablet (compare to Diclegis®) QTY LIMIT: 4 tablets/day	**Bonjesta, Doxylamine/Pyridoxone:** patient has a documented intolerance to Diclegis.
NK1 ANTAGONISTS		
CINVANTI® (aprepitant) injection EMEND® (fosaprepitant) injection ***<u>Preferred After Clinical Criteria Are Met</u>*** EMEND® (aprepitant) 80 mg *QTY LIMIT:* 2 caps/28 days EMEND® (aprepitant) Tri-fold Pack *QTY LIMIT:* 1 pack/28 days	Aprepitant (compare to Emend®) 40 mg *QTY LIMIT:* 1 cap/28 days Aprepitant (compare to Emend®) 80 mg *QTY LIMIT:* 2 caps/28 days Aprepitant (compare to Emend®) 125 mg *QTY LIMIT:* 1 cap/28 days Emend® (aprepitant) oral suspension Varubi® (rolapitant) *QTY LIMIT:* 4 tabs/28 days	**Aprepitant, Emend (aprepitant):** medication will be prescribed by an oncology practitioner. AND patient requires prevention of nausea and vomiting associated with moderate to highly emetogenic cancer chemotherapy. AND The requested quantity does not exceed one 125 mg and two 80 mg capsules OR one Tri-Fold Pack per course of chemotherapy. Patients with multiple courses of chemotherapy per 28 days will be approved quantities sufficient for the number of courses of chemotherapy. For approval of generic aprepitant, the patient must have a documented intolerance to brand Emend. **Emend oral suspension:** medication will be prescribed by an oncology practitioner AND patient requires prevention of nausea and vomiting associated with moderate to highly emetogenic cancer chemotherapy **AND** patient has a documented medical necessity for the specialty dosage form (e.g. swallowing disorder) **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 patient has had a documented side effect, allergy, or treatment failure with Emend®.
THC DERIVATIVES		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
All products require PA	Dronabinol (compare to Marinol®) Marinol® (dronabinol) Cesamet® (nabilone)	**Pharmacology:** Marinol® is a schedule III cannabinoid agent containing the same active ingredient, tetrahydrocannabinol, as marijuana. While its exact mechanism of action is unknown, it is speculated to inhibit medullary activity as well as suppress prostaglandin and endorphin synthesis. Cesamet® is a schedule II synthetic cannabinoid that acts by activating the endocannabinoid receptors, CB1 and CB2, which are involved in nausea/vomiting regulation. Both Marinol® and Cesamet® are FDA-approved for use in chemotherapy associated nausea and vomiting refractory to conventional antiemetics. In addition, Marinol® is indicated for patients with HIV/AIDS-related anorexia or wasting syndrome. **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. **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) Moexepril Perindopril 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		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
BENAZEPRIL/HYDROCHLOROTHIAZIDE (compare to Lotensin HCT®) CAPTOPRIL/HYDROCHLOROTHIAZIDE ENALAPRIL/HYDROCHLOROTHIAZIDE (compare to Vaseretic®) FOSINOPRIL/HYDROCHLOROTHIAZIDE LISINOPRIL/HYDROCHLOROTHIAZIDE (compare to Zestoretic®) QUINAPRIL/HYDROCHLOROTHIAZIDE (compare to Accuretic®)	Accuretic® (quinapril/HCTZ) Lotensin HCT® (benazepril/HCTZ) Vaseretic® (enalapril/HCTZ) Zestoretic® (lisinopril/HCTZ)	**ACE Inhibitor/Hydrochlorothiazide combinations:** patient has had a documented side effect, allergy, or treatment failure to all available preferred generic ACEI/Hydrochlorothiazide combination. If a medication has an AB rated generic, there must have been a trial of the generic formulation.
ACE INHIBITOR W/CALCIUM CHANNEL BLOCKER		
AMLODIPINE/BENAZEPRIL (compare to Lotrel®)	Lotrel® amlodipine/(benazepril) Tarka® (trandolopril/verapamil) Trandolapril/Verapamil ER (compare to Tarka®)	**Lotrel:** The patient has had a documented side effect, allergy, or treatment failure to the generic formulation. **Tarka, Trandolapril/Verapamil ER:** The patient has had a documented side effect, allergy, or treatment failure to amlodipine/benazepril AND the patient is unable to take as the individual separate agents.
ANGIOTENSIN RECEPTOR BLOCKERS (ARBs)		
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 Telmisartan (compare to Micardis®)	**Avapro, Benicar, Candesartan, Cozaar, Diovan, Edarbi, and Telmisartan:** Patient has had a documented side effect, allergy, or treatment failure with TWO preferred Angiotensin Receptor Blocker (ARB) or ARB combinations. AND If brand name product with generic available, the patient has had a documented intolerance with the generic product.
ANGIOTENSIN RECEPTOR BLOCKER/DIURETIC COMBINATIONS		
IRBESARTAN/HYDROCHLOROTHIAZIDE (compare to Avalide®) LOSARTAN/HYDROCHLOROTHIAZIDE (compare to Hyzaar®) OLMESARTAN/HYDOCHLOROTHIAZIDE (compare to Benicar HCT®)	Avalide® (irbesartan/hydrochlorothiazide) Benicar HCT® (olmesartan/hydrochlorothiazide) Candesartan/hydrochlorothiazide Diovan HCT® (valsartan/hydrochlorothiazide) Edarbyclor® (azilsartan/chlorthalidone) Tablet *QTY LIMIT:* 1 tablet/day	**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.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
VALSARTAN/HYDROCHLOROTHIAZIDE (compare to Diovan HCT®)	Hyzaar® (losartan/hydrochlorothiazide) Micardis HCT® (telmisartan/hydrochlorothiazide) Telmisartan/hydrochlorothiazide (compare to Micardis HCT®)	
ANGIOTENSIN RECEPTOR BLOCKER/CALCIUM CHANNEL BLOCK COMBINATIONS		
VALSARTAN/AMLODIPINE (compare to Exforge®) *QTY LIMIT:* 1 tablet/day	Azor®(olmesartan/amlodipine) *QTY LIMIT:* 1 tablet/day Amlodipine/telmisartan (compare to Twynsta®) *QTY LIMIT:* 1 tablet/day Exforge® (valsartan/amlodipine) *QTY LIMIT:* 1 tablet/day Olmesartan/amlodipine (compare to Azor®)	**Azor, Amlodipine/Telmisartan, Exforge, Olmesartan/amlodipine:** 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®) *QTY LIMIT:* 1 tablet/day	Exforge HCT® (amlodipine/valsartan/hydrochlorothiazide) *QTY LIMIT:* 1 tablet/day Olmesartan/amlodipine/hydrochlorothiazide (compare to Tribenzor®) *QTY LIMIT:* 1 tablet/day Tribenzor® (amlodipine/olmesartan/hydrochlorothiazide) *QTY LIMIT:* 1 tablet/day	**Exforge HCT, Olmesartan/amlodipine/HCTZ, Tribenzor:** patient has had a documented side effect, allergy, or treatment failure to Valsartan/amlodipine/HCTZ.
BETA BLOCKERS		
SINGLE AGENT ACEBUTOLOL ATENOLOL (compare to Tenormin®) BISOPROLOL FUMARATE BYSTOLIC® (nebivolol) CARVEDILOL (compare to Coreg®) LABETALOL METOPROLOL TARTRATE (compare to Lopressor®) METOPROLOL SUCCINATE XL (compare to Toprol XL®) NADOLOL NEBIVOLOL (compare to Bystolic®)	Betapace® (sotalol) Betapace AF® (sotalol) Betaxolol Carvedilol CR (compare to Coreg®) *QTY LIMIT:* 1 tablet/day Coreg® (carvedilol) Coreg CR® (carvedilol CR) *QTY LIMIT:* 1 tablet/day Corgard® (nadolol) Inderal LA® (propranolol ER) Inderal XL® (propranolol SR)	**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

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
PINDOLOL PROPRANOLOL PROPRANOLOL ER (compare to Inderal LA®) SOTALOL (compare to Betapace®, Betapace AF®) ***Preferred After Clinical Criteria Are Met*** HEMANGEOL® oral solution (propranolol) **BETA-BLOCKER/DIURETIC COMBINATION** ATENOLOL/CHLORTHALIDONE (compare to Tenoretic®) BISOPROLOL/HYDROCHLOROTHIAZIDE (compare to Ziac®) METOPROLOL/HYDROCHLOROTHIAZIDE	Innopran XL® (propranolol SR) Kapspargo Sprinkle™ (metoprolol succinate XL) Lopressor® (metoprolol tartrate) Sorine® (sotalol) Tenormin® (atenolol) Timolol Toprol XL® (metoprolol succinate XL) Nadolol/bendroflumethiazide Propranolol/HCTZ Tenoretic® (atenolol/chlorthalidone) Ziac® (bisoprolol/HCTZ)	treatment failure to 3 (three) preferred anti-hypertensive beta-blockers. **Hemangeol:** indication for use is the treatment of proliferating infantile hemangioma **Kapspargo:** patient is unable to take a solid oral dosage form and has a treatment failure with an immediate release oral solution or crushed tablets.
CALCIUM CHANNEL BLOCKERS		
SINGLE AGENT **DIHYDROPYRIDINES** AMLODIPINE (compare to Norvasc®) FELODIPINE ER NIFEDIPINE IR (compare to Procardia®) NIFEDIPINE SR osmotic (compare to Procardia® XL) NIFEDIPINE SR (compare to Adalat® CC) **MISCELLANEOUS** CARTIA® XT (diltiazem SR, compare to Cardizem® CD) DILT-XR® (diltiazem SR) DILTIAZEM (compare to Cardizem®)	Isradipine Katerzia ® (amlodipine) oral suspension Nicardipine Nimodipine Nisoldipine ER (compare to Sular®) Norvasc® (amlodipine) Nymalize® (nimodipine) Oral Solution Procardia® (nifedipine IR) Procardia XL® (nifedipine SR osmotic) Sular® (nisoldipine) Calan® SR (verapamil CR) Cardizem® (diltiazem) Cardizem® CD (diltiazem SR)	**Criteria for approval (except as noted below:)** patient has had a documented side effect, allergy, or treatment failure to at least three preferred drugs. (If a medication has an AB rated generic, one trial must be the generic formulation.) **Katerzia, Nymalize** 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
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: Angiotensin Receptor Blockers (ARBs) PDL category for ARB/CCB combination therapies	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)	
CENTRAL ALPHA AGONISTS		
ORAL TABLETS CLONDIDNE IR Tablets (compare to Catapres®) GUANFACINE IR Tablets (compare to Tenex®) METHYLDOPA Tablets **TRANSDERMAL** CATAPRES-TTS® (clonidine) Transdermal Patch *QTY LIMIT:* 1 patch/7 days	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 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)	**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).

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

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
CEPHALOSPORINS 3RD GENERATION		
CAPSULES/TABLETS CEFDINIR CAPSULE CEFPODOXIME TABLET **SUSPENSION** CEFDINIR suspension IV drugs are not managed at this time	Suprax® (cefixime) capsule Suprax® (cefixime) chewable tablets Cefixime suspension Cefpodoxime proxetil suspension Suprax® (cefixime) suspension	**Suprax capsule, chewable tablet:** patient is completing a course of therapy which was initiated in the hospital. OR patient has had a documented side effect or treatment failure to cefdinir or cefpodoxime. **Cefpodoxime Proxetil Susp, Cefixime Susp, Suprax Susp:** patient is completing a course of therapy which was initiated in the hospital. OR patient has had a documented side effect or treatment failure to cefdinir suspension.
CLINDAMYCIN DERIVATIVES		
CLINDAMYCIN (compare to Cleocin®) capsules CLINDAMYCIN (compare to Cleocin®) oral solution	Cleocin (clindamycin) Capsules Cleocin® Ped (clindamycin) oral solution	**Cleocin:** the patient has a documented intolerance to the generic equivalent.
MACROLIDES		
AZITHROMYCIN tabs, liquid (≤ 5-day supply) (compare to Zithromax®) Maximum 10 days therapy/30 days CLARITHROMYCIN (compare to Biaxin®) tablets	Azithromycin tablets and liquid (if > 5-day supply) (compare to Zithromax®) Azithromycin packet (compare to Zithromax®) *QTY LIMIT:* 2 grams/fill Zithromax® (azithromycin) tablets and liquid *QTY LIMIT:* 5 days supply/RX, maximum 10 days, therapy/30 days Zithromax® (azithromycin) packet *QTY LIMIT:* 2 grams/fill Clarithromycin SR (compare to Biaxin® XL) Clarithromycin suspension E.E.S.® (erythromycin ethylsuccinate) ERY-TAB® (erythromycin base, delayed release) ERYTHROMYCIN BASE Erythromycin base, delayed release (compare to Ery-tab®)	**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)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
IV drugs are not managed at this time	ERYTHROMYCIN ETHYLSUCCINATE (compare to E.E.S.®) Eryped® (erythromycin ethylsuccinate) Erythrocin (erythromycin stearate) Dificid® (fidaxomicin) tablet *QTY LIMIT:* 2 tablets per day, 10-day supply per 30 days	*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 oral vancomycin.
NITROFURANTOIN DERIVATIVES		
NITROFURANTOIN MACROCRYSTALLINE capsules (compare to Macrodantin®) NITROFURANTOIN MONOHYDRATE MACROCYSTALLINE capsules (compare to Macrobid®) NITROFURANTOIN SUSPENSION (age ≤ 12 yrs)	Macrobid® (nitrofurantoin monohydrate macrocrystalline) capsules Macrodantin® (nitrofurantoin macrocrystalline) capsules	**Macrobid, Macrodantin:** the patient has a documented intolerance to the generic equivalent. **Nitrofurantoin susp (age > 12 yrs):** patient must have medical necessity for a liquid formulation (i.e. swallowing disorder)
OXAZOLIDINONES		
IV form of this medication not managed at this time	Linezolid (compare to Zyvox®) *QTY LIMIT*:56 tablets per 28 days Linezolid (compare to Zyvox®) suspension *QTY LIMIT*:60 ml/day, maximum 28 days supply Sivextro® (tedizolid) *QTY LIMIT:*1 tab/day Zyvox® (linezolid) *QTY LIMIT:*56 tablets per 28 days Zyvox® (linezolid) suspension *QTY LIMIT:* 60 ml/day, maximum 28 days supply	**Criteria for Approval:** patient has been started on intravenous or oral linezolid or tedizolid in the hospital and will be finishing the course of therapy in an outpatient setting OR patient has a documented blood, tissue, sputum, or urine culture that is positive for Vancomycin-Resistant Enterococcus (VRE) species. OR patient has a documented blood 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.
PLEUROMUTILINS		
All products require PA IV form of this medication not managed at this time	Xenleta® (lefamulin acetate) *QTY LIMIT:* 2 tabs/day	**Xenleta:** patient is completing a course of therapy which was initiated in the hospital OR patient is ≥ 18 years of age AND has a confirmed diagnosis of community-acquired bacterial pneumonia (CABP) AND culture and sensitivity (C&S) report shows isolated pathogen is a susceptible to lefamulin (If obtaining a C&S report is not feasible, provider must submit documentation.) AND patient has a documented treatment failure, intolerance, or contraindication to 2 preferred antibiotics AND patient has no known risk factors for increased QT prolongation (e.g. cardiac arrhythmias, symptomatic bradycardia, hypokalemia, or congenital prolongation of the QT interval) AND medication is not being used in combination

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		with other drugs known to prolong the QT interval (e.g. antipsychotics, erythromycin, tricyclic antidepressants). If use of Xenleta® cannot be avoided in these patients, baseline EKG and plan for ongoing monitoring must be documented.
PENICILLINS (ORAL)		
SINGLE ENTITY AGENTS **NATURAL PENICILLINS** PENICILLIN V POTASSIUM tablets, oral solution **PENICILLINASE-RESISTANT PENICILLINS** DICLOXACILLIN Capsules **AMINOPENICILLINS** AMOXICILLIN capsules, tablets, chewable tablets, suspension AMPICILLIN capsules, suspension **COMBINATION PRODUCTS** AMOXICILLIN/CLAVULANATE (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, solution MOXIFLOXACIN tabs IV drugs are not managed at this time	Baxdela™ (delafloxacin) Cipro® (ciprofloxacin) tabs Levaquin® (levofloxacin) tabs, solution Ofloxacin	**Cipro, Levaquin:** the patient has had a documented intolerance to the generic equivalent. **Baxdela:** patient is completing a course of therapy with the requested medication that was initiated in the hospital OR patient is ≥ 18 years of age AND has a confirmed diagnosis of acute bacterial skin and skin structure infection (ABSSSI) AND current culture and sensitivity (C&S) report shows isolated pathogen is a gram-positive or gram-negative organism susceptible to delafloxacin (If obtaining a C&S report is not feasible, provider must submit documentation.) AND member has a documented treatment failure, intolerance or contraindication to 2 preferred antibiotics, one of which must be a fluoroquinolone AND duration of therapy does not exceed 14 days. **Ofloxacin:** patient has had a documented side effect, allergy, or treatment failure with two preferred fluoroquinolones

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
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). **Traveler's Diarrhea (Xifaxan 200 mg Tablets Only**): patient has a diagnosis of traveler's diarrhea caused by noninvasive strains of Escherichia coli. AND Patient has had a documented side effect, allergy, treatment failure or contraindication with a fluoroquinolone. AND Quantity limit is 9 tablets/RX (200 mg tablets only). **Small Intestinal Bacterial Overgrowth (Xifaxan 550 mg or 200 mg Tablets:** patient has a diagnosis of SIBO AND Quantity limit is 1,200 mg to 1,650mg/day, maximum of 14 days. **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. **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. **Clostridium difficile Diarrhea (Xifaxan 200 mg Tablets):** patient has a diagnosis of C. difficile diarrhea. AND Patient has had a documented side effect, allergy, treatment failure or contraindication to vancomycin AND Quantity limit is 1200mg/day.
TETRACYCLINES		
DOXYCYCLINE MONOHYDRATE 50 MG,	Adoxa® (doxycycline monohydrate) 150 mg tab Demeclocycline 150mg, 300mg tabs	**Non-preferred doxycycline/minocycline products (except as listed below):** patient has had a documented side effect, allergy, or treatment failure with a preferred

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
100 MG capsules, tablets DOXYCYCLINE HYCLATE 100 MG capsules, tablets DOCYCYCLINE HYCLATE 50MG capsules DOXYCYCLINE MONOHYDRATE suspension 25 MG/5ML MINOCYCLINE 50 MG, 100 MG capsules	Doryx (doxycycline hyclate) delayed release tabs Doxycycline hyclate delayed release tabs Doxycycline 75mg, 150mg caps, tabs Minolira® ER (minocycline extended release) tablet QTY LIMIT: 1 tablet/day Oracea® (doxycycline monohydrate) 40mg cap Vibramycin® (doxycycline hyclate) cap, suspension Vibramycin® (doxycycline calcium) syrup Minocycline 50 mg, 75 mg, 100 mg tabs Nuzyra® (omadacycline) tabs *QTY LIMIT:* Max 14-day supply Solodyn®(minocycline) tabs ER Tetracycline 250 mg, 500 mg cap Ximino® (minocycline) caps ER All other brands	doxycycline/minocycline. If a product has an AB rated generic, the trial must be the generic formulation. **Nuzyra:** patient has been started on intravenous or oral omadacycline in the hospital and will be finishing the course of therapy in an outpatient setting OR the patient has a diagnosis of community-acquired bacterial pneumonia (CABP) or acute bacterial skin and skin structure infections (ABSSSI) AND the patient has had a documented treatment failure with two preferred antibiotics (from any class) OR the provider submits clinical rationale as to why the preferred agents would not be appropriate for the patient. **Oracea:** patient has a diagnosis of Rosacea AND patient has had a documented side effect, allergy, or treatment failure with both a preferred doxycycline and minocycline. **Minolira ER/Solodyn/Ximino:** patient is ≥ 12 years of age AND indication is to treat non-nodular inflammatory lesions of acne vulgaris AND patient has had a documented side effect, allergy, or treatment failure with a preferred minocycline. **Note:** no effect has been demonstrated on non-inflammatory acne lesions. **Vibramycin Suspension, Syrup:** patient has a medical necessity for a liquid dosage form AND a documented failure of preferred doxycycline suspension. **Tetracycline:** patient has had a documented side effect, allergy, or treatment failure with at least two preferred products OR the indication for use is the treatment of H. Pylori infection.
VANCOMYCIN		
All products require PA IV vancomycin products are not managed at this time	Firvanq™ (vancomycin HCl) powder for oral solution *QTY LIMIT:* 1 bottle (150ml) per course of therapy. If more than 150ml is required, use of 300ml bottle is required. Vancocin® (vancomycin) capsules Vancomycin (compare to Vancocin®) capsules	**Criteria for Approval:** patient's diagnosis or indication is Clostridium difficile associated diarrhea (CDAD) AND For approval of brand Vancocin, the patient must meet the above criteria and have a documented intolerance to the generic.
ANTI-INFECTIVES ANTIFUNGAL		
ALLYLAMINES		
TERBINAFINE tabs (compare to Lamisil®) *QTY LIMIT:* 30 tablets/month (therapy limit of 90 days) GRISEOFULVIN MICROSIZE Suspension	Griseofulvin Microsize Tablets Griseofulvin Ultramicrosize Tablets	**Griseofulvin Microsize Tabs/Griseofulvin Ultramicrosize:** patient has had a documented side effect, allergy, or treatment failure with terbinafine tablets and a preferred formulation of griseofulvin.
AZOLES		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
FLUCONAZOLE (compare to Diflucan®) tabs, suspension CLOTRIMAZOLE Troche (compare to Mycelex®) IV drugs are not managed at this time.	Cresemba® (isavuconazonium) caps Diflucan® (fluconazole) tabs, suspension Itraconazole (compare to Sporanox®) caps, solution Ketoconazole tabs Noxafil® (posaconazole) oral suspension Noxafil® (posaconazole) DR Tablets *QTY LIMIT:* 93 tablets/30 days Oravig® (miconazole) 50 mg buccal tablet Posaconazole DR Tablets (compare to Noxafil®) *QTY LIMIT:* 93 tablets/30 days Sporanox® (itraconazole) caps, solution Tolsura® (itraconazole) caps *QTY LIMIT:* 4 caps/day VFend® (voriconazole) tabs, suspension Voriconazole (compare to VFend®) tabs, suspension	**Cresemba:** patient is completing a course of therapy that was initiated in the hospital OR patient has a diagnosis of mucormycosis OR patient has a diagnosis of invasive aspergillosis and has had a documented side effect, allergy, contraindication, or treatment failure with voriconazole. **Ketoconazole/Itraconazole 100mg cap/Itraconzaole Solution/Sporanox** patient has a documented side-effect, allergy, or treatment failure to at least ONE of the preferred medications OR patient is completing a course of therapy that was initiated in the hospital. For approval of Sporanox® capsules, the patient must have a documented intolerance to generic itraconazole. For approval of Itraconazole solution, the patient must have a medical necessity for a liquid dosage form. **Limitations:** Coverage of Onychomycosis agents will NOT be approved solely for cosmetic purposes. **Tolsura:** patient has a diagnosis of aspergillosis intolerant of or refractory to Amphotericin B therapy AND patient has a documented intolerance to both generic itraconazole and voriconazole OR patient has a diagnosis of blastomycosis or histoplasmosis AND the patient has a documented intolerance to itraconazole capsules and solution. **Voriconazole/Vfend:** Patient has a diagnosis of invasive aspergillosis. OR patient is completing a course of therapy with the requested medication that was initiated in the hospital. OR patient has a documented side-effect, allergy, or treatment failure to ONE of the preferred medications AND itraconazole. AND For approval of Vfend®, the patient must have a documented intolerance to generic voriconazole. AND For approval of voriconazole suspension, the patient must have a medical necessity for a liquid dosage form. **Noxafil, posaconazole:** patient has a diagnosis of HIV/immunocompromised status (neutropenia secondary to chemotherapy, hematopoietic stem cell transplant recipients) AND medication is being used for the prevention of invasive Aspergillosis/ Candida infections. OR patient is completing a course of therapy with the requested medication that was initiated in the hospital. OR For Oral Suspension ONLY the patient has a documented side-effect, allergy, or treatment failure to one of the preferred medications and itraconazole AND the patient is being treated for oropharyngeal candidiasis. **Diflucan (brand):** For approval of Diflucan brand name product, the patient must have a documented intolerance to generic fluconazole. **Oravig:** The indication for use is treatment of oropharyngeal candidiasis AND patient has had a documented side effect, allergy, or treatment failure/ inadequate response to both nystatin suspension and clotrimazole troche.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ANTI-INFECTIVES ANTIMALARIALS		
ATOVAQUONE/PROGUANIL (compare to Malarone®) CHLOROQUINE COARTEM® (artemether/lumefantrine) DARAPRIM® (pyrimethamine) HYDROXYCHLOROQUINE SULFATE MEFLOQUINE PRIMAQUINE QUINIDINE SULFATE ***Preferred After Clinical Criteria Are Met*** KRINTAFEL® (tafenoquine succinate)	Malarone® (atovaquone/proguanil) Pyrimethamine (compare to Daraprim®) Quinine Sulfate (compare to Qualquin®) Qualaquin® (quinine sulfate)	**Krintafel:** the patient is ≥ 16 years of age AND is receiving concurrent antimalarial therapy **Malarone:** patient has a documented intolerance to the generic equivalent **Pyrimethamine:** patient has a documented intolerance to brand Daraprim **Quinine sulfate, Qualaquin**: diagnosis or indication is for the treatment of malaria. (Use for leg cramps not permitted.) AND If the request is for brand Qualaquin, the patient has a documented intolerance to the generic equivalent.
ANTI-PARASITICS		
ALBENDAZOLE (compare to Albenza®) BILTRICIDE® (praziquantel) IVERMECTIN (compare to Stromectol®)	Albenza® (albendazole) Benznidazole Emverm® (mebendazole) Lampit (nifurtimox) Stromectol® (ivermectin)	**Benznidazole, Lampit:** patient must be between 2-12 years of age (Benznidazole) or ≤ 18 years (Lampit) AND patient has a diagnosis of Chagas Disease (American trypanosomiasis) AND length of therapy does not exceed 60 days. **Emverm:** patient has a documented side effect, allergy, treatment failure, or contraindication to albendazole OR indication for use is hookworm infection (e.g. ancyclostomiasis, necatoriasis, uninariasis). **Albenza, Stromectol:** patient has a documented intolerance to the generic product.
ANTI-INFECTIVES ANTI-VIRALS		
HERPES SIMPLEX VIRUS MEDICATIONS (ORAL)		
ACYCLOVIR (compare to Zovirax®) tablets, capsules ACYCLOVIR suspension (age ≤ 12 yrs) VALACYCLOVIR (compare to Valtrex®)	Famciclovir (compare to Famvir®) Sitavig® (acyclovir) Buccal Tablet *QTY LIMIT:* 2 tablets/30 days Valtrex® (valacyclovir) Zovirax® (acyclovir) tablets, capsules, suspension	**Acyclovir suspension (age > 12 yrs), Zovirax suspension:** patient has a medical necessity for a non-solid oral dosage form AND for approval of brand Zovirax, the patient has a documented intolerance to generic acyclovir suspension. **Famciclovir, Zovirax (tabs, caps):** patient has a documented side effect or allergy, treatment failure (at least one course of ten or more days) with acyclovir or valacyclovir. **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.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		Valtrex: patient has a documented intolerance to generic valacyclovir
INFLUENZA MEDICATIONS		
OSELTAMIVIR (compare to Tamiflu®) *QTY LIMIT:* 45 and 75 mg caps =10 caps/30 days, 30 mg caps = 20 caps/30 days, 6 mg/ml suspension = 180ml/30 days RELENZA® (zanamivir) *QTY LIMIT:* 20 blisters/30 days	Tamiflu® (oseltamivir) *QTY LIMIT:* 45 and 75 mg caps = 10 caps/30 days, 30 mg caps = 20 capsule /30 days, 6 mg/ml suspension = 180 ml/30 days Xofluza™ (baloxavir marboxil) *QTY LIMIT:*2 tablets/30 days	**Tamiflu:** Patient has a documented intolerance to generic Oseltamivir **Xofluza:** Patient is ≥ 12 years of age AND there is a clinical, patient-specific reason the patient cannot use a preferred agent. **Note:** A maximum of one single dose per 30 days will be approved based on the patient's body weight: 40mg (2 x 20mg tablets) for patients weighing between 40kg and 80kg or 80mg (2 x 40mg tablets) for patients weighing at least 80kg. **Limitations:** Amantadine and rimantadine are not CDC recommended for use in influenza treatment or chemoprophylaxis at this time and are not covered for this indication. For information regarding amantadine see "Parkinson's Medications".
CYTOMEGALOVIRUS (CMV) INFECTION MEDICATIONS		
VALGNCICLOVIR (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, QUADRIVALENT (IIV4), STANDARD DOSE (EGG BASED)** AFLURIA® QUADRIVALENT Injection	**ADJUVANTED INACTIVATED INFLUENZA VACCINE, QUADRIVALENT (IIV4), STANDARD DOSE (EGG BASED)** Fluad™ Injection **INACTIVATED INFLUENZA VACCINE,**	**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 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

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
FLUARIX® QUADRIVALENT Injection FLULAVAL® QUADRIVALENT Injection FLUZONE® QUADRIVALENT Injection	**QUADRIVALENT (IIV4), 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	(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		**Gardasil**: Covered for 19 years old to 45 years old (those under 19 should be referred to their pediatrician or PCP for state-supplied vaccine) **Shingrix**: Covered if ≥ 50 years of age Vaccines on the Advisory Committee on Immunization Practices (ACIP) list of recommended vaccines for children ≤ 18 years of age are supplied through the Vaccines for Children program administered by the Vermont Department of Health, and are not available through DVHA's pharmacy Programs. • Vaccines on the ACIP list of recommended vaccines for adults ≥ 19 years of age are available at many primary care provider offices and through the pharmacy programs. Vaccines are subject to the same limitations as the ACIP guideline recommendations. Providers who participate in the Blueprint for Health initiative must enroll in the Vaccines for Adults program administered by the Vermont Department of Health. The ACIP guidelines and information about enrollment in these programs can be found at http://healthvermont.gov/hc/imm/provider.aspx •Vaccines not on the recommended list may require Prior Authorization.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
MIGRAINE THERAPY: PREVENTATIVE TREATMENTS		
Calcitonin gene-related peptide (CGRP) Inhibitors: Initial approval is 6 months; renewals are 1 year		

Preferred After Clinical Criteria Are Met
AJOVY® (fremanezumab-vfrm)
QTY LIMIT: 225 mg (1 injection) per 30 days or 675 mg (3 injections) every 90 days
EMGALITY® (galcanezumab-gnlm) 120 mg/mL
QTY LIMIT: 240 mg (2 injections) for the first 30 days followed by 120 mg (1 injection) per 30 days
 	
Note: Please refer to "Botulinum Toxins" for Botox
	Aimovig™ (erenumab-aooe)
	QTY LIMIT: 1 injection (1mL) per 30 days
	Emgality ® (galcanezumab-gnlm) 100 mg/mL
	*QTY LIMIT:*300 mg (3 injections) per 30 days, maximum of 6 months per year approved
	Vyepti® (eptinezumab-jjmr)
	Nurtec® ODT (Rimegepant)
	QTY LIMIT: 16 tablets/30 days
		Aimovig, Ajovy, Emgality 120mg/mL, Vyepti: 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. Clinical justification must be provided if there is an increase in triptan use noted in the patient's profile.
		Nurtec ODT: 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) AND patient has failed or has a contraindication to an adequate trial (≥ 60 days) of at least TWO medications for migraine prophylaxis from at least 2 different classes (tricyclic antidepressants, SNRI's, beta-blockers, or anticonvulsants). Initial approval will be granted for 6 months. For re-approval after 6 months, the patient must have documentation of a decrease in the number of headache days per month or decreased use of acute migraine medications such as triptans. Pharmacy claims will also be evaluated to assess compliance with the medication. Clinical justification must be provided if there is an increase in triptan use noted in the patient's profile.
		Aimovig, Nurtec ODT, Vyepti additional criteria: The patient must have a documented side effect, allergy, or treatment failure to Emgality and Ajovy.
		Emgality 100mg/mL:
		• Patient is 18 years of age or older AND
		• Patient has a diagnosis of episodic cluster headache as defined by the following:
		  ○ Severe to very severe unilateral pain felt in the orbital, supraorbital, and/or temporal regions lasting 15-180 minutes (when untreated)
		  ○ Pain is accompanied by a sense of restlessness or agitation OR at least one of the following signs or symptoms, ipsilateral to the headache:
		  ▪ Conjunctival injection and/or lacrimation
		  ▪ Eyelid edema
		  ▪ Miosis and/or ptosis

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		▪ Nasal congestion and/or rhinorrhea ▪ Forehead and facial sweating • Patient has ≥ 2 active cluster periods lasting 7 days to 1 year, separated by remission for periods lasting ≥ 3 months AND • Patient has not achieved satisfactory response to adequate doses of corticosteroids (≥ 30mg prednisone or ≥ 16mg dexamethasone daily) started promptly at the start of the cluster period (Failure is defined as the need to use acute/abortive medications (oxygen, triptans, ergotamines, lidocaine) at least once daily for at least 2 days/week after the first full week of steroid therapy) AND • Patient has not achieved satisfactory response to adequate doses of verapamil (480mg/day, titrated up as needed to a max of 960mg/day) given for at least 3 weeks (Failure is defined as the need to use acute/abortive medications (oxygen, triptans, ergotamines, lidocaine) at least once daily for at least 2 days/week after 3 weeks of adequately dosed verapamil) **Note:** this requirement will be waived if the patient's 2 most recent active cluster periods were less than 3 weeks in duration.
MIGRAINE THERAPY: ACUTE TREATMENTS		
GEPANTS		
Preferred After Clinical Criteria Are Met NURTEC® ODT (rimegepant) *QTY LIMIT:* 8 tablets/30 days	Ubrelvy® (ubrogepant) *QTY LIMIT:* 10 tablets/30 days	**Nurtec ODT:** Patient has a documented side effect, allergy, or treatment failure with 2 preferred triptans, unless contraindicated. **Ubrelvy:** Patient has a documented side effect, allergy, or treatment failure with 2 preferred triptans, unless contraindicated AND patient has a documented side effect, allergy, or treatment failure with Nurtec ODT.
DITANS		
All products require PA	Reyvow® (lasmiditan) *QTY LIMIT:* 8 tablets/30 days	**Reyvow:** Patient has a documented side effect, allergy, or treatment failure with 2 preferred triptans, unless contraindicated AND patient has a documented side effect, allergy, or treatment failure with Nurtec ODT AND counseling has been documented regarding the risks of driving impairment
TRIPTANS		
SINGLE AGENT **ORAL** SUMATRIPTAN (compare to Imitrex®) *QTY LIMIT:* 25 mg = 18 tablets/30 days, 50 and 100 mg = 9 tablets/30 days RELPAX® (eletriptan) 20 mg, 40 mg	Almotriptan 6.25 mg, 12.5 mg *QTY LIMIT:* 12 tablets/30 days Amerge® (naratriptan) 1 mg, 2.5 mg *QTY LIMIT:* 9 tablets/30 days Eletriptan (compare to Relpax®)	**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.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
QTY LIMIT: 12 tablets/30 days RIZATRIPTAN (compare to Maxalt®) *QTY LIMIT:*12 tablets/30 days RIZATRIPTAN ODT (compare to Maxalt-MLT®) *QTY LIMIT:* 12 tablets/30 days	*QTY LIMIT:* 12 tablets/30 days Frova® (frovatriptan) 2.5 mg *QTY LIMIT:* 9 tablets/30 days Frovatriptan (compare to Frova®) 2.5 mg *QTY LIMIT:* 9 tablets/30 days Imitrex® (sumatriptan) *QTY LIMIT:* 25 mg = 18 tablets/30 days, 50 and 100 mg = 9 tablets/30 days Maxalt® (rizatriptan) 5 mg, 10 mg tablet *QTY LIMIT:* 12 tablets/30 days Maxalt-MLT® (rizatriptan ODT) *QTY LIMIT:* 12 tablets/30 days Naratriptan (compare to Amerge®) *QTY LIMIT:* 9 tablets/30 days Zomig® (zolmitriptan) tablets *QTY LIMIT:* 2.5 mg = 12 tablets/30 days, 5 mg = 6 tablets/30 days Zomig® ZMT (zolmitriptan ODT) *QTY LIMIT:* 2.5 mg = 12 tablets/30 days, 5 mg = 6 tablets/30 days Zolmitriptan (compare to Zomig®) tablets *QTY LIMIT:* 2.5 mg = 12 tablets/30 days, 5 mg = 6 tablets/30 days Zolmitriptan ODT (compare to Zomig® ZMT) *QTY LIMIT:* 2.5 mg = 12 tablets/30 days, 5 mg = 6 tablets/30 days	**Sumatriptan/naproxen, Treximet:** patient has had a documented side effect, allergy or treatment failure with 2 preferred Triptans, AND patient is unable to take the individual components separately. **Zomig Nasal Spray, Imitrex Nasal Spray, Onzetra Xsail, Tosymra:** patient has had a documented side effect, allergy or treatment failure with Sumatriptan Nasal Spray **Imitrex, Zembrace**: patient has had a documented intolerance to generic sumatriptan injection. **To exceed quantity limits:** patient is taking a medication for migraine prophylaxis.
NASAL SPRAY SUMATRIPTAN (compare to Imitrex®) *QTY LIMIT:* 5 mg nasal spray = 12 units/30 days, 20 mg nasal spray = 6 units/ 30 days	Imitrex® (sumatriptan) *QTY LIMIT:* 5 mg nasal spray = 12 units/30 days, 20 mg nasal spray = 6 units/ 30 days Tosymra® (sumatriptan) *QTY LIMIT:* 6 units/30 days Zomig® (zolmitriptan) *QTY LIMIT:* 2.5 and 5 mg nasal spray = 12 units/30 days	
NASAL POWDER All products require PA	Onzetra Xsail® (sumatriptan succinate) *QTY LIMIT:* 8 doses/30 days	

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
INJECTABLE SUMATRIPTAN (compare to Imitrex®) *QTY LIMIT:* 4 and 6 mg injection = 8 injections (4ml)/30 days **COMBINATION PRODUCT ORAL**	Imitrex® (sumatriptan) *QTY LIMIT:* 4 and 6 mg injection = 8 injections (4ml)/30 days Zembrace® SymTouch (sumatriptan) 3 mg/5ml *QTY LIMIT:* 4 injections/ 30 days Sumatriptan/Naproxen (compare to Treximet®) *QTY LIMIT:* 9 tablets/30 days Treximet® (sumatriptan/naproxen) *QTY LIMIT:* 9 tablets/ 30 days	
ANTI-PSYCHOTIC ATYPICAL & COMBINATIONS (CHILDREN < 18 YEARS OLD)		
Preferred After Clinical Criteria Are Met **TABLETS/CAPSULES** ARIPIPRAZOLE (compare to Abilify®) *QTY LIMIT:* 5, 10, and 15 mg = 1.5 tabs/day FDA maximum recommended dose = 30 mg/day OLANZAPINE (compare to Zyprexa®) *QTY LIMIT:* 2.5, 5, 7.5, and 10 mg = 1.5 tabs/day FDA maximum recommended dose = 20 mg/day 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	Abilify® (aripiprazole) *QTY LIMIT:* 5, 10, and 15 mg = 1.5 tabs/day FDA maximum recommended dose = 30 mg/day Asenapine (compare to Saphris®) *QTY LIMIT:* 2 tabs/day FDA maximum recommended dose = 20 mg/day Clozapine (compare to Clozaril®) FDA maximum recommended dose = 900 mg/day Clozaril® (clozapine) FDA maximum recommended dose = 900 mg/day Geodon® (ziprasidone) FDA maximum recommended dose = 160 mg/day Invega® (paliperidone) *QTY LIMIT:* 3 and 9 mg = 1 tab/day, 6 mg = 2 tabs/day FDA maximum recommended dose = 12 mg/day Latuda® (lurasidone) *QTY LIMIT:* 1 tab/day FDA maximum recommended dose = 80 mg/day Paliperidone (compare to Invega®) *QTY LIMIT:* 3 and 9 mg = 1 tab/day, 6 mg = 2 tabs/day FDA maximum recommended dose = 12 mg/day Quetiapine ER (compare to Seroquel® XR) *QTY LIMIT:* 150 and 200 mg = 1 tab/day, 50 mg = 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. **Asenapine, Invega, Paliperidone, Saphris:** patient has had a documented side effect, allergy or treatment failure with at least two preferred products (typical or atypical antipsychotics) one of which is risperidone. **Abilify, Clozaril, Geodon, 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.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	FDA maximum recommended dose = 800 mg/day Risperdal® (risperidone) FDA maximum recommended dose = 16 mg/day Seroquel® (quetiapine) FDA maximum recommended dose = 800 mg/day Saphris® (asenapine) *QTY LIMIT*: 2 tabs/day FDA maximum recommended dose = 20 mg/day Seroquel XR® (quetiapine XR) *QTY LIMIT:* 150 and 200 mg = 1 tab/day, 50 mg = 2 tabs/day FDA maximum recommended dose = 800 mg/day Zyprexa® (olanzapine) *QTY LIMIT:* 2.5, 5, 7.5, and 10 mg = 1.5 tabs/day FDA maximum recommended dose = 20 mg/day	*Indication for use is Bipolar 1 depression:* patient is ≥ 10 years of age or older AND patient has had a documented side effect, allergy or treatment failure with at least two preferred products (typical or atypical antipsychotics) OR the prescriber feels that quetiapine or olanzapine/fluoxetine combination would not be appropriate alternatives for the patient because of pre-existing conditions such as obesity or diabetes; the patient would not be required to have 2 preferred trials if pregnant. **Quetiapine XR, 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. **Aripiprazole Oral Solution:** patient has had a documented side effect, allergy or treatment failure with risperidone oral solution OR prescriber feels that risperidone would not be an appropriate alternative for the patient because of pre-existing medical conditions such as obesity or diabetes. **Versacloz Oral Solution:** patient has had a documented side effect, allergy or treatment failure with at least three other antipsychotic medications (typical or atypical antipsychotics). AND patient is unable to use clozapine orally disintegrating tablets. **Aripiprazole ODT, Olanzapine ODT, Risperidone ODT, Zyprexa Zydis:** 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 Zyprexa Zydis, the patient has a documented intolerance to the generic equivalent. **Clozapine ODT:** Medical necessity for a specialty dosage form has been provided AND patient has had a documented side effect, allergy or treatment failure with at least three other antipsychotic medications (typical or atypical antipsychotics)
Preferred After Clinical Criteria Are Met **ORAL SOLUTIONS** RISPERIDONE (compare to Risperdal®) oral solution FDA maximum recommended dose = 16 mg/day	Aripiprazole oral solution FDA maximum recommended dose = 25 mg/day Risperdal® (risperidone) oral solution FDA maximum recommended dose = 16 mg/day Versacloz® (clozapine) Oral Suspension *QTY LIMIT:* 18ml/day FDA maximum recommended dose = 900 mg/day	
ORALLY DISINTEGRATING TABLETS All products require PA	Aripiprazole orally disintegrating tablets *QTY LIMIT*: 10 and 15 mg = 2 tabs/day FDA maximum recommended dose = 30 mg/day Clozapine orally disintegrating tablets FDA maximum recommended dose = 900 mg/day Olanzapine orally disintegrating tablets (compare to Zyprexa Zydis®) *QTY LIMIT:* 5 and 10 mg = 1.5 tabs/day FDA maximum recommended dose = 20 mg/day Risperidone ODT FDA maximum recommended dose = 16 mg/day Zyprexa Zydis® (olanzapine orally disintegrating tablets) *QTY LIMIT:* 5 and 10 mg = 1.5 tabs/day FDA maximum recommended dose = 20 mg/day	

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ANTI-PSYCHOTIC ATYPICAL & COMBINATIONS (ADULTS ≥ 18 YEARS OLD)		
TABLETS/CAPSULES ARIPIPRAZOLE (compare to Abilify®) *QTY LIMIT:* 5, 10, and 15 mg = 1.5 tabs/day FDA maximum recommended dose = 30 mg/day CLOZAPINE (compare to Clozaril®) FDA maximum recommended dose = 900 mg/day OLANZAPINE (compare to Zyprexa®) *QTY LIMIT:* 2.5, 5, 7.5, and 10 mg = 1.5 tabs/day FDA maximum recommended dose = 20 mg/day 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	Abilify® (aripiprazole) *QTY LIMIT:* 5, 10, and 15 mg = 1.5 tabs/day FDA maximum recommended dose = 30 mg/day Abilify® Mycite (aripiprazole tablets with sensor) *QTY LIMIT:* 1 tab/day FDA maximum recommended dose=30mg/day Asenapine sublingual tablet (compare to Saphris® FDA maximum recommended dose = 20 mg/day Clozaril® (clozapine) FDA maximum recommended dose = 900 mg/day Caplyta® (lumateperone) *QTY LIMIT:* 1 capsule/day FDA maximum recommended dose = 42 mg/day Fanapt® (iloperidone) *QTY LIMIT:* 2 tablets/day FDA maximum recommended dose = 24 mg/day Geodon® (ziprasidone) FDA maximum recommended dose = 160 mg/day Invega® (paliperidone) *QTY LIMIT:* 3 and 9 mg = 1 tab/day, 6 mg = 2 tabs/day FDA maximum recommended dose = 12 mg Latuda® (lurasidone) *QTY LIMIT:* 80 mg = 2 tablets/day All other strengths = 1 tablet/day FDA maximum recommended dose = 160 mg/day Nuplazid™ (primavaserin) *QTY LIMIT:* 2 tablets/day FDA maximum recommended dose = 34 mg Paliperidone (compare to Invega®) *QTY LIMIT:* 3 and 9 mg = 1 tab/day, 6 mg = 2 tabs/day FDA maximum recommended dose = 12 mg Quetiapine ER (compare to Seroquel® XR) Rexulti® (brexpiprazole)	**Criteria for approval of ALL non-preferred drugs:** patient has been started and stabilized on the requested medication (Note: samples are not considered adequate justification for stabilization.) OR patient meets additional criteria outlined below. **Caplyta:** The indication for use is the treatment of schizophrenia AND The patient has had a documented side effect, allergy or treatment failure with at least three preferred products (typical or atypical antipsychotics). **Fanapt:** The indication for use is the treatment of schizophrenia/schizoaffective disorder or bipolar disorder. AND The patient has had a documented side effect, allergy or treatment failure with at least three preferred products (typical or atypical antipsychotics). **Asenapine, Invega, Paliperidone, Saphris:** The indication for use is the treatment of schizophrenia/schizoaffective disorder or bipolar disorder AND The patient has had a documented side effect, allergy, or treatment failure with at least two preferred products (typical or atypical antipsychotics), one of which is risperidone. **Note:** Prior therapy with injectable Invega Sustenna® is not considered to be started and stabilized for oral Invega. Patients transferring to oral therapy from Invega Sustenna® should transition to oral risperidone (unless patient previously failed such treatment). **Abilify, Clozaril, Geodon, 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 there is a clinically compelling reason why Abilify Maintena or Aristada cannot be used. Initial approval will be granted for 3 months. For renewal, documentation supporting use of the tracking software must be provided and pharmacy claims will be evaluated to assess compliance with therapy. **Vraylar:** *Indication for use is schizophrenia/schizoaffective disorder:* the patient has had a documented side effect, allergy or treatment failure with three preferred products (typical or atypical antipsychotics) OR *Indication for use is Bipolar I depression:* the patient has had a documented side

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	FDA maximum recommended dose = 3 mg (adjunct of MDD) or 5 mg (schizophrenia) Risperdal® (risperidone) FDA maximum recommended dose = 16 mg/day Saphris® (asenapine) sublingual tablet FDA maximum recommended dose = 20 mg/day Seroquel® (quetiapine) FDA maximum recommended dose = 800 mg/day Seroquel XR® (quetiapine XR) *QTY LIMIT:* 150 and 200 mg = 1 tab/day, 50 mg = 2 tabs/day FDA maximum recommended dose = 800 mg/day Vraylar® (cariprazine) *QTY LIMIT:* 1 capsule/day FDA maximum recommended dose = 6 mg/day Zyprexa® (olanzapine) *QTY LIMIT:* 2.5, 5, 7.5, and 10 mg = 1.5 tabs/day FDA maximum recommended dose = 20 mg/day	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. **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 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 (typical or atypical antipsychotics), one of which must be aripiprazole OR *Indication for use is adjunct treatment of Major Depressive Disorder (MDD)*: the patient has had a documented inadequate response to at least 3 different antidepressants from two different classes AND the patient has had a documented side effect, allergy or treatment failure with two preferred atypical antipsychotic products being used as adjunctive therapy, one of which must be aripiprazole **Quetiapine ER, Seroquel XR:** 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 **Aripiprazole 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
ORAL SOLUTIONS RISPERIDONE (compare to Risperdal®) oral solution FDA maximum recommended dose = 16 mg/day	Aripiprazole oral solution FDA maximum recommended dose = 25 mg/day Risperdal® (risperidone) oral solution FDA maximum recommended dose = 16 mg/day Versacloz® (clozapine) Oral Suspension *QTY LIMIT:* 18ml/day FDA maximum recommended dose = 900 mg/day	
SHORT-ACTING INJECTABLE PRODUCTS GEODON® IM (ziprasidone intramuscular injection) FDA maximum recommended dose = 40 mg/day	Olanzapine intramuscular injection (compare to Zyprexa® IM) FDA maximum recommended dose = 30 mg/day Zyprexa® IM (olanzapine intramuscular injection) FDA maximum recommended dose = 30 mg/day	
LONG-ACTING INJECTABLE PRODUCTS ABILIFY MAINTENA® (aripiprazole monohydrate) *QTY LIMIT:* 1 vial/28 days		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
FDA maximum recommended dose = 400 mg/month ARISTADA® (aripiprazole lauroxil) *QTY LIMIT:* 441, 662, and 882 mg = 1 syringe/28 days, 1064 mg = 1 syringe/60 days ARISTADA Initio™ (aripiprazole lauroxil) INVEGA SUSTENNA® (paliperidone palmitate) FDA maximum recommended dose = 234 mg/ month PERSERIS® (risperidone) *QTY LIMIT:* 1 syringe/28 days FDA maximum recommended dose = 120 mg/month RISPERDAL® CONSTA (risperidone microspheres) FDA maximum recommended dose = 50 mg/14 days ZYPREXA RELPREVV® (olanzapine pamoate) *QTY LIMIT:* 405 mg = 1 vial/month, 210 and 300 mg = 2 vials/month FDA maximum recommended dose = 600 mg/month ***Preferred After Clinical Criteria Are Met*** INVEGA TRINZA® (paliperidone palmitate) FDA maximum recommended dose = 819 mg/3 months **ORALLY DISINTEGRATING TABLETS** All products require PA	Aripiprazole ODT QTY LIMIT: 10 and 15 mg = 2 tabs/day FDA maximum recommended dose = 30 mg/day Clozapine orally disintegrating tablets FDA maximum recommended dose = 900 mg/day Olanzapine orally disintegrating tablets (compare to Zyprexa Zydis®) *QTY LIMIT:* 5 and 10 mg = 1.5 tabs/day FDA maximum recommended dose = 20 mg/day Risperidone ODT FDA maximum recommended dose = 16 mg/day Zyprexa Zydis® (olanzapine orally disintegrating tablets) *QTY LIMIT:* 5 and 10 mg = 1.5 tabs/day FDA maximum recommended dose = 20 mg/day	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. **ORALLY DISINTEGRATING TABLETS:** Medical necessity for a specialty dosage form has been provided AND If the request is Zyprexa Zydis, the patient has a documented intolerance to the generic equivalent. **COMBINATION PRODUCTS:** The patient has had a documented side effect, allergy, or treatment failure with two preferred products OR The prescriber provides a clinically valid reason for the use of the requested medication. **Secuado:** The indication for use is the treatment of schizophrenia/schizoaffective disorder AND The patient has had a documented side effect, allergy or treatment failure with at least three preferred products (typical or atypical antipsychotics) and Saphris OR The indication for use is the treatment of schizophrenia/schizoaffective disorder AND the patient is unable to take oral medications AND the patient has had a documented side effect, allergy or treatment failure with a preferred long-acting injectable.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
COMBINATION PRODUCTS All products require PA **TRANSDERMAL PRODUCTS** All products require PA	Olanzapine/fluoxetine FDA maximum recommended dose = 18 mg/75 mg (per day) Secuado (asenapine) transdermal patch *QTY LIMIT:* 1 patch/day FDA maximum recommended dose = 7.6 mg/day	
ANTI-PSYCHOTIC: TYPICALS		
ORAL HALOPERIDOL LOXAPINE PERPHENAZINE PIMOZIDE TRIFLUOPERAZINE **LONG ACTING INJECTABLE PRODUCTS** FLUPHENAZINE DECANOATE HALOPERIDOL DECANOATE (compare to Haldol® decanoate)	Chlorpromazine Fluphenazine Molindone 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)		
SINGLE PRODUCT REGIMENS		
Tablets (STRs) BIKTARVY® (bictegravir/emtricabine/tenofovir AF) COMPLERA® (emtricitabine/relpivirine/tenofovir) DELSTRIGO® (doravirine/lamivudine/tenofovir) DOVATO® (dolutegravir/lamivudine)	Stribild® (elvitegravir/cobicistat/ emtricitabine/tenofovir) Symtuza® (darunavir/cobicistat/emtricitabine/tenofovir AF)	**Atripla:** patient must have a documented intolerance to the generic equivalent. **Cabenuva:** The patient has been started and stabilized on the requested medication (Note: samples are not considered adequate justification for stabilization.) OR patient is virologically suppressed (HIV-1 RNA < 50 copies per mL) on a stable oral antiretroviral regimen with no history of treatment failure AND medical

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
EFAVIRENZ/EMTRICITABINE/TENOFOVIR GENVOYA® (elvitegravir/cobicistat/ emtricitabine/tenofovir AF) JULUCA® (dolutegravir/rilpivirine) ODEFSEY® (emtricitabine/relpivirine/ tenofovir AF) SYMFI™ (efavirenz/lamivudine/tenofovir) SYMFI™ LO (efavirenz/lamivudine/tenofovir) TRIUMEQ® (abacavir/lamivudine/dolutegravir) **Long-Acting Injectables** All products require PA	Cabenuva® (cabotegravir/rilpivirine) Kit *QTY LIMIT:* 600mg/900mg kit = 6mL per month for the first month then 400mg/600mg kit = 4mL per month thereafter	reasoning beyond convenience or enhanced compliance over preferred agents is provided. **Note:** oral lead-in with Vocabria® (cabotegravir) and Edurant® (rilpivirine) are provided at no charge and sent directly to the prescriber or patient by a specialty distributor and should be dispensed ONLY for those with prior approval for Cabenuva. **Stribild:** • The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR • Genotype testing supporting resistance to other regimens OR • Intolerance or contraindication to preferred combination of drugs AND • Medical reasoning beyond convenience or enhanced compliance over preferred agents AND • CrCl > 70mL/min to initiate therapy OR CrCl > 50mL/min to continue therapy **Symtuza:** The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR Medical reasoning beyond convenience or enhanced compliance over preferred agents (Prezcobix & Descovy)
COMBINATION PRODUCTS - NRTIs		
ABACAVIR/LAMIVUDINE (compare to Epzicom®) ABACAVIR/LAMIVUDINE/ZIDOVUDINE (compare to Trizivir®) LAMIVUDINE/ZIDOVUDINE (compare to Combivir®)	Combivir® (lamivudine/zidovudine) Epzicom® (abacavir/lamivudine) Trizivir® (abacavir/lamivudine/zidovudine)	**Combivir, Epzicom:** patient must have a documented intolerance to the generic equivalent **Trizivir:** The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR The prescriber must provide a clinically compelling reason for the use of the requested medication including reasons why any of the preferred products would not be suitable alternatives
COMBINATION PRODUCTS – NUCLEOSIDE & NUCLEOTIDE ANALOG RTIs		
CIMDUO™ (lamivudine/tenofovir) DESCOVY® (emtricitabine/tenofovir AF) EMTRICITABINE/TENOFOVIR (compare to Truvada®)	Truvada® (emtricitabine/tenofovir)	**Truvada:** patient must have a documented intolerance to the generic equivalent
COMBINATION PRODUCTS – PROTEASE INHIBITORS		
KALETRA® (lopinavir/ritonavir)	Lopinavir/ritonavir (compare to Kaletra®)	**Lopinavir/ritonavir:** patient must have a documented intolerance to brand Kaletra
IMMUNOLOGIC THERAPIES		
Preferred After Clinical Criteria Are Met TROGARZO™ (ibalizumab-uiyk) *QTY LIMIT:* 10 vials (2000 mg) x 1 dose then 4		**Rukobia, Trogarzo:** The patient must meet ALL of the following criteria: • ≥ 18 years of age

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

vials (800 mg) every 14 days thereafter		• Prescription is written by or in consultation with an infectious disease specialist
		• Viral Load is ≥ 1,000 copies/mL (results must be submitted)
		• Patient has been compliant but has had an inadequate response to at least 6 months of treatment with anti-retroviral therapy (ART), including recent failure within the last 8 weeks
		• Patient has multi-drug resistant HIV-1 infection including documented resistance to at least one medication from each of the following classes:
		  ○ Protease Inhibitor (PI)
		  ○ Nucleoside Reverse Transcriptase Inhibitor (NRTI)
		  ○ Non-nucleoside Reverse Transcriptase Inhibitor (NNRTI)
		• Medication will be used in combination with ART that includes at least one drug to which the individual's virus is susceptible
		• Initial approval will be granted for 6 months. For continuation of therapy, there must be a decrease in viral load from baseline AND the patient must continue to be compliant with the optimized background regiment of ART.

GP120 DIRECTED ATTACHMENT INHIBITOR		
Preferred After Clinical Criteria Are Met RUKOBIA® (fostemsavir) *QTY LIMIT* = 2 tablets per day		
INTEGRASE STRAND TRANSFER INHIBITORS		
ISENTRESS® (raltegravir potassium) ISENTRESS HD (raltegravir potassium) TIVICAY® (dolutegravir sodium) TIVICAY® PD (dolutegravir sodium)		
NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTI)		
ABACAVIR SULFATE (compare to Ziagen®) EMTRIVA® (emtricitabine) LAMIVUDINE (compare to Epivir®) TENOFOVIR DISOPROXIL FUMARATE (compare to Viread®) 300mg VIREAD® (tenofovir disoproxil fumarate) 150mg, 200mg, 250mg tablet, 40mg/gm powder ZIAGEN® (abacavir sulfate) ZIDOVUDINE (compare to Retrovir®)	Didanosine DR Epivir® (lamivudine) Retrovir® (zidovudine) Stavudine (compare to ZERIT®) Videx EC (didanosine) Videx® (didanosene) Solution Viread® (tenofovir disoproxil fumarate) 300mg tablet Ziagen® (abacavir sulfate) tablet	**Epivir, Retrovir, Viread 300mg, Ziagen:** patient must have a documented intolerance to the generic equivalent **Didanosine, Stavudine, Videx:** The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR The prescriber must provide a clinically compelling reason for the use of the requested medication including reasons why any of the preferred products would not be suitable alternatives.
NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NNRTI)		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
EDURANT® (rilpivirine) EFAVIRENZ (compare to Sustiva®) INTELENCE® (etravirine) PIFELTRO (doravirine)	Nevirapine (compare to Viramune®) Nevirapine ER (compare to Viramune® ER) Sustiva® (efavirenz) Viramune® ER (nevirapine ER)	**Sustiva:** patient must have a documented intolerance to the generic equivalent **Nevirapine. Nevirapine ER, Viramune ER:** The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR The prescriber must provide a clinically compelling reason for the use of the requested medication including reasons why any of the preferred products would not be suitable alternatives.
PHARMACOENHANCER-CYTOCHROME P450 INHIBITOR		
All products require PA	Tybost® (cobicistat)	**Tybost:** The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR a clinically valid reason beyond compliance or convenience is given for not using a preferred combination drug or a ritonavir- based regimen with similar components
PROTEASE INHIBITORS (PEPTICIC)		
ATAZANAVIR (compare to Reyataz®) EVOTAZ® (atazanavir/cobicistat) NORVIR® (ritonavir) RITONAVIR (compare to Norvir®)	Fosemprenavir (compare to Lexiva®) Invirase® (saquinavir mesylate) Lexiva® (fosemprenavir) Reyataz® (atazanavir) Viracept® (nelfinavir)	**Fosemprenavir, Invirase, Lexiva, Viracept:** The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR The prescriber must provide a clinically compelling reason for the use of the requested medication including reasons why any of the preferred products would not be suitable alternatives. **Reyataz:** patient must have a documented intolerance to the generic equivalent
PROTEASE INHIBITORS (NON-PEPTIDIC)		
PREZCOBIX® (darunavir/cobicistat) PREZISTA® (darunavir ethanolate)	Aptivus® (tipranavir)	**Aptivus:** The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR The prescriber must provide a clinically compelling reason for the use of the requested medication including reasons why any of the preferred products would not be suitable alternatives.
ENTRY INHIBITORS-CCR5 CO-RECEPTOR ANTAGONISTS		
All products require PA	Selzentry® (maraviroc)	**Selzentry:** The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR The prescriber must provide a clinically compelling reason for the use of the requested medication including reasons why any of the preferred products would not be suitable alternatives.
ENTRY INHIBITORS-FUSION INHIBITORS		
All products require PA	Fuzeon® (enfuvirtide)	**Fuzeon:** The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR The prescriber must provide a clinically compelling reason for the use of the requested medication including reasons why any of the preferred products would not be suitable alternatives.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
BILE SALTS AND BILIARY AGENTS		
URSODIOL capsules	Actigall® (ursodiol) Chenodal® (chendiol) Cholbam® (cholic acid) Ocaliva® (obeticholic acid) Urso® (Urosiol) Ursodiol tablets 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 pregnant or may become pregnant, known hepatocyte dysfunction or bile ductal abnormalities such as intrahepatic cholestasis, primary biliary cirrhosis or sclerosing cholangitis. **Cholbam:** The indication for use is the treatment of bile acid synthesis disorders due to single enzyme defects OR for the adjunctive treatment of peroxisomal disorders, including Zellweger spectrum disorders, AND the patient exhibits manifestations of liver disease, steatorrhea, or complications from decreased fat-soluble vitamin absorption AND the prescriber is a hepatologist or gastroenterologist. Initial approval will be granted for 3 months. For re-approval after 3 months, there must be documented clinical benefit. **Ocaliva:** The indication for use is the treatment of primary biliary cholangitis (PBC) AND the patient has had an inadequate response or is unable to tolerate ursodiol. **Urso, Ursodiol tablets, Urso Forte, Actigall:** The patient must have a documented treatment limiting side effect to generic ursodiol capsules.
BONE RESORPTION INHIBITORS		
ORAL BISPHOSPHONATES TABLETS/CAPSULES ALENDRONATE (compare to Fosamax®) tablets	Actonel® (risedronate) Alendronate oral solution Atelvia (risedronate) Delayed Release Tablet *QTY LIMIT:*4 tablets/28 days Boniva® (ibandronate) *QTY LIMIT:* 150 mg = 1 tablet/28 days Fosamax® (alendronate) Fosamax Plus D® (alendronate/vitamin D) Ibandronate (compare to Boniva®) *QTY LIMIT:* 150 mg = 1 tablet/28 days Risedronate (compare to Actonel®)	**Actonel, Atelvia, Boniva (oral), Ibandronate (oral), Risedronate** patient has had a documented side effect, allergy, or treatment failure (at least a six-month trial) to generic alendronate tablets AND if the request is for brand, the patient has also had a documented intolerance to generic equivalent. **Alendronate Oral Solution:** prescriber provides documentation of medical necessity for the specialty dosage form (i.e. inability to swallow tablets, dysphagia). **Evista, Fosamax, Reclast:** patient has a documented intolerance to the generic formulation. **Calcitonin Nasal:** patient is started and stabilized on the requested medication. Note: Calcitonin Nasal Spray (brand and generic) no longer recommended for osteoporosis. **Miacalcin Injection:** patient has a diagnosis/indication of Paget's Disease

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

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
All products require PA		
BOTULINUM TOXINS		
All products require PA	Botox® (onabotulinumtoxinA) Dysport® (abobotulinumtoxinA) Myobloc® (rimabotulinumtoxinB) Xeomin® (incobotulinumtoxinA)	**Criteria for approval of ALL drugs:** The medication is being prescribed for an FDA approved indication AND the patient's age is FDA approved for the given indication AND the patient meets the following additional criteria (if applicable). Initial approval will be granted for 3 months unless otherwise noted. For re-approval, the patient must have documented improvement in symptoms. *Additional criteria for Severe Axillary Hyperhidrosis (Botox only):* the patient failed an adequate trial of topical therapy. *Additional criteria for Overactive bladder or detrusor overactivity (Botox only):* the patient failed an adequate trial of at least TWO urinary antispasmodics (either short- or long-acting formulations) *Additional criteria for Chronic migraine (Botox only):* the patient has ≥ 15 headache days per month, of which ≥ 8 are migraine days, for at least 3 months AND the member has failed or has a contraindication to an adequate trial of at least TWO medications for migraine prophylaxis from at least two different classes (tricyclic antidepressants, SNRI's, beta-blockers, or anticonvulsants). Initial approval will be granted for 6 months. For re-approval after 6 months, the patient must have documentation of a decrease in the number of headache days per month or decreased use of acute migraine medications such as triptans. *Additional criteria for chronic sialorrhea (Myobloc and Xeomin):* the patient has a documented side effect, allergy, treatment failure, or contraindication to at least two anticholinergic agents (e.g. scopolamine, glycopyrrolate). **LIMITATIONS:** Coverage of botulinum toxins will not be approved for cosmetic use (e.g., glabellar lines, vertical glabellar eyebrow furrows, facial rhytides, horizontal neck rhytides, etc.). (BOTOX Cosmetic (onabotulinumtoxinA) is not

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		covered)
BPH AGENTS		
ALPHA BLOCKERS ALFUZOSIN ER (compare to Uroxatral®) *QTY LIMIT:*1 tablet/day DOXAZOSIN (compare to Cardura®) TAMSULOSIN (compare to Flomax®) *QTY LIMIT:* 2 capsules/day TERAZOSIN (formerly Hytrin®)	Cardura® (doxazosin) Cardura XL® (doxazosin) *QTY LIMIT:*1 tablet/day Flomax® (tamsulosin) *QTY LIMIT:*2 capsules/day Rapaflo® (silodosin) *QTY LIMIT:*1 tablet/day Silodosin (compare to Rapaflo®) *QTY LIMIT: 1 tablet/day*	**Cardura, Cardura XL:** The patient has had a documented side effect, allergy or treatment failure with two alpha blockers, one of which must be generic doxazosin. **Flomax:** The patient has had a documented side effect, allergy or treatment failure with two preferred alpha blockers, one of which must be generic tamsulosin. **Rapaflo, Silodosin:** The patient has had a documented side effect, allergy or treatment failure with two preferred alpha blockers **Avodart, Proscar** The patient has a documented intolerance to the generic equivalent. **Finasteride for males age < 45:** The patient has a diagnosis of BPH (benign 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 Jalyn, the patient must have a documented intolerance to generic dutasteride/tamsulosin. **LIMITATIONS:** Coverage of androgen hormone inhibitors will not be approved for cosmetic use in men or women (male-pattern baldness/alopecia or hirsutism). (This includes Propecia (finasteride) 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.
ANDROGEN HORMONE INHIBITORS DUTASTERIDE (compare to Avodart®) *QTY LIMIT:* 1 capsule/day FINASTERIDE (compare to Proscar®) *QTY LIMIT:*1 tablet/day	Avodart® (dutasteride) *QTY LIMIT:*1 capsule/day Finasteride (compare to Proscar®) females; males age < 45 *QTY LIMIT:*1 tablet/day Proscar® (finasteride) *QTY LIMIT:*1 tablet/day	
COMBINATION PRODUCT	Dutasteride/tamsulosin (compare to Jalyn®) *QTY LIMIT:*1 capsule/day Jalyn® (dutasteride/tamsulosin) *QTY LIMIT:*1 capsule/day	
BULK POWDERS		
https://dvha.vermont.gov/sites/dvha/files/documents/providers/Pharmacy/Covered%20Compounding%20Products_09.25.20.pdf		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
CARDIAC GLYCOSIDES		
DIGOXIN DIGOXIN Oral Solution		
CHEMICAL DEPENDENCY		
ALCOHOL DEPENDENCY		
ACAMPROSATE DISULFIRAM 250 mg, 500 mg tab (compare to Antabuse®) NALTREXONE oral ***Preferred After Clinical Criteria Are Met*** VIVITROL® (naltrexone for extended-release injectable suspension) *QTY LIMIT:* 1 injection (380 mg) per 30 days	Antabuse® (disulfiram)	**Antabuse**: The patient has had a documented intolerance to the generic equivalent product
OPIATE DEPENDENCY		
NALTREXONE oral BUPRENORPHINE/NALOXONE (formerly Suboxone®) sublingual TABLET *QTY LIMIT:* 8 mg = 2 tablets/day (Maximum Daily Dose = 16 mg/day, PA required for over 16 mg) SUBOXONE® sublingual FILM (buprenorphine/naloxone) *QTY LIMIT:* 8 mg = 2 films per day, 4 and 12 mg = 1 film per day (Maximum daily Dose = 16 mg/day, PA required for over 16 mg) ***Maximum days supply for Suboxone Films, Buprenorphine/naloxone tablets is 30 days*** Note: Methadone for opiate dependency can only be prescribed through a Methadone Maintenance Clinic ***Preferred After Clinical Criteria Are Met*** VIVITROL® (naltrexone for extended-release injectable suspension)	Buprenorphine sublingual TABLET (formerly Subutex®) *QTY LIMIT:* 2 mg = 3 tablets per day, 8 mg = 2 tablets/day Maximum Daily Dose = 16 mg/day Buprenorphine/naloxone (compare to Suboxone®) sublingual FILM *QTY LIMIT:* 8 mg = 2 films per day, 4 and 12 mg = 1 film per day Maximum daily Dose = 16 mg/day Bunavail® (buprenorphine/naloxone) buccal film *QTY LIMIT:* 2.1/0.3 mg = 1 film per day, 4.2/0.7 mg = 2 films per day Zubsolv® (buprenorphine/naloxone) sublingual tablet *QTY LIMIT:* 1 film per day of all strengths ****Maximum days supply for oral buprenorphine/naloxone films or buprenorphine is 30 days**** Probuphine® (buprenorphine) subdermal implant *QTY LIMIT:* 4 implants per 6 months	**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. **Bunavail, Zubsolv:** Clinical documentation is submitted detailing a provider-observed reaction to both Suboxone films and buprenorphine/naloxone tablets severe enough to require discontinuation (documentation of measures tried to mitigate/manage symptoms is required). **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

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
QTY LIMIT: 1 injection (380 mg) per 30 days	Maximum length of therapy = 1 year Sublocade® (buprenorphine extended-release) injection *QTY LIMIT:* Maximum 30-day supply	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 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		
<u>Central Alpha Agonists</u> 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.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
OVERDOSE TREATMENT		
NALOXONE HCL Prefilled luer-lock needleless syringe plus intranasal mucosal atomizing device (Rescue kit) NARCAN® (naloxone hcl) Nasal Spray *QTY 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.**
CUSHING'S DISEASE		
All products require PA	Isturisa® (osilodrostat) tablets Korlym® tablets (mifepristone) *QTY LIMIT: 4 tablets/day* Signifor® (pasireotide) Ampules *QTY LIMIT: all strengths = 2 ml (2 amps)/day* Maximum day supply = *30 days*	**Korlym:** Patient is ≥18 years of age AND Patient has a diagnosis of endogenous Cushing's syndrome AND Patient is diagnosed with type 2 diabetes mellitus or glucose intolerance AND Patient has hyperglycemia secondary to hypercortisolism AND Patient has failed or is not a candidate for surgery AND Patient has a documented side effect, allergy, treatment failure or contraindication to at least 2 adrenolytic medications (e.g. ketoconazole, etomidate) AND Patient does not have any of the following contraindications to Korlym: Pregnancy (pregnancy must be excluded before the initiation of therapy or if treatment is interrupted for >14 days in females of reproductive potential. Nonhormonal contraceptives should be used during and one month after stopping treatment in all women of reproductive potential) OR Patient requires concomitant treatment with systemic corticosteroids for serious medical conditions/illnesses (immunosuppression for organ transplant) OR Patient has a history of unexplained vaginal bleeding OR Patient has endometrial hyperplasia with atypia or endometrial carcinoma OR Patient is concomitantly taking simvastatin, lovastatin, or a CYP3A substrate with a narrow therapeutic index (e.g., cyclosporine, dihydroergotamine, ergotamine, fentanyl, pimozide, quinidine, sirolimus, or tacrolimus). **Isturisa, Signifor:** Patient has a diagnosis of (pituitary) Cushing's disease AND Patient is 18 years of age or older AND Pituitary surgery is not an option or has not been curative Note: Re-approval requires confirmation that the patient has experienced an objective response to therapy (i.e., clinically meaningful reduction in 24-hour urinary free cortisol levels and/or improvement in signs or symptoms of the disease).
GASTROINTESTINAL AGENTS: BOWEL PREP AGENTS, CONSTIPATION/DIARRHEA, IRRITABLE BOWEL SYNDROME-CONSTRIPATION (IBS-C), IRRITABLE BOWEL SYNDROME-DIARRHEA (IBS-D), SHORT BOWEL SYNDROME, OPIOID INDUCED CONSTIPATION		
Constipation: Chronic, IBS_C, or Opioid-Induced: Length of approval for non-preferred agents: Initial PA of 3 months and & 12 months thereafter		
BULK-PRODUCING LAXATIVES PSYLLIUM		**Linzess 72mcg:** The patient is 18 years of age or older. AND The patient has a

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
OSMOTIC LAXATIVES LACTULOSE POLYETHYLENE GLYCOL 3350 (PEG) **STIMULANT LAXATIVE** BISACODYL SENNA **STOOL SOFTENER** DOCUSATE **MISCELLANEOUS** DICYCLOMINE **GUANYLATE CYCLASE-C AGONIST** LINZESS® (linaclotide) 145 mcg and 290 mcg *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 **5-HT4 RECEPTOR ANTAGONISTS** All products require PA	Linzess® (linaclotide) 72mcg *QTY LIMIT:* 1 capsule/day Trulance (plecanatide) *QTY LIMIT:* 1 tablet/day Relistor® (methylnaltrexone) tablets *QTY LIMIT:* 3 tablets/day Relistor® (methylnatrexone) injection Symproic® (naldemedine) *QTY LIMIT:* 1 tablet/day Motegrity® (prucalopride) *QTY LIMIT:* 1 tablet/day	diagnosis of chronic idiopathic constipation (CIC) AND the patient is unable to tolerate the 145 mcg dose **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. **Motegrity, 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 day supply = 30 days	**Gattex:** Patient has a diagnosis of short bowel syndrome AND Patient is receiving specialized nutritional support administered intravenously (i.e. parenteral nutrition) AND Patient is 18 years of age or older AND Patient does not have an active gastrointestinal malignancy (gastrointestinal tract, hepatobiliary,

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		pancreatic), colorectal cancer, or small bowel cancer. Note: Re-approval requires evidence of decreased parenteral nutrition support from baseline.
Antidiarrheal: HIV/AIDs: Length of approval: Initial approval 3 months, subsequent 1 year		
DIPHENOXYLATE/ATROPINE LOPERAMIDE	Mytesi® (crofelemer) 125 mg DR Tablets *QTY LIMIT:* 2 tablets/day	**Mytesi:** Patient has HIV/AIDS and is receiving anti-retroviral therapy AND Patient is at least 18 years of age AND Patient requires symptomatic relief of noninfectious diarrhea AND Infectious diarrhea (e.g. cryptosporidiosis, c. difficile, etc.) has been ruled out AND Patient has tried and failed at least one anti-diarrheal medication (i.e. loperamide or atropine/diphenoxylate)
Antidiarrheal: IBS-D: Length of approval: Initial approval 3 months; subsequent 1 year		
All products require PA	Alosetron (compare to Lotronex®) Lotronex® (alosetron) Viberzi® (eluxadoline) Xermelo™ (telotristat ethyl) *QTY LIMIT:* 3 tablets/day	**Lotronex/alosetron:** The patient is a woman and has a diagnosis of severe diarrhea-predominant irritable bowel syndrome (IBS) with symptoms lasting 6 months or longer AND has had anatomic or biochemical abnormalities of the GI tract excluded AND has not responded adequately to conventional therapies loperamide, cholestyramine, and TCA's. For approval of generic alosetron, the patient must have documented intolerance to brand Lotronex. **Viberzi:** The patient has a diagnosis of IBS-D AND does not have any of the following contraindications to therapy A) known or suspected biliary duct obstruction, or sphincter of Oddi disease or dysfunction B) alcoholism, alcohol abuse, alcohol addiction, or drink more than 3 alcoholic beverages/day C) a history of pancreatitis; structural diseases of the pancreas D) severe hepatic impairment (Child-Pugh Class C) AND has not responded adequately to conventional therapies loperamide, cholestyramine, and TCA's. **Xermelo:** The patient has a diagnosis of carcinoid syndrome diarrhea AND had an inadequate treatment response (defined as 4 or more bowel movements per day) despite use of a long-acting somatostatin analog for at least 3 consecutive months AND the medication will be used in combination with a long-acting somatostatin analog therapy. For reauthorization, documentation showing a decrease in the number of bowel movements per day is required. **Note:** Xermelo will not be approved in treatment naïve patients or as monotherapy.
BOWEL PREP AGENTS		
GAVILTYE-G, GAVILYTE-H, GAVILYTE-N MOVIPREP PEG-3350 SUPREP®	Clenpiq® Gavilyte-C Golytely Nulytely Plenvu®	**Non-preferred agents:** The patient has a documented intolerance or treatment failure of at least one preferred agent (defined by failure to complete cleansing of the colon as a preparation for colonoscopy) AND if the product has an AB rated generic, there must have been a trial with the generic formulation.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Sutab®	
CONTINUOUS GLUCOSE MONITORS		
Initial approval will be granted for 6 months; renewals up to 1 year thereafter		
Preferred After Clinical Criteria Are Met DEXCOM G6 **Initial prescription:** 1 receiver, 1 wireless transmitter, and 1 3-pack of sensors **Refill Quantity Limits:** 1 transmitter every 3 months, 1 sensor every 10 days (maximum of 9 sensors every 90 days) FREESTYLE LIBRE PRO (10-DAY SENSORS) **Initial Prescription:** 1 reader, 3 sensors **Refill Quantity Limits:** 1 sensor every 10 days (maximum of 9 sensors every 90 days) FREESTYLE LIBRE 14 DAY (14-DAY SENSORS) **Initial Prescription:** 1 reader, 2 sensors **Refill Quantity Limits:** 1 sensor every 14 days (maximum of 6 sensors every 84 days) FREESTYLE LIBRE 2 (14-DAY SENSORS) **Initial Prescription:** 1 reader, 2 sensors **Refill Quantity Limits:** 1 sensor every 14 days (maximum of 6 sensors every 84 days)	Medtronic Guardian™ Connect **Initial Prescription**: 1 transmitter, 5 sensors **Refill Quantity Limits:** 1 transmitter every year, 1 sensor every 7 days (maximum of 5 sensors every 35 days) Medtronic 670G Guardian Link 3 **Initial Prescription:** 1 transmitter, 5 sensors **Refill Quantity Limits:** 1 transmitter every year, 1 sensor every 7 days (maximum of 5 sensors every 35 days) Medtronic 770G Guardian Link 3 **Initial Prescription:** 1 transmitter, 5 sensors **Refill Quantity Limits:** 1 transmitter every year 1 sensor every 7 days (maximum of 5 sensors every 35 days) Medtronic MiniLink (includes Enlite Serter) **Initial Prescription:** 1 transmitter, 5 sensors **Refill Quantity Limits:** 1 transmitter every year, 1 sensor every 7 days (maximum of 5 sensors every 35 days)	Patient has a diagnosis of Diabetes Mellitus AND • 2 years of age or older for Dexcom G6, ≥ 14 years for Medtronic Guardian, or ≥ 4 years for Freestyle Libre 2, or ≥ 18 for Freestyle Libre AND • Patient requires multiple daily injections of a rapid/short acting insulin or is on an insulin pump. • Approval of non-preferred products will be limited to cases where the CGM is directly integrated with the patient's insulin pump. The make and model of pump must be documented on the prior authorization. **Re-authorization:** • There is documented evidence of compliance to CGM (log data and/or office visit notes required). • Replacement will be considered when medically necessary and not for recent technology upgrades (device must be malfunctioning and out of warranty).
CONTRACEPTIVES		
SELECT PRODUCTS: Length of approval: 1 year **MONOPHASIC AGENTS:**		
Due to the extensive list of products, any monophasic BCP not listed as non-preferred is considered preferred.	Beyaz (drospirenone/ethinyl estradiol/levomefol) Blisovi FE 24 (norethindrone/ethinyl estradiol/FE) Drospirenone/ethinyl estradiol/levomefol Kaitlib (norethindrone/ethinyl	**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
	estradiol/FE) Layolis FE (norethindrone/ethinyl estradiol/FE) Lo-Estrin (norethindrone/ethinyl estradiol) Lo-Estrin FE (norethindrone/ ethinyl estradiol/FE) Melodetta FE (drospirenone/ethinyl estradiol/levomefol) Mibelis FE (norethindrone/ethinyl estradiol/FE) Nexstellis (drospirenone/estetrol) Noretin-Eth Estra-Ferros Fum Tab Chew 0.8-25(24) (norethindrone/ethinyl estradiol/FE) Noretin-Eth Estra-Ferros Fum Tab Chew 1MG-20(24) (norethindrone/ethinyl estradiol/FE) Ogestrel (norgestrel/ethinyl estradiol) Sayfral (drospirenone/ethinyl estradiol/levomefol) Taytulla (norethindrone/ethinyl estradiol/FE) Wymza FE (norethindrone/ethinyl estradiol/FE) Yaz (drospirenone/ ethinyl estradiol) Yasmin 28 (drospirenone/ ethinyl estradiol)	
BIPHASIC AGENTS		
AZURETTE (desogestrel/ ethinyl estradiol) BEKYREE (desogestrel/ethinyl estradiol) DESOGESTREL ETHINYL ESTRADIOL KARIVA (desogestrel/ ethinyl estradiol) KIMIDESS (desogestrel/ethinyl estradiol) NORETHIDRONE/ETHINYL ESTRADIOL 0.5/1-35 PIMTREA (desogestrel/ ethinyl estradiol) SIMLIYA (desogestrel/ethinyl estradiol) VIORELE (desogestrel/ ethinyl estradiol) VOLNEA (desogestrel/ethinyl estradiol)	Lo Loestrin FE (norethindrone/ ethinyl estradiol/FE) Mircette (desogestrel/ ethinyl estradiol)	**Non-preferred agents:** Trial with at least three preferred contraceptive products including the preferred formulation of the requested non-preferred agent
TRIPHASIC AGENTS		
ALYACEN (norethindrone ethinyl estradiol) ARANELLE (norethindrone/ethinyl estradiol) CAZIANT (desogestrel/ ethinyl estradiol) CYCLAFEM (norethindrone/ethinyl estradiol) DASETTA (norethindrone/ethinyl estradiol)	Estrostep FE (norethindrone/ethinyl estradiol/FE) Tilia FE (norethindrone/ethinyl estradiol/FE) Tri-Legest FE (norethindrone/ethinyl estradiol/FE)	**Non-preferred agents:** Trial with at least three preferred contraceptive products including the preferred formulation of the requested non-preferred agent

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ENPRESSE (levonorgestrel/ ethinyl estradiol) LEENA (norethindrone/ethinyl estradiol) LEVONEST (levonorgestrel/ ethinyl estradiol)) NATAZIA (dienogest/estradiol valerate) NORGESTIMATE ETHINYL ESTRADIOL NORTREL 7/7/7 (norethindrone/ethinyl estradiol) PIRMELLA (norethindrone/ethinyl estradiol) TRI-ESTARYLLA (norgestimate/ ethinyl estradiol) TRI-FEMYNOR (norgestimate/ ethinyl estradiol) TRI-LINYAH (norgestimate/ ethinyl estradiol) TRI-LO-ESTARYLLA (norgestimate/ethinyl estradiol) TRI-LO-MARZIA (norgestimate/ethinyl estradiol) TRI-LO-SPRINTEC (norgestimate/ethinyl estradiol) TRI-PREVIFEM (norgestimate/ ethinyl estradiol) TRI-SPRINTEC (norgestimate/ ethinyl estradiol) TRI-VYLIBRA (norgestimate/ ethinyl estradiol) TRI-VYLIBRA LO (norgestimate/ ethinyl estradiol) TRIVORA (levonorgestrel/ ethinyl estradiol) VELIVET (desogestrel/ ethinyl estradiol)		
EXTENDED CYCLE		
AMETHIA (levonorgestrel/ ethinyl estradiol) AMETHIA LO (levonorgestrel/ ethinyl estradiol) AMETHYST (levonorgestrel/ ethinyl estradiol) ASHLYNA (levonorgestrel/ ethinyl estradiol) CAMRESE (levonorgestrel/ ethinyl estradiol) CAMRESE LO (levonorgestrel/ ethinyl estradiol) DAYSEE (levonorgestrel/ ethinyl estradiol) INTROVALE (levonorgestrel/ ethinyl estradiol 3MTH) JAIMIESS (levonorgestrel/ ethinyl estradiol) JOLESSA (levonorgestrel/ ethinyl estradiol 3MTH) LEVONORGESTREL ETHINYL ESTRADIOL TBDSPK 3 month LO-SEASONIQUE (levonorgestrel/ ethinyl estradiol) SIMPESSE (levonorgestrel/ ethinyl estradiol) SEASONIQUE (levonorgestrel/ ethinyl estradiol) SETLAKIN (levonorgestrel/ethinyl estradiol)	Fayosim (levonorgestrel/ ethinyl estradiol) Quartette (levonorgestrel/ ethinyl estradiol) Rivelsa (levonorgestrel/ ethinyl estradiol)	**Non-preferred agents:** Trial with at least three preferred contraceptive products including the preferred formulation of the requested non-preferred agent
PROGESTIN ONLY CONTRACEPTIVES		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
CAMILA (norethindrone) DEBLITANE (norethindrone) ERRIN (norethindrone) HEATHER (norethindrone) INCASSIA (norethindrone) JENCYCLA (norethindrone) JOLIVETTE (norethindrone) LYZA (norethindrone) NORA-BE (norethindrone) NORETHINDRONE 0.35MG NORLYNDA (norethindrone) SHAROBEL (norethindrone) TULANA (norethindrone)	Ortho® Micronor (norethindrone) Slynd® (drospirenone)	**Non-preferred agents:** Trial with at least three preferred contraceptive products including the preferred formulation of the requested non-preferred agent.
INJECTABLE CONTRACEPTIVES		
MEDROXYPROGESTERONE ACETATE 150MG (IM) VIAL/SYRINGE DEPO-PROVERA 104 (SUB-Q) SYRINGE (medroxyprogesterone acetate)	Depo-Provera (IM) (medroxyprogesterone acetate) 150 mg Susp vial/syringe	**Depo-Provera IM:** Patient must have a documented intolerance to medroxyprogesterone acetate 150mg.
VAGINAL RING		
ETONOGESTREL/ETHINYL ESTRADIOL vaginal ring	Annovera® (segesterone acetate/ethinyl estradiol vaginal ring) *QTY LIMIT:* 1 ring/year Eluryng (etonogestrel/ethinyl estradiol vaginal ring)	**Non-preferred agents:** Trial with at least three preferred contraceptive products including the preferred formulation of the requested non-preferred agent.
LONG ACTING REVERSIBLE CONTRACEPTIVES (LARCs)		
KYLEENA (levonorgestrel) IUD LILETTA (levonorgestrel) IUD MIRENA (levonorgestrel) IUD PARAGARD (copper) IUD SKYLA (levonorgestrel) IUD NEXPLANON (etonogestrel) Implant		
TOPICAL CONTRACEPTIVES		
XULANE PATCH (norelgestromin/ ethinyl estradiol)	Twirla® (levonorgestrel/ethinyl estradiol) patch	**Twirla:** 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
VAGINAL CONTRACEPTIVES		
Please refer to the DVHA website for covered OTC spermicidal gels https://dvha.vermont.gov/sites/dvha/files/documents/providers/Pharmacy/OTCWebList.pdf	Phexxi™ (lactic acid, citric acid, and potassium bitartrate) vaginal gel	**Phexxi:** Use of hormonal contraceptives is contraindicated AND the patient has a documented side effect or allergy to nonoxynol-9
EMERGENCY CONTRACEPTIVES		
AFTERA (levonorgestrel) ECONTRA EZ (levonorgestrel) LEVONORGESTREL MY CHOICE (levonorgestrel) MY WAY (levonorgestrel) NEW DAY (levonorgestrel) OPCICON ONE-STEP (levonorgestrel) OPTION 2 (levonorgestrel) TAKE ACTION (levonorgestrel)		
CORONARY VASODILATORS/ANTIANGINALS/SINUS NODE INHIBITORS		
ORAL		
ISOSORBIDE DINITRATE tablet (compare to Isordil®) ISOSORBIDE DINITRATE ER tablet ISOSORBIDE MONONITRATE tablet ISOSORBIDE MONONITRATE ER tablet NITROGLYCERIN SPRAY LINGUAL (compare to Nitrolingual Pump Spray®) NITROSTAT® (nitroglycerin SL tablet) RANOLAZINE SR 12 HR (compare to Ranexa®) *QTY LIMIT:* 500 mg = 3 tablets/day, 1000 mg = 2 tablets/day	BiDil® (isosorbide dinitrate/hydralazine) Dilatrate-SR® (isosorbide dinitrate SR capsule) Isosorbide dinitrate SL tablet Isordil® (isosorbide dinitrate tablet) Nitrolingual Pump Spray® Ranexa® (ranolazine) *QTY LIMIT:* 500 mg = 3 tablets/day, 1000 mg = 2 tablets/day	**Dilatrate-SR, Isosorbide dinitrate SL tablet, Isordil:** the patient has had a side effect, allergy, or treatment failure to at least two preferred agents. **Nitrolingual Pump Spray:** the patient has had a side effect, allergy, or treatment failure to Nitroglycerin spray lingual. **Bidil:** The prescriber provides a clinically valid reason why the patient cannot use isosorbide dinitrate and hydralazine as separate agents. **Ranexa:** the patient has a documented intolerance to the generic equivalent.
TOPICAL		
NITRO-BID® (nitroglycerin ointment) NITROGLYCERIN TRANSDERMAL PATCHES (compare to Nitro-Dur®)	Nitro-Dur® (nitroglycerin transdermal patch)	**Nitro-Dur:** patient has had a side effect, allergy, or treatment failure to generic nitroglycerin transdermal patches.
SINUS NODE INHIBITORS		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Corlanor® (ivabradine) *QTY LIMIT:* 60 tabs/30 days	**Corlanor Clinical 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		
DEXAMETHASONE tablets, elixir, intensol, solution DEXPAK® tabs (dexamethasone taper pack) HYDROCORTISONE tab (compare to Cortef®) MEDROL® (methylprednisolone) 2mg tablets METHYLPREDNISOLONE (compare to Medrol®) tabs METHYLPREDNISOLONE DOSE PACK (compare to Medrol Dose Pack®) tabs PREDNISOLONE 3 mg/ml oral solution, syrup PREDNISOLONE SODIUM PHOSPHATE 3 mg/ml oral solution (compare to Orapred®) PREDNISOLONE SOD PHOSPHATE ORAL SOLUTION 6.7mg/5ml (5mg/5ml base) (compare to Pediapred®) PREDNISONE intensol, solution, tablets	Alkindi® Sprinkle (hydrocortisone) granule Cortef® (hydrocortisone) tablets Hemady® (dexamethasone) tablets Medrol® (methylprednisolone) tablets Medrol Dose Pak® (methylprednisolone) tabs Prednisolone sodium phosphate oral solution 25 mg/5ml Rayos® (prednisone) Delayed Release Tablet *QTY LIMIT:* 1 tablet/day	**Rayos:** The patient has had a trial of generic immediate release prednisone and has documented side effects that are associated with the later onset of activity of immediate release prednisone taken in the morning. **All Others:** The patient has a documented side effect, allergy, or treatment failure to at least two preferred medications. If a product has an AB rated generic, one trial must be the generic formulation.
COUGH AND COLD PREPARATIONS		
Please refer to the DVHA website for covered OTC cough & cold products https://dvha.vermont.gov/sites/dvha/files/documents/providers/Pharmacy/OTCWebList.pdf All RX generics MUCINEX ® (guaifenesin) 600mg ER 12HR tab **Note:** The FDA restricts the use of prescription codeine pain and cough medicines in children.	Hydrocodone/chlorpheniramine (compare to Tussionex®) *QTY LIMIT:* 60 ml/RX Tussionex® (hydrocodone/chlorpheniramine) *QTY LIMIT:* 60 ml/RX TussiCaps® (hydrocodone/chlorpheniramine) *QTY LIMIT:* 12 capsules/RX All other brands	**Tussionex, TussiCaps, Hydrocodone/chlorpheniramine suspension (generic):** The patient has had a documented side effect, allergy, or treatment failure to two of the following generically available cough or cough/cold products: hydrocodone/homatropine (compare to Hycodan), promethazine/codeine (previously Phenergan with Codeine), guaifenesin/codeine (Cheratussin AC) or benzonatate. AND patient is 6 years old of age or greater. AND The quantity requested does not exceed 60 ml (Tussionex) or 12 capsules (TussiCaps). AND If the request is for Tussionex, the patient has a documented intolerance to generic hydrocodone/chlorpheniramine suspension.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
Prior authorization is required for patients <12 years of age.		**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 *QTY LIMIT:* 56 vials/56 days; maximum day supply = 56 days (2 vials/day for 28 days, then 28 days off) KITABIS® (tobramycin sol) *QTY LIMIT:* 56 vials/56 days; maximum day supply = 56 days (2 vials/day for 28 days, then 28 days off) TOBI® PODHaler (tobramycin capsules for inhalation) *QTY LIMIT:* 224 capsules/56 days; maximum day supply = 56 days (4 capsules twice daily for 28 days, then 28 days off) TOBRAMYCIN inhalation solution (compare to Tobi®) 300mg/5mL *QTY LIMIT:* 56 vials/56 days; maximum day supply = 56 days (2 vials/day for 28 days, then 28 days off)	Bronchitol® (mannitol) capsules for inhalation *QTY LIMIT:* 560 capsules/28 days; maximum day supply = 28 days Cayston® (aztreonam) inhalation solution *QTY LIMIT:* 84 vials/56 days; maximum day supply = 56 days (3 vials/day for 28 days, then 28 days off) Kalydeco® (ivacaftor) tablets *QTY LIMIT:* 2 tablets/day, maximum day supply = 30 days Kalydeco® (ivacaftor) packets *QTY LIMIT:* 2 packets/day; maximum day supply = 30 days Orkambi® (lumacaftor/ivacaftor) *QTY LIMIT:* 120/30 days; maximum day supply=30 days Pulmozyme® (dornase alfa) inhalation solution *QTY LIMIT:* 60/30 days; maximum day supply=30 days Symdeko® (tezacaftor/ivacaftor and ivacaftor) *QTY LIMIT:* 56/28 days; maximum day supply = 28 days TOBI® (tobramycin) inhalation solution *QTY LIMIT:* 56 vials/56 days; maximum day supply = 56 days (2 vials/day for 28 days, then 28 days off) Tobramycin inhalation solution 300mg/4mL *QTY LIMIT:* 56 vials/56 days; maximum day supply = 56 days (2 vials/day for 28 days, then 28 days off) Trikafta® (elexacaftor/tezacaftor/ivacaftor) QTY LIMIT: 84/28 days; maximum day supply = 28 days	**Bethkis, Kitabis, Tobramycin inhalation solution (300mg/5mL), Pulmozyme:** diagnosis or indication is cystic fibrosis **TOBI, tobramycin inhalation solutions (300mg/4mL):** Diagnosis or indication is cystic fibrosis and the patient has a documented failure or intolerance to two preferred formulations of tobramycin inhalation solution. **Bronchitol:** Diagnosis or indication is cystic fibrosis AND the patient is 18 years of age or older AND the patient has a documented inadequate response or contraindication to hypertonic saline and Pulmozyme AND the patient has passed the Bronchitol Tolerance Test (BTT) AND the patient has been counseled to use a short-acting beta agonist (SABA) 5-15 minutes prior to each dose. **Cayston:** diagnosis or indication is cystic fibrosis and the patient has had a documented failure, intolerance or inadequate response to inhaled tobramycin therapy alone **Kalydeco:** The patient has a diagnosis of Cystic Fibrosis AND Patient has a mutation on at least one allele in the cystic fibrosis transmembrane conductance regulator gene (CFTR gene) shown to be responsive to Kalydeco per FDA approval (documentation provided). AND The patient is ≥ 6 months old. Note: Renewal of Prior Authorization will require documentation of member response. **TOBI PODHALER:** allowed after a trial of another form of inhaled tobramycin **Orkambi/Symdeko/Trikafta:** The patient has a diagnosis of Cystic Fibrosis AND Initial Criteria • ≥ 2 years of age for Orkambi or ≥ 6 years of age for Symdeko or Trikafta • Patient must have a confirmed mutation in the CFTR gene shown to be responsive to the requested medication per FDA approval (documentation provided) • 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 clinically documented improvement in lung function (will be applied to the first renewal request only; requirement waived on subsequent renewals)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		• 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
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.
ANTIBIOTICS TOPICAL		
SINGLE AGENT BACITRACIN MUPIROCIN OINTMENT (compare to Bactroban®) **COMBINATION PRODUCTS** BACITRACIN-POLYMYXIN NEOMYCIN-BACITRACIN-POLYMYXIN *C=cream, F=foam, G=gel, L=lotion, O=ointment, S=solution*	Centany® Ointment (mupirocin) Gentamicin Cream or Ointment Mupirocin cream (compare to Bactroban®) Xepi cream (ozenoxacin) Cortisporin® Cream (neomycin-polymyxin-hydrocortisone) Cortisporin® Ointment(bacitracin-neomycin-polymyxin-hydrocortisone) All other branded products	**Mupirocin cream, Centany Ointment, Xepi cream:** The patient has had a documented intolerance with generic mupirocin ointment **Cortisporin Cream or Ointment, Gentamicin Cream or Ointment:** The patient has had a documented side-effect, allergy or treatment failure with at least one preferred generic topical antibiotic

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ANTIFUNGALS: ONYCHOMYCOSIS		
CICLOPIROX 8 % solution *QTY LIMIT:* 6.6 ml/90 days	Ciclodan® (ciclopirox 8% solution) Kerydin® (tavaborole 5% solution) Jublia® (efinaconazole 10% solution) *QTY LIMIT:* 48 weeks treatment	**Ciclodan, Jublia, Kerydin:** The patient meets at least 1 of the following criteria: Pain to affected area that limits normal activity, Diabetes Mellitus, Patient is immunocompromised, Patient has diagnosis of systemic dermatosis, Patient has significant vascular compromise AND Documented intolerance to generic ciclopirox 8% solution. **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 0.77% C, Sus, G; 1% Sh CLOTRIMAZOLE 1% C, S KETOCONAZOLE 2% C, 2% Sh MICONAZOLE all generic/OTC products NYSTATIN O, C, P (compare to Mycostatin®, Nystop®, Nyamyc®) TOLNAFTATE 1% C, P, S **COMBINATION PRODUCTS** CLOTRIMAZOLE W/ BETAMETHASONE C, L NYSTATIN W/TRIAMCINOLONE C, O *C=cream, F=foam, G=gel, L=lotion, P=powder, S=solution, Sh=shampoo, Sp=spray, Sus=suspension*	Butenafine (compare to Mentax®) 1% C Ciclodan® (ciclopirox) C Econazole 1% C Ertaczo® (sertaconazole) 2% C Extina® (ketoconazole) 2% F Ketoconazole (compare to Extina®) 2 % Foam Luliconazole 1% C Luzu® (luliconazole) 1% Cream Mentax® 1% C Naftifine (compare to Naftin®) 1% & 2% C, 1% G Naftin® (naftifine) 1% C, 1%, 2% G Nystop®, Nyamyc® (nystatin) P Oxistat® (oxiconazole) 1% C Miconazole w/ zinc oxide (compare to Vusion®) O *QTY LIMIT: 50 g/30 days* Vusion® (miconazole w/zinc oxide) O *QTY LIMIT: 50 g/30 days* **All other branded products** **Note**: Please refer to "Dermatological: Antifungals: Onychomycosis" for ciclopirox solution	**All Non-Preferred Agents (except Vusion):** The patient has had a documented side effect, allergy, or treatment failure to at least TWO different preferred generic topical antifungal agents. (If a product has an AB rated generic, one trial must be the generic equivalent of the requested product.) OR The patient has a contraindication that supports the need for a specific product or dosage form of a brand topical antifungal. **Miconazole w/ Zinc Oxide, Vusion:** The patient has a diagnosis of diaper dermatitis complicated by documented candidiasis AND The patient is at least 4 weeks of age. AND The patient has had two trials (with two different preferred antifungal agents) used in combination with a zinc oxide diaper rash product resulting in documented side effects, allergy, or treatment failures.
ANTIVIRALS: TOPICAL		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
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 docosanol 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. **
AXILLARY HYPERHIDROSIS THERAPY		
Xerac-AC (aluminum chloride) 6.25% Solution	Qbrexza™ (glycopyrronium) 2.4% single use pads *QTY LIMIT:* 30 pads/month	**Qbrexza**: the patient has had a documented side effect, allergy, or treatment failure with Xerac-AC
CORTICOSTEROIDS: LOW POTENCY		
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 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®) HYDROCORTISONE VALERATE 0.2% C, O MOMETASONE FUROATE 0.1% C, L, O, S (compare to Elocon®) TRIAMCINOLONE ACETONIDE 0.025%, 0.1% C, L, O	Beser™ (fluticasone) 0.05% L Clocortolone 0.1% C (compare to Cloderm®) Cloderm® (clocortolone) 0.1% C Cutivate® (fluticasone) 0.05% L Desoximetasone 0.05% C, O (compare to Topicort®) Flurandrenolide (compare to Cordran®) C, L, O Fluticasone (compare to Cutivate®) 0.05%, L Hydrocortisone Butyrate 0.1% C, O, S Kenalog® (triamcinolone) Aerosol Spray Luxiq® (betamethasone valerate) F Prednicarbate 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	**CRITERIA FOR APPROVAL (NON-PREFERRED AGENTS):** The patient has a documented side effect, allergy, or treatment failure to at least two different preferred agents of similar potency. (If a product has an AB rated generic, one trial must be the generic.)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
C=cream, F=foam, G=gel, L=lotion, O=ointment, S=solution	All other brands	
CORTICOSTEROIDS: HIGH POTENCY		
AUGMENTED BETAMETHASONE 0.05% C, L (compare to Diprolene® AF) BETAMETHASONE VALERATE 0.1% C, O DESOXIMETASONE 0.05% G; 0.25% C, O (compare to Topicort®) FLUOCINONIDE 0.05% C, G, O, TRIAMCINOLONE ACETONIDE 0.5% C, O *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 Halcinonide 0.1% C 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		
AUGMENTED BETAMETHASONE 0.05% C, L, O (compare to Diprolene®) 0.05% G CLOBETASOL PROPIONATE (compare to Temovate®/Cormax®) 0.05%, C, G, L, O, S, Spray HALOBETASOL PROPIONATE (compare to Ultravate®) 0.05% C, O *C=cream, F=foam, G=gel, L=lotion, O=ointment, S=solution*	Bryhali® (halobetasol propionate) L Clobetasol propionate (compare to Clobex®) 0.05% Sh Clobetasol 0.05% F (compare to Oulux®) Clobetasol propionate emulsion (compare to Olux E®) 0.05% F Clobex® (clobetasol propionate) 0.05% L, Sh, Spray Diprolene® (augmented betamethasone) 0.05% L, O Diprolene® AF 0.05% C Fluocinonide (compare to Vanos®)0.1% C Halobetasol (compare to Lexette™) 0.05% F Impeklo™ (clobetasol propionate) 0.05% L Lexette™ (halobetasol) 0.05% F Olux®/Olux E® (clobetasol propionate) 0.05% F Temovate® (clobetasol propionate) 0.05% C, O Tovet® (clobetasol propionate aerosol) 0.05% F Vanos® (fluocinonide) 0.1% C Ultravate® (halobetasol propionate) 0.05% C, O All other brands	**CRITERIA FOR APPROVAL (NON-PREFERRED AGENTS):** The patient has a documented side effect, allergy, or treatment failure to at least two different preferred agents of similar potency. (If a product has an AB rated generic, one trial must be the generic.)
GENITAL WART THERAPY		
IMIQUIMOD 5 % (compare to Aldara®) cream PODOFILOX SOLUTION (compare to Condylox®)	Aldara® (imiquimod) 5% cream Condylox® Gel (podofilox gel) Imiquimod (compare to Zyclara®) 3.75% Cream Pump *QTY LIMIT:* 2 pumps/ 8 weeks	**Aldara cream, Zyclara cream:** The patient has had a documented intolerance to generic imiquimod **Condylox gel, Veregan:** The patient has had a documented side effect, allergy, or treatment failure with imiquimod.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Veregan® (sinecatechins ointment) *QTY LIMIT:* 15 grams (1 tube)/per 30 days Zyclara® (imiquimod 2.5%, 3.75%) Cream *QTY LIMIT:* 56 packets/per 8 weeks Zyclara® (imiquimod 3.75%) Cream Pump *QTY LIMIT:* 2 pumps/per 8 weeks	**Imiquimod pump, Zyclara pump:** The patient has had a documented intolerance to generic imiquimod cream and Zyclara cream.
IMMUNOMODULATORS		
Preferred After Clinical Criteria Are Met DUPIXENT® (dupilumab) subcutaneous injection, prefilled syringe, and auto-injector pen *QTY LIMIT:* 4 syringes/pens the first 28 days then 2 Syringes/pens every 28 days thereafter ELIDEL® (pimecrolimus) PROTOPIC® (tacrolimus) ***Note:*** please refer to *Dermatological Agents: Corticosteroids* category for preferred topical corticosteroids.	Eucrisa® (crisaborole) Ointment Pimecrolimus cream (compare to Elidel®) Tacrolimis Ointment (compare to Protopic®)	**Criteria for Approval (topical medications)**: The patient has a diagnosis of atopic dermatitis (eczema). AND The patient has had a documented side effect, allergy, or treatment failure (defined as daily treatment for at least one month) with at least one moderate to high potency topical corticosteroid within the last 6 months. **Note:** Protopic ointment 0.1% is not indicated for use in children 2 to 15 years of age, only the 0.03% strength. Initial approval will be granted for 6 months. For re-approval after 6 months, the prescriber must submit documentation of clinical improvement in symptoms. Renewals may be granted for up to 1 year. **Elidel, Pimecrolimus additional criteria**: The patient is ≥2 years of age AND the quantity requested does not exceed 30 grams/fill and 90 grams/6 months. AND If the request is for generic forms of pimecrolimus, the patient has a documented intolerance to the brand name equivalent. **Protopic, Tacrolimus additional criteria:** The patient is ≥2 years of age AND the quantity requested does not exceed 30 grams/fill and 90 grams/6 months. AND If the request is for generic tacrolimus ointment, the patient has a documented intolerance to the brand name equivalent. **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. Trial of calcineurin inhibitor will be waived for patients ≥ 3 months through < 2 years of age. **Dupixent**: • The patient is ≥ 6 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

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		one moderate to high potency topical corticosteroid and one preferred topical calcineurin inhibitor within the last 6 months AND • Initial approval will be granted for 6 months. For re-approval after 6 months, the prescriber must submit documentation of clinical improvement in symptoms. Renewals may be granted for up to 1 year.
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 *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 Sklice® (Ivermectin 0.5 %) 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 treatment failure with two treatments of OTC permethrin and/or piperonyl butoxide and pyrethrins and one treatment of Natroba. For approval of Ovide® Lotion, the patient must also have a documented intolerance to the generic equivalent product.
DESMOPRESSIN: INTRANASAL/ORAL		
INTRANASAL All products require PA **ORAL** DESMOPRESSIN	DDAVP® (desmopressin) Nasal Solution or Spray 0.01% Desmopressin Nasal Solution or Spray 0.01 % (compare to DDAVP®) Noctiva™ (desmopressin) Nasal Spray Stimate® (desmopressin) Nasal Solution 1.5 mg/ml Nocdurna® (desmopressin) SL tablets *QTY LIMIT:* 1 tablet/day DDAVP® (desmopressin) tablets	**CRITERIA FOR APPROVAL:** **Intranasal (except as indicated below):** The diagnosis or indication for the requested medication is (1) Diabetes Insipidus, (2) hemophilia type A, or (3) Von Willebrand disease AND If the request is for brand DDAVP, the patient has a documented intolerance to generic desmopressin spray or solution. **Oral**: The diagnosis or indication for the requested medication is (1) Diabetes Insipidus and/or (2) primary nocturnal enuresis AND The patient has had a documented intolerance to generic desmopressin tablets **Nocdurna, Noctiva:** Patient is ≥18 years of age (Nocdurna) or ≥ 50 years of age (Noctiva) AND the indication for use is the treatment of nocturia due to nocturnal polyuria (defined as nighttime urine production exceeding 1/3 of the 24-hour urine production) causing patient to awaken more than 2 times per night to void for at least 6 months AND patient has eGFR > 50ml/min/1.73m2 AND patient does not have increased risk of severe hyponatremia (e.g. concomitant use of loop diuretics or corticosteroids, diagnosis of CHF, or uncontrolled hypertension) AND serum sodium concentrations are normal before starting therapy AND patient has had a

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		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. https://dvha.vermont.gov/sites/dvha/files/documents/providers/Pharmacy/Vermont%20PDSL%20July%202020.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. **LANCETS** All brands and store brands		**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.
ENDOMETRIOSIS/UTERINE FIBROIDS AGENTS		
LUPRON DEPOT® (leuprolide acetate for depot suspension) *QTY LIMIT:* 3.75 mg kit/month or 11.25 mg kit/3 months SYNAREL® (nafarelin acetate) nasal solution ZOLADEX® (goserelin acetate) implant *QTY LIMIT:* 3.6 mg/month ***Preferred After Clinical Criteria are Met*** ORIAHNN® (elagolix and elagolix/estradiol/norethindrone) capsules ORILISSA® (elagolix) tablets	Lupaneta Pack™ (leuprolide acetate for depot suspension and norethindrone acetate tablets) *QTY LIMIT:* 3.75 mg kit/month or 11.25 mg kit/3 months Myfembree® (relugolix/estradiol/norethindrone) tablet	**Lupaneta Pack:** patient has a documented intolerance to Lupron Depot and norethindrone tablets used in combination. **Myfembree:** Patient is premenopausal and is experiencing heavy menstrual bleeding associated with uterine leiomyomas (fibroids) AND patient has a documented side effect, allergy, or treatment failure to at least TWO medications from at least 2 different classes (oral contraceptives, NSAIDs, progestins) AND patient has a documented side effect, allergy, or treatment failure with Oriahnn. Approval will be limited to 1 tablet/day. Use of GnRH receptor antagonists will be limited to 2 years. **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). **Note:**

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		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. Use of GnRH receptor antagonists will be limited to 2 years. **Oriahnn:** Patient is premenopausal and is experiencing heavy menstrual bleeding associated with uterine leiomyomas (fibroids) AND patient has a documented side effect, allergy, or treatment failure to at least TWO medications from at least 2 different classes (oral contraceptives, NSAIDs, progestins). **Note:** Approval will be limited to 2 tablets/day. Use of GnRH receptor antagonists will be limited to 2 years.
EPINEPHRINE: SELF-ADMINISTERED		
EPINEPHRINE INJ (compare to EpiPen-Jr®) (authorized generic, Mylan labeler code 49502 is the only preferred form) 0.15mg EPINEPHRINE INJ (compare to EpiPen®) (authorized generic, Mylan labeler code 49502 is the only preferred form) 0.3mg	Epinephrine Inj 0.15 mg Epinephrine Inj 0.3 mg EpiPen® 2-PAK inj 0.3 mg EpiPen-Jr® 2-PAK inj 0.15 mg Symjepi® Inj 0.15mg Symjepi® Inj 0.3mg	**Non-preferred Agents:** 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 **ESTRADIOL ACETATE** FEMRING® Vaginal Ring		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
GASTROINTESTINAL		
INFLAMMATORY BOWEL DISEASE BIOLOGICS: Initial approval is 3 months; renewals are 1 year		
Preferred After Clinical Criteria Are Met **INJECTABLE** HUMIRA® (adalimumab) *QTY LIMIT*: 6 syringes/28 days for the first month (Crohn's starter kit);2 syringes/28 days subsequently REMICADE® (infliximab) RENFLEXIS™ (infliximab-abda) biosimilar to Remicade® **ORAL** XELJANZ® (tofacitinib) tablet *QTY LIMIT*: 2 tablets/day	Avsola ® (infliximab-axxq) biosimilar to Remicade Cimzia® (certolizumab pegol) *QTY LIMIT:* 1 kit/28 days Inflectra® (infliximab-dyyb) biosimilar to Remicade® Entyvio® (vedolizumab) *QTY LIMIT:* 300 mg X 3/42 days, 300 mg X 1 every 56 days thereafter Simponi® (golimumab) SC *QTY LIMIT*: 3 of 100 mg prefilled syringe or autoinjector X 1, then 100 mg/28days Stelara® (ustekinumab) Tysabri® (natalizumab) Xeljanz® XR (tofacitinib) tablet *QTY LIMIT*: 1 tablet/day	**Clinical Criteria (Crohn's Disease)** **Avsola, Humira, Remicade, Cimzia, Tysabri, Entyvio, Inflectra, Renflexis, Stelara, Xeljanz:** • 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 **Cimzia additional criteria:** • Patient age > 18 years AND • The prescriber must provide a clinically valid reason why Humira and Remicade or Renflexis cannot be used. **Avsola, Inflectra, Tysabri additional criteria:** • The prescriber must provide a clinically valid reason why Humira and Remicade or Renflexis cannot be used. **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)** **Avsola, Entyvio, Humira, Inflectra, Remicade, Renflexis, Simponi, Stelara:** • 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-

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		mercaptopurine, cyclosporine, etc.). **Avsola, Inflectra:** the prescriber must provide a clinically valid reason why Humira and Remicade or Renflexis cannot be used. **Entyvio, Simponi, Stelara additional criteria:** Age > 18 years AND the prescriber must provide a clinically valid reason why Humira and Remicade/Renflexis cannot be used. **Xeljanz XR additional criteria:** Patient has not been able to tolerate or adhere to twice daily dosing of immediate release Xeljanz, resulting in significant clinical impact. **Note:** Induction of Xeljanz 10mg twice daily or XR 22mg once daily will be limited to 16 weeks. Treatment should be discontinued after 16 weeks if adequate therapeutic response is not achieved. For patients with loss of response during maintenance treatment with 5mg twice daily or XR 11mg once daily, approval of 10mg twice daily or XR 22mg once daily will be considered and limited to the shortest duration possible.
H. PYLORI COMBINATION THERAPY		
LANSOPRAZOLE, AMOXICILLIN, CLARITHROMYCIN *QTY LIMIT:* 112 caps & tabs/14 days PYLERA® (bismuth subcitrate, metronidazole, tetracycline) capsules *QTY LIMIT:* 120 caps/10 days	Omeclamox-Pak® (omeprazole, clarithromycin, amoxicillin) *QTY LIMIT:* 80 caps & tabs/10 days Talicia® (omeprazole, amoxicillin, rifabutin) delayed release capsules *QTY LIMIT:* 168 caps/14 days	**CRITERIA FOR APPROVAL:** The patient has a documented treatment failure with Lansoprazole, amoxicillin, clarithromycin combo package or Pylera used in combination with a PPI.
H-2 BLOCKERS		
FAMOTIDINE (compare to Pepcid®) tablet	Cimetidine (compare to Tagamet®) tablet Nizatidine capsule Pepcid® (famotidine) tablet	**Cimetidine tablet, Nizatidine capsule, Pepcid tablet:** The patient has had a documented side effect, allergy, or treatment failure to famotidine.
SYRUPS AND SPECIAL DOSAGE FORMS FAMOTIDINE oral suspension (compare to Pepcid®) age ≤ 12 years	Cimetidine oral solution Famotidine (compare to Pepcid®) oral suspension (age >12 years) Nizatidine Oral Solution	**Cimetidine Oral Solution, Nizatidine oral solution:** Patient has a medical necessity for a liquid dosage form AND the patient has had a documented side effect, allergy, or treatment failure to famotidine oral suspension. **Famotidine Oral Suspension (Age >12):** Patient has a medical necessity for a liquid dosage form
INFLAMMATORY BOWEL AGENTS (ORAL & RECTAL PRODUCTS)		
MESALAMINE PRODUCTS **ORAL** ASACOL HD® (mesalamine tablet delayed release) APRISO® (mesalamine capsule extended release) LIALDA® (mesalamine tablet extended release)	Delzicol® (mesalamine capsule delayed-release) *QTY LIMIT:* 6 capsules/day Mesalamine capsule delayed release (compare to Delzicol®)	**Azulfidine, Colazal:** patient has had a documented intolerance to the generic equivalent of the requested medication. **Budesonide ER 9mg, Uceris:** The diagnosis is ulcerative colitis AND induction therapy with mesalamine (≥2 gram/day), balsalazide, or olsalazine has failed or is not tolerated AND for approval of Uceris, the patient must have a

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
PENTASA ER ® (mesalamine cap CR)	*QTY LIMIT:* 6 capsules/day Mesalamine capsule extended release 0.375gm (compare to Apriso®) Mesalamine tablet delayed release (compare to Asacol® HD) Mesalamine tablet extended release 1.2 g (compare to Lialda®)	documented intolerance to the generic budesonide ER 9mg tablets. **Delzicol, mesalamine capsule DR, Mesalamine tablet DR, Mesalamine tablet ER:** The patient has had a documented side effect, allergy, or treatment failure to 2 preferred oral mesalamine products. **Entocort EC, Ortikos:** The patient had a documented intolerance to the generic budesonide 3mg 24 hr capsules. **sfRowasa, Uceris Rectal Foam:** The patient has had a documented intolerance to mesalamine enema or suppositories. **LIMITATIONS:** Kits with non-drug products are not covered.
RECTAL MESALAMINE ENEMA (compare to Rowasa®) MESALAMINE SUPPOSITORY	sfRowasa® (mesalamine enema sulfite free)	
CORTICOSTEROIDS **ORAL** BUDESONIDE 24HR 3mg (compare to Entocort EC®) *QTY LIMIT:* 3 capsules/day	Budesonide ER 9 mg tablet (compare to Uceris®) *QTY LIMIT*: 1 tablet/day Entocort EC® (budesonide 24 hr cap) *QTY LIMIT:* 3 capsules/day Ortikos® (budesonide) ER capsule QTY LIMIT: 1 capsule/day Uceris® (budesonide) ER Tablet *QTY LIMIT:* 1 tablet/day	
RECTAL All products require PA	Uceris® Rectal Foam (budesonide)	
OTHER BALSALAZIDE (compare to Colazal®) DIPENTUM® (olsalazine) SULFAZINE SULFAZINE EC SULFASALAZINE (compare to Azulfidine®) SULFASALAZINE DR	Azulfidine® (sulfasalazine) Colazal® (balsalazide)	
PROKINETIC AGENTS		
TABLETS METOCLOPRAMIDE tabs (compare to Reglan®) **ORAL SOLUTION** METOCLOPRAMIDE oral solution	Reglan® (metoclopramide)	**Reglan:** The patient has had a documented intolerance to generic metoclopramide tablets. **Gimoti:** The patient has a documented intolerance to metoclopramide tablets and oral solution.
NASAL SPRAY All products require PA	Gimoti™ (metoclopramide) nasal spray	

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

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Prilosec® (omeprazole magnesium) packet *QTY LIMIT:* 2 packets/day Protonix® (pantoprazole) packet *QTY LIMIT:* 1 packet/day	
GAUCHER'S DISEASE MEDICATIONS		

All products require PA	Cerezyme® (imiglucerase for injection)
	Cerdelga® (eliglustat)
	QTY LIMIT: 2 caps/day
	Elelyso® (taliglucerase alfa for injection)
	Vpriv® (velaglucerase alfa for injection)
	
	Miglustat (compare to Zavesca®)
	QTY LIMIT: 3 caps/day
	Zavesca® (miglustat)
	*QTY LIMIT:*3 caps/day
	
	****Maximum days supply per fill for all drugs is 14 days****
		CRITERIA FOR APPROVAL: The diagnosis or indication is Gaucher disease (GD) type I. AND The diagnosis has been confirmed by molecular or enzymatic testing.
		Age Limits
		Elelyso, Vpriv: for patients ≥ 4 years old
		Cerezyme: for patients ≥ 2 years old
		Cerdelga, Miglustat, Zavesca: for patients ≥ 18 years old
		
		Cerezyme/Vpriv additional criteria: Failure, intolerance or other contraindication to enzyme replacement therapy with Elelyso
		
		Cerdelga additional criteria:
		• Testing to verify if CYP2D6 extensive metabolizer (EM), intermediate metabolizer (IM), poor metabolizer (PM), or if CYP2D6 genotype cannot be determined
		  ○ 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		
ALLOPURINOL (compare to Zyloprim®) COLCHICINE tablets (compare to Colcrys®) COLCHICINE/PROBENECID PROBENECID	Colcrys® (colchicine) tablet *QTY LIMIT:* 3 tablets/day (gout) or 4 tablets/day (FMF) Colchicine capsules Febuxostat (compare to Uloric®) *QTY LIMIT:* 40 mg tablets = 1 tablet/day Gloperba® (colchicine) oral solution *QTY LIMIT: 10 ml/day*	**Colchicine capsules, Colcrys, Mitgare:** the patient has a documented intolerance to generic colchicine tablets. **Febuxostat, Uloric:** The diagnosis or indication is treatment of gout AND The patient has had a documented side effect, allergy, treatment failure or a contraindication to allopurinol. NOTE: Treatment failure is defined as inability to reduce serum uric acid levels to < 6 mg/dl with allopurinol doses of 600 mg/day taken consistently. Additionally, renal impairment is not considered a

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Mitigare® (colchicine) capsule *QTY LIMIT:* 2 capsules/day Uloric® (febuxostat) *QTY LIMIT:* 40 mg tablets = 1 tablet/day Zyloprim® (allopurinol)	contraindication to allopurinol use. **Gloperba:** Medical necessity for a specialty dosage form has been provided. **Zyloprim:** The patient has had a documented intolerance to generic allopurinol
GROWTH STIMULATING AGENTS		
Preferred After Clinical Criteria Are Met GENOTROPIN® NORDITROPIN®	Nutropin® AQ Omnitrope® Saizen® Zomacton® **Specialized Indications – See Specific Criteria** Increlex® (mecasermin) Serostim® Zorbtive®	**Criteria for Approval Pediatric:** 1) The patient must have one of the following indications for growth hormone: □ Turner syndrome confirmed by genetic testing. □ Prader-Willi Syndrome confirmed by genetic testing. □ Growth deficiency due to chronic renal failure. □ Patient who is Small for Gestational Age (SGA) due to Intrauterine Growth Retardation (IUGR)and catch up growth not achieved by age 2 (Birth weight less than 2500g at gestational age of <37 weeks or a birth weight or length below the 3rd percentile for gestational age). OR □ Pediatric Growth Hormone Deficiency confirmed by results of two provocative growth hormone stimulation tests (insulin, arginine, levodopa, propranolol, clonidine, or glucagon) showing results (peak level) <10ng/ml. 2) The requested medication must be prescribed by a pediatric endocrinologist (or pediatric nephrologist if prescribed for growth deficiency due to chronic renal failure). 3) Confirmation of non-closure of epiphyseal plates (x-ray determining bone age) must be provided for females > age 12 and males > age 14. 4) Initial requests can be approved for 6 months. Subsequent requests can be approved for up to 1 year with documentation of positive response to treatment with growth hormone. **Criteria for Approval Adult:** The patient must have one of the following indications for growth hormone: Panhypopituitarism due to surgical or radiological eradication of the pituitary. OR Adult Growth Hormone Deficiency confirmed by one growth hormone stimulation test (insulin, arginine, levodopa, propranolol, clonidine, or glucagon) showing results (peak level) <5ng/ml. Growth hormone deficient children must be retested after completion of growth. **LIMITATIONS:** Coverage of Growth Hormone products will not be approved for patients who have Idiopathic Short Stature. **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

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		< -3 AND Basal IGF-1 standard deviation score < -3 AND Normal or elevated growth hormone level AND Member is ≥ 2 years old (safety and efficacy has not been established in patients younger than 2), AND Member has open epiphysis, AND Member is under the care of an endocrinologist or other specialist trained to diagnose and treat growth disorders. **Serostim:** A diagnosis of AIDS associated wasting/anorexia **Zorbtive:** A diagnosis of short bowel syndrome. Concomitant use of specialized nutritional support (specialty TPN) Prescription must be issued by gastroenterologist (specialist)
hATTR TREATMENTS		
	Onpattro® (patisiran) 10 mg/5ml intravenous injection Weight < 100kg (0.3 mg/kg every 3 weeks) Weight ≥ 100kg (30 mg every 3 weeks) Tegsedi® (inotersen) 284 mg/1.5ml injection for subcutaneous use *QTY LIMIT:* 4 syringes/28 days Vyndamax® (tafamidis) *QTY LIMIT:* 1 capsule/day Vyndaqel® (tafamidis meglumine) *QTY LIMIT:* 4 capsules/day	**Onpattro, Tegsedi:** • The patient is ≥ 18 years of age with a diagnosis of polyneuropathy of heredity transthyretin mediated (hATTR) amyloidosis (Documentation of TTR mutation by genetic testing and the presence of amyloid deposits via tissue biopsy has been submitted) AND • The medication is being prescribed by or in consultation with a neurologist AND • Clinical signs and symptoms of the disease (e.g., peripheral/autonomic neuropathy, motor disability, cardiovascular dysfunction, renal dysfunction) are present and other causes of neuropathy have been excluded AND • The patient has tried or is currently receiving at least one systemic agent for symptoms of polyneuropathy from the tricyclic antidepressant (TCA) class and/or anticonvulsant class AND • Patient is receiving vitamin A supplementation AND • For approval of Tegsedi, the patient has had a documented side effect, allergy, or treatment failure with Onpattro AND the prescriber, patient, and pharmacy are registered with the REMS program. Initial approval will be granted for 3 months. For re-approval, the patient must have documentation of clinical improvement or slower progression of the disease than would otherwise be expected. **Vyndamax, Vyndaqel:** • The patient is ≥ 18 years of age with a diagnosis of cardiomyopathy of wild type transthyretin-mediated amyloidosis or heredity transthyretin mediated (hATTR) amyloidosis AND • Documentation of TTR mutation by genetic testing and the presence of amyloid deposits showing cardiac involvement via tissue biopsy or imaging has been submitted AND • The medication is being prescribed by or in consultation with a cardiologist AND Initial approval will be granted for 6 months. For re-approval, the patient must have a decrease in the frequency of cardiovascular-related hospitalizations or slower

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		progression of the disease than would otherwise be expected.
HEART FAILURE		
ANGIOTENSIN RECEPTOR – NEPRILYSIN INHIBITOR (ARNI)		
Preferred After Clinical Criteria Are Met ENTRESTO® (valsartan/sacubitril) *QTY LIMIT:* 2 tablets/day		**Entresto:** Diagnosis is chronic heart failure. **Note:** This is processed via automated (electronic) PA.
SODIUM-GLUCOSE CO-TRANSORTER 2 (SGLT2) INHIBITORS AND COMBINATIONS		
FARXIGA® (dapagliflozin) *QTY LIMIT:* 1 tab/day		
SOLUBLE GUANYLATE CYCLASE (sGC) STIMULATORS		
All products require PA	Verquvo® (vericiguat) tablet *QTY LIMIT:* 1 tablet/day	**Verquvo:** The diagnosis or indication is symptomatic heart failure (HF) with ejection fraction < 45% AND the patient has been hospitalized for HF within the previous 6 months or required the use of IV diuretics within the past 3 months AND the patient is not pregnant AND the patient is concurrently receiving the maximum tolerated dose of one agent from each of the following classes, unless contraindicated: • ARNI, ACE-I, or ARB • Beta Blocker (metoprolol, carvedilol, or bisoprolol) • Aldosterone antagonist if LVEF ≤ 35% or LVEF ≤ 40% with diabetes mellitus or post myocardial infarction (MI) with HF symptoms
HEMATOPOIETICS		
Colony Stimulating Factors		
FULPHILA™ (pegfilgrastim-jmdb) Syringe NEULASTA® (pegfilgrastim) Syringe NEULASTA® Onpro® (pegfilgrastim) kit NEUPOGEN® (filgrastim) Vial, Syringe UDENYCA™ (pegfilgrastim-cbqv) ZIEXTENZO® (pegfilgrastim-bmez)	Granix® (tbo-filgrastim) Vial, Syringe Nivestym™ (figrastim-aafi) Vial, Syringe Nyvepria (pegfilgrastim-apgf) Zarxio® (filgrastim-sndz) Syringe	**Granix, Leukine, 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 alternatives.
Erythropoietic Stimulating Agents		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
Preferred After Clinical Criteria Are Met EPOGEN® (epoetin alpha) RETACRIT® (epoetin alpha-epbx)	Aranesp® (darbepoetin alfa) Mircera® (methoxypolyethylene glycolepoetin beta) Procrit® (epoetin alpha)	**Aranesp, Procrit, Epogen, Retacrit:** diagnosis or indication for the requested medication is anemia due to one of the following: Chronic kidney disease/renal failure, Post-renal transplant, use of zidovudine for the treatment of human immunodeficiency virus (HIV) (other causes of anemia, such as iron/folate/vitamin B12 deficiency have been eliminated), Surgery patients at high risk for perioperative blood loss, Cancer chemotherapy, Use of ribavirin or interferon therapy for Hepatitis C, Myelodysplastic syndrome. Hemoglobin level at initiation of therapy is <10 g/dL OR for patients currently maintained on therapy, hemoglobin level is < 11 g/dL in dialysis patients with chronic kidney disease, < 10 g/dL in non-dialysis patients with chronic kidney disease, or < 12 g/dL in patients treated for other indications AND for approval of Aranesp or Procrit, 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 Sevenfact®	**Novoseven RT:** Medication is being used for the treatment of acute bleeding episodes in a patient with Hemophilia A or B with inhibitors OR Patient has congenital Factor VII deficiency. **Sevenfact:** Medication is being used for the treatment of acute bleeding episodes in a patient with Hemophilia A or B with inhibitors AND there is a clinically compelling reason why Novoseven RT cannot be used.
AHF-Factor VIII		
ADVATE® AFSTYLA® ESPEROCT® HEMLIBRA® (emicizumab-kxwh) HEMOFIL® M KOATE®-DVI KOGENATE FS® NOVOEIGHT®	Adynovate® Eloctate® Jivi® Kovaltry® Nuwiq®	**All Non-Preferred Products:** The prescriber must provide a clinically compelling reason for the use of the requested medication including reasons why any of the preferred products would not be suitable alternatives. For approval of Adynovate, Eloctate, or Jivi, documentation must include why the member is unable to use the preferred extended half-life concentrate Esperoct.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
OBIZUR® RECOMBINATE® XYNTHA®		
AHF-Factor IX		
ALPHANINE® SD ALPROLIX® BENEFIX® IDELVION® IXINITY® MONONINE® PROFILNINE® RIXUBIS®	Kcentra® Rebinyn®	**All Non-Preferred Products:** The prescriber must provide a clinically compelling reason for the use of the requested medication including reasons why any of the preferred products would not be suitable alternatives. For approval of Rebinyn, documentation must include why the member is unable to use a preferred extended half-life concentrate Alprolix or Idelvion.
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.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		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		
RIBAVIRIN PRODUCTS RIBAVIRIN 200 mg tablets	Ribavirin 200 mg capsules	**Non-preferred Ribavirin Brands/strengths:** The patient is unable to use generic ribavirin 200 mg tablets
PEGINTERFERON PRODUCTS PEG-INTRON/PEG-INTRON REDIPEN (peginterferon alfa-2b) *QTY LIMIT:* 1 kit (4 pens per) 28 days	Pegasys® (peginterferon alfa-2a) *QTY LIMIT:* 4 vials/28 days Pegasys Convenience PAK® (peg-interferon alfa-2a) *QTY LIMIT:* 1 kit/28 days	**Pegasys:** Diagnosis is hepatitis C AND the patient has a documented side effect, allergy or treatment failure to Peg-Intron
DIRECT ACTING ANTIVIRALS ***Preferred After Clinical Criteria Are Met*** MAVYRET™ (glecaprevir/pibrentasvir) SOFOSBUVIR/VELPATASVIR (compare to Epclusa®)	Epclusa® (sofosbuvir/velpatasvir) Harvoni® (ledipasvir/sofosbuvir) Ledipasvir/sofosbuvir (compare to Harvoni®) Sovaldi® (sofosbuvir) Viekira PAK® (ombitasvir, paritaprevir, ritonavir tablet with dasabuvir tablet) Vosevi® (sofosbuvir/velpatasvir/voxilaprevir) Zepatier® (elbasvir/grazoprevir)	**Direct Acting Agents: Epclusa, Harvoni, Ledipasvir/sofosbuvir, Mavyret, Sofosbuvir/velpatasvir, Sovaldi, Viekira pak, Vosevi, Zepatier:** • Hep C PA form must be completed, and clinical documentation supplied. • Combination therapy will be either approved or denied in its entirety. • Prescriber is, or has consulted with, a hepatologist, gastroenterologist or infectious disease specialist. Consult must be within the past year with documentation of recommended regimen. Specialist requirement will NOT apply for patients meeting all the following: treatment naïve, non-cirrhotic, HBV negative, HIV negative, no prior liver transplatation, and not pregnant. • See PA form for detailed requirements and for documentation required For approval of a non-preferred agent, the provider must submit clinical documentation detailing why the patient is not a candidate for a preferred direct acting agent regimen.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
HEREDITARY ANGIOEDEMA MEDICATIONS		
TREATMENT		
Preferred After Clinical Criteria are Met BERINERT® (human C1 inhibitor) ICATIBANT (compare to Firazyr®) *QTY LIMIT:* 3 syringes (9 ml)/fill	Firazyr® (icatibant) *QTY LIMIT:* 3 syringes (9 ml)/fill Kalbitor® (escallantide) *QTY LIMIT:* 6 vials (2 packs) per fill Ruconest® (recombinant C1 esterase inhibitor) *QTY LIMIT:* 4 vials/fill	**Berinert, Firazyr, Icatibant:** The diagnosis or indication is treatment of an acute Hereditary Angioedema (HAE) attack AND for approval of Firazyr, the patient must have a documented intolerance to generic Icatibant. (Approval may be granted so that 2 doses may be kept on hand for Berinert and 3 doses for Icatibant/Firazyr). **Kalbitor, Ruconest:** The diagnosis or indication is treatment of an acute Hereditary Angioedema (HAE) attack AND the patient has a documented side effect, allergy, treatment failure or contraindication to a preferred agent (Approval may be granted so that 2 doses may be kept on hand.)
PROPHYLACTIC		
Preferred After Clinical Criteria are Met CINRYZE® (human C1 inhibitor) *QTY LIMIT:* 20 vials/30days HAEGARDA® (human C1 inhibitor) ORLADEYO™ (berotralstat) QTY LIMIT: 1 capsule/day TAKHZYRO™ (lanadelumab-flyo) *QTY LIMIT:* 2 vials/28 days		**Cinryze, Haegarda, Orladeyo, Takhzyro:** The diagnosis or indication is prophylaxis of Hereditary Angioedema (HAE) attacks.
HYPERKALEMIA AGENTS		
Lokelma™ (sodium zirconium cyclosilicate) SPS® (sodium polystyrene sulfonate) suspension	Veltassa® (patiromer sorbitex calcium) powder packets *QTY LIMIT:* 1 packet/day	**Veltassa:** The patient requires therapy for the treatment of non-emergent hyperkalemia AND where clinically appropriate, medications known to cause hyperkalemia (e.g. ACE inhibitors, ARBs, aldosterone antagonists, NSAIDs) have been discontinued or reduced to the lowest effective dose AND where clinically appropriate, a loop or thiazide diuretic has failed for potassium removal, AND the patient has been counseled to follow a low potassium diet (≤ 3 grams/day).
IDIOPATHIC PULMONARY FIBROSIS (IPF)		
	Esbriet® (pirfenidone) *QTY LIMIT:*267 mg tablets = 270 tabs/month,	**Clinical Criteria: Esbriet, Ofev** ○ Age ≥ 18

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	801 mg tablets = 90 tabs/month Ofev® (nintedanib) *QTY LIMIT:* 60 tabs/month	○ Diagnosis of idiopathic pulmonary fibrosis (Esbriet and Ofev) OR chronic fibrosing interstitial lung disease or systemic sclerosis associated interstitial lung disease (Ofev Only) ○ May not be used in combination 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 **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		
Preferred After Clinical Criteria are Met DUPIXENT® (dupilumab) subcutaneous injection, pre-filled syringe, and auto-injector pen *QTY LIMIT*: 4 syringes/pens the first 28 days then 2 syringes/pens every 28 days thereafter FASENRA® (benralizumab) subcutaneous Injection, pre-filled syringe and auto-injector pen *QTY LIMIT:* 1 mL every 28 days for 3 doses then 1 mL every 56 days	Cinqair® (reslizumab) Intravenous injection Nucala® (mepolizumab) subcutaneous injection, vial, pre-filled syringe, and auto-injector pen *QTY LIMIT:* 1mL every 28 days Xolair® (omalizumab) subcutaneous injection vial, pre-filled syringe *QTY LIMIT:* 900 mg every 28 days	**Xolair:** *Diagnosis of moderate to severe persistent asthma:* • The patient must be 6 years of age or older AND • The patient has a history of uncontrolled asthma symptoms (symptoms occurring almost daily or waking at night with asthma at least once a week) or 2 or more exacerbations in the previous year despite regular use of medium-high dose ICS/LABA for a minimum of 3 consecutive months, with or without oral corticosteroids. Pharmacy claims will be evaluated to assess compliance with therapy. AND • The prescriber is a pulmonologist, allergist, or immunologist AND • Patient has tested positive to at least one perennial aeroallergen by skin or blood test (i.e.: RAST, CAP, intracutaneous test) AND • Patient has an IgE level ≥ 30 and ≤ 700 IU/ml (ages 12 and older) OR IgE level ≥ 30 and ≤ 1300 IU/ml (ages 6-11) prior to beginning therapy with Xolair. AND • For approval of prefilled syringe, a clinically compelling reason must be provided detailing why vials cannot be used. • For continuation of therapy after the initial 6-month authorization, the patient must have either a decreased frequency of exacerbations, decreased use of maintenance oral corticosteroids, reduction in the signs and symptoms of asthma, or an increase in predicted FEV1 from baseline.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		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 • For approval of prefilled syringe, a clinically compelling reason must be provided detailing why vials cannot be used. • For continuation of therapy after the initial 6-month authorization, the patient must have documented clinical improvement in symptoms. *Diagnosis of Chronic Rhinosinusitis with Nasal Polyps:* • Patient is 18 years of age or older AND • Prescriber is an allergist or ENT specialist AND • Patient has had an inadequate response to at least a 3-month trial of 2 different nasal corticosteroids AND • Patient has had an inadequate response to at least a 10-14 day course of oral corticosteroids AND • Patient will use Xolair concurrently with an Intranasal corticosteroid AND • For approval of prefilled syringe, a clinically compelling reason must be provided detailing why vials cannot be used AND • For continuation of therapy after the initial 6-month authoriaton, the patient must continue to receive therapy with an intranasal corticosteroid AND there must be documented improvement in nasal symptoms. **Limitations:** Xolair use will not be approved if requested for prevention of peanut related allergic reaction or in patients with a diagnosis of moderate to severe persistent asthma who are currently smoking. **Fasenra, Nucala, Cinqair:** • The patient must be 6 years of age or older for Nucala, 12 years of age or older for Fasenra, or 18 years of age or older for Cinqair AND • The patient must have a diagnosis of severe persistent asthma with an eosinophilic phenotype as defined by pre-treatment blood eosinophil count of ≥ 150 cells per mcL within the previous 6 weeks or ≥ 300 cells per mcL within 12 months prior to initiation of therapy AND • The patient has a history of uncontrolled asthma symptoms (symptoms occurring almost daily or waking at night with asthma at least once a week) or 2 or more exacerbations in the previous year despite regular use of medium-high dose ICS/LABA for a minimum of 3 consecutive months, with or without oral corticosteroids. Pharmacy claims will be evaluated to assess compliance with therapy. AND • The prescriber is an allergist, immunologist, or pulmonologist. AND

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		• For approval of Cinqair or Nucala, the patient must have a documented side effect, allergy, or treatment failure with Dupixent or Fasenra. • For continuation of therapy after the initial 6-month authorization, the patient must continue to receive therapy with an ICS/LABA AND have either a decreased frequency of exacerbations, decreased use of maintenance oral corticosteroids, reduction in the signs and symptoms of asthma, or an increase in predicted FEV_1 from baseline. *Diagnosis of hypereosinophilic syndrome (Nucala only):* • Patient must be 12 years of age or older AND • The patient must have a blood eosinophil count of ≥ 1,000 cells per mcl AND • The patient has had at least 2 HES flares within the past 12 months AND • The patient is on a stable dose of background HES therapy (chronic or episodic corticosteroids, immunosuppressive, or cytotoxic therapy) for at least 4 weeks prior to treatment initiation AND • The prescriber is an allergist, hematologist, immunologist, or pulmonologist **Dupixent:** *Diagnosis of moderate to severe persistent asthma:* • The patient must be 6 years of age or older AND • The patient must have an eosinophilic phenotype as defined by pre-treatment blood eosinophil count of ≥ 150 cells per mcL within the previous 6 weeks or ≥ 300 cells per mcL within 12 months prior to initiation of therapy OR the patient is dependent on oral corticosteroids. • The patient has a history of uncontrolled asthma symptoms (symptoms occurring almost daily or waking at night with asthma at least once a week) or 2 or more exacerbations in the previous year despite regular use of medium-high dose ICS/LABA for a minimum of 3 consecutive months, with or without oral corticosteroids. Pharmacy claims will be evaluated to assess compliance with therapy. AND • The prescriber is an allergist, immunologist, or pulmonologist AND • For continuation of therapy after the initial 6 month authorization, the patient must continue to receive therapy with an ICS/LABA AND have either a decreased frequency of exacerbations OR decreased use of maintenance oral corticosteroids OR reduction in the signs and symptoms of asthma OR an increase in predicted FEV1 from baseline. *Diagnosis of Chronic Rhinosinusitis with Nasal Polyps:* • Patient is 18 years of age or older AND • Prescriber is an allergist or ENT specialist AND • Patient has had an inadequate response to at least a 3-month trial of 2 different nasal corticosteroids AND • Patient has had an inadequate response to at least a 10–14-day course of oral corticosteroids AND

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		• Patient will use Dupixent concurrently with an intranasal corticosteroid • For continuation of therapy after the initial 6 month authorization, the patient must continue to receive therapy with an intranasal corticosteroid AND there must be documented improvement in nasal symptoms. **Limitations:** Dupixent®, Fasenra®, Nucala® and Cinqair® will not be considered in patients who are currently smoking or in combination with omalizumab.
IMMUNOSUPPRESANTS, ORAL		
AZATHIOPRINE tablet CYCLOSPORINE capsule CYCLOSPORINE MODIFIED MYCOPHENOLATE MOFETIL tablet, capsule, suspension MYCOPHENOLIC ACID delayed release tablet SIROLIMUS tablet TACROLIMUS capsule	Astagraf® XL (tacrolimus) capsule Azasan® (azathioprine) tablet Cellcept® (mycophenolate mofetil) tablet, capsule, suspension Envarsus® XR (tacrolimus) tablet Everolimus (compare to Zortress®) tablet Gengraf® (cyclosporine modified) capsule, solution Imuran® (azathioprine) tablet Lupkynis™ (voclosporin) capsule Myfortic® (mycophenolic acid) delayed release tablet Neoral® (cyclosporine modified) capsule, solution Prograf® (tacrolimus) capsule, granules for suspension Rapamune® (sirolimus) tablet, solution Sandimmune® (cyclosporine) capsule, solution Zortress® (everolimus) tablet	**Criteria (except Lupkynis):** The patient has been started and stabilized on the requested product OR the patient has a documented side effect, allergy, or treatment failure to a preferred agent (if a product has and AB rated generic, there must be a trial of the generic formulation). **Lupkynis:** • The patient has a diagnosis of Systemic Lupus Erythematosus (SLE) AND • The patient has active Lupus Nephritis confirmed by urine/blood tests or kidney biopsy AND • The patient is ≥ 18 years of age AND • Medication is prescribed by, or in consultation with, a nephrologist or rheumatologist AND • The patient has clinical progression (e.g. worsening of proteinuria or serum creatinine) after 3 months of induction therapy with corticosteroids plus cyclophosphamide or mycophenolate mofetil OR failure to respond after 6 months of induction therapy with corticosteroids plus cyclophosphamide or mycophenolate mofetil AND • Medication will be used in combination with background immunosuppressive therapy (e.g. mycophenolate mofetil and systemic corticosteroids) AND • The patient has a documented intolerance or treatment failure with Benlysta
CRYOPYRIN ASSOCIATED PERIODIC SYNDROMES (CAPS) AND PERIODIC FEVER SYNDROME (PFS)		
	Arcalyst® (rilonacept) *QTY LIMIT:* 2 vials for loading dose, then 1 vial per Week Ilaris® (canakinumab)	**Ilaris:** The diagnosis is Cryopyrin-Associated Periodic Syndrome (CAPS) OR The diagnosis is Familial Cold Autoinflammatory Syndrome (FCAS), Familial Mediterranean Fever (FMF), Hyper-IgD periodic fever syndrome (HIDS), Muckle-Wells Syndrome (MWS), or Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS) AND The patient is > 4 years old **Arcalyst:** The diagnosis is Cryopyrin-Associated Periodic Syndrome (CAPS) OR The diagnosis is Familial Cold Autoinflammatory Syndrome (FCAS) OR The

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		diagnosis is Muckle-Wells Syndrome (MWS) AND The patient is > 12 years old **Note:** Medical Records to support the above diagnosis must accompany the Prior Authorization request. Authorization for continued use shall be reviewed at least every 12 months to confirm patient has experienced disease stability or improvement while on therapy.
IRON CHELATING AGENTS		
EXJADE® (deferasirox)	Deferasirox Ferripirox® (deferiprone) Jadenu®(deferasirox)	**Deferasirox, Jadenu, Ferripirox:** patient has had a documented side effect allergy or treatment failure to Exjade AND for approval of Jadenu, the patient must have a documented intolerance to generic deferasirox tablets
LIPOTROPICS		
BILE ACID SEQUESTRANTS		
CHOLESTYRAMINE powder (compare to Questran®) CHOLESTYRAMINE LIGHT powder (compare to Questran Light®) COLESTIPOL tablets, granules (compare to Colestid®) WELCHOL® (colesevelam) tablets, powder packets	Colesevelam (compare to Welchol®) Colestid® tablets, granules (colestipol) Prevalite powder (cholestyramine light) Questran® powder (cholestyramine) Questran Light® powder (cholestyramine light)	**Colesevelam:** The patient has had a documented intolerance to the brand name equivalent. **Prevalite, Questran, Questran Light, Colestid:** The patient has had a documented intolerance to the preferred generic formulation.
FIBRIC ACID DERIVATIVES		
GEMFIBROZIL (compare to Lopid®) 600 mg FENOFIBRATE NANOCRYSTALIZED (compare to Tricor®) 48 mg, 145 mg tablets *QTY LIMIT:* 1 tablet/day	Antara® (fenofibrate micronized) 30 mg, 43 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) 45 mg, 135 mg delayed release capsule Fenofibric acid 35 mg, 105 mg *QTY LIMIT:* 1 capsule/day	**Lopid:** The patient has had a documented intolerance to generic gemfibrozil. **Antara, Fenofibrate, Fenofibrate micronized, Fenofibric acid (all strengths), Fenoglide, Lipofen, Tricor, 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
	Fenoglide® (fenofibrate MeltDose) 40 mg, 120 mg Lipofen® (fenofibrate) 50 mg, 150 mg Lopid® (gemfibrozil) 600 mg Tricor® (fenofibrate nanocrystallized) 48 mg, 145 mg Trilipix (fenofibric acid) 45 mg, 135 mg delayed release capsule	
MISC. HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMA (HoFH) AGENTS		
All products require PA	Evkeeza™ (evinacumab-dgnb) intravenous solution Juxtapid® (lomitapide) Capsule *QTY LIMIT: 5 and 10 mg caps = 1/day, 20 mg cap = 3/day* Maximum day supply per fill is 28 days	**CRITERIA FOR APPROVAL:** • Total cholesterol levels > 290mg/dL or LDL-C > 190mg/dL (adults) OR Total cholesterol levels > 260mg/dL or LDL-C > 155mg/dL (children < 16 years) and TG within reference range or Confirmation of diagnosis by gene testing AND • Documented adherence to prescribed lipid lowering medications for the previous 90 days AND • Recommended or prescribed by a lipidologist or Cardiologist AND • Inability to reach goal LDL-C despite a trial of 2 or more maximum tolerated dose of statins (one of which must be atorvastatin or rosuvastatin), ezetimibe 10mg daily, and Repatha
NICOTINIC ACID DERIVATIVES		
NIACIN 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®) 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 except Lovastatin 40mg which has a quantity limit of 2 tablets/day	Altoprev® (lovastatin SR) Crestor® (rosuvastatin) Ezallor ® (rosuvastatin) sprinkle capsule 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. **Ezallor:** medical necessity for a specialty dosage form has been provided **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

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
MISCELLANEOUS/COMBOS		
Ezetimibe (compare to Zetia®) *QTY LIMIT:* 1 tab/day	Amlodipine/atorvastatin (compare to Caduet®) *QTY LIMIT:* 1 tab/day Caduet® (atorvastatin/amlodipine) *QTY LIMIT:* 1 tab/day Ezetimibe/simvastatin (compare to Vytorin®) Lovaza® (omega-3-acid ethyl esters) Omega-3-acid ethyl esters (compare to Lovaza®) Nexletol® (bempedoic acid) *QTY LIMIT: 1 tab/day* Nexlizet® (bempedoic acid/ezetimibe) *QTY LIMIT: 1 tab/day* Vascepa® (icosapent ethyl) *QTY LIMIT:* 4 caps/day Vytorin® (ezetimibe/simvastatin) *QTY LIMIT:* 1 tab/day Zetia® (ezetimibe) *QTY LIMIT:* 1 tab/day	**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. **Nexletol, Nexlizet:** The patient has had an inadequate response to a 3-month trial of atorvastatin or rosuvastatin OR Patient has demonstrated statin intolerability as defined by statin-related rhabdomyolysis or skeletal related muscle symptoms AND Patient (if eligible) will continue adjunct therapy with maximally tolerated high intensity statin. If patient is using simvastatin, dose should not exceed 20 mg/day; if patient is using pravastatin, dose should not exceed 40 mg/day **Vytorin, ezetimibe/simvastatin:** The patient must be unable to use the individual separate agents AND If the request is for Vytorin 10/80, the patient has been taking this dose for 12 or more months without evidence of muscle toxicity.
PCSK9 INHIBITORS		
Preferred After Clinical Criteria Are Met PRALUENT® (alirocumab) (Sanofi US labeler 72733 is the only preferred form) *QTY LIMIT:* 2ml (75 mg injection every 2 weeks or 300 mg every month)/28 days Max 28-day supply REPATHA® (evolocumab) Sureclick, prefilled syringe QTY LIMIT: 2ml (2 injections)/28 days Max 28-day supply REPATHA® (evolocumab) Pushtronix™ QTY LIMIT: 3.5ml (One single-use infusor and prefilled cartridge)/28 days, Max 28-day supply		**Criteria for approval:** • The patients's age is FDA approved for the given indication AND • Concurrent use with statin therapy AND • Documented adherence to prescribed lipid lowering medications for the previous 90 days AND • Recommended or prescribed by a lipidologist or cardiologist AND • Inability to reach goal LDL-C despite a trial of 2 or more maximum tolerated dose of statins (one of which must be atorvastatin or rosuvastatin) and ezetimibe 10mg daily • Approval of Praluent NDC's with labeler code 00024 will be considered only if labeler code 72733 NDC's are on a long-term backorder and unavailable from the manufacturer. **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

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		○ Presence of tendon xanthomas **OR** ○ In 1st or 2nd degree relative-documented tendon xanthomas, MI at age ≤ 60 years or TC > 290 mg/dL **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 **Additional criteria for the diagnosis of homozygous familial hypercholesterolemia (Repatha only):** • Total cholesterol levels > 290mg/dL or LDL-C > 190mg/dL (adults) OR Total cholesterol levels > 260mg/dL or LDL-C > 155mg/dL (children < 16 years) and TG within reference range OR Confirmation of diagnosis by gene testing
MISCELLANEOUS		
GLYCOPYRROLATE 1 mg, 2 mg tablets (compare to Robinul®, Robinul Forte®) KUVAN® (sapropterin) 100mg, 500mg powder PYRIDOSTIGMINE BROMIDE (Compare to Mestinon) SAPROPTERIN 100mg powder ***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	Benlysta® (belimumab) Maximum days supply per fill = 28 days Brineura™ (cerliponase alfa) *QTY LIMIT:* 1 package per 14 days (Brineura Injection, 2 vials of 150mg/5ml, and Intraventricular Electrolytes Injection, 1 vial of 5ml) Cuvposa® oral solution (glycopyrrolate) Maximum days supply per fill is 30 days Elaprase® (idursulfase) *QTY LIMIT:* calculated dose/week Fensolvi® (leuprolide acetate) subcutaneous injection *QTY LIMIT:* 1 vial every 6 months Firdapse® (amifampridine) *QTY LIMIT:* 8 tablets/day Galafold™ (migalastat) *QTY LIMIT:* 14 caps/28 days Maximum day supply = 28 days Gamifant® (emapalumab-lzsg) Hetlioz® (tasimelteon) 20 mg oral capsule *QTY LIMIT:* 1 capsule/day Maximum days supply per fill is 30 days Kuvan (sapropterin) tablets Hydroxyprogesterone caproate 250 mg/ml vial (intramuscular injection) Luxturna® (voretigine neparvovec-rzyl) suspension for subretinal injection	**Benlysta:** *Indication for use is Systemic Lupus Erythematosus (SLE):* • The patient is positive for autoantibodies (anti-nuclear antibody (ANA) and/or anti-double-stranded DNA (anti-dsDNA) AND • The patient has had a documented inadequate response or intolerance to at least TWO of the following agents: NSAIDs, hydroxychloroquine, corticoseroids, azathioprine, methotrexate, mycophenolate mofetil AND • Initial approval will be granted for 3 months. For therapy continuation, clinical documentation must be submitted documenting stable disease activity OR reduction in disease activity or corticosteroid dose. **Note:** The efficacy of Benlysta® has not been evaluated in patients with s severe active central nervous system lupus. Benlysta has not been studied in combination with other biologics or intravenous cyclophosphamide. Use of Benlysta is not recommended in these situations. *Indication for use is Active Lupus Nephritis:* • Diagnosis has been confirmed by urine/blood tests or kidney biopsy AND • The patient is ≥ 18 years of age AND • Medication is prescribed by, or in consultation with, a nephrologist or rheumatologist AND • The patient has clinical progression (e.g. worsening of proteinuria or serum creatinine) after 3 months of induction therapy with corticosteroids plus cyclophosphamide or mycophenolate mofetil OR failure to respond after 6 months of induction therapy with corticosteroids plus cyclophosphamide or mycophenolate mofetil AND

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	QTY LIMIT: one injection per eye per lifetime Lysteda® tablets (tranexamic acid) *QTY LIMIT:* 30 tablets/28 days Mestinon® Myalept® (metreleptin) vial for subcutaneous injection *QTY LIMIT:* one vial/day Maximum day supply per fill = 30 days Oxlumo™ (lumasiran) Palynziq™ (pegvaliase-pqpz) Radicava® (edaravone) IV injection Ruzurgi® (amifampridine) *QTY LIMIT:* 10 tablets/day Sapropterin (compare to Kuvan®) tablets, 500mg powder Tranexamic acid (compare to Lysteda®) *QTY LIMIT:* 30 tablets/28 days Xatmep™ (methotrexate) oral solution Zinplava™ (Bezlotoxumab) injection Zokinvy® (lonafarnib) capsule	• Medication will be used in combination with background immunosuppressive therapy (e.g. mycophenolate mofetil and systemic corticosteroids) AND • Initial approval will be granted for 3 months. For therapy continuation, clinical documentation must be submitted documenting stable disease activity OR reduction in disease activity. **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 geneticist) or prescriber is in consultation with a specialist **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. **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

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		• 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. **Fensolvi:** There is a documented diagnosis of Central Precocious Puberty (CPP) AND All other underlying causes have been ruled out including a brain tumor, spinal cord tumor, hypothyroidism, brain defect at birth (e.g. hematoma or hydrocephalus), injury to the brain or spinal cord, McCune-Albright syndrome, congenital adrenal hyperplasia, radiation to the spinal cord or brain AND There is a documented inability to tolerate (not due to pain) monthly injections of Leuprolide IM **Firdapse, Ruzurgi:** patient has a diagnosis of Lambert-Eaton myasthenic syndrome (LEMS) AND prescription is initiated by or in consultation with a neurologist AND patient does not have a history of seizures AND for approval of Firdapse, the patient must have a documented intolerance to Ruzurgi. Initial approval will be granted for 3 months with documentation of the patient's baseline clinical muscle strength assessment using a standardized rating scale. For re-approval after 3 months, the patient must have improved, or stable symptoms documented with the appropriate standardized rating scale **Galafold:** Patient is ≥ 18 years of age AND Diagnosis or indication is Fabry Disease with an amenable galactosidase alpha (GLA) gene variant for treatment (results must be submitted) AND enzyme replacement therapy is not a therapeutic option (e.g. due to allergy, hypersensitivity, or poor venous access). **Gamifant**: the patient has a diagnosis of primary hemophagocytic lymphohistiocytosis (HLH) with refractory, recurrent, or progressive disease or

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		intolerance with conventional HLH therapy (e.g. etoposide + dexamethasone) AND the patient is a candidate for a stem cell transplant AND Gamifant will be administered in combination with dexamethasone **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. **Kuvan tabs, Sapropterin tabs:** patient has a documented intolerance to the powder formulation. **Luxturna:** patient must have inherited retinal dystrophy due to mutations in both copies of the RPE65 gene (results of genetic testing must be submitted) AND patient has sufficient viable retinal cells as determined by the treating physician(s) AND Luxturna will be administered by a retinal specialist;/surgeon experienced in performing intraocular surgery and associated with an Ocular Gene Therapy Treatment Center. **Lysteda, 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 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. **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

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		in hemoglobin A1c (HbA1c) level from baseline OR • Sustained reduction in triglyceride (TG) levels from baseline. **Oxlumo:** The patient has a diagnosis of Primary Hyperoxaluria Type I (PH1) confirmed via genetic testing (identification of alanine: glyoxylate aminotransferase gene (AGXT) mutation) AND urinary oxalate excretion > 0.5mmol/1.73 m^2 or urinary oxalate: creatinine ratio is above the upper limit of normal for age AND medication is being prescribed by, or in consultation, with a nephrologist or urologist AND patient has not previously received a liver transplant **Palynziq:** Patient is 18 years of age or older AND has a diagnosis of phenylketonuria AND has uncontrolled blood phenylalanine (PHE) concentrations (> 600 micromol/L) on existing management, including restricting dietary phenylalanine and protein intake and treatment with sapropterin. For re-approval, the patient must have achieved at least a 20% reduction in PHE concentration from pre-treatment baseline or a PHE ≤ 600 micromol/L after 16 weeks of continuous treatment with the maximum dosage of 40mg daily. **Note:** Palynziq has a black box warning for anaphylaxis which can occur at any time during treatment. Patients, pharmacies, and physicians must be enrolled in the Palynziq REMS program AND concurrent auto-injectable epinephrine must be prescribed. **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 **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. **Sapropterin 500mg powder:** patient has a documented intolerance to brand Kuvan **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)

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		Zinplava:
		• 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)
		Zokinvy: The patient meets FDA approved age and BSA AND the patient has a diagnosis of Hutchinson-Gilford Progeria Syndrome (HGPS) OR the patient has a diagnosis of processing-deficient Progeroid Laminopathies with documentation of either Heterozygous LMNA mutation with progerin-like protein accumulation or Homozygous or compound heterozygous ZMPSTE24 mutations.
		Note: A single-dose of 10mg/kg will be approved per active CDI. A repeat dose will not be approved for recurrence of the same active infection.

AMYOTROPHIC LATERAL SCLEROSIS (ALS)		
RILUZOLE (Compare to Rilutek®)	Exservan™ (riluzole) film Rilutek® (riluzole) Tiglutik™ (riluzole) suspension	**Rilutek:** patient must have a documented intolerance with riluzole **Exservan, Tiglutik**: patient must be unable to take whole or crushed Riluzole tablets
COMPLEMENT INHIBITORS		
	Empaveli™ (pegcetacoplan) subcutaneous solution *QTY LIMIT: 8 vials/28 days* Soliris® (eculizumab) vial Ultomiris® (ravulizumab-cwvz)	**Empaveli:** The patient has a diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) documented by flow cytometry AND The patient has received the meningococcal vaccine at least 2 weeks prior to therapy initiation. Authorization for continued use shall be reviewed to confirm that the patient has experienced an objective response to the therapy (e.g. stabilization of hemoglobin levels, reductions in transfusions, improvement in hemolysis, etc.). **Note:** For patients switching from eculizumab, an additional 4 weeks of eculizumab will be approved before continuing monotherapy with Empaveli. For patients switching from ravulizumab, Empaveli will be initiated no more than 4 weeks after the last dose of ravulizumab. Ongoing combination therapy of complement inhibitors will not be approved. **Soliris:**

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		Indication for use is Atypical Hemolytic Uremic Syndrome: Dose requested must be within the FDA parameters for loading and maintenance dose *Indication for use is paroxysmal nocturnal hemoglobinuria (PNH):* Diagnosis is documented by flow cytometry AND The patient has received the meningococcal vaccine at least 2 weeks prior to therapy initiation. Authorization for continued use shall be reviewed to confirm that the patient has experienced an objective response to the therapy (e.g. stabilization of hemoglobin levels, reductions in transfusions, improvement in hemolysis, etc.) *Indication for use is Myasthenia Gravis:* The patient is anti-aceytlcholine receptor (AchR) antibody positive AND the patient has a documented side effect, allergy, or treatment failure with at least 2 immunosuppressive therapies (e.g. corticosteroids, azathioprine, cyclosporine, mycophenolate, etc.). **Ultomiris**: The patient has a diagnosis of Atypical Hemolytic Uremic Syndrome or a diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) documented by flow cytometry AND The patient has received the meningococcal vaccine at least 2 weeks prior to therapy initiation. Authorization for continued use shall be reviewed to confirm that the patient has experienced an objective response to the therapy (e.g. stabilization of hemoglobin levels, reductions in transfusions, improvement in hemolysis, etc.) **Note:** Dose requested must be within the weight-based parameters for loading and maintenance dose
INJECTABLE METHOTREXATE		
METHOTREXATE 25 MG/ML solution for injection	Otrexup® or Rasuvo® Single-dose auto-injector for subcutaneous use (methotrexate) QTY LIMIT: 4 syringes/28 days RediTrex® Prefilled syringe for subcutaneous use (methotrexate) QTY LIMIT: 4 syringes/28 days	**Otrexup, Rasuvo, Reditrex:** The patient has a diagnosis of rheumatoid arthritis (RA), polyarticular juvenile idiopathic arthritis (pJIA) or psoriasis. AND The patient has been intolerant to oral methotrexate AND The patient has been unable to be compliant with a preferred form of injectable methotrexate (includes difficulty with manual dexterity)
NEUROMYELITIS OPTICA SPECTRUM DISORDERS (NMOSD)		
All Products Require PA	Enspryng® (satralizumab-mwge) prefilled syringe QTY LIMIT = 3/28 days for the first month then 1/28 days thereafter Soliris® (eculizumab) vial Uplizna® (inebilizumab-cdon) vial QTY LIMIT = 300mg x 2 doses for the first 2 weeks then 300mg every 6 months thereafter	**Enspryng, Soliris, Uplizna:** • The patient is ≥ 18 years AND • Diagnosis or indication is the treatment of neuromyelitis optica spectrum disorder (NMOSD) AND • Patient is anti aquaporin-4 (AQP4) antibody positive AND • Patient has a history of one or more relapses that required rescue therapy within the year prior to screening, or 2 or more relapses that required rescue therapy in 2 years prior to screening AND • Patient must have a documented side effect, allergy, treatment failure, or contraindication to rituximab. • Initial approval will be granted for 6 months. Renewal requires documentation of improvement or stabilization of neurologic symptoms such as a decrease in acute relapses, reduced hospitalization, or reduction in plasma exchange treatments.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		Soliris, Uplizna additional criteria: The patient must have a documented side effect, allergy, treatment failure or contraindication to Enspryng.
SOMATOSTATIN ANALOGS		
OCTREOTIDE ACETATE solution for injection SANDOSTATIN® (octreotide acetate) LAR Depot	Bynfezia® (octreotide) pen Mycapssa® (octreotide) capsule QTY LIMIT: 4 caps/day Sandostatin® (octreotide) solution for injection Somatuline® Depot Injection (lanreotide) *QTY LIMIT:* 60 mg syringe = 0.2 ml/28 days, 90 mg syringe = 0.3 ml/28 days, 120 mg = 0.5 ml/28 days	**Bynfezia, Sandostatin:** the patient has a documented intolerance to Octreotide injection. **Mycapssa:** the diagnosis or indication is long-term maintenance treatment of acromegaly AND the patient has already responded to and tolerated treatement with an injectable somatostatin alalog AND there is a clinically valid reason why the patient is unable to use Sandostatin LAR Depot. **Somatuline:** the patient has a documented side effect, allergy, treatment failure, or contraindication to Sandostatin LAR Depot.
SPINAL MUSCULAR ATROPHY		

Preferred After Clinical Criteria Are Met
ZOLGENSMA® (onasemnogene abeparvovec-xioi) intravenous suspension
	Evrysdi® (risdiplam) oral solution
	Spinraza (nusinersen) injection 12mg/5ml single-dose vial
		Evrysdi:
		• The diagnosis is spinal muscular atrophy (SMA) AND
		• Patient is 2 months of age or older AND
		• Medication is prescribed per the dosing guidelines in the package insert AND
		• A negative pregnancy test is obtained for females of reproductive potential prior to initiating therapy and patient has been advised to use effective contraception during treatment and for at least 1 month after her last dose AND
		• A patient who has been started on Spinraza will not be approved for Evrysdi until at least 3 months after the fifth dose (i.e. nine months after the first loading dose, three months after the fifth dose). Concurrent use will not be approved.
		Note: For therapy continuation, clinical documentation must be submitted documenting improvement or maintenance of motor ability OR slower disease progression than would otherwise be expected.
		Spinraza:
		• The diagnosis is spinal muscular atrophy (SMA) type 1,2, or 3 (results of genetic testing must be submitted) AND
		• The patient has at least 2 copies of the SMN2 gene AND
		• The need for invasive or noninvasive ventilation (if applicable) does not exceed more than 16 hours per 24 hour period AND
		• Baseline motor ability has been established using one of the following exams:
		  ○ Hammersmith Infant Neurological Exam (HINE)
		  ○ Hammersmith Functional Motor Scale Expanded (HFMSE)
		  ○ Upper Limb Module Test (non-ambulatory)
		  ○ Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND) AND
		• Prior to starting therapy, and prior to each dose, the following laboratory tests will be conducted: Platelet count, prothrombin time (PT), activated

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		partial thromboplastin time (aPTT), and quantitative spot urine protein • Concurrent use with Evrysdi will not be approved. **Note:** Initial approval will be granted for 4 loading doses (the first 3 loading doses should be administered at 14-day intervals; the 4th loading dose should be administered 30 days after the 3rd dose). Renewal may be granted for up to 12 months with a maximum of 3 doses approved per year (12mg(5ml) every 4 months). For therapy continuation, clinical documentation must be submitted documenting improvement or maintenance of motor ability OR slower progression of disease than would otherwise be expected. **Zolgensma:** • The patient is less than 2 years of age AND • The diagnosis is spinal muscular atrophy (SMA) AND • The patient has bi-allelic mutations of the SMN1 gene AND • The patient does not have advanced SMA (e.g. complete paralysis of limbs or permanent ventilator dependence) AND • Medication is prescribed per the dosing guidelines in the package insert (recommended dose is 1.1 x 10^4 vector genomes per kilogram) AND • Baseline anti-AAV9 antibodies are less than 1:50 AND • Prior to starting therapy and periodically for at least 3 months, the following laboratory tests will be conducted: Liver function (AST, ALT, total bilirubin, prothrombin time), platelet counts, and troponin-I **Note:** The safety and effectiveness of repeat administration has not been evaluated. Approval is limited to a single intravenous infusion.
MOOD STABILIZERS		
LITHIUM CARBONATE (formerly Eskalith®) LITHIUM CARBONATE SR (compare to Lithobid®, formerly Eskalith CR®) LITHIUM CITRATE SYRUP	Equetro® (carbamazepine SR) Lithobid® (lithium carbonate SR)	**Lithobid:** The patient has had a documented side effect, allergy, or treatment failure with the generic equivalent of the requested medication. **Equetro:** The patient has had a documented side effect, allergy, or treatment failure with a carbamazepine product from the anticonvulsant therapeutic drug category

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
MOVEMENT DISORDERS		
Preferred After Clinical Criteria Are Met TETRABENAZINE (compare to Xenazine®) *QTY LIMIT:* 50 mg/day at initial approval (12.5 mg tablets ONLY), up to 100 mg/day at subsequent approvals (12.5 mg or 25 mg tablets) Maximum 1-month supply per fill	Austedo® (deutetrabenazine) tablets *QTY LIMIT:* 48 mg/day Maximum 1-month supply per fill Ingrezza® (valbenazine tosylate) capsules *QTY LIMIT:* 80 mg/day Maximum 1-month supply per fill Xenazine® (tetrabenazine) tablets *QTY LIMIT:* 50 mg/day at initial approval (12.5 mg tablets ONLY), up to 100 mg/day at subsequent approvals (12.5 mg or 25 mg tablets) Maximum 1-month supply per fill	**Austedo:** The diagnosis or indication for the requested medication is Huntington's Disease (HD) with chorea or Tardive Dyskinesia (TD) AND the results of an Abnormal Involuntary Movement Scale (AIMS) exam have been submitted AND the patient is ≥18 years of age AND the patient has a documented side effect, allergy, contraindication or treatment failure withtruvada tetrabenazine. For re-approved, a 30% improvement from baseline in AIMS score must be documented. **Ingrezza:** The diagnosis or indication for the requested medication is Tardive Dyskinesia (TD) AND the results of an Abnormal Involuntary Movement Scare (AIMS) exam have been submitted AND the patient is ≥18 years of age AND the patient has a documented side effect, allergy, contraindication or treatment failure with tetrabenazine. For re-approval, a 30% improvement from baseline in the AIMS score must be documented. **Tetrabenazine, Xenazine:** The diagnosis or indication for use is Tourette Syndrome OR the diagnosis or indication for use is Huntington's Disease (HD) with Chorea or Tardive Dyskinesia (TD) AND the patient is ≥18 years of age AND for approval of Xenazine, the patient must have a documented intolerance to tetrabenazine. **Note:** Austedo, Tetrabenazine, and Xenazine are contraindicated in patients with Huntington's Disease who are suicidal or with untreated/inadequately treated depression.
MULTIPLE SCLEROSIS MEDICATIONS		
INJECTABLES **INTERFERONS** AVONEX® (interferon B-1a) BETASERON® (interferon B-1b) REBIF® (interferon B-1a) REBIF® REBIDOSE (interferon B-1a) **OTHER** COPAXONE® 20 mg (glatiramer acetate) *QTY LIMIT:* 1 kit/30 days ***Preferred After Clinical Criteria are Met***	Extavia® (interferon beta-1b) Copaxone® 40 mg (glatiramer) *QTY LIMIT:* 12 syringes (12 ml)/28 days Glatiramer Acetate (compare to Copaxone®)20 mg *QTY LIMIT:* 1 kit/30days Glatiramer Acetate (compare to Copaxone®) 40 mg *QTY LIMIT:* 12 syringes (12 ml)/28 days Glatopa® 20 mg (glatiramer acetate) *QTY LIMIT:* 1 carton (30 syringes/30 days Glatopa® 40 mg (glatiramer)	**Ampyra, Tecfidera:** patient must have a documented intolerance to the generic equivalent **Bafiertam, Vumerity:** Patient is ≥ 18 years AND has a diagnosis of relapsing forms of Multiple Sclerosis AND the patient has a documented side effect, allergy, treatment failure, or contraindication to at least two preferred drugs, one of which must be Dimethyl fumarate. **Copaxone 40 mg Syringe:** The patient is unable to tolerate or be compliant with Copaxone 20 mg daily dosing. **Extavia:** Patient has a diagnosis of multiple sclerosis. AND The provider provides a clinical reason why Betaseron cannot be prescribed. **Glatiramer, Glatopa:** Patient is ≥ 18 years AND diagnosis of relapsing forms of Multiple Sclerosis AND the provider provides a clinical reason why Copaxone

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
TYSABRI® (natalizumab) **ORAL** AUBAGIO® (teriflunamide) tablet *QTY LIMIT:* 1 tablet/day *M*aximum 30-day supply per fill DALFAMPRIDINE ER tablet (compare to Ampyra®) *QTY LIMIT:* 2 tablets/day *M*aximum 30-day supply per fill DIMETHYL FUMARATE QTY LIMIT: 2 capsules/day Maximum 30-day supply per fill GILENYA® (fingolimod) capsule *QTY LIMIT:* 1 capsule/day *M*aximum 30-day supply per fill	*QTY LIMIT:* 12 syringes (12 ml)/28 days Kesimpta® (ofatumumab) Lemtrada® (alemtuzumab) intravenous Ocrevus® (ocrelizumab) *QTY LIMIT:* 300 mg X 2 doses, then 600 mg every 6 months thereafter Plegridy® (peginterferon beta-1a) Ampyra® (dalfampridine ER) tablet *QTY LIMIT:* 2 tablets/day Maximum 30-day supply per fill Bafiertam® (monomethyl fumarate) capsule QTY LIMIT: 4 capsules/day Maximum 30-day supply per fill Mavenclad® (cladribine) tablet Mayzent® (siponimod) tablet Ponvory™ (ponesimod) tablet *QTY LIMIT:* 1 tablet/day Maximum 30-day supply per fill Tecfidera® (dimethyl fumarate) *QTY LIMIT:* 2 capsules/day Maximum 30-day supply per fill Vumerity® (diroximel fumarate) capsule *QTY LIMIT:* 4 capsules/day Zeposia® (ozanimod) capsule *QTY LIMIT:* 1 capsule/day	cannot be prescribed. **Mavenclad:** Patient is ≥ 18 years AND has a diagnosis of relapsing-remitting MS (RRMS) or active secondary progressive MS (SPMS) AND Documentation is provided showing ≥ 1 relapse within the past year AND baseline CBC w/ diff (including lymphocyte count), liver function tests, and MRI (within the past 3 months) have been completed AND the patient is negative for HIV, Hepatitis B, and Hepatitis C infections AND the patient is not pregnant AND patient has a documented side effect, allergy, treatment failure or contraindication to at least three preferred drugs AND dosing does not exceed any of the following: 2 tablets per day, 10 tablets per cycle, 2 treatment cycles per course, 1 course per year. Following the administration of 2 treatment courses, Mavenclad may not be administered during the next 2 years. **Mayzent, Ponvory, Zeposia:** *Diagnosis of relapsing-remitting MS, Clinical Isolated Syndrome, or Active Secondary Progressive MS (SPMS):* • Patient is ≥ 18 years AND • Patient CYP2C9 variant status has been tested to determine genotyping (Mayzent only; required for dosing; therapy is contraindicated in CYP2C9*3/*3) AND • Baseline CBC, electrocardiogram (ECG), and ophthalmic evaluation have been completed AND • Patient has a documented side effect, allergy, treatment failure or contraindication to at least two preferred drugs, one of which must be Gilenya **Kesimpta, Lemtrada, Ocrevus:** Patient is ≥18 years AND has a diagnosis of relapsing multiple sclerosis AND has a documented side effect, allergy, treatment failure or contraindication to at least two preferred drugs, one of which must be Gilenya or Tysabri, unless contraindicated. OR Patient is ≥18 years AND has a diagnosis of primary progressive multiple sclerosis (Ocrevus only). **Plegridy:** Patient is ≥ 18 years AND has a diagnosis of relapsing form of Multiple Sclerosi AND has a documented side effect, allergy, treatment failure or contraindication to at least three preferred drugs including at least one preferred form of interferon. **Tysabri:** Patient is ≥ 18 years AND has a diagnosis of relapsing multiple sclerosis (including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease
MUSCLE RELAXANTS, SKELETAL		
MUSCULOSKELETAL AGENTS		**Amrix, cyclobenzaprine 7.5 mg, Fexmid**: The prescriber must provide a

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
SINGLE AGENTS CYCLOBENZAPRINE 5 mg, 10 mg tablets (compare to Flexeril®) *QTY LIMIT:* 5 mg = 6 tablets/day, 10 mg = 3 tablets/day METHOCARBAMOL tablets (compare to Robaxin®) *QTY LIMIT:* 8 tablets/day ORPHENADRINE CITRATE ER 100 mg tablet *QTY LIMIT:* 2 tablets/day **COMBINATION PRODUCT** All products require PA *ASA = aspirin* **Maximum duration of therapy all musculoskeletal agents = 90 days** **ANTISPASTICITY AGENTS** BACLOFEN DANTROLENE (compare to Dantrium®) TIZANIDINE (compare to Zanaflex®) tablets	Amrix® (cyclobenzaprine sustained-release) capsule *QTY LIMIT:* 1 capsule/day Carisoprodol tablets *QTY LIMIT:* 8 tablets/day Chlorzoxazone tablets *QTY LIMIT:* 4 tablets/day Cyclobenzaprine 7.5 mg tab (compare to Fexmid®) *QTY LIMIT:* 3 tablets/day Fexmid® (cyclobenzaprine) 7.5 mg tablet *QTY LIMIT:* 3 tablets/day Lorzone® (chlorzoxazone) tablets *QTY LIMIT:* 4 tablets/day Metaxalone (compare to Skelaxin®) tablets *QTY LIMIT:* 4 tablets/day Robaxin® (methocarbamol) tablets *QTY LIMIT:* 8 tablets/day Skelaxin® (metaxalone) tablets *QTY LIMIT:* 4 tablets/day Soma® (carisoprodol) tablets *QTY LIMIT:* 4 tablets/day Carisoprodol, ASA, codeine *QTY LIMIT:* 4 tablets/day Dantrium® (dantrolene) Ozobax® (baclofen) oral solution Tizanidine (compare to Zanaflex®) capsules Zanaflex® (tizanidine) capsules Zanaflex® (tizanidine) tablets	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/codeine, chlorzoxazone, Lorzone, Soma, metaxalone, Skelaxin:** The patient has had a documented side effect, allergy or treatment failure with two different preferred musculoskeletal agents. Additionally, if a brand name product is requested where an AB rated generic exists, the patient must also have had a documented intolerance to the generic product. **Dantrium, Zanaflex tablets:** The patient must have a documented intolerance with the AB rated generic product. **Ozobax:** Patient has a medical necessity for a non-solid oral dosage form. **Tizanidine capsules, Zanaflex capsules:** The prescriber must provide a clinically valid reason why generic tizanidine tablets cannot be used. AND If the request is for Zanaflex capsules, the patient must have a documented intolerance to generic tizanidine capsules
MUSCULAR DYSTROPHY AGENTS		
All products require PA	Amondys®45 (casimersen) Emflaza™ (deflazacort) Maximum 30-day supply per fill Exondys 51™ (eteplirsen) Viltepso® (viltorsen) Vyondys 53™ (golodirsen)	**Emflaza:** • The patient must be ≥ 2 years of age AND • The patient must have a diagnosis of Duchenne Muscular Dystrophy AND • There is documented improvement in muscle function or strength with use of prednisone, but the patient has experienced weight gain >10% of

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		body weight within 3 months or >25% within 1 year. **Amondys, Exondys, Viltepso, Vyondys:** • The patient must have a diagnosis of Duchenne Muscular Dystrophy with a confirmed mutation of the DMD gene that is amenable to exon 45 skipping (for Amondys) or exon 51 skipping (for Exondys) or exon 53 skipping (for Viltepso, Vyondys) (results of genetic testing must be submitted) AND • The prescriber is, or has consulted with, a neuromuscular disorder specialist AND • The dose does not exceed 30mg/kg once weekly (for Amondys, Exondys, Vyondys) or 80mg/kg once weekly (for Viltepso) AND • The patient is currently on a stable corticosteroid dose for at least 6 months. • 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.
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

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
NEUROPATHIC PAIN & FIBROMYALGIA AGENTS		
Oral		
DULOXETINE (compare to Cymbalta®) *QTY LIMIT:* 2 capsules/day PREGABALIN (compare to Lyrica®) capsules *QTY LIMIT:* 3 capsules/day	Cymbalta® (duloxetine) *QTY LIMIT:* 2 capsules/day Gralise® (gabapentin) tablet, starter pack *QTY LIMIT:* 3 tablets/day Maximum 30-day supply per fill Horizant® (gabapentin enacarbil) ER Tablet FDA maximum recommended dose = 1200 mg/day Lyrica® (pregabalin) capsules *QTY LIMIT:* 3 capsules/day Lyrica® CR (pregabalin, extended release) FDA maximum recommended dose = 330 mg/day (DPN), 660 MG/day (PHN) Lyrica® (pregabalin) solution Pregabalin (compare to Lyrica®) solution Savella® (milnacipran) tablet, titration pack *QTY LIMIT:* 2 tablets/day	**Cymbalta, Lyrica:** 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 pregabalin 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. **Pregabalin solution, Lyrica solution:** the patient is unable to use Lyrica capsules (e.g. Swallowing disorder) AND for approval of brand Lyrica oral solution, the patient must have a documented intolerance to the generic equivalent. **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 pregabalin.
NUTRITIONALS, LIQUID ORAL SUPPLEMENTS		
All products require PA	Note: Nutritional supplements administered via tube feeds may be provided through the Medical Benefit	**EleCare, EleCare Jr:** The patient is an infant or child who needs an amino acid-based medical food or who cannot tolerate intact or hydrolyzed protein. AND The product is being requested for the dietary management of protein maldigestion, malabsorption, severe food allergies, short-bowel syndrome, eosinophilic GI disorders, GI-tract impairment, or other conditions for which an amino acid-based diet is required. **All Others:** Requested nutritional supplement will be administered via tube feeding. OR Patient has one of the following conditions where feeding is difficult or malabsorption or maldigestion occurs: AIDS, Cancer, Celiac Disease, Cerebral Palsy, Chronic Diarrhea, Cognitive Impairment, Cystic Fibrosis, Dementia (includes Alzheimer's), Developmental Delays, Difficulty

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		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: DRUGS (select)		
		Clinical Criteria: Medication is being used for an FDA approved indication AND age, dose, duration, required concurrent therapy, and past treatment failures (if applicable) are consistent with prescribing information AND the patient does not have any contraindications prohibiting use of the medication OR medication is being used in accordance with the National Comprehensive Cancer Network® (NCCN®) Clinical Practice Guidelines. Requests outside of these parameters require medical director review. For physician-administered drugs, please refer to the Fee Schedule for which codes require a PA: http://vtmedicaid.com/#/feeSchedule/hcpcs
OPHTHALMICS		
ANTIBIOTICS		
QUINOLONES BESIVANCE® (besifloxacin) suspension CILOXAN® ointment CIPROFLOXACIN HCL (compare to Ciloxan®) solution	Ciloxan® (ciprofloxacin) solution Gatifloxacin 0.5% solution (compare to Zymaxid®) Levofloxacin 0.5 % solution Moxeza® (moxifloxacin 0.5%) (preservative free)	**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

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
MOXIFLOXACIN 0.5% solution	solution Ocuflox® (ofloxacin) solution Ofloxacin (compare to Ocuflox®) solution Vigamox® (moxifloxacin 0.5%) (preservative free) solution Zymaxid® (gatifloxacin 0.5%) solution	rated generic, there must have also been a trial of the generic formulation.)
MACROLIDES ERYTHROMYCIN ointment		
AMINOGLYCOSIDES **SINGLE AGENT** AK-TOB (tobramycin) solution GARAMYCIN® (gentamicin) ointment, solution GENTAK (gentamicin) ointment, solution GENTAMICIN ointment, solution TOBRAMYCIN solution (compare to Tobrex®)	Azasite® (azithromycin) solution All other brands	
COMBINATION TOBRADEX® (tobramycin/dexamethasone) suspension, ointment ZYLET® (tobramycin/loteprednol) suspension	Tobrex® ointment, solution (tobramycin) Tobramycin w/Dexamethasone (compare to Tobradex®) suspension Tobradex ST® (tobramycin/dexamethasone) suspension Pred-G® S.O.P. (gentamicin/prednisolone) ointment Pred-G® (gentamicin/prednisolone) ointment, suspension	
MISCELLANEOUS **SINGLE AGENT** All products require PA	Bacitracin ointment Bleph-10® (sulfacetamide) solution Sulfacetamide sodium (compare to Bleph-10®) solution Sulfacetamide sodium ointment	
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	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	

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
PHOSPHATE solution		
ANTIHISTAMINES		
AZELASTINE (compare to Optivar®) *QTY LIMIT:* 1 bottle/month KETOTIFEN 0.025 % (e.g. Alaway®, Zaditor® OTC, others) *QTY LIMIT:* 1 bottle/month OLOPATADINE 0.1%, 0.2% *QTY LIMIT:* 1 bottle/month	Bepreve® (bepotastine besilate) Epinastine *QTY LIMIT:* 1 bottle/month Lastacaft® (alcaftadine) *QTY LIMIT:* 1 bottle/month Zerviate® (cetirizine 0.24%) *QTY LIMIT:*60 vials/30 days	**Bepreve, Epinastine:** The patient has had a documented side effect, allergy, or treatment failure to a preferred Olopatadine product. **Lastacaft:** 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. **Zerviate:** The patient has had a documented side effect, allergy, or treatment failure to TWO preferred ophthalmic antihistamines.
CORTICOSTEROIDS: TOPICAL		
ALREX® (loteprednol) 0.2% suspension DEXAMETHASONE sodium phosphate 0.1% solution DUREZOL® (difluprednate) 0.05% emulsion FLAREX® (fluorometholone acetate) 0.1% suspension FML Forte® (fluorometholone) 0.25% suspension FLUOROMETHOLONE 0.1% suspension FML® (fluorometholone) 0.1% ointment LOTEMAX® (loteprednol) 0.5% suspension, ointment MAXIDEX® (dexamethasone) suspension PRED MILD® (prednisolone acetate) 0.12% suspension PREDNISOLONE ACETATE 1% suspension PREDNISOLONE SODIUM PHOSPHATE 1% solution	FML Liquifilm® (fluorometholone) 0.1% suspension Inveltys™ (loteprednol) suspension Lotemax® (loteprednol) 0.5% gel Lotemax SM (loteprednol) 0.038% gel drops Loteprednol suspension Pred Forte® (prednisolone acetate) 1% suspension All other brands	**Non-preferred agents:** The patient has had a documented side effect, allergy, or treatment failure with TWO preferred ophthalmic corticosteroids. (If a product has an AB rated generic, there must have been a trial of the generic formulation)
CYSTEAMINE		
All products require PA	Cystadrops® (cysteamine) 0.37% ophthalmic solution QTY LIMIT: 4 bottles (20 ml)/28 days Maximum day supply/Rx = 28 days Cystaran® (cysteamine) 0.44% ophthalmic solution *QTY LIMIT:* 4 bottles (60 ml)/ 28 days Maximum day supply/RX = 28 days	**Cystadrops, Cystaran:** The indication for use is corneal cystine accumulation in patients with cystinosis.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
DRY EYE SYNDROME		
OCULAR LUBRICANTS Please refer to the DVHA wsebsite for covered OTC ocular lubricants https://dvha.vermont.gov/sites/dvha/files/documents/providers/Pharmacy/OTCWebList.pdf **IMMUNOMODULATORS** RESTASIS® (cyclosporine ophthalmic emulsion) 0.05% droperette (NDC 00023916330 and 00023916360 are the only preferred NDC's) *QTY LIMIT:* 180 vials per 90 days	Cequa™ (cyclosporine ophthalmic solution) 0.09% Eysuvis® (loteprednol etabonate ophthalmic suspension) 0.25% Restasis® (cyclosporine ophthalmic emulsion) 0.05% multidose bottle *QTY LIMIT:* 1 bottle (5.5ml) per 25 days Xiidra® (lifitegrast) solution *QTY LIMIT:* 60 vials per 30 days	**Cequa, Xiidra:** The patient has a diagnosis of Dry Eye Disease AND has a documented side effect, allergy or treatment failure to Restasis. **Eysuvis**: The patient has a diagnosis of Dry Eye Disease AND has failed at least a 14-day course of a preferred OTC ocular lubricant AND has a documented side effect, allergy, or treatment failure with 2 preferred ophthalmic corticosteroids, one of which must be a formulation of loteprednol. **Restasis Multidose:** Both package sizes of the droperettes must be on a long-term backorder and unavailable from the manufacturer.
GLAUCOMA AGENTS/MIOTICS		
ALPHA-2 ADRENERGIC SINGLE AGENT ALPHAGAN P® 0.1 %, 0.15 % (brimonidine tartrate) BRIMONIDINE TARTRATE 0.2 % **COMBINATION** COMBIGAN® (brimonidine tartrate/timolol maleate) SIMBRINZA® (brinzolamide 1% and brimonidine 0.2%) Suspension **BETA BLOCKER** CARTEOLOL HCL LEVOBUNOLOL HCL TIMOLOL MALEATE (compare to Timoptic®) **PROSTAGLANDIN INHIBITORS** LATANOPROST (compare to Xalatan®) LUMIGAN®(bimatoprost) TRAVATAN Z® (travoprost) (BAK free)	Apraclonidine (compare to Iopidine®) Brimonidine tartrate 0.15 % (compare to Alphagan P®) Iopidine® (apraclonidine) Betaxolol HCl solution Betoptic S® (betaxolol suspension) Istalol® (timolol) Timoptic® (timolol maleate) Timoptic XE® (timolol maleate gel) Timolol maleate gel (compare to Timotic XE®) Bimatoprost 0.03% (Lumigan®) Durysta® (bimatoprost) 10 mcg implant Vyzulta® (latanoprostene bunod)	**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 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. **Durysta:** The patient has had a documented side effect, allergy, or treatment failure with at least 2 preferred prostaglandin inhibitors OR the patient is not a candidate for topical drop therapy AND the patient does not have any of the following contraindications: • History of prior corneal transplantation or endothelial cell transplants (e.g. Descemet's Stripping Automated Endothelial Keratoplasty) • Diagnosis of corneal endothelial dystrophy (e.g. Fuchs' Dystrophy) • Absent or ruptured posterior lens capsule Approval will be limited to a single implant per eye without retreatment. **CARBONIC ANHYDRASE INHIBITORS**

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
RHO KINASE INHIBITORS **SINGLE AGENT** RHOPRESSA® (netarsudil) **COMBINATION** ROCKLATAN® (netarsudil/latanoprost) **CARBONIC ANHYDRASE INHIBITOR** **SINGLE AGENT** AZOPT® (brinzolamide 1%) DORZOLAMIDE 2 % (compare to Trusopt®) **COMBINATION** DORZOLAMIDE w/TIMOLOL (compare to Cosopt®) **MISCELLANEOUS** ISOPTO® CARPINE (pilocarpine) PILOCARPINE HCL PHOSPHOLINE IODIDE® (echothiophate)	Xelpros® (latanoprost) (BAK free) Zioptan® (tafluprost) Trusopt® (dorzolamide 2 %) Cosopt PF® (dorzolamide w/timolol) (pres-free) Miochol-E® (acetylcholine)	**Trusopt:** The patient has had a documented intolerance to the generic equivalent product. **Cosopt PF:** The patient has had a documented intolerance to the preservatives in 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
NEUROTROPHIC KERATITIS		
All products require PA	Oxervate™ (cenegermin-bkbj) ophthalmic solution 0.002% *QTY LIMIT:* 1 vial (1mL) per eye per day Maximum of 8 weeks therapy	**Oxervate:** Medication is being prescribed by, or in consultation with, an ophthalmologist AND Patient has a diagnosis of Stage 2 or 3 neurotrophic keratitis (in one or both eyes) as evidenced by persistent epithelial defect or corneal ulceration AND patient has evidence of decreased corneal sensitivity in at least one corneal quadrant AND patient has failed one or more conventional non-surgical treatments such as artificial tears, gels, or ointments.
NON-STEROIDAL ANTI-INFLAMMATORY DRUGS (NSAIDs)		
DICLOFENAC 0.1% ophthalmic solution KETOROLAC 0.4 % ophthalmic solution (compare to Acular LS®)	Acular® (ketorolac 0.5% ophthalmic solution) Acular LS ® (ketorolac 0.4% ophthalmic solution)	**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

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
KETOROLAC 0.5 % ophthalmic solution (compare to Acular®) NEVANAC® ophthalmic suspension (nepafenac 0.1%)	Acuvail (ketorolac 0.45 %) Ophthalmic Solution *QTY LIMIT:* 30-unit dose packets/15 days Bromfenac 0.09 % ophthalmic solution BromSite™ (bromfenac 0.075%) solution Flurbiprofen 0.03% ophthalmic solution Ilevro® ophthalmic suspension (nepafenac 0.3%) Prolensa® ophthalmic solution (bromfenac 0.07%)	hypersensitivity to the preservative benzalkonium chloride. **All other non-preferred agents:** The patient has had a documented side effect, allergy, or treatment failure to TWO preferred agents. In addition, if a product has an AB rated generic, there must have also been a trial of the generic formulation.
OTIC ANTI-INFECTIVES		
ANTI-INFECTIVE SINGLE AGENT OFLOXACIN 0.3% Otic solution	Ciprofloxacin 0.2% otic solution *QTY LIMIT:* 14-unit dose packages/ 7 days Otiprio® (ciprofloxacin 6%) otic suspension	**All non-preferred products:** The patient has had a documented side effect, allergy, or treatment failure to two preferred products.
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, SUSPENSION	Cortisporin-TC® (neomycin/colistin/thonzium/hydrocortisone) Otovel® (ciprofloxacin 0.3%/fluocinolone 0.025%) otic solution *QTY LIMIT:* 28-unit dose packages/7days	
MISCELLANEOUS AGENTS ACETIC ACID Otic solution	Acetic Acid/Hydrocortisone Otic Solution	
OVER THE COUNTER (OTC) MEDICATIONS		
Please refer to the DVHA website for covered OTC categories not already managed on the PDL. Many categories limited to generics ONLY and other categories not covered. No PA process for non-covered OTCs. **https://dvha.vermont.gov/sites/dvha/files/documents/providers/Pharmacy/OTCWebList.pdf**		

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

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

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Zelapar® (selegiline ODT) *QTY LIMIT:* 2.5 mg/day	(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.
ANTICHOLINERGICS BENZTROPINE TRIHEXYPHENIDYL **ADENSOSINE RECEPTOR AGONIST** All products require PA **OTHER** APOKYN® (apomorphine) AMANTADINE syrup AMANTADINE capsules, tablets (PA required for ≤ 10-day supply) CARBIDOPA/LEVODOPA/ENTACAPONE (compare to Stalevo®)	Nourianz (istradefylline) *QTY LIMIT:* 1 tab/day Gocovri™ (amantadine extended release) *QTY LIMIT:* 2 tabs/day Kynmobi® (apomorphine) sublingual film Osmolex® ER (amantadine extended-release) *QTY LIMIT:* 1 tablet/strength/day Stalevo® (carbidopa/levodopa/entacapone)	**Neupro:** The patient has a medical necessity for a specialty dosage form. **Nourianz:** The patient has a diagnosis of Parkinson's disease with intermittent presence of OFF episodes AND the patient is currently taking Carbidopa/Levodopa AND the patient has had a documented side effect, allergy, or treatment failure with TWO preferred medications being used as adjunct therapy. **Osmolex ER:** patient has not been able to be adherent to the dosing schedule of amantadine immediate release resulting in a significant clinical impact. **Tasmar, Tolcapone:** The diagnosis or indication is Parkinson's disease. AND The patient has had a documented side effect, allergy, or treatment failure with entacapone AND patient has provided written acknowledgement of risks per the package insert. For approval of brand Tasmar, the patient must have documented intolerance to the generic equivalent. **Xadago:** The diagnosis or indication is Parkinson's disease AND The patient is on current therapy with levodopa/carbidopa AND The patient has had a documented side effect, allergy, or treatment failure with selegiline. Note: Xadago will not be approved for monotherapy. **Zelapar:** The diagnosis or indication is Parkinson's disease. AND The patient is on current therapy with levodopa/carbidopa. AND Medical necessity for disintegrating tablet administration is provided (i.e. inability to swallow tablets or drug interaction with oral selegiline). AND the dose requested does not exceed 2.5 mg/day **Limitations:** To prevent the use of amantadine in influenza treatment/prophylaxis, days supply < 10 days will require PA.
PLATELET INHIBITORS		
AGGREGATION INHIBITORS BRILINTA® (ticagrelor) Tablet *QTY LIMIT:* 2 tablets/day CILOSTAZOL CLOPIDOGREL 75 mg (compare to Plavix®)	Effient® (prasugrel) Tablet *QTY LIMIT:* 1 tablet/day Plavix® 75 mg (clopidogrel bisulfate) Zontivity® (vorapaxar) Tablet	**Agrylin, Effient, Plavix:** The patient has had a documented intolerance to the generic formulation of the medication. **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)

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

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		30 x 10^9/L AND The patient has had a documented side effect, allergy, treatment failure or a contraindication to therapy with corticosteroids AND the patient has failed at least one of the following additional treatments: immunoglobulins, rituximab, splenectomy, or a thrombopoietin receptor agonist (e.g. eltrombopag, romiplostim, etc.). **Note:** Initial approval will be granted for 12 weeks. For therapy continuation, the patient must have achieved and maintained a platelet count of at least 50 x 10^9/L and/or have a documented decrease in rescue treatment(s) with platelet transfusions.
PSEUDOBULBAR AFFECT AGENTS		
All products require PA	Nuedexta® capsules (dextromethorphan/quinidine) *QTY LIMIT:* 2 capsules/day	**Nuedexta:** The patient must have a diagnosis of pseudobulbar affect (PBA) secondary to a neurological condition AND the patient has had a trial and therapy failure at a therapeutic dose with a tricyclic antidepressant (TCA) or an SSRI AND the patient has documentation of a current EKG (within the past 3 months) without QT prolongation AND initial authorizations will be approved for 6 months with a baseline Center for Neurologic Studies Lability Scale (CNS-LS) questionnaire AND subsequent prior authorizations will be considered at 6 month intervals with documented efficacy as seen in an improvement in the CNS-LS questionnaire
PROGESTATIONAL AGENTS		
Preferred After Clinical Criteria Are Met MAKENA® (hydroxyprogesterone caproate) 275 mg/1.1ml auto-injector (subcutaneous injection) *QTY LIMIT:* 28-day supply	Hydroxyprogesterone caproate 250 mg/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 for Makena AND the patient must be unable to use 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.
PSORIASIS		
BIOLOGICS: Initial approval is 3 months, renewals are 1 year		
Preferred After Clinical Criteria Are Met		**Clinical Criteria:**

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
INJECTABLE ENBREL® (etanercept) *QTY LIMIT:* 50 mg = 8 syringes/28 days for the first 3 months; then 4 syringes/28 days 25 mg = 8 syringes/28 days subsequently HUMIRA® (adalimumab) *QTY LIMIT:* 4 syringes/28 days for one month; 2 syringes/28 days subsequently TALTZ® (ixekizumab) *QTY LIMIT:* 3 syringes/28 days for the first month, 2 syringes/28 days months 2 and 3 and 1 syringe/28 days subsequently **ORAL** OTEZLA® tablet (apremilast) *QTY LIMIT:* Starter Pack = 55 tablets/28 days, 30 mg = 2 tablets/day	Avsola® (infliximab-axxq) biosimilar to Remicade® Cimzia® (certolizumab pegol) *QTY LIMIT:* 1 kit/28 days (starter X 1, then regular) Cosentyx® (secukinumab) Ilumya™ (tildrakizumab-asmn) *QTY LIMIT:* 2 ml (2 syringes) for the first month then 1 ml (1 syringe)/84 days subsequently Inflectra® (infliximab-dyyb) biosimilar to Remicade® Remicade® (infliximab) Renflexis™ (infliximab-abda) biosimilar to Remicade® Siliq™ (brodalumab) injection *QTY LIMIT:* 6 ml (4 syringes) for the first month then 3 ml (2 syringes)/28 days subsequently Skyrizi™ (risankizumab-rzaa) *QTY LIMIT:* 4 syringes for the first month followed by 2 syringes (150 mg) every 12 weeks thereafter Stelara® (ustekinumab) *QTY LIMIT:* 45 mg (0.5 ml) or 90 mg (1 ml) per dose (90mg dose only permitted if patient weight > 100kg) Tremfya® (guselkumab) *QTY LIMIT:* 2 syringes/28 days for the first month, then 1 syringe every 56 days thereafter	**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 Taltz:** The prescriber must provide evidence of a trial and failure or contraindication to Humira® **Additional Criteria for Cimzia, Cosentyx, Ilumya, Remicade, Renflexis, Siliq, Skyrizi, Stelara, Tremfya:** The prescriber must provide a clinically valid reason why both Humira® and Taltz® cannot be used. **Note:** Cosentyx approvals for 300mg dose(s) must use "300DOSE" package (containing 2x150mg pens or syringes) Approval will not be granted for 2 separate 150mg packages. **Additional Criteria for Avsola, Inflectra:** The prescriber must provide a clinically valid reason why Humira®, Taltz®, and Remicade/Renflexis cannot be used.
NON-BIOLOGICS		
ORAL ACITRETIN (compare to Soriatane®) capsules CYCLOSPORINE (generic) METHOTREXATE (generic) **TOPICAL** CALCIPOTRIENE Ointment, Solution DOVONEX® cream (calcipotriene)	Methoxsalen (compare to Oxsoralen-Ultra®) Oxsoralen-Ultra® (methoxsalen) Soriatane® (acitretin) capsules Calcitriol (compare to Vectical®) Ointment *QTY LIMIT:* 200 g (2 tubes)/week Calcipotriene Cream (compare to Dovonex®) Calcipotriene/betamethasone ointment (compare to Taclonex®)	**Soriatane:** The patient has a documented intolerance to the generic equivalent. **Calcipotriene cream:** The patient has a documented intolerance to Brand Dovonex cream. **Duobrii lotion:** the patient has had an inadequate response to at least 2 different preferred high or very high potency corticosteroids AND tazarotene cream. **Enstilar, Taclonex or Calcipotriene/betamethasone dipropionate Ointment or Scalp Suspension:** The patient has had an inadequate response to a trial (defined as daily treatment for at least one month) of a betamethasone dipropionate product and Dovonex (or generic calcipotriene), simultaneously. **Tazarotene, Vectical Ointment, Calcitriol Ointment:** The patient has a diagnosis of mild-to-moderate plaque psoriasis AND The patient has

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	QTY LIMIT: Initial fill = 60 grams Duobrii™ (halobetasol propionate/tazarotene) lotion Enstilar® (calcipotriene/betamethasone) foam Sorilux® (calcipotriene) foam Taclonex® (calcipotriene/betamethasone ointment/scalp suspension) *QTY LIMIT:* Initial fill = 60 grams Tazarotene Cream Vectical® Ointment (calcitriol) *QTY LIMIT:* 200 g (2 tubes)/week	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.
PULMONARY AGENTS		
ANTICOLINERGICS: INHALED		
SHORT-ACTING BRONCHODILATORS ATROVENT HFA® (ipratropium) COMBIVENT® RESPIMAT (ipratropium/albuterol) *QTY LIMIT:* 3 inhalers (12 grams)/90 days IPRATROPIUM NEBULIZER SOLN IPRATROPIUM/ALBUTEROL NEBULIZER SOLN		**Tudorza:** The patient has had documented side effect, allergy or treatment failure with a preferred LAMA. **Bevespi Aerosphere, Duaklir Pressiar:** The patient has a documented side effect, allergy, or treatment failure to TWO preferred LAMA/LABA combinations. **Lonhala Magnair, Yupelri:** patient has a diagnosis of COPD (not FDA approved for asthma) AND has a failure of nebulized ipratropium solution AND at least 3 inhaled LAMAs.
LONG-ACTING BRONCHODILATORS (LAMA) INCRUSE ELLIPTA® (umeclidinium bromide) *QTY LIMIT:* 1 inhaler/30 days SPIRIVA® HANDIHALER (tiotropium) *QTY LIMIT:* 1 capsule/day SPIRIVA® RESPIMAT (tiotropium) *QTY LIMIT:* 3 inhalers/90 days	Lonhala® Magnair (glycopyrollate) inhalation solution *QTY LIMIT:* 60 vials/30 days Tudorza® Pressair® (aclidinium bromide) *QTY LIMIT:* 3 inhalers/90 days Yupelri™ (revefenacin) inhalation solution *QTY LIMIT:* 300 vials/30 days	**Breztri:** patient has a diagnosis of COPD (not FDA approved for asthma) AND patient has a treatment failure of at least 2 different combinations of a preferred Inhaled Corticosteroid, LABA, and LAMA used in combination for a minimum of 30 consecutive days AND patient has a documented side effect, allergy, treatment failure, or contraindication with Trelegy Ellipta. **Trelegy Ellipta:** patient has a treatment failure of at least 2 different combinations of a preferred Inhaled Corticosteroid, LABA, and LAMA used in combination for a minimum of 30 consecutive days.
COMBINATION LONG-ACTING BRONCHODILATORS (LAMA & LABA) ANORO® ELLIPTA (umeclidinium/vilanterol) *QTY LIMIT:* 3 inhalers (180 blisters)/90 days STIOLTO® RESPIMAT (tiotropium/olodaterol) QTY LIMIT: 3 inhalers/90 days	Bevespi Aerosphere® (glycopyrrolate/formoterol) *QTY LIMIT:* 3 inhalers/90 days Duaklir® Pressair (aclidinium bromide/ formoterol fumarate) QTY LIMIT: 3 inhalers/90 days	

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
LAMA/LABA/ICS COMBINATION All products require PA	Breztri® Aerosphere (budesonide/glycopyrrolate/formoterol fumarate) QTY LIMIT: 1 inhaler (120 blisters)/30 days Trelegy® Ellipta (fluticasone/umeclidinium/vilanterol) *QTY LIMIT:* 1 inhaler (60 blisters)/30 days	
ANTIHISTAMINES: INTRANASAL		
AZELASTINE 0.1% Nasal Spray *QTY LIMIT:* 1 bottle (30 ml)/25 days **COMBO WITH CORTICOSTEROID** DYMISTA® (azelastine/fluticasone) Nasal Spray *QTY LIMIT:* 1 bottle (23 gm)/30 days	**SINGLE AGENT** Azelastine 0.15 % Nasal Spray *QTY LIMIT:* 1 bottle (30 ml)/25 days Olopatadine 0.6% (compare to Patanase®) Nasal Spray *QTY LIMIT:* 1 bottle (31 gm)/30 days Patanase® (olopatadine 0.6%) Nasal Spray *QTY LIMIT:* 1 bottle (31 gm)/30 days Azelastine/fluticasone (compare to Dymista®) Nasal Spray *QTY LIMIT:* 1 bottle (23 gm)/30 days	**Azelastine/Fluticasone:** The patient has a documented intolerance to brand Dymista. **Azelastine 0.15%, Olopatadine, Patanase:** The patient has a documented side effect, allergy, or treatment failure to Azelastine 0.1%
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 CETIRIZINE OTC 5 mg, 10 mg tablets LEVOCETIRIZINE 5mg tablets LORATADINE **COMBINATION WITH PSEUDOEPHEDRINE** CETIRIZINE/PSEUDOEPHEDRINE SR 12hr 5 mg/120 mg LORATADINE/PSEUDOEPHEDRINE SR 12hr 5 mg/120 mg LORATADINE/PSEUDOEPHEDRINE SR 24hr 10 mg/240 mg	Clarinex® (desloratadine) 5 mg tablet Desloratadine (compare to Clarinex®) 5 mg tablet Fexofenadine tablets All other brands Clarinex-D® 12 hr (desloratadine/pseudoephedrine 2.5 mg/120 mg)	**FEXOFENADINE TABLETS, CLARINEX TABLETS, DESLORATADINE TABLETS:** The patient has had a documented side effect, allergy, or treatment failure to loratadine AND cetirizine AND If they request is for Clarinex, the patient must also have a documented intolerance to the generic equivalent tablets. **CETIRIZINE CHEWABLE TABLETS, 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. **FEXOFENADINE SUSPENSION, LEVOCETIRIZINE SOLUTION:** the patient has had a documented side effect, allergy, or treatment failure to loratadine syrup AND cetirizine syrup.

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SINGLE AGENT ORAL LIQUID CETIRIZINE syrup LORATADINE syrup **CHEWABLE/ORALLY DISINTEGRATING TABLET** LORATADINE rapidly disintegrating tablet (RDT) 10 mg	Fexofenadine (compare to Allegra®) suspension Levocetirizine Solution Certirizine OTC Chewable Tablets 5 mg, 10 mg Desloratadine ODT (compare to Clarinex Reditabs®) 2.5 mg, 5 mg All other brands	**CLARINEX-D:** The patient has had a documented side effect, allergy, or treatment failure to loratadine-D and cetirizine-D. **LIMITATIONS:** Many Allegra® and Zyrtec® brand products as well as Claritin capsules are not covered as no Federal Rebate is offered. Fexofenadine/pseudoephedrine combination products) (brand and generic) are not covered – individual components may be prescribed separately.
BETA-ADRENERGIC AGENTS		
METERED-DOSE INHALERS (SHORT-ACTING) PROAIR® HFA (albuterol) PROAIR® Respiclick (albuterol) VENTOLIN® HFA (albuterol) **METERED-DOSE INHALERS (LONG-ACTING)** ***Preferred After Clinical Criteria Are Met*** SEREVENT® DISKUS (salmeterol xinafoate) *QTY LIMIT:* 1 inhaler (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 PA	Albuterol HFA (compare to Proventil® HFA, ProAir® HFA, Ventolin® HFA) Levalbuterol Aerosol (compare to Xopenex ® HFA) ProAir® Digihaler (albuterol) Proventil® HFA (albuterol) Xopenex® HFA (levalbuterol) Striverdi Respimat® (olodaterol) Levalbuterol neb solution (compare to Xopenex®) (age > 12 years) Xopenex® neb solution (all ages) Arformoterol (compare to Brovana®) *QTY LIMIT*: 2 vials/day	**Albuterol HFA, Levalbuterol (aerosol), Proventil 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. **ProAir Digihaler:** Preferred albuterol metered dose inhalers and Xopenex HFA are on a long-term backorder and unavailable from the manufacturer **Serevent**: The patient has a diagnosis of asthma and is prescribed an inhaled corticosteroid (pharmacy claims will be evaluated to assess compliance with long term controller therapy) OR the patient has a diagnosis of COPD. **Striverdi:** The patient has a diagnosis of COPD (not FDA approved for asthma). AND The patient has a documented side effect, allergy, or treatment failure to Serevent. **Levalbuterol, 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 **Arformoterol, Brovana, Formoterol, Perforomist Nebulizer Solution:** The patient must have a diagnosis of COPD. AND The patient must be unable to use a non-nebulized long-acting bronchodilator or anticholinergic (Serevent or Spiriva) due to a physical limitation **Terbutaline tablets:** The medication is not being prescribed for the

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
TABLETS/SYRUP (SHORT-ACTING) ALBUTEROL tablets/syrup **TABLETS (LONG-ACTING)** ALBUTEROL ER tablets	Brovana® (arformoterol) *QTY LIMIT:* 2 vials/day Formoterol (compare to Perforomist®) *QTY LIMIT*: 2 vials/day Perforomist® (formoterol) *QTY LIMIT:* 2 vials/day Terbutaline tablets	prevention/treatment of preterm labor.
CORTICOSTEROIDS/COMBINATIONS: INHALED		
METERED DOSE INHALERS (SINGLE AGENT) ASMANEX® (mometasone furoate) *QTY LIMIT:* 3 inhalers/90 days FLOVENT® DISKUS (fluticasone propionate) *QTY LIMIT:* 3 inhalers/90 days FLOVENT® HFA (fluticasone propionate) *QTY LIMIT:* 3 inhalers (36 gm)/90 days PULMICORT FLEXHALER® (budesonide) *QTY LIMIT:* 6 inhalers/90 days QVAR® REDIHALER™ 40mcg/inh *QTY LIMIT:* 2 inhalers (21.2 gm)/90 days QVAR® REDIHALER™ 80mcg/inh *QTY LIMIT:* 3 inhalers (31.8 gm)/90 days **METERED DOSE INHALERS (COMBINATION PRODUCT)** ADVAIR® DISKUS (fluticasone/salmeterol) *QTY LIMIT:* 3 inhalers/90 days ADVAIR® HFA (fluticasone/salmeterol) *QTY LIMIT:* 3 inhalers (36 gm)/90 days DULERA® (mometasone/formoterol) *QTY LIMIT:* 3 inhalers (39 gm)/90 days SYMBICORT® (budesonide/formoterol) *QTY LIMIT: 9 inhalers (91.8gm)*/90 days	Armonair® Digihaler (fluticasone propionate) QTY LIMIT = 3 inhalers/90 days Alvesco® (ciclesonide) *QTY LIMIT:* 80 mcg = 3 inhalers/90 days Arnuity Ellipta 100 or 200 mcg/inh (fluticasone furoate) *QTY LIMIT:* 90 blisters/90 days Asmanex® (mometasone furoate) HFA *QTY LIMIT:* 3 inhalers (39 gm)/90 days AirDuo® Digihaler (fluticasone/salmeterol) QTY LIMIT: 3 inhalers/90 days AirDuo Respiclick® (fluticasone/salmeterol) *QTY LIMIT:* 3 inhalers/90 days Breo Ellipta® (fluticasone furoate/vilanterol) *QTY LIMIT:* 3 inhalers (180 blisters) 90 days Budesonide/formoterol (compare to Symbicort®) *QTY LIMIT:* 9 inhalers (91.8gm)/90 days Fluticasone/salmeterol (compare to AirDuo Respiclick®) *QTY LIMIT:* 3 inhalers/90 days Fluticasone/salmeterol inhalation Powder (compare to Advair® Diskus) *QTY LIMIT:* 3 inhalers/90 days Wixela™ Inhub™ (fluticasone/salmeterol inhalation powder) (compare	**Metered-dose inhalers (single agent):** The patient has had a documented side effect, allergy, or treatment failure to at least two preferred agents AND for approval of Asmanex HFA, there must be a clinically compelling reason the patient is unable to use Asmanex. **AirDuo Digihaler, AirDuo Respiclick, Breo Ellipta, Fluticasone/Salmeterol (non-authorized generics):** The patient has had a documented side effect, allergy, or treatment failure to any 2 of the following: Advair HFA, Advair Diskus, Dulera, or Symbicort. **Budesonide/formoterol:** the patient has a documented intolerance to brand Symbicort. **Budesonide Inh Suspension:** Medical necessity for the use of a nebulized solution has been provided AND if the dose is 1mg, the patient must be unable to use two 0.5 mg vials **Fluticasone/salmeterol powder (authorized generic), Wixela Inhub:** A clinically compelling reason must be provided detailing why the patient is unable to use Advair HFA or Advair Diskus. **Pulmicort Respules:** medical necessity for the use of a nebulized solution has been provided AND if the dose is 1 mg, the patient must be unable to use two 0.5 mg vials AND the patient has a documented intolerance to the generic.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	to Advair® Diskus) *QTY LIMIT:* 3 inhalers/90 days	
NEBULIZER SOLUTIONS BUDESONIDE INH SUSPENSION 0.25mg, 0.5mg (Age ≤ 12 yrs)	Budesonide Inh Suspension 1mg (all ages), 0.25mg and 0.5mg (age >12 years) Pulmicort Respules® (budesonide)	
CORTICOSTEROIDS: INTRANASAL		
SINGLE AGENT BUDESONIDE *QTY LIMIT:* 1 inhaler (8.43 ml)/30 days FLUTICASONE PROPIONATE *QTY LIMIT:* 1 inhaler (16 gm)/30 days OMNARIS® (ciclesonide) *QTY LIMIT:* 1 inhaler (12.5 gm)/30 days TRIAMCINOLONE *QTY LIMIT:* 1 inhaler (16.9 ml)/30 days ZETONNA® (ciclesonide) *QTY LIMIT:* 1 inhaler (6.1 gm)/30 days	Beconase AQ® (beclomethasone) *QTY LIMIT:* 2 inhalers (50 gm)/30 days Flunisolide 25 mcg/spray *QTY LIMIT:* 2 inhalers (50 ml)/30 days Mometasone (compare to Nasonex®) *QTY LIMIT:* 1 inhaler (17 gm)/30 days Nasonex® (mometasone) *QTY LIMIT:* 1 inhaler (17 gm)/30 days QNASL® (beclomethasone dipropionate) HFA *QTY LIMIT:* 1 inhaler (10.6 gm)/30 days Xhance™ (fluticasone propionate) *QTY LIMIT:* 1 inhaler (16 ml)/30 days	**Beconase AQ, Flunisolide 25 mcg/spray, 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. **Xhance:** The patient has had a documented side effect, allergy, or treatment failure of three preferred nasal glucocorticoids, one of which must be fluticasone. **Limitations:** Nasacort Allergy OTC and Flonase are not covered as no Federal Rebate is offered.
LEUKOTRIENE MODIFIERS		
Preferred After Age Criteria Are Met MONTELUKAST SODIUM (compare to Singulair®) tablets, 10mg for ages ≥ 15 MONTELUKAST SODIUM (compare to Singulair®) chews, 4 mg for ages 2-5, 5 mg for age 6-14 MONTELUKAST SODIUM (compare to Singulair®) granules, ages 6 months-23 months	Accolate® (zafirlukast) *QTY LIMIT:* 2 tablets/day Singulair® (montelukast sodium) tablets, chew tabs, granules *QTY LIMIT:* 1 tablet or packet per day Zafirlukast (compare to Accolate®) Zileuton ER (compare to Zyflo CR®) *QTY LIMIT:* 4 tablets/day Zyflo (zileuton) *QTY LIMIT:* 4 tablets/day	**Montelukast:** Clinical rationale must be provided for prescribing a dose and formulation that differs from age recommendations AND If the request is for brand Singulair, the patient has a documented intolerance to the generic equivalent montelukast preparation. **Zafirlukast, Accolate:** The diagnosis or indication for the requested medication is asthma. AND If the request is for Accolate, the patient has a documented intolerance to generic zafirlukast. **Zileuton ER, Zyflo:** The diagnosis or indication for the requested medication is asthma. AND The patient has had a documented side effect, allergy, or treatment failure to Accolate/Zafirlukast or Singulair/Montelukast
PHOSPHODIESTERASE-4 (PDE-4) INHIBITORS		
All products require PA	Daliresp® tablet (roflumilast) *QTY LIMIT:* 1 tablet/day *** 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

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		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.
SYNAGIS		
	SYNAGIS® (palivizumab) *QTY LIMIT:* 50 mg = 1 vial/month, 100 mg = 2 vials/month	**CRITERIA FOR APPROVAL:** • Infants born at 28 weeks of gestation or earlier (i.e., ≤ 28 weeks, 6 days) and under twelve months of age at the start of the RSV season (maximum 5 doses). • Infants born at 29-32 weeks (i.e., between 29 weeks, 0 days and 31 weeks, 6 days) of gestation and under 1 year of age at the start of the RSV season who develop chronic lung disease of prematurity defined as a requirement for >21% oxygen for at least the first 28 days after birth (maximum 5 doses). • Children under 24 months of age with chronic lung disease of prematurity defined as born at 31 weeks, 6 days or less who required >21% oxygen for at least the first 28 days after birth and continue to require medical support (chronic corticosteroid therapy, diuretic therapy, or supplemental oxygen) during the 6-month period before the start of the second RSV season (maximum 5 doses). • Children under 12 months of age with hemodynamically significant congenital heart disease (CHD) (dosing continues in the RSV season through the end of the month the infant reaches 12 months old - maximum 5 doses): Acyanotic heart disease and receiving medication to control congestive heart failure and will require cardiac surgical procedures, Moderate to severe pulmonary hypertension, Cyanotic heart disease and recommended for Synagis therapy by Pediatric Cardiologist • Infants under 12 months of age with either: (dosing continues in the RSV season through the end of the month the infant reaches 12 months old -maximum 5 doses) Congenital abnormalities of the airways that impairs the ability to clear secretions from the upper airway because of ineffective cough, Neuromuscular condition that impairs the ability to clear secretions from the upper airway because of ineffective cough • Infants and children less than 24 months of age who will undergo a heart transplant during the RSV season • Infants and children less than 24 months of age who are profoundly immunocompromised during the RSV season (e.g. undergoing organ or stem cell transplant or receiving chemotherapy). **EXCLUDED FROM APPROVAL:**

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		• 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		
ENDOTHELIN RECEPTOR ANTAGONISTS LETAIRIS® (ambrisentan) Tablet *QTY LIMIT:* 1 tablet/day TRACLEER® (bosentan) tablet (62.5 mg, 125 mg) *QTY 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	Ambrisentan (compare to Letairis®) *QTY LIMIT:* 1 tablet/day Bosentan (compare to Tracleer) *QTY LIMIT:* 2 tablets/day Opsumit® (macitentan) Tablet *QTY LIMIT:* 1 tablet/day Tracleer® tablets for oral suspension (32 mg) Flolan® (epoprostenol) Treprostinil sodium injection (compare to Remodulin®) Uptravi® (selexipag) tablets *QTY LIMIT:* 200 mcg = 140 tablets/30 days for the	**Adempas:** The patient has a diagnosis of pulmonary arterial hypertension (PAH) with New York Heart Association (NYHA) Functional Class II or III. OR The patient has a diagnosis of chronic thromboembolic pulmonary hypertension (CTEPH, WHO Group 4) AND the patient has persistent or recurrent disease after surgical treatment (e.g., pulmonary endarterectomy) or has CTEPH that is inoperable AND The patient is 18 years of age or older AND The patient will not use Adempas concomitantly with the following: Nitrates or nitric oxide donors (such as amyl nitrate) in any form. Phosphodiesterase (PDE) inhibitors, including specific PDE-5 inhibitors (such as sildenafil, tadalafil, or vardenafil) or non-specific PDE inhibitors (such as dipyridamole or theophylline) AND The patient is not pregnant AND Female patients are enrolled in the Adempas REMS Program **Ambrisentan, Bosentan:** patient has a documented intolerance to the brand name equivalent **Tracleer tablets for oral suspension:** Patient has a diagnosis of PAH with NYHA Functional Class II or III AND patient is ≤ 12 years of age and <40kg. **Flolan:** Clinical diagnosis of pulmonary hypertension AND The patient has had a documented intolerance to the generic epoprostenol. **Opsumit:** Patient has a diagnosis of PAH with NYHA Functional Class II or III

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	first 2 months, then 2 tablets/day thereafter All other strengths = 2 tablets/day	AND Patient is not pregnant AND Female patients have been enrolled in the REMS Program AND the patient has a documented side effect, allergy, or treatment failure with Tracleer or Letairis.
sGC STIMULATOR All products require PA ****Maximum days supply for all drugs is 30 days****	Adempas® (riociguat) Tablets *QTY LIMIT:* 3 tablets/day	**Treprostinil:** Patient has a diagnosis of pulmonary arterial hypertension AND The patient has had a documented intolerance to the brand Remodulin. **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
PHOSPHODIESTERASE-5 (PDE-5) INHIBITORS **Effective 7/1/06, phosphodiesterase-5 (PDE-5) inhibitors are no longer a covered benefit for all Vermont Pharmacy Programs for the treatment of erectile dysfunction. This change is resultant from changes set into effect January 1, 2006 and as detailed in Section 1903 (i)(21)(K) of the Social Security Act (the Act), precluding Medicaid Federal Funding for outpatient drugs used for the treatment of sexual or erectile dysfunction. Sildenafil will remain available for coverage via prior-authorization for the treatment of Pulmonary Arterial Hypertension.**		
Preferred After Clinical Criteria Are Met SILDENAFIL CITRATE (compare to Revatio®) tablet *QTY LIMIT:* 3 tablets/day TADALAFIL (compare to Adcirca®) *QTY LIMIT:* 2 tablets/day	Adcirca® (tadalafil) *QTY LIMIT:* 2 tablets/day Revatio® (sildenafil) tabs *QTY LIMIT:* 3 tablets/day Revatio® (sildenafil citrate) suspension Revatio® (sildenafil citrate) vial *QTY LIMIT:* 3 vials/day Maximum 14-day supply per fill	**Sildenafil, tadalafil:** Clinical Diagnosis of Pulmonary Hypertension **Adcirca (tadalafil) 20 mg, Revatio (sildenafil citrate) 20 mg:** Clinical diagnosis of pulmonary hypertension AND No concomitant use of organic nitrate-containing products AND patient has a documented intolerance to the generic equivalent. **Revatio Suspension:** Clinical diagnosis of pulmonary hypertension AND medical necessity for a liquid formulation is provided OR the patient is unable to tolerate a 20 mg dose. **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.
RENAL DISEASE: PHOSPHATE BINDERS		
CALCIUM ACETATE (compare to Phos Lo®) capsule CALCIUM ACETATE tablet SEVELAMER CARBONATE (compare to Renvela®) tablets **ORAL SOLUTIONS** PHOSLYRA® (calcium acetate) oral solution	Auryxia® (ferric citrate) *QTY LIMIT:* 12/day Fosrenol® (lanthanum carbonate) Lanthanum carbonate (compare to Fosrenol) Renagel® (sevelamer) Renvela® (sevelamer carbonate) Oral Suspension Packet *QTY LIMIT:* 0.8 g = 2 packs/day Renvela® (sevelamer carbonate) tablets Sevelamer carbonate Oral Suspension Packet (compare	**Renvela Oral Suspension Packet, Sevelamer Packet:** The patient has a requirement for a liquid dosage form. **Auryxia, lanthanum carbonate, Renagel, Renvela tablets, sevelamer hydrochloride tablets, Velphoro Chew Tablet:** The patient must have a documented side effect, allergy, or inadequate response to one preferred phosphate binder.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	to Renvela®) *QTY LIMIT:* 0.8 g = 2 packs/day Sevelamer hydrochloride (compare to Renagel®) Velphoro® (sucroferric oxyhydroxide) Chew Tablet	
RESTLESS LEG SYNDROME MEDICATIONS		
DOPAMINE AGONISTS (ORAL) PRAMIPEXOLE (compare to Mirapex®) ROPINIROLE (compare to Requip®) **DOPAMINE AGONISTS (TRANSDERMAL)** All products require PA **GAMMA-AMINOBUTYRIC ACID ANALOG** GABAPENTIN IR	Mirapex® (pramipexole) Neupro® (rotigotine) transdermal patch *QTY LIMIT:* 1, 2, and 3 mg ONLY = 1 patch/day Horizant® (gabapentin enacarbil) ER Tablet *QTY LIMIT:* 1 tablet/day	**Mirapex:** The patient has had a documented intolerance to the generic product. **Neupro:** The patient has a medical necessity for a specialty dosage form. **Horizant:** The patient has a diagnosis of restless legs syndrome (RLS). AND The patient has had a documented side effect, allergy, contraindication or treatment failure to two preferred dopamine agonists AND gabapentin IR. **Limitations:** Requests for Mirapex ER and Requip XL will not be approved for Restless Leg Syndrome (RLS).
RHEUMATOID, JUVENILE & PSORIATIC ARTHRITIS: IMMUNOMODULATORS		
Preferred After Clinical Criteria Are Met **INJECTABLE** ENBREL® (etanercept) *QTY LIMIT:* 50 mg = 4 syringes/28 days, 25 mg = 8 syringes/28 days KINERET® (anakinra) *QTY LIMIT:* 1 syringe/day HUMIRA® (adalimumab) *QTY LIMIT:* 4 syringes/28 days OTEZLA® tablet (apremilast) *QTY LIMIT:* Starter Pack = 55 tablets/28 days, 30 mg = 2 tablets/day Maximum 30 days supply TALTZ® (ixekizumab) *QTY LIMIT*: 80 mg prefilled syringe or autoinjector = 2/28 days for the first month and 1/28 days subsequently	Actemra® (tocilizumab) Intravenous Infusion *QTY LIMIT:* 80 mg vial = 4 vials/28 days, 200 mg vial = 3 vials/28 days, 400 mg vial = 2 vials/28 days Actemra® (tocilizumab) Subcutaneous *QTY LIMIT:* 4 prefilled syringes (3.6ml)/28 days Avsola® (infliximab-axxq) biosimilar to Remicade® Cimzia® (certolizumab pegol) *QTY LIMIT:* 1 kit/28 days Cosentyx® (secukinumab) Inflectra® (Infliximab-dyyb) biosimilar to Remicade® Kevzara® (sarilumab) *QTY LIMIT:* 2 syringes/28 days Ilaris® (canakinumab) Orencia® (abatacept) Subcutaneous Injection *QTY LIMIT:* 4 syringes/28 days Orencia® (abatacept) Intravenous Infusion Remicade® (infliximab) Renflexis™ (Infliximab-abda) biosimilar to Remicade® Simponi® (golimumab) Subcutaneous *QTY LIMIT:* 50 mg = 1 prefilled syringe or autoinjector/28 days	**Clinical Criteria for all drugs:** Patient has a diagnosis of rheumatoid arthritis (RA), juvenile idiopathic arthritis* or psoriatic arthritis and has already been stabilized on the drug being requested OR Diagnosis is RA, juvenile idiopathic arthritis or psoriatic arthritis, and methotrexate therapy resulted in an adverse effect, allergic reaction, inadequate response, or treatment failure. If methotrexate is contraindicated, another DMARD should be tried prior to approving therapy. Other DMARDs include leflunomide, sulfasalazine, gold, antimalarials, minocycline, D-penicillamine, azathioprine, cyclophosphamide and cyclosporine **Taltz additional criteria:** patient must be ≥ 18 years of age AND the prescriber must provide evidence of a trial and failure or contraindication to Humira (indication only for psoriatic arthritis) **Actemra, Cimzia, Kevzara, Remicade, Renflexis, Simponi (subcutaneous), and Stelara additional criteria:** The prescriber must provide clinically valid reason why at least 2 preferred agents cannot be used. **Ilaris:** The diagnosis is systemic juvenile idiopathic arthritis (sJIA) with active systemic features and varying degrees of synovitis with continued disease 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

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ORAL XELJANZ® (tofacitinib) 5 mg tablet *QTY LIMIT:* 2 tablets/day Maximum 30 days supply **Note:** Xeljanz 10mg BID and XR 22mg are NOT recommended for Rheumatoid Arthritis or Psoriatic Arthritis. Please refer to Gastrointestinal: Inflammatory Bowel Disease Biologics for Ulcerative Colitis criteria.	Simponi Aria® (golimumab) 50 mg/4 ml Vial for Intravenous Infusion Stelara® (ustekinumab) *QTY LIMIT*: 45 mg (0.5 ml) or 90 mg (1 ml) per dose (90 mg dose only permitted for pt weight > 100 kg) Olumiant® (baricitinib) tablets *QTY LIMIT:* 1 tablet/day Maximum 30 days supply Rinvoq ® (upadactinib) extended release tablet *QTY LIMIT: 1 tablet/day* Maximum 30 days supply Xeljanz® XR (tofacitinib) tablet *QTY LIMIT:* 1 tablet/day Maximum 30 days supply	NSAIDs). AND patient is > 2 years of age. **Avsola, Inflectra additional criteria:** The prescriber must provide a clinically valid reason why at least 2 preferred agents cannot be used AND the patient must be unable to use Remicade or Renflexis. **Simponi Aria additional criteria:** The patient has not responded adequately to Simponi subcutaneous. AND The prescriber must provide a clinically valid reason why at least 2 preferred agents cannot be used. **Orencia additional criteria:** The prescriber must provide a clinically valid reason why at least 2 preferred agents cannot be used. **Xeljanz XR additional criteria:** Patient has not been able to tolerate or adhere to twice daily dosing of immediate release Xeljanz, resulting in significant clinical impact. **Olumiant, Rinvoq additional criteria:** The patient must be ≥ 18 years of age AND The prescriber must provide a clinically valid reason why at least two preferred agents cannot be used, one of which must be Xeljanz. **Note:** Patients with systemic juvenile arthritis (SJRA/SJIA) and fever are not required to have a trial of a DMARD, including methotrexate. Patients with systemic juvenile arthritis without fever should have a trial of methotrexate, but a trial of another DMARD in the case of a contraindication to methotrexate is not required. * Patients with psoriatic arthritis with a documented diagnosis of active axial involvement should have a trial of NSAID therapy, but a trial with DMARD is not required before a TNF-blocker is approved. If no active axial skeletal involvement, then an NSAID trial and a DMARD trial are required (unless otherwise contraindicated).
SICKLE CELL DISEASE THERAPIES		
DROXIA® (hydroxyurea) 200 mg, 300 mg, 400 mg cap HYDROXYUREA (compare to Hydrea®) 500 mg cap	Adakveo® (crizanlizumab-tmca) Endari (L-glutamine powder for oral solution) *QTY LIMIT:* maximum of 30-day supply Hydrea® (hydroxyurea) 500 mg cap Oxbryta® (voxelotor) 500 mg tablet *QTY LIMIT:* 3 tablets/day Siklos® (hydroxyurea) 100 mg, 1000 mg tablet	**Adakveo:** Patient has a diagnosis of Sickle Cell Disease AND patient is at least 16 years of age or older AND patient has had an inadequate response to a 6-month trial of hydroxyurea dosed at 15-35 mg/kg/day, unless contraindicated AND patient has experienced at least 2 vaso-occlusive crises in the previous 12 months despite compliance with hydroxyurea. Initial approval will be granted for 6 months. For re-approval, the patient must have a decrease in the frequency or severity of VOC compared to baseline. **Note:** Adakveo will not be approved in conjunction with Oxbryta. **Endari:** Indication for use is to reduce the acute complications of Sickle Cell Anemia AND medication will be approved with quantity limits based on patient weight (<30kg = 2 packets/day, 30-65kg = 4 packets/day, > 65kg = 6 packets/day. **Hydrea:** Patient has had a documented intolerance to the generic equivalent. **Oxbryta:** Patient has a diagnosis of Sickle Cell Disease AND patient is at least 12 years of age or older AND patient has a baseline hemoglobin (Hb) ≥ 5.5-10.5 g/dL

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		AND patient has had an inadequate response to a 6-month trial of hydroxyurea dosed at 15-35 mg/kg/day, unless contraindicated AND patient has experienced at least 2 vaso-occlusive crises in the previous 12 months despite compliance with hydroxyurea. Initial approval will be granted for 6 months. For re-approval, the patient must have a decrease in the frequency or severity of VOC compared to baseline. **Note:** Oxbryta will not be approved in conjunction with Adakveo. **Siklos:** Patient has a diagnosis of Sickle Cell Anemia with recurrent moderate to severe pain crises AND the required dose is < 200mg OR Patient has a diagnosis of Sickle Cell Anemia with recurrent moderate to severe pain crises AND has a documented intolerance to a preferred hydroxyurea formulation. For re-approval, the patient must have a documented decrease in vaso-occlusive episodes, acute chest syndrome, SCD related hospitalizations, or blood transfusions.
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 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		
ESZOPICLONE (compare to Lunesta) *QTY LIMIT:* 1 tab/day ZALEPLON *QTY LIMIT:* 5 mg = 1 cap/day, 10 mg = 2 caps/day ZOLPIDEM (compare to Ambien®) *QTY LIMIT:* 1 tab/day	Ambien® (zolpidem) *QTY LIMIT:* 1 tab/day Ambien CR® (zolpidem) *QTY LIMIT:* 1 tab/day Belsomra® (suvorexant) *QTY LIMIT:* 1 tab/day Dayvigo® (lemborexant) tablet *QTY LIMIT*: 1 tab/day Edluar® (zolpidem) sublingual tablet *QTY LIMIT:* 1 tab/day Intermezzo® (zolpidem) sublingual tablet *QTY LIMIT:* 1 tab/day	**Ambien, Lunesta:** The patient has had a documented intolerance to the generic equivalent. **Ambien CR, Belsomra, Zolpidem CR:** The patient has had a documented side effect, allergy or treatment failure to two preferred sedative/hypnotics. If the request is for brand Ambien CR, there has also been a documented intolerance to the generic. **Dayvigo:** The patient has had a documented side effect, allergy, or treatment failure to two preferred sedative/hypnotics and Belsomra. **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

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Lunesta® (eszopiclone) *QTY LIMIT:* 1 tab/day Ramelteon (compare to Rozerem®) *QTY LIMIT:* 1 tab/day Rozerem® (ramelteon) *QTY LIMIT:* 1 tab/day Silenor® (doxepin) *QTY LIMIT:* 1 tab/day Zolpidem CR (compare to Ambien CR®) *QTY LIMIT:* 1 tab/day	awakening followed by difficulty returning to sleep AND The patient has had a documented inadequate response to two preferred sedative/hypnotics. **Ramelteon, Rozerem:** The patient has had a documented side effect, allergy, contraindication, or treatment failure to one preferred sedative/hypnotic OR the patient has had a treatment failure after a minimum 2-week trial of melatonin. OR There is a question of substance abuse with the patient or family of the patient. If the request is for Ramelteon, there must also have been a documented intolerance to brand Rozerem. **Silenor:** The patient has had a documented side effect, allergy, contraindication or treatment failure to two preferred sedative/hypnotics AND The patient has had a documented intolerance with 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) *QTY LIMIT:* 2 tabs/day Max duration 24 weeks (2x12 weeks)/365 days)	Nicotrol Inhaler® Nicotrol Nasal Spray®	**Nicotrol Inhaler, Nicotrol Nasal Spray:** The patient has had a documented treatment failure with nicotine patch used in combination with nicotine gum or lozenge. *Smoking Cessation Counseling is encouraged with the use of smoking cessation therapies* *The combined prescribing of long acting (patch) and faster acting (gum or lozenge) nicotine replacement therapy is encouraged for greater likelihood of quit success* **Vermont QUIT LINE** (available free to all patients) 1-800-QUIT-NOW (1-800-784-8669) https://802quits.org/ **GETQUIT™** Support Plan available free to all Chantix® patients 1-877-CHANTIX (242-6849) https://www.get-quit.com/
TESTOSTERONE REPLACEMENT THERAPY		
TOPICAL		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ANDRODERM® Transdermal 2 mg, 4 mg (testosterone patch) *QTY LIMIT:* 1 patch/day/strength ANDROGEL® GEL (testosterone) 1% gel packets *QTY LIMIT:* 2.5 gm packet = 1 packet/day, 5 gm packet = 2 packets/day TESTOSTERONE 1.62% Gel Packets *QTY LIMIT:* 1.25 gm packet (1.62%) = 1 packet/day, 2.5 gm packet (1.62%) = 2 packets/day TESTOSTERONE 1.62% Gel Pump (compare to Androgel®) *QTY LIMIT:* 2 bottles/30 days	Androgel® gel (testosterone) 1.62% gel packets *QTY LIMIT:* 1.25 gm packet (1.62%) = 1 packet/day, 2.5 gm packet (1.62%) = 2 packets/day Androgel® pump 1.62% (testosterone pump bottles) *QTY LIMIT:* 2 bottles/30 days Fortesta® (testosterone 2 % Gel) 60 gm Pump Bottle *QTY LIMIT:* 2 bottles/30 days Testim® Gel 5 gm (testosterone 1% gel tube) *QTY LIMIT:* 2 tubes/day Testosterone 1% Gel Packets (compare to Androgel®, Vogelxo®) *QTY LIMIT:* 2.5 gm packet = 1 packet/day, 5 gm packet = 2 packets/day Testosterone 1% gel tube (compare to Testim® Gel 5 gm, Vogelxo®, Androgel®) *QTY LIMIT:* 2 tubes/day Testosterone 1% Gel Pump (Vogelxo®) *QTY LIMIT:* 4 bottles/30 days Testosterone 2% gel 60 gm pump bottle (compare to Fortesta®) *QTY LIMIT:* 2 bottles/30 days Testosterone 2% solution 90ml Pump Bottle *QTY LIMIT:* 2 bottles/30 days Vogelxo® 1% (testosterone 1%) gel, pump *QTY LIMIT:* 2 tubes/day (5 gm gel tubes), 4 bottles/30 days (gel pump bottle)	**Non-preferred agents:** The patient has a documented side effect, allergy, or treatment failure to at least two preferred topical products.
NASAL		
	Natesto® (testosterone) nasal gel *QTY LIMIT:* 3 bottles/30 days	**Natesto:** The patient has had a documented side effect, allergy, or treatment failure to TWO preferred testosterone products (topical and/or injectable formulations)
ORAL		
All products require PA	Methitest (methyltesterone) tablet 10 mg Methyltestosterone capsule 10 mg Jatenzo (testosterone undecanoate) capsule *Maximum day supply all products is 30 days*	**Oral non-preferred agents:** The patient has had a documented side effect, allergy, or treatment failure to TWO preferred testosterone products (topical and/or injectable formulations) AND if the request is for Methitest or methyltestosterone, the patient has had a documented side effect, allergy, or treatment failure with Jatenzo.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
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 **LONG-ACTING AGENTS** OXYBUTYNIN XL (compare to Ditropan® XL) *QTY LIMIT:* 1/day SOLIFENACIN (compare to Vesicare®) *QTY LIMIT:* 1/day TOVIAZ® (fesoterodine) *QTY LIMIT:* 1/day **TRANSDERMAL/TOPICAL** All products require PA **BETA-3 ADRENERGIC AGONISTS** MYRBETRIQ® (mirabegron) ER Tablet *QTY LIMIT*: 1 tablet/day	Detrol® (tolterodine) Flavoxate Tolterodine (compare to Detrol®) Trospium Darifenacin ER (compare to Enablex®) Ditropan XL® (oxybutynin XL) Enablex® (darifenacin) Tolterodine SR (compare to Detrol LA®) Trospium ER Vesicare® (solifenacin) Vesicare LS™ (solifenacin) oral suspension Gelnique 10%® (oxybutynin topical gel) *QTY LIMIT:* 1 sachet/day Oxytrol® (oxybutinin transdermal) *QTY LIMIT:* 8 patches/28 days Gemtesa® (vibegron) tablet *QTY LIMIT:* 1 tablet/day	**Please note**: Patients < 21 years of age are exempt from all ORAL ANTIMUSCARINIC Urinary Antispasmodics PA requirements **Darifenacin, Detrol, 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 two preferred long-acting agents. If a medication has an AB rated generic, there must have also been a trial of the generic formulation. **Gelnique 10%, Oxytrol:** The patient is unable to swallow a solid oral formulation (e.g. patients with dysphagia) OR The patient is unable to be compliant with solid oral dosage forms. **Gemtesa:** The patient has had a documented side effect, allergy, treatment failure, or contraindication with one preferred long-acting urinary antimuscarinic agent and Myrbetriq. **Vesicare LS:** The patient has a diagnosis of neurogenic detrusor activity AND the patient has a documented side effect, allergy, or treatment failure with oxybutynin AND for patients ≥ 18 years of age, medical necessity has been provided for a liquid formulation. **Limitations:** Oxytrol (for Women) OTC not covered. Oxytrol RX is available but subject to prior authorization.
VAGINAL ANTI-INFECTIVES		
CLEOCIN® Vaginal Ovules (clindamycin vaginal	Cleocin® (clindamycin vaginal cream 2%)	**Cleocin:** The patient has had a documented side effect, allergy, or treatment

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
suppositories) CLINDAMYCIN VAGINAL (clindamycin vaginal cream 2%) CLINDESSE® (clindamycin vaginal cream 2%) CLOTRIMAZOLE Vaginal cream MICONAZOLE Nitrate Vaginal cream, suppositories MICONAZOLE 1 Vaginal Kit MICONAZOLE 3 Vaginal Kit, cream MICONAZOLE 7 Vaginal cream, suppositories METRONIDAZOLE VAGINAL GEL 0.75% NUVESSA™ (metronidazole 1.3% Vaginal Gel)	Gynazole-1® (butoconazole vaginal cream 2%) Solosec™ (secnidazole) oral granules packet Terconazole (compare to Terazol®) vaginal cream 0.4%, 0.8%, vaginal suppositories 80 mg Vandazole (metronidazole vaginal 0.75%)	failure to a preferred clindamycin vaginal cream. **Vandazole:** The patient has had a documented side effect, allergy, or treatment failure to preferred metronidazole vaginal gel. **Solosec:** The patient has had a documented side effect, allergy, or treatment failure to a preferred topical anti-infective and oral metronidazole. **Gynazole, Terconazole:** The patient has a documented side effect, allergy, or treatment failure to a preferred miconazole or clotrimazole formulation.
VASOPRESSIN RECEPTOR ANTAGONIST		
	Jynarque® tablets (tolvaptan) *QTY LIMIT:* 56 tablets/28 days Samsca® tablets (tolvaptan) *QTY LIMIT:* 15 mg = 1 tablet/day, 30 mg 2 tablets/day	**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 **Samsca:** The agent is being used for the treatment of euvolemic or hypervolemic hyponatremia AND Despite optimal fluid restriction, the patient's serum sodium < 120 mEq/L or the patient is symptomatic with a serum sodium < 125 mEq/L. AND The treatment will be initiated or is being reinitiated in a hospital setting where serum sodium can be monitored
VITAMINS: PRENATAL MULTIVITAMINS		
C-NATE DHA NIVA-PLUS PRENATAL PLUS IRON PRENATAL VITAMINS PLUS PREPLUS PRETAB SE-NATAL CHEW	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.