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

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

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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		
DOXYCYCLINE MONOHYDRATE 50MG, 100MG CAPS DOXYCYCLINE MONOHYDRATE SUSP 25MG/5ML MINOCYCLINE 50MG 100MG CAPS ISOTRETINOIN† CAP (AMNESTEEM, CLARAVIS, MYORISAN)	Adoxa®* (doxycycline monohydrate) 150mg tab Doryx (doxycycline hyclate) tabs Doxycycline 50mg, 75mg, 100mg, 150mg tabs Doxycycline 75mg, 150mg caps Oracea® (doxycycline monohydrate) 40 mg cap Vibramycin®* (doxycycline hyclate) 100 mg cap Vibramycin®* (doxycycline hyclate) suspension Vibramycin® (doxycycline calcium) syrup All other brands Eryped® (erythromycin ethylsuccinate) Erythrocin (erythromycin stearate) PCE Dispertab® (erythromycin base) All other brands Minocycline 50mg, 75mg, 100mg tabs Solodyn® (minocycline) tabs ER E.E.S.® (erythromycin ethylsuccinate) Eryped® (erythromycin ethylsuccinate) ERY-TAB® (erythromycin base, delayed release) Erythrocin (erythromycin stearate) Erythromycin Based Erythromycin Ethylsuccinate (E.E.S. ®, Eryped®) PCE Dispertab® (erythromycin base) Tetracycline 250mg, 500mg cap Absorica® (isotretinoin) capsules Zenatane cap (isotrentinoin) All other brands	**Non-preferred doxycycline/minocycline products:** patient has had a documented side effect, allergy, or treatment failure with a preferred doxycycline/minocycline. If a product has an AB rated generic, the trial must be the generic formulation. **Oracea:** patient has a diagnosis of Rosacea AND patient has had a documented side effect, allergy, or treatment failure with both a preferred doxycycline and minocycline. **Vibramycin Suspension, Syrup:** patient has a medical necessity for a liquid dosage form AND a documented failure of preferred doxycycline suspension. **Erythromycin products:** patient has had a documented side effect or treatment failure with at least two preferred products. **Tetracycline products:** patient has had a documented side effect, allergy, or treatment failure with at least two preferred products. **Absorica/Zenatane:** patient has had a documented side effect, allergy, or treatment failure with at least two isotretinoin preferred products.
TOPICAL ANTI-INFECTIVES		
<u>BENZOYL PEROXIDE PRODUCTS</u> BENZOYL PEROXIDE † 2.5%,5%, 10% *G*, *5%, 6%,7%, 10% CL*; 10%*C*; 5%, 10% *L*; 5.3%, 9.5% F	Benzepro 5.3%, 9.8% F; 6% P; 7% CL PanoxylG; 10% B, 4% CL All other brands Cleocin-T®* (clindamycin) 1% S, P, L, G All other brands	**Single ingredient products:** patient has had a documented side effect, allergy, or treatment failure with two preferred products including one from the same sub-category, if there is one available. If a product has an AB rated generic, there must have been a trial of the generic. **Combination products:** patient has had a documented side effect, allergy, or treatment failure with generic erythroymycin/benzoyl peroxide. (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

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		product, if applicable.
CLINDAMYCIN PRODUCTS CLINDAMYCIN 1% *S, G, L, P,F* †	Erygel®* (erythromycin 2% G) All other brands	**Azelex:** the diagnosis or indication is acne AND patient has had a documented side effect, allergy, or treatment failure with two generic topical anti-infective agents (benzoyl peroxide, clindamycin, erythromycin, erythroymcin/benzoyl peroxide,)
ERYTHROMYCIN PRODUCTS ERYTHROMYCIN 2% *S, G, P* †	Klaron®* (sodium sulfacetamide 10% L) Sodium Sulfacetamide 10% *L*† All other brands	**Limitations:** Kits with non-drug products are not covered **Onexton :** Prior authorization and be available to the few patients who are unable to tolerate or who have failed on preferred medications.
SODIUM SULFACETAMIDE PRODUCTS All Products Require PA	Benzaclin® (clindamycin/benyoyl peroxide)	
COMBINATION PRODUCTS	Azelex® (azelaic acid 20%C) DUAC® (clindamycin/benzoyl peroxide) gel	
ERYTHROMYCIN / BENZOYL PEROXIDE†	Benzamycin®* (erythromycin/benzoyl peroxide) Onexton® (clindamycin/benzoyl peroxide)	
OTHER	Sodium Sulfacetamide/Sulfur C*L, C, P, E,*† Sodium Sulfacetamide/Sulfur *W* †	
C=cream, CL=cleanser, E=emulsion, F=Foam, G=gel, L=lotion,O=ointment, P=pads, S=solution, W=wash, B=bar	Sumaxin ® (sulfacetamide/sulfur*L,P,W*) Rosula®* (sulfacetamide/sulfur P, W) All other brands Aczone® (dapsone 5% G) All other brands any topical acne anti-infective medication	
TOPICAL - RETINOIDS		
TRETINOIN† *(specific criteria required for ages <10 or >34)* 0.025%, 0.05%, 0.1% *C*; 0.01%, 0.025% *G* AVITA® (tretinoin) FABIOR® (tazarotene 0.1% F) TAZORAC® (tazarotene) 0.1% *C, G* C= *cream*, G=*gel*	All brand tretinoin products (Atralin® 0.05% G, Retin-A®*, Retin-A Micro® 0.1%, 0.04%, etc.) Tretinoin microsphere† (compare to Retin-A Micro®) 0.1%, 0.04% adapalene† (compare to Differin®) 0.1% C, G, 0.3% G Differin® (adapalene) 0.1% C, G; L 0.3% G	**Brand name tretinoin products and generic tretinoin microsphere:** diagnosis or indication is acne vulgaris, actinic keratosis, or rosacea AND patient has had a documented side effect, allergy, or treatment failure with a preferred generic topical tretinoin product. If a product has an AB rated generic, the trial must be the generic formulation. **Differin** (brand) and adapalene (generic): diagnosis or indication is acne vulgaris, actinic keratosis, or rosacea AND patient has had a documented side effect, allergy, or treatment failure with a preferred generic topical tretinoin product AND the request is for the brand product, the patient has had a documented intolerance to a generic adapalene product. **Tretinoin** (age < 10 or > 34): diagnosis or indication is acne vulgaris, actinic

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Avage® (tazarotene) ♣ Renova® (tretinoin) ♣ Solage® (tretinoin/mequinol) ♣ Tri-Luma® (tretinoin/hydroquinone/fluocinolone) ♣ Veltin® (clindamycin/tretinoin) G ♣ Not indicated for acne. Coverage of topical retinoid products will not be approved for cosmetic use (wrinkles, age spots, etc.).	keratosis, or rosacea. **Limitations:** Coverage of topical retinoid products will not be approved for cosmetic use (wrinkles age spots, etc.) (i.e. Avage, Renova, Solage, Tri-Luma).
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)	**Brand name metronidazole products,** metronidazole 1% gel (generic) and Soolantra: diagnosis or indication is roacea AND patient has had a documented side effect, allergy or treatment failure with a preferred generic topical metronidazole product. If a product has an AB rated generic, there must have also been a trial of the generic formulation. **Limitations**: The use of Mirvaso (brimonidine topical gel) for treating skin redness is considered cosmetic. Medications used for cosmetic purposes are excluded from coverage. Mirvaso topical gel has not been shown to improve any other symptom of rosacea (e.g. pustules, papules, flushing, etc) or to alter the course of the disease.
ADHD AND NARCOLEPSY CATAPLEXY MEDICATIONS		
SHORT/INTERMEDIATE ACTING STIMULANTS		
DEXMETHYLPHENIDATE † (compare to Focalin®) METADATE ER® (compare to Ritalin® SR) METHYLIN® (compare to Ritalin®) solution METHYLPHENIDATE † (compare to Ritalin®) tablets, chewable tablets METHYLPHENIDATE SR † (compare to Ritalin ® SR) AMPHETAMINE/DETROAMPHETAMINE † (compare to Adderall®)	Dextroamphetamine IR† (Zenzedi 5 or 10mg, formerly Dexedrine®) Evekeo® (amphetamine sulfate) Focalin® (dexmethylphenidate) Ritalin®* (methylphenidate) Ritalin SR®* (methylphenidate SR) Adderall®* (amphetamine/dextroamphetamine) Desoxyn® (methamphetamine) Dextroamphetamine sulfate† 1 mg/ml oral solution Methamphetamine † (compare to Desoxyn®) Methylphenidate solution Procentra® (dextroamphetamine sulfate) 1 mg/ml oral solution	**Clinical Criteria for ALL non-preferred drugs:** patient has a diagnosis of ADD, ADHD or narcolepsy AND patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR patient meets additional clinical criteria outlined below. **Focalin, Adderall:** the patient must have had a documented intolerance to the preferred generic equivalent. **Ritalin and Ritalin SR**: patient has had a documented intolerance to the preferred equivalent. For Ritalin SR this is Metadate ER. For Ritalin, this is methylphenidate tablets. **Methamphetamine and Desoxyn:** Given the high abuse potential of methamphetamine and Desoxyn, the patient must have a diagnosis of ADD, ADHD or narcolepsy and have failed all preferred treatment alternatives. In addition, for approval of brand name Desoxyn, the patient must have had a documented intolerance to generic methamphetamine. **Methylphenidate solution:** patient has a documented intolerance to Methylin solution. **Procentra, dextroamphetamine oral solution:** patient has a medical necessity

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Zenzedi® (dextroamphetamine IR) 2.5 mg, 7.5 mg, 15 mg, 20 mg, 30 mg tablets	for an oral liquid dosage form. (eg. Swallowing disorder). AND if the request is for Procentra, the patient has a documented intolerance to the generic equivalent. **Dextroamphetamine IR, Zenzedi, Evekeo:** the patient has had a documented side-effect, allergy, or treatment failure of at least 2 preferred agents.
LONG ACTING STIMULANTS		
Methylphenidate Products **Oral** FOCALIN® XR (dexmethylphenidate SR 24 HR IR/ER, 50:50%) METHYLPHENIDATE SA OSM IR/ER, 22:78%† (compare to Concerta®) (authorized generic, labeler code 00591 is only preferred form) QUILLICHEW ER ™ (methylphenidate IR/ER, 30:70%) chewable tablets **Oral Suspension** QUILLIVANT XR® (methylphenidate IR/ER, 20:80%) QL = 1 bottle (60ml, 120ml, 150ml)/30days 2 bottles (180ml)/30days **Transdermal** DAYTRANA® (methylphenidate patch) (*QL = 1 patch/day)* **Amphetamine Products** **Oral** ADDERALL XR® (amphetamine/dextroamphetamine SR 24 HR, IR/ER, 50:50%) ADZENYS XR® ODT (amphetamine/dextroamphetamine SR 24 HR, IR/ER, 50:50%) (QL= 1 cap/day) VYVANSE® (lisdexamfetamine) *(QL = 1 cap/day)*	Aptensio®XR (methylphenidate DR 24HR IR/.ER, 40:60%) Concerta®* (methylphenidate SA OSM IR/ER, 22:78%) Dexmethylphenidate SR 24 HR IR/ER, 50:50% † (compare to Focalin XR®) methylphenidate CR, IR/ER, 30:70% (compare to Metadate CD®) Methylphenidate SA OSM IR/ER, 22:78% (compare to Concerta®) (non-authorized generic forms) Methylphenidate SR 24 HR, IR/ER, 50:50%† (compare to Ritalin LA®) Ritalin LA® (methylphenidateSR 24 HR, IR/ER, 50:50%) Amphetamine/dextroamphetamine SR 24 HR, IR/ER, 50:50% † (compare to Adderall XR®) Dyanavel ™ suspension (amphetamine/dextroamphetamine SR) (QL=240ml/30days) Dexedrine CR®* (dextroamphetamine 24 hr SR) Dextroamphetamine 24 hr SR† (compare to Dexedrine CR®)	**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. **Aptensio XR, Ritalin LA, and Methylphenidate CR, Methylphenidate SR 24 HR:** patient has had a documented side-effect, allergy, or treatment failure on Focalin XR or Methylphenidate SR OSM. AND for approval of generic methylphenidate CR or methylphenidate SR 24 HR, the patient must have had a documented intolerance to the brand equivalent. **Concerta and non-authorized generic:** patient has had a documented intolerance to authorized generic Methylphenidate SA OSM. **Amphetamine/dextroamphetamine SR 24 HR (generic), dexmethylphenidate SR 24 HR ER (generic):** patient must have a documented intolerance to the brand name equivalent. **Dexedrine CR, dextroamphetamine SR, Dyanavel:** patient must have a documented intolerance to one preferred amphetamine product. For approval of brand Dexedrine CR, the patient must also have a documented intolerance to the generic equivalent.
MISCELLANEOUS		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
GUANFACINE ER (Intuniv®) Kapvay® (clonidine extended release) Tablet *Qty limit = 4 tablets/day* Strattera® (atomoxetine) *Qty limit:10, 18, 25 and 40 mg = 2 capsules/day* *60, 80 and 100 mg = 1 capsule/day* *FDA maximum recommended dose = 100 mg/day*	Armodafinil (compare to Nuvigil®) *Qty Limit:* 50mg = 2 tabs/day *150mg/200mg/250mg = 1 tab/day* Clonidine ER (compare to Kapvay®) Qty limit = 4 tabs/day Modafinil (compare to Provigil®) **(not approvable for ADHD in children age ≤12)** ***(Max days supply = 30 days)*** *Qty limit: 100 mg = 1.5 tablets/day;200 mg = 2 tablets/day* *Maximum Daily Dose = 400 mg* Nuvigil® (armodafinil) *Qty limit: 50 mg = 2 tablets/day; 150 mg/200 mg/250 mg = 1 tablet/day* Provigil® (modafinil) ***(not approvable for ADHD in children age ≤12).*** *Qty limit: 100 mg = 1.5 tablets/day;200 mg = 2 tablets/day* *Maximum Daily Dose = 400 mg* ***(Max days supply = 30 days)*** Intuniv® (guanfacine extended release) Tablet *Qty limit = 1 tablet/day* Xyrem® (sodium oxybate) oral solution *Qty limit = 540 ml/30 days*	**Nuvigil®, Armodafinil:** *Diagnosis or indication is narcolepsy, excessive sleepiness associated with shift work sleep disorder/ obstructive sleep apnea/hypopnea syndrome (adjunct to standard treatment):* The patient is > 17 years old AND The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR The patient has had a documented side-effect, allergy or treatment failure to a CNS stimulant or has a contraindication for use of these agents (e.g. substance abuse history) AND if the request is for armodafinil, the patient has a documented intolerance to brand Nuvigil. **Note:** Nuvigil®/armodafinil will not be approved for idiopathic hypersomnolence, excessive daytime sleepiness, fatigue associated with use of narcotic analgesics, or for ADHD (for any age patient). **Provigil®, Modafinil**: *Diagnosis or indication is narcolepsy* OR Diagnosis or indication is *excessive sleepiness associated with shift work sleep disorder/obstructive sleep apnea/hypopnea syndrome (adjunct to standard treatment), fatigue associated with multiple sclerosis, fatigue associated with the treatment of depression or schizophrenia:* The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR The patient has had a documented side-effect, allergy or treatment failure to a CNS stimulant or has a contraindication for use of these agents (e.g. substance abuse history) AND if the request is for modafinil, the patient has a documented intolerance to brand Provigil *Diagnosis or indication is ADHD age >12*: The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR The patient has a documented treatment failure, due to lack of efficacy, to two long-acting CNS stimulants or the patient has had a documented side effect, allergy, or direct contraindication (e.g. comorbid tics, moderate -to-severe anxiety, substance abuse) to one Long -acting CNS stimulant. AND The patient has had a documented side-effect, allergy, or treatment failure to Strattera® AND if the request is for modafinil, the patient has a documented intolerance to brand Provigil. **Provigil®/Modafinil** will not be approved for idiopathic hypersomnolence, excessive daytime sleepiness, fatigue associated with use of narcotic analgesics, or for ADHD in children age ≤12. **Intuniv:** patient has a documented intolerance to generic guanfacine ER **Clonidine ER:** patient must have had a documented intolerance to brand Kapvay. **Limitations:** Kapvay dose pack not covered - prescribe multiple strengths individually.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ALLERGEN IMMUNOTHERAPY		
	Grastek® *(QL = 1 tablet/day)* Oralair® *(QL = 1 tablet/day)* Ragwitek® *(QL = 1 tablet/day)*	**Clinical Criteria** **All agents in class** • Prescriber must provide the testing to show that the patient is allergic to the components in the prescribed therapy and must provide a clinically valid rationale why single agent sublingual therapy is being chosen over subcutaneous therapy • Treatment must start 12 weeks before expected onset of pollen season and only after confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for short ragweed pollen (Ragwitek), timothy grass or cross-reactive grass pollens (Grastek), or any of the 5 grass species contained in Oralair • Have an auto-injectable epinephrine on-hand **Grastek additional criteria:** • Patient age ≥5 years and ≤65 years **Oralair additional criteria:** • Patient age ≥10 years and ≤65 years **Ragwitek additional criteria:** • Patient age ≥18 years and ≤65 years
ALPHA1-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		

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

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		currently taking an anticoagulant (warfarin or heparin) and has had a previous trial of generic celecoxib, Patient is currently taking an oral corticosteroid and has had a previous trial of generic celecoxib, and Patient is currently taking methotrexate and has had a previous trial of generic celecoxib.
ANALGESICS		
MISCELLANEOUS: TRANSDERMAL PATCH		
Note: Please refer to "Analgesics: Long Acting Narcotics" for Duragesic® and fentanyl patch	Lidocaine 5% patch† (compare to Lidoderm®) *(QL = 3 patches/day)* Lidoderm® Patch (lidocaine 5 %) *(QL = 3 patches/day)* Qutenza® Patch (capsaicin 8 %) (*QL =4 patches/90 days)* (Note: Please refer to Analgesics: COX IIs and NSAID s for topical NSAIDS)	**Lidoderm, Lidocaine Patch:** diagnosis or indication is neuropathic pain/post-herpetic neuralgia AND patient has had a documented side effect, allergy, treatment failure or contraindication to 2 drugs in the tricyclic antidepressant (TCA) class and/or anticonvulsant class AND patient has had a documented side effect, allergy, treatment failure or contraindication to Lyrica, OR patient has a medical necessity for a transdermal formulation (ex. dysphagia, inability to take oral medications), AND if the request is for generic lidocaine patch, the patient has had a documented intolerance to the brand product. **Qutenza:** diagnosis or indication is post-herpetic neuralgia AND patient has had a documented side effect, allergy, treatment failure or contraindication to 2 drugs in the tricyclic antidepressant (TCA) class and/or anticonvulsant class AND patient has had a documented side effect, allergy, treatment failure or contraindication to Lyrica AND patient has had a documented side effect, allergy treatment failure or contraindication to Lidoderm OR patient has a medical necessity for transdermal formulation (ex. dysphagia, inability to take oral medications) AND patient has had a documented side effect, allergy, treatment failure or contraindication to Lidoderm.
OPIOIDS: SHORT ACTING		
ACETAMINOPHEN W/CODEINE† (compare to Tylenol® w/codeine) ACETAMINOPHEN W/HYDROCODONE† (compare to Vicodin®, Lorcet®, Maxidone®, Norco®, Zydone®) *(QL 5/500 = 8 tablets/day, 10/500 = 8 tablets/day, 7.5/750 = 5 tablets/day)* ACETAMINOPHEN W/OXYCODONE† (compare to Percocet®) *(QL 10/650 = 6 tablets/day)* ASPIRIN W/CODEINE† BUTALBITAL COMP. W/CODEINE† (compare	Abstral® (fentanyl) Sublingual Tablets Acetaminophen w/codeine: *all branded products* Acetaminophen w/hydrocodone: *all branded products* *(QL 5/500 = 8 tablets/day, 10/500 = 8 tablets/day, 7.5/750 = 5 tablets/day)* Acetaminophen w/hydrocodone (compare to Xodol®) *(QL=13 tablets/day)* Acetaminophen w/oxycodone: *all branded products* *(QL 10/650 = 6 tablets/day)* Actiq® (fentanyl lozenge on a stick: 200 mcg, 400 mcg, 600 mcg, 800 mcg, 1200 mcg, 1600 mcg)	**Butorphanol Nasal Spray:** documented site effect, allergy, treatment failure, or contraindication to codeine, hydrocodone, morphine, & oxycodone (all 4 generic entities) as single or combination products. OR is unable to use tablet or liquid formulations. **Abstral, Actiq, fentanyl transmucosal, Fentora, Lazanda, Subsys:** indication of cancer breakthrough pain AND patient is opioid tolerant AND is on a long acting opioid formulation AND is 18 years of age or older (Actiq 16 years of age or older) AND prescriber is registered in the Transmucosal Immediate Release Fentanyl (TIRF) Risk Evaluation and Mitigation Strategy (REMS) Access program AND member has had a documented treatment failure with or intolerance to 2 of the following 3 immediate release treatment options: morphine, hydromorphone or oxycodone. OR is unable to use tablet or liquid formulations AND if the request is for brand name Actiq, member has a documented intolerance to generic fentanyl transmucosal.

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to Fiorinal® w/codeine) CODEINE SULFATE† DIHYDROCODEINE COMPOUND† (compare to Synalgos-DC®) ENDOCET® (oxycodone w/ acetaminophen) HYDROCODONE† (plain, w/acetaminophen, or w/ibuprofen) (some exceptions apply) HYDROMORPHONE† tablets (compare to Dilaudid®) *First fill limited to 14 days' supply* *(Qty limit = 16 tablets/day)* MEPERIDINE† (compare to Demerol®) (30 tabs or 5 day supply) MORPHINE SULFATE† MORPHINE SULFATE† (compare to Roxanol®) OXYCODONE† (plain) *First fill limited to 14 days' supply* *(For tablets, Qty limit = 12 tablets/day)* OXYCODONE† (w/acetaminophen, w/aspirin or w/ibuprofen) TRAMADOL† (compare to Ultram®) *(Qty Limit = 8 tablets/day) (Age ≥ 16)* TRAMADOL/APAP† (compare to Ultracet®) *(Qty Limit = 8 tablets/day)* (Age ≥18) ZAMICET† (Hydrocodone-Acetaminophen Soln 10-325 Mg/15ml)	Anexsia®* (acetaminophen w/hydrocodone) Butorphanol Nasal Spray† (Qty Limit = 2 bottles/month) Capital® w/codeine* (acetaminophen w/codeine) Combunox®* (oxycodone w/ ibuprofen) Demerol* (meperidine) Dilaudid®*(hydromorphone) tablets *First fill limited to 14 days' supply* *(Qty limit = 16 tablets/day)* Dilaudid-5®(hydromorphone) oral solution *First fill limited to 14 days' supply* fentanyl citrate transmucosal† (compare to Actiq®) Fentora® (fentanyl citrate buccal tablets) Fioricet® w/codeine*(butalbital/acetaminophen/caffeine/codeine) Hydrocodone-Acetaminophen Soln 10-325 Mg/15ml Hydromorphone† oral soln (compare to Dilaudid-5®) *First fill limited to 14 days' supply* Ibudone®* (hydrocodone w/ ibuprofen) Lazanda® (fentanyl) Nasal Spray Lortab®*(hydrocodone w/ acetaminophen) Meperidine† (Qty > 30 tabs or 5 day supply) Nucynta® (tapentadol) Opana® (oxymorphone) Oxycodone† (plain) capsules First fill limited to 14 days' supply (Qty limit = 12 capsules/day) Oxymorphone† (compare to Opana®) Panlor DC® (acetaminophen/caffeine/dihydrocodeine) Pentazocine w/acetaminophen† Pentazocine w/naloxone† Reprexain®* (hydrocodone w/ ibuprofen) Roxanol®*(morphine sulfate) Rybix® ODT (tramadol ODT) (Qty Limit = 8 tablets/day) Subsys® (fentanyl) Sublingual Spray Synalgos DC®*(dihydrocodeine compound) Talwin®* (pentazocine) and branded combinations Tylenol® #3*,#4*(acetaminophen w/codeine) Ultracet® (tramadol w/ acetaminophen) (Qty Limit = 8	**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. **Nucynta, Opana, Oxymorphone**: member has had a documented side effect, allergy, or treatment failure to at least two of the following 3 immediate release generic short acting narcotic analgesics - morphine, hydromorphone, or oxycodone AND if the request if for brand Opana, member has a documented intolerance to generic oxymorphone. **Oxycodone (generic) Capsules:** member has a documented intolerance to generic oxycodone tablets. **Oxecta:** prescriber provides a clinically valid rationale why the generic immediate release oxycodone cannot be used AND member has a documented side effect, allergy, or treatment failure to at least 2 other preferred short acting narcotic analgesics. NOTE: a history of substance abuse does not warrant approval of Oxeta (oxycodone IR) since a clear advantage of this product over preferred short acting opioids in this population has not been established. **Ultram, Ultracet:** member has a documented intolerance to the generic formulation **Rybix ODT:** member has a medical necessity for a disintegrating tablet formulation (i.e. swallowing disorder) **Xartemis XR:** diagnosis is acute pain AND member has a documented side effect, allergy, or treatment failure to at least 2 short acting opioids not requiring prior approval, one of which is oxycodone w/ apap AND prescriber must provide a compelling clinical reason why an extended release product is required for treatment of acute pain. **Other Short acting Opioids:** member has had a documented side effect, allergy, or treatment failure to at least 2 medications not requiring prior approval. (If a product has an AB rated generic, one trial must be the generic) **PA Requests to Exceed QL for Oxycodone IR or Hydromorphone IR:** if dose consolidation is not possible (i.e. use of higher strength dosage form), all requests will be referred to the DVHA Medical Director for review unless the medication is being prescribed for pain related to an oncology diagnosis which will be approved by the Clinical Call Center. **Limitations:** APAP containing products: daily doses that result in > 4 grams of acetaminophen/day will reject for PA; Meperidine 75mg/ml injection no longer available - 25mg/ml, 50mg/ml and 100mg/ml available. Brand name Demerol 75mg/ml and 100mg/2ml not covered - no generic equivalents. `

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	tablets/day) Ultram®* (tramadol) (Qty Limit = 8 tablets/day) Xartemis XR® (oxycodone w/acetaminophen) (Qty Limit = 4 tablets/day)	
OPIOIDS: LONG ACTING		
TRANSDERMAL BUTRANS (buprenorphine) TRANSDERMAL SYSTEM *(QL = 2 patches/14 days) (Maximum 14-day fill)* FENTANYL PATCH† (compare to Duragesic®) 12 mcg/hr, 25 mcg/hr, 50 mcg/hr (*QL=15 patches/30 days)* 75 mcg/hr, 100 mcg/hr (*QL=30 patches/30 days)* **BUCCAL** All Products require PA **ORAL** BUPRENORPHINE **All products require PA.** HYDROMORPHONE **All products require PA.** METHADONE **All products require PA** **MORPHINE** MORPHINE SULFATE CR 12 hr† tablet (compare to MS Contin® (*QL=90 tablets/strength/30 days)* EMBEDA® (morphine sulfate/naltrexone hydrochloride) Capsules *(QL=2 capsules/day)* **TRAMADOL** **All products require PA.**	Duragesic®* (fentanyl patch) 12 mcg/hr, 25 mcg/hr, 50 mcg/hr (QL=15 patches/30 days) 75 mcg/hr, 100 mcg/hr (QL= 30 patches/30 days) Fentanyl patch 37.5mcg/hr, 62.5mcg/hr, 87.5mcg/hr Exalgo® (hydromorphone XR) tablet (*QL= 30 tablets/30 days (8 mg, 12 mg, 16 mg tabs), 60 tablets/30 days (32 mg tabs)* hydromorphone XR† (compare to Exalgo®) tablet *(QL= 30 tablets/30 days (8 mg, 12 mg, 16 mg tabs))* Belbuca® (buprenorphine hcl buccal film) (*QL= 28 films/14 days, Maximum 14-day fill)* Dolophine® (methadone) tablets Methadone† (compare to Dolophine®) 5 mg, 10 mg tablets Methadone† oral solution (no PA required for patient less than 1 year old) Methadone† oral concentrate 10 mg/ml ****Maximum initial daily dose all products = 30 mg/day**** Kadian® (morphine sulfate XR*) (QL= 60 capsules/strength/30 days)* MS Contin®* (morphine sulfate CR 12 hr) Tablets (*QL=90 tablets/strength/30 days)* Morphine sulfate SR 24hr† capsule (compare to Kadian®) *(QL= 60 capsules/strength/30 days)* Morphine sulfate SR beads 24hr† capsule *(QL 30 capsules/strength/30 days)*	**CLINICAL CONSIDERATIONS:** Long acting opioid dosage forms are intended for use in opioid tolerant patients only. These tablet/capsule/topical medication strengths may cause fatal respiratory depression when administered to patients not previously exposed to opioids. LA opioids should be prescribed for patients with a diagnosis or condition that requires a continuous, around-the-clock analgesic. LA opioids should be reserved for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain. LA opioids are NOT intended for use as 'prn' analgesic. LA opioids are NOT indicated for pain in the immediate post-operative period (the first 12-24 hours following surgery) or if the pain is mild, or not expected to persist for an extended period of time. LA opioids are not intended to be used in a dosage frequency other than FDA approved regimens. Patients should not be using other extended release opioids prescribed by another physician. Prescribers should consult the VPMS (Vermont Prescription Monitoring System) to review a patient's Schedule II - IV medication use before prescribing long acting opioids. **Belbuca Films:** the patient has had a documented intolerance to Butrans patches **Duragesic Patches:** patient has had a documented intolerance to generic fentanyl patches. **Fentanyl patches 37.5mcg/hr, 62.5mcg/hr, 87.5mcg/hr:** provider must submit clinical rationale detailing why the patient is unable to use a combination of the preferred strengths. **Methadone Tablet:** patient has had a documented side effect, allergy, or treatment failure to morphine sulfate CR 12 hr tablets AND the initial methadone daily dose does not exceed 30mg AND for approval of brand Dolophine tablets, the patient must have a documented intolerance to the equivalent generic tablet. (Note: Methadone products, when used for treatment of opioid addiction in detoxification or maintenance programs, shall be dispensed ONLY by certified opioid treatment programs as stipulated in 42 CFR 8.12, NOT retail pharmacy) **Methadone Liquid:** Patient must have a medical necessity for an oral liquid (i.e. swallowing disorder, inability to take oral medications) AND the initial daily dose does not exceed 30mg OR patient has been started and stabilized on the requested oral liquid medicationNote: Methadone products, when used for treatment of opioid addiction in detoxification or maintenance programs, shall be dispensed ONLY by certified opioid treatment programs as stipulated in 42 CFR 8.12, NOT retail pharmacy

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
HYDROCODONE **All products require PA.**	Oxycodone ER† (compare to OxyContin®) *(QL= 90 tablets/strength/30 days)* OxyContin® (Oxycodone ER) *(QL= 90 tablets/strength/30 days)* Opana ER® (oxymorphone ER) (crush resistant) *(QL=60 tablets/strength/30 days)* Oxymorphone ER *(QL=60 tablets/strength/30 days)* Nucynta ER® (tapentadol ER) *(QL=2 tablets/day)* Xtampza ER® (oxycodone ER) *(QL = 60 tabs/strength/30days)* Conzip® (tramadol ER biphasic release) Capsule *(QL = 1 capsule/day)* Tramadol SR† (compare to Ultram ER®) *(Qty Limit = 1 tablet/day)* Tramadol ER biphasic-release® Capsule *(Qty Limit = 1 capsule/day) (150 mg strength)* Tramadol ER biphasic-release† tablet (formerly Ryzolt®) *(Qty Limit = 1 tablet/day)* Ultram ER® (tramadol SR 24 hr) *(Qty Limit = 1 tablet/day)* Hysingla ER® w/abuse deterrent properties (hydrocodone bitartrate) *(Qty Limit = 1 tablet/ day)* Zohydro ER® (hydrocodone bitartrate)	**Conzip, Tramadol ER biphasic-release Capsule, Tramadol ER biphasic-release Tablet, Tramadol ER/SR, Ultram ER:** member has had a documented treatment failure to a preferred short-acting tramadol product. In addition, for approval of tramadol ER biphasic-release capsule or tablet or Ultram ER, the patient must have a documented intolerance to generic tramadol ER/SR. **Oral Non-Preferred (except methadone & tramadol containing products):** 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 if there is a history of substance abuse, the patient must have a documented side effect, allergy, or treatment failure to the preferred abuse deterrent formulation (Embeda) before OxyContin or Xtampza ER will be approved. **Hysingla ER/Zohydro ER:** Available with PA for those unable to tolerate any preferred medications. All requests will go to the DVHA Medical Director for approval. **Limitations:** Methadone 40mg dispersible tablet not approved for retail dispensing.
NSAIDS		
ORAL **SINGLE AGENT** DICLOFENAC POTASSIUM† DICLOFENAC SODIUM† (compare to Voltaren®) ETODOLAC† (formerly Lodine®) ETODOLAC ER†	Anaprox DS®* (naproxen sodium) Cambia® (diclofenac potassium) packet for oral solution *(QL = 9 packets/month))* Daypro®* (oxaprozin) EC-Naprosyn® * (naproxen sodium enteric coated)	**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

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FLURBIPROFEN† IBUPROFEN† (compare to Motrin®) INDOMETHACIN† (formerly Indocin®, Indocin SR®) INDOMETHACIN ER† KETOPROFEN† KETOPROFEN ER† KETOROLAC† (formerly Toradol®) *(QL = 20 doses/5 day supply every 90 days)* MECLOFENAMATE SODIUM† MELOXICAM† tabs (compare to Mobic®) NABUMETONE† NAPROXEN† (compare to Naprosyn®) NAPROXEN ENTERIC COATED† (compare to EC-Naprosyn®) NAPROXEN SODIUM† (compare to Anaprox®, Anaprox DS®, Naprelan®) OXAPROZIN† (compare to Daypro®) PIROXICAM† (compare to Feldene®) JLINDAC† **INJECTABLE** KETOROLAC † Injection (formerly Toradol®) *(QL = 1 dose per fill)* **NASAL SPRAY** **All products require PA.** **TRANSDERMAL** **All products require PA.** **NSAID/ANTI-ULCER** **All products require PA.** Note: Please refer to "Dermatological: Actinic Keratosis Therapy" for Solaraze® or Diclofenac 3% Gel	Feldene®* (piroxicam) Fenoprofen 400mg cap Fenoprofen† 600 mg tab Indocin®* (indomethacin) suspension, suppository mefenamic acid† capsules (compare to Ponstel®) meloxicam suspension Mobic® (meloxicam) suspension Mobic®* (meloxicam) tablets Nalfon® (fenoprofen) 400 mg capsules Naprelan®* (naproxen sodium) Naprosyn®* (naproxen sodium) Ponstel® (mefenamic acid) Tivorbex (indomethacin) capsules (QL=3 caps/day) Vivlodex® (meloxicam) capsules Voltaren XR®* (diclofenac sodium SR) Zipsor® (diclofenac potassium) Zorvolex® (diclofenac) Capsules *(QL = 3 capsules/day)* Sprix® (ketorolac) Nasal Spray *(QL = 5 bottles/5 days – once every 90 days)* diclofenac† (compare to Pennsaid®) 1.5 % Topical Solution Flector® (diclofenac) 1.3 % Patch *(QL = 2 patches/day)* Pennsaid® (diclofenac) 2% Topical Solution Voltaren® (diclofenac) 1 % Gel Arthrotec® (diclofenac sodium w/misoprostol) diclofenac sodium w/misoprostol† (compare to Arthrotec®) Duexis® (ibuprofen/famotidine) *(QL = 3 tablets/day)* Vimovo® (naproxen/esomeprazole) *(QL = 2 tablets/day)*	separately AND if the request is for brand Arthrotec, the patient has a documented intolerance to the generic equivalent. **Cambia:** drug is being prescribed for treatment of acute migraine attacks AND patient has had a documented side effect or treatment failure to 2 or more preferred generic NSAIDs, one of which must be generic diclofenac OR drug is being prescribed for treatment of acute migraine attacks AND patient has a requirement for an oral liquid dosage form (i.e. swallowing disorder, inability to take oral medications) AND patient has had a documented side effect or treatment failure with the generic ibuprofen suspension and the generic naproxen suspension. **Flector Patch, Pennsaid, Diclofenac 1.5% Topical Solution:** diagnosis or indication is osteoarthritis or acute pain caused by minor strains, sprains, and contusions AND patient has had a documented side effect or inadequate response to Voltaren gel OR patient is not a candidate for therapy with a preferred generic NSAID due to one of the following: Patient is 60 years of age or older, Patient has a history of GI bleed, Patient is currently taking an oral corticosteroid, Patient is currently taking methotrexate OR patient has a documented medical necessity for a topical/transdermal formulation (ex. dysphagia, inability to take oral medications), AND for approval of Pennsaid 1.5%, the patient has had a documented intolerance to the generic equivalent. **Sprix:** indication or diagnosis is moderate to moderately severe pain. AND patient has had a documented inadequate response or intolerance to generic ketorolac tablets. OR patient has a documented medical necessity for the specialty dosage form (i.e. inability to take medication orally (NPO)). **Tivorbex:** patient has had a documented side effect, allergy, or treatment failure to 4 or more preferred generic NSAIDs, including generic indomethacin. **Vivlodex®:** patient has had a documented side effect, allergy, or treatment failure to 4 or more preferred generic NSAIDs, including generic meloxicam. **Voltaren Gel, Diclofenac 1% Gel:** diagnosis or indication is osteoarthritis or acute pain caused by minor strains, sprains, and contusions. AND patient has had a documented side effect or treatment failure with at least 2 preferred generic NSAIDs. OR patient is not a candidate for therapy with a preferred generis NSAID due to one of the following: Patient is 60 years of age or older, Patient has a history of GI bleed, Patient is currently taking an oral corticosteroid, Patient is currently taking methotrexate OR patient has a documented medical necessity for a topical/transdermal formulation (ex. dysphagia, inability to take oral medication). For approval of generic Diclofenac 1% gel, the patient must have had a documented intolerance to Brand Voltaren. **Vimovo:** patient has had a documented side effect or treatment failure to 2 or more preferred generic NSAIDs OR patient is not a candidate for therapy with a preferred generis NSAID due to one of the following: Patient is 60 years of age or older, Patient has a history of GI bleed, Patient is currently taking an oral corticosteroid, Patient is currently taking methotrexate AND patient is unable to take naproxen and a preferred proton pump inhibitor, separately. **Zipsor, Zorvolex:** patient has had a documented intolerance to diclofenac tablets. AND patient has had a documented side effect, allergy, or treatment failure to 4

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		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.)
ANEMIA: HEMATOPOIETIC/ERYTHROPOIETIC AGENTS		
PREFERRED AFTER CLINICAL CRITERIA ARE MET ARANESP® (darbepoetin alfa) PROCRIT® (epoetin alpha)	Epogen® (epoetin alpha)	**Aranesp, Procrit, Epogen:** diagnosis or indication for the requested medication is anemia due to one of the following: Chronic kidney disease/renal failure, Post-renal transplant, Use of zidovudine for the treatment of human immunodeficiency virus (HIV) (other causes of anemia, such as iron/folate/vitamin B12 deficiency have been eliminated), Surgery patients at high risk for perioperative blood loss, Cancer chemotherapy, Use of ribavirin or interferon therapy for Hepatitis C, Myelodysplastic syndrome. Hemoglobin level at initiation of therapy is <10 g/dL OR for patients currently maintained on therapy, hemoglobin 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 Epogen, the patient has had a documented side effect, allergy, or treatment failure to both Aranesp and Procrit.
ANKYLOSING SPONDYLITIS: INJECTABLES		
Length of Authorization: Initial PA 3 months; 12 months thereafter		
PREFERRED AFTER CLINICAL CRITERIA ARE MET ENBREL® (etanercept) *Qty Limit = 4 syringes/28 days (50 mg), 8 syringes/28 days (25 mg)* HUMIRA® (adalimumab) *Qty Limit = 2 syringes/28 days*	Cimzia® (certolizumab pegol) *(Quantity limit = 1 kit/28 days (starter X 1, then regular))* Cosentyx® (secukinumab) subcutaneous (*Quantity limit = 8 pens or vials month one, then 4 pens or vials monthly)* Inflectra® (infliximab-dyyb) biosimilar to Remicade® Remicade® (infliximab) Simponi® (golimumab) Subcutaneous *Qty Limit = 1 of 50 mg prefilled syringe or autoinjector/28 days)*	**Humira:** patient has a diagnosis of ankylosing spondylitis (AS) and has already been stabilized on Humira. OR patient has a confirmed diagnosis of AS, and conventional NSAID treatment and DMARD therapy (e.g. methotrexate therapy) resulted in an adverse effect, allergic reaction, inadequate response, or treatment failure. If methotrexate is contraindicated, another DMARD should be tried. Notes: Approval should be granted in cases where patients have been treated with infliximab but have lost response to therapy. **Enbrel:** patient has a diagnosis of ankylosing spondylitis (AS) and has already been stabilized on Enbrel. OR diagnosis is AS, and conventional NSAID treatment and DMARD therapy (e.g. methotrexate therapy) resulted in an adverse effect, allergic reaction, inadequate response, or treatment failure. If methotrexate is contraindicated, another DMARD should be tried. **Cimzia, Cosentyx, Inflectra, Remicade, Simponi:** patient has a diagnosis of ankylosing spondylitis (AS) and has already been stabilized on the medication being requested OR diagnosis is AS, and conventional NSAID treatment and DMARD therapy (e.g. methotrexate therapy) resulted in an adverse effect, allergic reaction, inadequate response, or treatment failure. If methotrexate is contraindicated, another DMARD should be tried. AND the prescriber must provide a clinically valid reason why BOTH Humira and Enbrel cannot be used.

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		Additional criteria for Cosentyx and Simponi: Patient must be ≥ 18 years of age. Safety and efficacy has not been established in pediatric patients. **Additional criteria for Inflectra:** the prescriber must provide a clinically valid reason why Remicade cannot be used. * Patients with documented diagnosis of active axial involvement should have a trial with two NSAIDs, but a trial with DMARD is not required. If no active axial skeletal involvement, then NSAID trial and a DMARD trial are required (unless otherwise contraindicated) prior to receiving Humira, Cimzia, Cosentyx, Enbrel, Remicade, or Simponi.
ANTI-ANXIETY: ANXIOLYTICS		
BENZODIAZEPINE		
CHLORDIAZEPOXIDE† (formerly Librium®) CLONAZEPAM† (compare to Klonopin®) *(QL = 4 tabs/day except 2 mg (QL = 3 tabs/day))* CLONAZEPAM ODT† (formerly Klonopin Wafers®) *(QL = 4 tabs/day except 2 mg (QL = 3 tabs/day))* DIAZEPAM† (compare to Valium®) LORAZEPAM† (compare to Ativan®) *(QL = 4 tablets/day)* OXAZEPAM† (formerly Serax®)	alprazolam† (compare to Xanax®) *(QL = 4 tablets/day)* alprazolam ER†, alprazolam XR® (compare to Xanax XR®) *(QL = 2 tablets/day)* alprazolam ODT† (compare to Niravam®) *(QL = 3 tablets/day)* Alprazolam Intensol® (alprazolam concentrate) Ativan®* (lorazepam) *(QL = 4 tablets/day)* Clorazepate† tabs (compare to Tranxene T®) Diazepam Intensol® (diazepam concentrate) Klonopin®* (clonazepam) *(QL = 4 tabs/day except 2 mg (QL = 3 tabs/day))* Lorazepam Intensol® (lorazepam concentrate) Niravam® (alprazolam ODT) *(QL = 3 tablets/day)* Tranxene T®* (clorazepate tablets) Valium®* (diazepam) Xanax® (alprazolam) *(QL = 4 tablets/day)*	**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
	Xanax XR® (alprazolam XR) *(QL = 2 tablets/day)*	
NON-BENZODIAZEPINE		
BUSPIRONE† (formerly Buspar®) HYDROXYZINE HYDROCHLORIDE† (formerly Atarax®) HYDROXYZINE PAMOATE† (compare to Vistaril®) (all strengths except 100 mg) MEPROBAMATE† (formerly Miltown®)	Hydroxyzine Pamoate† (100 mg strength ONLY) (compare to Vistaril®) Vistaril®* (hydroxyzine pamoate)	**Hydroxyzine Pamote 100mg strength ONLY:** patient is unable to use generic 50mg capsules **Vistaril:** patient has a documented intolerance to the generic formulation. **PA Requests to Exceed QL:** all requests will be referred to the DVHA Medical Director for review unless (a) the medication is being prescribed for acute alcohol withdrawal for a maximum 10-day supply or (b) the patient has been started and stabilized on the requested quantity for treatment of a seizure disorder.
ANTICOAGULANTS		
ORAL		
Vitamin K Antagonist WARFARIN † (compare to Coumadin®) **Direct Thrombin Inhibitor** PRADAXA® (dabigatran etexilate) *(Quantity Limit = 2 capsules/day)* **Factor Xa Inhibitor** Eliquis® (apixaban) *(Quantity Limit = 2 tablets/day)* *(Quantity limit 5mg = 4 tablets/day for 7 days if indication is treatment of DVT or PE) (followed by 5 mg twice daily)* XARELTO® (rivaroxaban) *(10mg- Quantity Limit = 1 tablet/day, maximum 30-day supply to complete total 35 days/every 180 days)* *(15m & 20mg -Quantity Limit = 1 tablet/day)* *(Quantity limit 15 mg = 2 tablets/day for 21 days if indication is treatment of DVT or PE) (followed by 20mg once daily)* Starter Pack (15 mg/20 mg) *(Quantity Limit = 51 tablets/30 days)*	Coumadin®* (warfarin) Savaysa® (edoxaban) *(Quantity limits=1 tablet/daily*	**Coumadin:** patient has been started and stabilized on the requested medication OR patient has had a documented intolerance to generic warfarin. **Savaysa:** Diagnosis or indication is nonvalvular atrial fibrillation or the indication is treatment of DVT or PE following 5-10 days of parenteral anticoagulation or the indication is reduction of risk of recurrent DVT or PE following initial therapy AND creatinine clearance is documented to be < 95 ml/min AND prescriber has provided another clinically valid reason why generic warfarin, Pradaxa, Xarelto or Eliquis cannot be used. A yearly creatinine clearance is required with renewal of PA request
INJECTABLE		
UNFRACTIONATED HEPARIN INJECTABLE	n/a	**Arixtra:** patient has a documented intolerance to generic fondaparinux.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
HEPARIN† **LOW MOLECULAR WEIGHT HEPARINS INJECTABLE** ENOXAPARIN † (compare to Lovenox®) *(QL = 2 syringes/day calculated in ml volume)* **SELECTIVE FACTOR XA INHIBITOR INJECTABLE** FONDAPARINUX† (compare to Arixtra®)	Lovenox® (enoxaparin) *(QL = 2 syringes/day calculated in ml volume)* Fragmin® (dalteparin) Arixtra®* (fondaparinux)	**Lovenox and Fragmin:** patient has a documented intolerance to generic enoxaparin
ANTICONVULSANTS		
ORAL		
CARBAMAZEPINE† Tablets (compare to Tegretol®) CARBAMAZEPINE Capsules (compare to Carbatrol®) CARBAMAZEPINE extended release † (compare to Tegretol XR®) CELONTIN® (methsuxamide) CLONAZEPAM† (compare to Klonopin®) *QL = 4 tablets/day* CLONAZEPAM ODT† (formerly Klonopin Wafers®) *QL = 4 tablets/day* DEPAKOTE SPRINKLES® (divalproex sodium caps) DIAZEPAM† (compare to Valium®) DILANTIN® (phenytoin) chewable tablets, capsules DIVALPROEX SODIUM † (compare to Depakote®) DIVALPROEX SODIUM ER† (compare to Depakote ER®) EPITOL† (carbamazepine) ETHOSUXAMIDE† (compare to Zarontin®) GABAPENTIN† 100 mg, 300 mg, 400 mg capsules, 600 mg, 800 mg tablets, 250 mg/5 ml oral solution (compare to	Aptiom® (eslicarbazepine acetate) *QL = 1 tab/day (200, 400 and 800 mg) and 2 tabs/day (600 mg)* Banzel® (rufinamide) *QL = 8 tabs/day (400 mg) and 16 tabs/day (200 mg)* Banzel® (rufinamide) oral suspension *QL = 80 ml/day (3,200 mg/day)* Briviact® (brivaracetam) tablets, oral suspension Carbatrol® (carbamazepine) capsules Clorazepate (compare to Tranxene-T®) tablets Depakene®* (valproic acid) Depakote®* (divalproex sodium) Depakote ER®* (divalproex sodium) divalproex sodium capsules † (compare to Depakote Sprinkles®) Dilantin® (phenytoin) suspension felbamate† (compare to Felbatol®) Felbatol® (felbamate) Fycompa® (perampanel) tablets *QL = 1 tablet/day* Keppra®* (levetiracetam) tablets, oral solution Keppra XR® (levetiracetam extended release)	**Aptiom:** The patient has been started and stabilized on the requested medication (Note: Samples are not considered adequate justification for stabilization.) OR 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. **Briviact:** The patient has been started and stabilized on the requested medication (Note: Samples are not considered adequate justification for stabilization.) OR the diagnosis is adjunctive therapy of partial-onset seizures and the patient has had a documented side effect, allergy, treatment failure/inadequate response, or a contraindication to at least TWO preferred anticonvulsants, one of which is levetiracetam. **Carbatrol, Depakene, Depakote, Depakote ER, Dilantin Suspension, Keppra tabs or oral solution, Klonopin, Klonopin Wafers, Lamictal tabs or chew tabs, Mysline, Neurontin caps, tabs, sol, Tegretol Tabs, Tegretol XR (200mg & 400mg), Topamax tabs, Topamax sprinkles, Trileptal tabs, Zarontin, Zonegran:** patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization) OR patient has had a documented intolerance to the generic equivalent of the requested medication. **Benzel:** diagnosis or indication is treatment of Lennox-Gastaut Syndrome. AND patient has had a documented side effect, allergy, treatment failure/inadequate response or a contraindication to at least TWO preferred anticonvulsants used for the treatment of Lennox-Gastaut syndrome (topiramate, lamotrigine, valproic acid) AND for approval of the oral suspension, patient must be unable to use Benzel tabs (i.e. swallowing disorder)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
Neurontin®) GABITRIL® (tiagabine) LAMOTRIGINE† chew tabs (compare to Lamictal® chew tabs) LAMOTRIGINE† tabs (compare to Lamictal® tabs) LEVETIRACETAM† tabs (compare to Keppra® tabs) LEVETIRACETAM† oral soln (compare to Keppra® oral soln) OXCARBAZEPINE† tablets (compare to Trileptal®) OXCARBAZEPINE † oral suspension (compare to Trileptal®) PEGANONE® (ethotoin) PHENYTEK® (phenytoin) PHENYTOIN† (compare to Dilantin®) PHENYTOIN EX† cap (compare to Phenytek®) PRIMIDONE† (compare to Mysoline®) TEGRETOL® (carbamazepine) suspension TEGRETOL XR® (carbamazepine) 100 mg ONLY TOPIRAMATE ER TOPIRAMATE† tabs (compare to Topamax® tabs) TOPIRAMATE† sprinkle caps (compare to Topamax® Sprinkles) VALPROIC ACID† (compare to Depakene®) ZONISAMIDE† (compare to Zonegran®)	Klonopin®* (clonazepam) *QL = 4 tablets/day* Lamictal®* tabs (lamotrigine tabs) Lamictal®* chew tabs (lamotrigine chew tabs) Lamictal ODT® (lamorigine orally disintegrating tablets) Lamictal XR® tablets (lamotrigine extended release) lamotrigine ER† (compare to Lamictal XR®) lamotrigine ODT (compare to Lamictal ODT®) levetiracetam ER† (compare to Keppra XR®) Lyrica® (pregabalin) § cap *(Quantity Limit = 3 capsules/day)* Lyrica® (pregabalin) oral solution Mysoline®* (primidone) Neurontin®* (gabapentin) capsules, tablets and solution Onfi® (clobazam) Oral Suspension 2.5 mg/ml *(Quantity limit = 16 ml/day)* Onfi® (clobazam) Tablets *(Quantity Limit = 3 tabs/day (10 mg), 2 tabs/day (20 mg))* Oxtellar® XR (oxcarbazapine ER) tablet Potiga® (ezogabine) tablets *(Quantity limit = 9 tablets/day (50mg), 3 tablets/day (all others)* Qudexy® XR (topiramate) capsules Sabril® (vigabatrin) Spritam® (levetiracetam) tablets for oral suspension Tegretol®* (carbamazepine) tablets Tegretol XR® (carbamazepine) (200 and 400 mg strengths) tiagabine† (compare to Gabitril®) Topamax®* (topiramate) tablets Topamax®* (topiramate) Sprinkle Capsules Tranxene-T®* (clorazepate) tablets Trileptal®* tablets (oxcarbazepine) TRILEPTAL® oral suspension (oxcarbazepine) Trokendi XR® (topiramate SR 24hr) Capsules *(Quantity limit = 2 caps/day (200mg), 1 cap/day all*	**Felbamate, Felbatol:** patient information/consent describing aplastic anemia and liver injury has been completed AND patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization). Additionally, if brand is requested, the patient has a documented intolerance to the generic product. OR diagnosis is adjunctive therapy of partial-onset seizures or Lennox-Gastaut seizures and the patient has had a documented side effect, allergy, treatment failure/inadequate response or a contraindication to at least THREE preferred anticonvulsants. Additionally, if brand is requested, the patient has a documented intolerance to the generic product. **Divalproex sodium capsules (sprinkles) and tiagabine generic:** patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization). OR patient has had a documented intolerance to the brand name product. **Keppra XR, Lamictal XR, lamotrigine ER, levetiracetam ER, Oxtellar XR:** patient has been unable to be compliant with or tolerate twice daily dosing of the immediate release product. Additionally, if brand Keppra XR or Lamictal XR is requested, the patient has a documented intolerance to the generic product. **Lamictal ODT, lamotrigine ODT:** medical necessity for a specialty dosage form has been provided AND lamotrigine chewable tabs cannot be used. For approval of brand Lamictal ODT, the patient must have a documented intolerance to the generic equivalent. **Spritam**: medical necessity for a specialty dosage form has been provided AND patient must have a documented intolerance to levetiracetam oral solution. **Lyrica caps, Lyrica oral solution:** patient has a diagnosis of epilepsy OR patient has had a documented side effect, allergy, or treatment failure to TWO drugs from the following: gabapentin, tricyclic antidepressant, SSRI antidepressant, SNRI antidepressant, miscellaneous antidepressant, cyclobenzaprine or Savella, if medication is being used for fibromyalgia. (This indication not processed via automated step therapy). OR if the diagnosis is for post-herpetic neuralgia or neuropathic pain, there is a documented side effect, allergy or treatment failure to TWO drugs from the following: tricyclic antidepressant, gabapentin, or SNRI, AND if the request is for the oral solution, the patient is unable to use Lyrica capsules (i.e. swallowing disorder) **Onfi:** patient has been started and stabilized on the requested medication (Note: samples are not considered adequate justification for stabilization) OR diagnosis or indication is adjunctive treatment of Lennox-Gastaut Syndrome. AND patient has had a documented side effect, allergy, treatment failure/inadequate response or a contraindication to at least TWO preferred anticonvulsants used for the treatment of Lennox-Gastaut syndrome (topiramate, lamotrigine, valproic acid) OR diagnosis or indication is adjunctive treatment of refractory epilepsy (may include different types of epilepsy) AND patient has had a documented side effect, allergy, treatment failure/inadequate response or a contraindication to at least THREE preferred anticonvulsants.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	others) Vimpat® (lacosamide) tablets, oral solution Zarontin®* (ethosuxamide) Zonegran®* (zonisamide)	**Clorazepate, Fycompa, Potiga:** patient has been started and stabilized on the requested medication (Note: samples are not considered adequate justification for stabilization) OR diagnosis is adjunctive therapy or partial-onset seizures OR diagnosis is adjunctive therapy for primary generalized tonic-clonic seizures (Fycompa only) AND the patient has had a documented side effect, allergy, treatment failure, inadequate response, or a contraindication to at least TWO preferred anticonvulsants. Sabril: prescriber and patient are registered with the SHARE program AND diagnosis is infantile spasms OR patient is > 16 years old and the indication is adjunctive therapy in refractory complex partial seizures and failure of THREE other preferred anticonvulsants. **Trileptal oral suspension:** patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization). OR patient has had a documented intolerance to the generic product. **Trokendi XR, Qudexy XR:** patient has failed treatment with topiramate ER **Vimpat:** patient has been started and stabilized on the requested medication (Note: samples are not considered adequate justification for stabilization) OR diagnosis is monotherapy adjunctive therapy of partial-onset seizures and the patient has had a documented side effect, allergy, treatment failure/inadequate response or a contraindication to at least TWO preferred anticonvulsants AND if the request is for the oral solution, the patient is unable to use Vimpat tables (eg. swallowing disorder). **PA Requests to Exceed QL for clonazepam/clonazepam ODT or Klonopin**: all requests will be referred to the DVHA Medical Director for review unless the patient has been started and stabilized on the requested quantity for treatment of a seizure disorder.
RECTAL		
DIASTAT® (diazepam rectal gel)	Diazepam rectal gel	**Diazepam Rectal Gel:** patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization) OR patient has had a documented intolerance to Diastat rectal gel.
ANTIDEPRESSANTS		
MAO INHIBITORS – Length of Authorization: Duration of Need for Mental Health Indications		
PHENELZINE SULFATE (compare to Nardil®) *FDA maximum recommended dose = 90 mg/day* TRANYLCYPROMINE (compare to Parnate®) *FDA maximum recommended dose = 60 mg/day*	Emsam® (selegiline) *(QL = 1 patch/day)* Marplan® (isocarboxazid) Nardil®* (phenylzine) *FDA maximum recommended dose = 90 mg/day* Parnate®* (tranylcypromine) *FDA maximum recommended dose = 60 mg/day*	**Marplan:** patient has been started and stabilized on the requested medication (Note: samples are not considered adequate justification for stabilization). OR patient has had a documented side effect, allergy, or treatment failure to phenelzine and tranylcypromine. **Nardil, Parnate:** patient has had a documented intolerance to generic equivalent product. **Emsam:** patient has had a documented side effect, allergy, or treatment failure with at least 3 antidepressants from 2 of the major antidepressants classes (Miscellaneous, SNRIs, SSRIs, and Tricyclic Antidepressants). OR patient is

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		unable to tolerate oral medication.
MISCELLANEOUS - Length of Authorization: Duration of Need for Mental Health Indications, 1 Year for Other Indications		
BUPROPION SR† (compare to Wellbutrin SR®) *FDA maximum recommended dose = 400mg/day* BUPROPION XL† (compare to Wellbutrin XL®) *FDA maximum recommended dose = 450 mg/day* BUPROPION† (compare to Wellbutrin®) *FDA maximum recommended dose = 450 mg/day* MAPROTILINE† *FDA maximum recommended dose = 225 mg/day* MIRTAZAPINE† (compare to Remeron®) *FDA maximum recommended dose = 45 mg/day* MIRTAZAPINE RDT† (compare to Remeron Sol-Tab®) *FDA maximum recommended dose = 45 mg/day* TRAZODONE HCL† (formerly Desyrel®) *FDA maximum recommended dose = 600 mg/day*	Aplenzin® (bupropion hydrobromide) ER tablets *Quantity Limit = 1 tablet/day* Trintellix® (vortioxetine) Tablet *Quantity Limit = 1 tablet/day* Forfivo XL® (bupropion SR 24hr) 450 mg tablet *FDA maximum recommended dose = 450 mg/day* *Quantity Limit = 1 tablet/day* Nefazodone† *FDA maximum recommended dose = 600 mg/day* Remeron®* (mirtazapine) *FDA maximum recommended dose = 45 mg/day* Remeron Sol Tab®* (mirtazapine RDT) *FDA maximum recommended dose = 45 mg/day* Viibryd® (vilazodone) Tablet *Quantity Limit = 1 tablet/day* Wellbutrin SR®* (bupropion SR) *FDA maximum recommended dose = 400mg/day* Wellbutrin XL®* (bupropion XL) *FDA maximum recommended dose = 450 mg/day*	**Criteria for approval for ALL non-preferred drugs:** The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR The patient meets additional criteria as outlined below. **Aplenzin:** The patient has had a documented side effect, allergy, or in adequate response to at least 3 different antidepressants from the SSRI, SNRI and/or Miscellaneous Antidepressant categories (may be preferred or non-preferred), one of which must be bupropion XL. **Forfivo XL**: The patient is unable to take the equivalent dose as generic bupropion XL **Nefazodone:** The patient has had a documented side effect, allergy, or inadequate response to at least 3 different antidepressants from the SSRI, SNRI and/or Miscellaneous Antidepressant categories (may be preferred or non-preferred) **Remeron, Remeron SolTab, Wellbutrin SR, and Wellbutrin XL:** The patient has had a documented intolerance to the generic formulation of the requested medication. **Trintellix, Viibryd:** The diagnosis or indication is MDD AND The patient has had a documented side effect, allergy, or inadequate response (defined by at least 4 weeks of therapy) to at least 3 different antidepressants from the SSRI, SNRI, and/or Miscellaneous Antidepressant categories (may be preferred or non-preferred. **Note:** After a 4-month lapse in use of a non-preferred agent for a mental health indication, or if there is a change in therapy, a lookback through claims information will identify the need to re-initiate therapy following the PDL and clinical criteria.
SNRI - Length of Authorization: Duration of Need for Mental Health Indications, 1 Year for Other Indications		
VENLAFAXINE ER† capsule (compare to Effexor XR®) *FDA maximum recommended dose = 225 mg/day, Quantity limit = 1 capsule/day (37.5 mg & 75 mg)*	Cymbalta® (duloxetine) Capsule *FDA maximum recommended dose = 120 mg/day (MDD and GAD), 60 mg/day all others* *Quantity limit = 2 capsules/day* Desvenlafax ER (desvenlafaxine fumarate SR 24hr) Tablet *FDA maximum recommended dose = 400 mg/day,* *Quantity limit = 1 tablet/day (50 mg tablet only)*	**Criteria for approval of ALL non-preferred drugs:** The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR The patient meets additional criteria as outlined below. **Venlafaxine IR:** The patient has had a documented side effect, allergy, or inadequate response to at least 2 different antidepressants. **Venlafaxine ER tablet (generic), Effexor XR Capsule (brand):** The patient has had a documented intolerance to generic venlafaxine ER caps. **Fetzima, Pristiq:** The diagnosis or indication is Major Depressive Disorder

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Desvenlafaxine ER® (desvenlafaxine base SR) *FDA maximum recommended dose = 400 mg/day, Quantity limit = 1 tablet/day (50 mg tablet only)* Duloxetine† (compare to Cymbalta®) Capsule *FDA maximum recommended dose = 120 g/day (MDD and GAD), 60 mg/day all others Quantity limit = 2 capsules/day* Effexor XR® (venlafaxine XR) capsule *FDA maximum recommended dose = 225 mg/day, Quantity limit = 1 capsule/day (37.5 mg & 75 mg)* Fetzima® (levomilnacipran ER) capsule *FDA maximum recommended dose = 120 mg/day Quantity limit = 1 capsule/day* Fetzima® (levomilnacipran ER) capsule titration pack *(QL = 1 pack per lifetime)* *FDA maximum recommended dose = 120 mg/day* Irenka 40mg (duloxetine) capsules *FD maximum recommended dose = 120g/day (MDD and GAD), 60mg/day all others, QL = 2 caps/day.* Khedezla® (desvenlafaxine base SR) *FDA maximum recommended dose = 400 mg/day, Quantity limit = 1 tablet/day (50 mg tablet only)* Pristiq® **§** (desvenlafaxine succinate SR) *FDA maximum recommended dose = 400 mg/day, Quantity limit = 1 tablet/day (50 mg tablet only)* Venlafaxine ER®† tablet *FDA maximum recommended dose = 225 mg/day, Quantity limit = 1 tablet/day (37.5 mg & 75 mg)* venlafaxine IR **†§** *FDA maximum recommended dose = 225 mg/day*	(MDD) AND The patient has had a documented side effect, allergy, or inadequate response to at least 3(three) different antidepressants, one of which must be Venlafaxine ER capsule. **Desvenlafaxine ER, Khedezla:** The patient has had a documented side effect, allergy, or inadequate response to at least 2 different antidepressants, one of which must be venlafaxine ER capsule AND The patient has had a documented intolerance with Pristiq. **Duloxetine:** Depression: The patient has had a documented side effect, allergy, or inadequate response to at least 2 different antidepressants, one of which must be venlafaxine ER capsule. Generalized Anxiety Disorder: The patient has had a documented side effect, allergy, or inadequate response to at least TWO different antidepressants from the SSRI, SNRI and/or TCA categories (may be preferred or non-preferred) or ONE antidepressant from the SSRI, SNRI and/or TCA categories (may be preferred or non-preferred) and buspirone. Neuropathic pain: The patient has had a documented side effect, allergy, or treatment failure to TWO drugs in the tricyclic antidepressant (TCA) class and/or anticonvulsant class. (this indication not processed via automated step therapy). Non-neuropathic musculoskeletal pain (osteoarthritis, chronic low back pain): The patient has had a documented side effect, allergy, inadequate response or contraindication to acetaminophen (Tylenol®) AND at least TWO nonsteroidal anti-inflammatory drugs (NSAIDs) (oral and/or topical). (this indication not processed via automated step therapy) Fibromyalgia: The patient has had a documented side effect, allergy, or treatment failure to TWO drugs from the following: gabapentin, tricyclic antidepressant, SSRI antidepressant, SNRI antidepressant, miscellaneous antidepressant, cyclobenzaprine, Lyrica® or Savella®. (this indication not processed via automated step therapy) **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. **Cymbalta, Irenka:** Must meet criteria for duloxetine (above) AND have a clinically compelling reason why the dosing needs cannot be accomplished with generic duloxetine.
SSRIs – Length of Authorization: Duration of Need for Mental Health Indications, 1 Year for Other Indications		
CITALOPRAM† (compare to Celexa®) *FDA maximum recommended dose = 40 mg/day* ESCITALOPRAM† (compare to Lexapro®) TABLETS *FDA maximum recommended dose = 20mg/day* *QL = 1.5 tabs/ day (5mg & 10mg tabs)*	Brisdelle® (paroxetine) *Quantity Limit = 1 capsule/day* Celexa®* (citalopram) *FDA maximum recommended dose = 40 mg/day* escitalopram† solution (compare to Lexapro® solution) *FDA maximum recommended dose = 20 mg/day,*	**Celexa, fluvoxamine CR, Lexapro, Paxil tablet, Pexva, Paroxetine CR, Paxil CR, Prozac, Sarafem, Zoloft:** The patient had a documented side effect, allergy, or treatment failure with 2 preferred SSRIs. One trial must be the generic formulation or IR formulation if CR formulation requested. **Brisdelle:** The indication for use is moderate to severe vasomotor symptoms (VMS) associated with menopause. AND The patient has tried and failed generic paroxetine.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
FLUOXETINE† (compare to Prozac®) CAPSULES, SOLUTION *FDA maximum recommended dose = 80 mg/day* FLUVOXAMINE† (formerly Luvox®) *FDA maximum recommended dose = 300 mg/day* PAROXETINE tablet† (compare to Paxil®) *FDA maximum recommended dose = 60 mg/day* SERTRALINE† (compare to Zoloft®) *FDA maximum recommended dose = 200 mg/day,* *Quantity limit = 1.5 tabs/day (25 mg & 50 mg tabs)*	Fluoxetine®Tablets *FDA maximum recommended dose = 80 mg/day* fluoxetine† 90 mg (compare to Prozac Weekly®) *FDA maximum recommended dose = 90 mg/week* Lexapro® (escitalopram) *FDA maximum recommended dose = 20 mg/day,* *Quantity limit = 1.5 tabs/day (5 mg & 10 mg tabs)* fluvoxamine CR† (compare to Luvox CR®) *FDA maximum recommended dose = 300 mg/day,* *Quantity limit = 2 capsules/day* paroxetine suspension† (compare to Paxil® susp) *FDA maximum recommended dose = 60 mg/day* Paroxetine CR† (compare to Paxil CR®) *FDA maximum recommended dose = 75 mg/day* Paxil®* (paroxetine) *FDA maximum recommended dose = 60 mg/day* Paxil® suspension (paroxetine) *FDA maximum recommended dose = 60 mg/day* Paxil CR® (paroxetine CR) *FDA maximum recommended dose = 75 mg/day* Pexeva® (paroxetine) *FDA maximum recommended dose = 60 mg/day* Prozac®* (fluoxetine) *FDA maximum recommended dose = 80 mg/day* Prozac Weekly® (fluoxetine) *FDA maximum recommended dose = 90 mg/week* Sarafem® (fluoxetine pmdd) *FDA maximum recommended dose = 80 mg/day* Zoloft®* (sertraline) *FDA maximum recommended dose = 200 mg/day,* *Quantity limit = 1.5 tabs/day (25 mg & 50 mg tabs)*	**Paroxetine suspension, Paxil suspension, Escitalopram solution, Lexapro solution:** The patient has a requirement for an oral liquid dosage form. AND The patient had a documented side effect, allergy, or treatment failure with 2 preferred SSRIs. If the request is for the brand product, the patient also has a documented intolerance to the generic equivalent. **Fluoxetine tablet:** Prescriber must provide a clinically compelling reason why the patient is unable to use capsules **Fluoxetine 90mg, Prozac Weekly:** The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR The patient failed and is not a candidate for daily fluoxetine. AND The prescriber provides clinically compelling rationale for once-weekly dosing. AND If the request is for Prozac Weekly, the patient has a documented intolerance of fluoxetine 90 mg capsules. Document clinically compelling information supporting the choice of a non-preferred agent on a General Prior Authorization Form. After a 4-month lapse in use of a non-preferred agent for a mental health indication, or if there is a change in therapy, a lookback through claims information will identify the need to re-initiate therapy following the PDL and clinical criteria.
TRICYCLICS – Length of Authorization: Duration of Need for Mental Health Information, 1 Year for Other Indications		
AMITRIPTYLINE† (formerly Elavil®) *FDA maximum recommended dose = 300 mg/day* AMOXAPINE† (formerly Asendin®) CLOMIPRAMINE† (compare to Anafranil®) DESIPRAMINE† (compare to Norpramin®) DOXEPIN† (formerly Sinequan®) IMIPRAMINE† (compare to Tofranil®)	Anafranil®* (clomipramine) Imipramine Pamoate† capsules Norpramin®* (desipramine) Pamelor®* (nortriptyline) Surmontil® (trimipramine) Tofranil®* (imipramine) *FDA maximum recommended dose = 300 mg/day*	**Criteria for approval of ALL non-preferred drugs:** patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR the patient meets additional criteria as outlined below. **Imipramine Pamoate:** The patient has had a documented side ffect, allergy, or treatment failure to 3 preferred TCAs, one of which must be imipramine tablets. **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

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
FDA maximum recommended dose = 300 mg/day NORTRIPTYLINE† (formerly Aventyl®, compare to Pamelor®) NORTRIPTYLINE Oral Solution PROTRIPTYLINE†		AB rated generic formulation if available **Limitation:** Chlordiazepoxide/amitriptyline and amitriptyline/perphenazine combinations are not covered. Generic agents may be prescribed separately.
ANTI-DIABETICS		
ALPHA-GLUCOSIDASE INHIBITORS		
ACARBOSE† (compare to Precose®) GLYSET® (miglitol)	Precose®* (acarbose)	**Precose:** patient must have a documented intolerance to generic acarbose
BIGUANIDES & COMBINATIONS		
SINGLE AGENT METFORMIN† (compare to Glucophage®) METFORMIN XR† (compare to Glucophage XR®) **COMBINATION** GLIPIZIDE/METFORMIN† (compare to Metaglip®) GLYBURIDE/METFORMIN† (compare to Glucovance®)	Fortamet® metformin ER Osmotic) Glucophage®* (metformin) Glucophage XR®* (metformin XR) Glumetza® (metformin ER) Metformin ER Osmotic† (compare to Fortamet®) Glucovance®* (glyburide/metformin) Riomet® (metformin oral solution)	**Fortamet, Glucophage XR, Glumetza, Metformin ER osmotic:** patient has had a documented intolerance to generic metformin XR (if product has an AB rated generic, there must have been a trial of the generic) **Glucophage, Glucovance:** patient has had a documented side effect, allergy OR treatment failure with at least one preferred biguanide OR biguanide combination product (if a product has an AB raged generic, the trial must be the generic) **Riomet:** prescriber provides documentation of medical necessity for the specialty dosage form (i.e. inability to swallow tablets, dysphagia)
DIPEPTIDYL PEPTIDASE (DPP-4) INHIBITORS		
PREFERRED AFTER CLINICAL CRITERIA ARE MET **SINGLE AGENT** JANUVIA® (sitagliptin) § *(Quantity Limit = 1 tablet/day)* TRADJENTA® *(linagliptin) (Quantity limit=1 tab/day)*	***NON-PREFERRED AFTER CLINICAL CRITERIA ARE MET*** Nesina® (alogliptin) *(Quantity limit=1 tablet/day)* Onglyza® (saxagliptin) *(Quantity limit=1 tablet/day)* Janumet XR® (sitagliptin/metformin ER) *(Qty limit=1 tab/day of 50/500 mg or 100/1000 mg or 2 tabs/day of 50/1000 mg)*	**Januvia, Tradjenta:** patient has had a documented side effect, allergy, contraindication OR treatment failure with metformin **Nesina, Onglyza:** patient has had a documented side effect, allergy, contraindication OR treatment failure with metformin AND patient has had a documented side effect, allergy OR treatment failure with at least one preferred DDP-4 agent. **Janumet:** patient has had an inadequate response with Januvia OR Metformin monotherapy OR patient has been started and stabilized on Januvia and

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
COMBINATION JANUMET® (sitagliptin/metformin) § *(Quantity Limit = 2 tablets/day)* JENTADUETO® (linagliptin/metformin) *(Quantity limit=2 tabs/day)*	Jentadueto XR (linagliptan/metformin ER) *(Quantity limit = 1 tab/day)* Kazano® (alogliptin/metformin) *(Quantity limit=2 tabs/day)* Kombiglyze XR® (saxagliptin/metformin ER) *(Quantity limit=1 tab/day)* Oseni® (alogliptin/pioglitazone) *(Quantity limit=1 tab/day)*	Metformin 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. **Janumet XR, Jentadueto XR:** patient is unable to take Januvia or Tradjenta in combination with Metformin XR as the individual separate agents. **Jentadueto:** patient has had an inadequate response with Tradjenta OR Metformin monotherapy OR patient has been started and stabilized on Tradjenta and Metformin combination therapy **Oseni:** patient is unable to take Nesina and Actos (pioglitazone) as the individual separate agents (after meeting clinical criteria for each individual agent)
INSULINS		
RAPID-ACTING INJECTABLE HUMALOG® (insulin lispro) NOVOLOG® (Aspart) **SHORT-ACTING INJECTABLE** HUMULIN R® (Regular) NOVOLIN R® (Regular) **INTERMEDIATE-ACTING INJECTABLE** HUMULIN N® (NPH) NOVOLIN N® (NPH) **LONG-ACTING ANALOGS INJECTABLE** LANTUS® (insulin glargine) LEVEMIR® (insulin detemir) **MIXED INSULINS INJECTABLE** HUMULIN 70/30® (NPH/Regular) NOVOLIN 70/30® (NPH/Regular) NOVOLOG MIX 70/30® (Protamine/Aspart) HUMALOG MIX 50/50® (Protamine/Lispro) HUMALOG MIX 75/25® (Protamine/Lispro)	Afrezza ® Inhaled (insulin human) Apidra® (insulin glulisine) Toujeo® (insulin glargine) Tresiba® Flextouch (insulin degludec) Basaglar® (insulin glargine)	**Apidra:** patient has had a documented side effect, allergy OR treatment failure to Novolog or Humalog **TOUJEO**: Diagnosis of diabetes mellitus AND Prescription is initiated in consultation with an Endocrinologist AND The patient is currently on insulin glargine U100 and cannot achieve glycemic control (defined as hemoglobin A1c ≤ 7%) because dose increases cannot be tolerated despite attempts at manipulating dosing time or splitting the dose and the volume at the injection site for each dose exceeds 1ml. **Note:** Pharmacy claims will be evaluated to assess compliance with insulin glargine U100 therapy prior to Toujeo approval. Initial approval will be granted for 6 months. For re-approval after 6 months, the patient must have a documented improvement in hemoglobin A1c of ≥ 0.5%. **TRESIBA FLEXTOUCH:** Diagnosis of diabetes mellitus AND prescription is initiated in consultation with an Endocrinologist AND the patient must have documented treatment failure with BOTH preferred long-acting agents. AND For approval of U200, the patient must currently be on Tresiba U100 and cannot achieve glycemic control (defined as hemoglobin A1c ≤ 7%) despite attempts as manipulating dosing time or splitting the dose and the volume at the injection site for each dose exceeds 1ml. **Note:** Initial approval will be granted for 6 months. For re-approval after 6 months, the patient must have a documented improvement in hemoglobin A1c of ≥ 0.5%. **BASAGLAR:** Diagnosis of diabetes mellitus AND prescription is initiated in consultation with an Endocrinologist AND the patient cannot achieve glycemic control (defined as hemoglobin A1c ≤ 7%) despite a 5-year trial of Lantus. **Note:** Pharmacy claims will be evaluated to assess compliance with Lantus therapy prior to Basaglar approval. Initial approval will be granted for 6 months. For re-approval after 6 months, the patient must have a documented improvement in hemoglobin A1c of ≥ 0.5%.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		AFREZZA INHALED INSULIN: • Baseline PFT with FEV1 ≥ 70 % predicted • Patient does not have underlying lung disease (Asthma, COPD) • Patient is a non-smoker or has stopped smoking more than six months prior to starting Afrezza • Patient is currently using a long-acting insulin • Patient has failed to achieve HbA1c goal (defined as ≤ 7%) on a short-acting insulin in combination with a long-acting insulin • Initial approval is for 3 months and improved glycemic control must be documented for further approvals
MEGLITINIDES		
Single Agent NATEGLINIDE† (compare to Starlix®) REPAGLINIDE† (compate to Prandin®) COMBINATION All products require PA	Prandin® (replaglinide) Starlix®* (nateglinide) Repaglinide/metformin	**Prandin,Starlix:** patient has had a documented intolerance to generic equivalent. **Repaglinide/metformin:** patient is unable to take repaglinide and metformin as the individual separate agents.
PEPTIDE HORMONES		
Preferred Agents After Clinical Criteria Are Met **GLP-1 Receptor Agonists** **Single Agents** BYDUREON® (exenatide extended-release) *(Quantity Limit=4 vials/28 days)* BYETTA® (exenatide) (*Quantity Limit =1 pen/30 days)* VICTOZA® (liraglutide) *(Quantity Limit=3 pens/30 days)* **COMBINATION AGENTS** All products require PA **Amylinomimetics** All products require PA	Adlyxin® (lixisenatide) Tanzeum ® (albiglutide) Trulicity® (dulaglutide) Soliqua® (insulin glargine/lixisenatide) QL = 3 pens/25 days Symlin® (pramlintide) *No Quantity Limit applies*	**Bydureon/Byetta/Victoza:** patient has a diagnosis of type 2 diabetes. AND patient is at least 18 years of age. AND patient has had a documented side effect, allergy, contraindication or treatment failure with metformin. **Adlyxin/Trulicity/Tanzeum:** patient has a diagnosis of type 2 diabetes AND patient is at least 18 years of age AND patient has had a documented side effect, allergy, contraindication or treatment failure with metformin AND patient has a documented side effect, allergy, contraindication, or treatment failure with Victoza, Bydureon or Byetta. **Soliqua:** 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 and Lantus used in combination. **Symlin:** patient has a diagnosis of diabetes mellitus. AND patient is at least 18 years of age. AND patient is on insulin.
SODIUM-GLUCOSE CO-TRANSPORTER 2 (SGLT2) INHIBITORS AND COMBINATIONS		
Preferred After Clinical Criteria Are Met JARDIANCE (empagliflozin)	Farxiga® (dapagliflozin)	Patient is 18 years of age or older AND patient has a diagnosis of type 2 diabetes mellitus and has had an inadequate response to diet and exercise alone AND patient has had a documented side effect, allergy, contraindication OR treatment

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
(Quantity limit = 1 tablet/day) SYNJARDY® (empagliflozin/metformin) *(Quantity Limit = 2 tablets/day)*	*(Quantity limit = 1 tablet/day)* Glyxambi® (empagliflozin/ linagliptin) *(Quantity limit = 1 tablet/day)* Invokamet (canagliflozin/metformin) *(Quantity limit = 1 tablet/day)* Invokamet® XR (canagliflozin/metformin ER) Invokana® (canagliflozin) *(Quantity limit = 1 tablet/day)* Xigduo XR® (dapagliflozin & metformin ER) *(Quantity limit 5/1000mg = 2/day)* *(Quantity limit All Other Strengths = 1/day)*	failure with metformin. **Invokana/Farxiga additional criteria:** • Patient has a documented side effect, allergy, or contraindication to Jardiance. Note: Exisiting users as of 1/1/17 will be grandfathered. **Invokamet/Invokamet XR/Xigduo XR® additional criteria:** • The patient has documentation of a failure of therapy with Synjardy or with Jardiance used incombination with metformin/metformin XR **Glyxambi additional criteria:** • The patient has documentation of a failure of therapy with the combination of the preferred SGL2 plus a preferred DPP-4 inhibitor
SULFONYLUREAS 2ND GENERATION		
GLIMEPIRIDE† (compare to Amaryl®) GLIPIZIDE† (compare to Glucotrol®) GLIPIZIDE ER† (compare to Glucotrol XL®) GLYBURIDE† GLYBURIDE MICRONIZED	Amaryl®* (glimepiride) Glucotrol®* (glipizide) Glucotrol XL®* (glipizide ER) Glynase® (glyburide micronized)	Patient must have a documented side effect, allergy or treatment failure to two preferred sulfonureas. If a product has an AB rated generic, one trial must be the generic.
THIAZOLIDINEDIONES & COMBINATIONS		
Preferred After Clinical Criteria Are Met **SINGLE AGENT** PIOGLITAZONE† (compare to Actos®) § **COMBINATION** PIOGLITAZONE/GLIMEPIRIDE† (compare to Duetact®) § *(Quantity Limit = 1 tablet/day)* PIOGLITAZONE/METFORMIN† (Compare to Actoplus Met®) §	Actos® (pioglitazone) Avandia® (rosiglitazone) Actoplus Met® (pioglitazone/metformin) Actoplus Met XR (pioglitazone/metformin ER) Duetact® (pioglitazone/glimepiride) *(Quantity Limit = 1 tablet/day)*	**Actos (pioglitazone), Actoplus Met, Duetact, Pioglitazone/Metformin:** Patient has been started and stabilized on the requested medication OR patient has had a documented side effect, allergy, contraindication OR treatment failure with metformin AND if the request is for brand Actos Met or Duetact, patient has a documented intolerance to the generic product. **Actoplus Met XR:** patient has been started AND stabilized on the requested medication OR patient has had a documented treatment failure with generic Metformin XR OR patient has had a documented treatment failure OR has been unable to be adherent to a twice daily dosing schedule of Actoplus Met resulting in a significant clinical impact. **Avandia:** patient has been started and stabilized on the requested medication and appears to be benefiting from it and the patient acknowledges that they understand the risks OR patient is unable to achieve glycemic control using other medications (including a documented side effect, allergy, contraindication or treatment failure with metformin).
ANTI-EMETICS		
5HT3 ANTAGONISTS: Length of Authorization: 6 months for chemotherapy or radiotherapy; 3 months for hyperemesis gravadarum, 1 time for prevention of post-op nausea/vomiting: see clinical criteria. Monthly quantity limits apply, PA required to exceed.		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ONDANSETRON† Injection (vial and premix) ONDANSETRON†tablet 4 mg (12 tabs/28 days), 8 mg (6 tabs/28 days) ONDANSETRON† ODT 4 mg (12 tabs/28 days), 8 mg (6 tabs/28 days	Akynzeo® (nutupitant/palonosetron) Anzemet® (dolansetron) 50 mg (4 tabs/28 days) Anzemet® (dolansetron) 100 mg (2 tabs/28 days) Granisetron† (formerly Kytril®) 1 mg (6 tabs/28 days) Granisetron† (formerly Kytril®) Injectable Ondansetron† (generic) Oral Solution 4 mg/5 ml Sancuso® 3.1 mg/24 hrs Transdermal Patch (granisetron) (Qty Limit = 4 patches/28 days) Sustol® (granisetron) injection 10mg/0.4ml QL = 4 injections per 28 days Zofran®* (ondansetron) Injection Zofran®* (ondansetron) Oral Tablets and ODT 4 mg (12 tabs/28 days), 8 mg (6 tabs/28 days) Zofran® (ondansetron) Oral Solution 4 mg/5 ml Zuplenz® (ondansetron) Oral Soluble Film *(Quantity Limit =12 films/28 days (4 mg), 6 films/28 days (8 mg))*	**Akynzeo:** Has a diagnosis of nausea and vomiting associated with cancer chemotherapy AND patient has a documented side effect, allergy, or treatment failure of a regimen consisting of a 5-HT3 antagonist, an NK1 antagonist, and dexamethasone **Anzemet:** has a diagnosis of nausea and vomiting associated with cancer chemotherapy. AND patient has had a documented side effect, allergy, or treatment failure to generic ondansetron. **Granisetron:** patient has a diagnosis of nausea and vomiting associated with cancer chemotherapy or radiotherapy. AND patient has had a documented side effect, allergy, or treatment failure to generic ondansetron. **Zofran:** The patient has a diagnosis of nausea and vomiting associated with cancer chemotherapy, radiotherapy, post-operative nausea and vomiting (1 time only) or hyperemesis gravadarum. AND patient must have a documented intolerance to the corresponding generic ondansetron product (tablets, orally disintegrating tablets (ODT), oral solution or injection). If the request is for oral solution, the patient must be unable to use ondansetron ODT or ondansetron tablets. **Ondansetron Oral Sol:** patient has a diagnosis of nausea and vomiting associated with cancer chemotherapy, radiotherapy, post-operative nausea and vomiting (1 time only) or hyperemesis gravadarum. AND patient is unable to use ondansetron ODT or ondansetron tablets. **Sancuso:** patient has a diagnosis of nausea and vomiting associated with cancer chemotherapy. AND prescriber provides documentation of medical necessity for the transdermal formulation. OR patient has had a documented side effect, allergy or treatment failure with generic ondansetron. **Sustol:** Patient has a diagnosis of nausea and vomiting associated with cancer chemotherapy or radiotherapy AND prescriber provides documentation of medical necessity for the specialty dosage form (i.e. inability to swallow tablets, dysphagia) AND the patient has a documented side effect, allergy, or treatment failure with Ondansetron injection and Sancuso transdermal. **Zuplenz:** patient has a diagnosis of nausea and vomiting associated with cancer chemotherapy or radiotherapy. AND prescriber provides documentation of medical necessity for the specialty dosage form (i.e. inability to swallow tablets, dysphagia) AND a clinical rationale as to why ondansetron ODT is not a suitable option for the patient. **CRITERIA FOR APPROVAL (to exceed quantity limit):** **Ondansetron/Zofran 4 mg and 8 mg tablets and ODT, Zuplenz:** For nausea and vomiting associated with chemotherapy or radiation therapy, 3 tablets for each day of chemotherapy/radiation and 3 tablets for each day for 2 days after completion of chemotherapy/radiation may be approved. **Ondansetron/Zofran 4 mg and 8 mg tablets and ODT:** For hyperemesis gravadarum, three tablets per day of 4 mg or 8 mg may be approved for 3 months. **Anzemet:** For nausea and vomiting associated with chemotherapy, 1 tablet for each day of chemotherapy and 1 tablet for 2 days after completion of chemotherapy may be approved.

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

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		Cesamet® are FDA-approved for use in chemotherapy associated nausea and vomiting refractory to conventional antiemetics. In addition, Marinol® is indicated for patients with AIDS-related anorexia or wasting syndrome. **Dronabinol/Marinol:** patient has a diagnosis of chemotherapy-induced nausea/vomiting AND patient has had a documented side effect, allergy, or treatment failure to at least 2 antiemetic agents, of which, one must be a preferred 5HT3 receptor antagonist. If the request is for Marinol, the patient must additionally have a documented intolerance to generic dronabinol. OR patient has a diagnosis of AIDS associated anorexia. AND patient has had an adequate response, adverse reaction, or contraindication to megestrol acetate. If the request is for Marinol, the patient must additionally have a documented intolerance to generic dronabinol. **Cesamet:** patient has a diagnosis of chemotherapy-induced nausea/vomiting AND patient has had a documented side effect, allergy, or treatment failure to at least 2 antiemetic agents, of which, one must be a preferred 5HT3 receptor antagonist.
ANTI-HYPERTENSIVES		
ACE INHIBITORS		
BENAZEPRIL† (compare to Lotensin®) ENALAPRIL† (compare to Vasotec®) EPANED® (enalapril) oral solution (age < 12 years old) FOSINOPRIL† (formerly Monopril®) LISINOPRIL† (compare to Zestril®, Prinivil®) QUINAPRIL† (compare to Accupril®) RAMIPRIL† (compare to Altace®) TRANDOLAPRIL† (compare to Mavik®)	Accupril®*(quinapril) Altace® (Ramipril) Captopril Epaned® (enalapril) oral solution (age ≥ 12 years old) Lotensin®* (benazepril) Mavik®* (trandolapril) perindopril Moexepril Prinivil®* (lisinopril) Qbrelis® (Lisinopril) 1mg/ml solution Vasotec®* (enalapril) Zestril®* (lisinopril)	**Epaned Oral Solution (Patients > 12 years old):** patient has a requirement for an oral liquid dosage form (i.e. swallowing disorder, inability to take oral medications). **Qbrelis Oral Solution:** patient has a requirement for an oral liquid dosage form (i.e. swallowing disorder, inability to take oral medications) AND has a side effect, allergy, or treatment failure to Epaned oral solution. **Other ACE Inhibitors:** patient has had a documented side effect, allergy, or treatment failure to all available preferred generic ACEI. If a medication has an AB rated generic, there must have been a trial of the generic formulation.
ACE INHIBITOR W/ HYDROCHLOROTHIAZIDE		
BENAZEPRIL/HYDROCHLOROTHIAZIDE† (compare to Lotensin HCT®) CAPTOPRIL/HYDROCHLOROTHIAZIDE	Accuretic®* (quinapril/HCTZ) Lotensin HCT®* (benazepril/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

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ENALAPRIL/HYDROCHLOROTHIAZIDE† (compare to Vaseretic®) FOSINOPRIL/HYDROCHLOROTHIAZIDE† (formerly Monopril HCT®) LISINOPRIL/HYDROCHLOROTHIAZIDE† (compare to Zestoretic®, MOEXIPRIL/HYDROCHLOROTHIAZIDE† (formerly Uniretic®) QUINAPRIL/HYDROCHLOROTHIAZIDE† (compare to Accuretic®)	Vaseretic®* (enalapril/HCTZ) Zestoretic®* (lisinopril/HCTZ)	rated generic, there must have been a trial of the generic formulation.
ACE INHIBITOR W/CALCIUM CHANNEL BLOCKER		
AMLODIPINE/BENAZEPRIL † (compare to Lotrel®) TRANDOLAPRIL/VERAPAMIL (Tarka®)	Lotrel®* amlodipine/(benazepril) Prestalia® (perindopril/amlodipine) Tarka® (trandolopril/verapamil)	**Lotrel, Tarka:** The patient has had a documented side effect, allergy, or treatment failure to the generic formulation. **Prestalia:** The patient has had a documented side effect, allergy, or treatment failure to amlodipine/benazepril AND the patient is unable to take perindopril and amlodipine as the individual separate agents.
ANGIOTENSIN RECEPTOR BLOCKERS (ARBs)		
IRBESARTAN† (compare to Avapro®) § LOSARTAN† (compare to Cozaar®) § MICARDIS® (telmisartan) VALSARTAN† (compare to Diovan®)	Atacand® (candesartan) Avapro® (irbesartan) Benicar® (olmesartan) § candesartan† (compare to Atacand®)§ Cozaar® (losartan) Diovan® (valsartan) § Edarbi® (azilsartan) Tablet *(Qty Limit = 1 tablet/day)* Eprosartan Olmesartan (compare to Benicar®) Telmisartan† (compare to Micardis®) §	**Atacand, Avapro, Benicar, Candasartan, Cozaar, Diovan, Edarbi, Eprosartan, Olmesartan, and Telmisartan:** Patient has had a documented side effect, allergy, or treatment failure with a preferred Angiotensin Receptor Blocker (ARB) or ARB combination. AND If brand name product with generic available, the patient has had a documented intolerance with the generic product.
ANGIOTENSIN RECEPTOR BLOCKER/DIURETIC COMBINATIONS		
IRBESARTAN/HYDROCHLOROTHIAZIDE† (compare to Avalide®) § LOSARTAN/HYDROCHLOROTHIAZIDE † (compare to Hyzaar®) §	Atacand HCT® (candesartan/hydrochlorothiazide) Avalide® (irbesartan/hydrochlorothiazide) Benicar HCT® (olmesartan/hydrochlorothiazide) candesartan/hydrochlorothiazide † (compare to Atacand	**Atacand HCT, Avalide, Benicar HCT, candesartan/HCTZ, Diovan HCT, Edarbyclor, Hyzaar, 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

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
MICARDIS HCT® (telmisartan/hydrochlorothiazide) VALSARTAN/HYDROCHLOROTHIAZIDE † (compare to Diovan HCT®) §	HCT®) § Diovan HCT® (valsartan/hydrochlorothiazide) Edarbyclor® (azilsartan/chlorthalidone) Tablet *(Qty Limit = 1 tablet/day)* Hyzaar® (losartan/hydrochlorothiazide) Telmisartan/hydrochlorothiazide † (compare to Micardis HCT®) §	generic product.
ANGIOTENSIN RECEPTOR BLOCKER/CALCIUM CHANNEL BLOCK COMBINATIONS		
Preferred After Clinical Criteria Are Met VALSARTAN/AMLODIPINE† (compare to Exforge®) *(QL= 1tab/day)*	Azor®(olmesartan/amlodipine) *(QL = 1 tablet/day)* amlodipine/telmisartan† (compare to Twynsta®) *(QL = 1 tablet/day)* Exforge® (valsartan/amlodipine) *(QL = 1 tab/day)* Olmesartan/amlodipine (compare to Azor®) Twynsta® (amlodipine/telmisartan) *(QL = 1 tablet/day)*	**Valsartan/amlodipine, Exforge:** patient has had a documented side effect, allergy, or treatment failure to an angiotensin converting enzyme inhibitor (ACEI), an ACEI combination or any other angiotensin receptor blocker (ARB) or ARB combination.AND if the request is for Exforge, the patient has had a documented intolerance with the generic product. **Azor, Amlodipine/Telmisartan, Olmesartan/amolodipine, Olmesartan/amlodipine/HCTZ and Twynsta:** The patient has had a documented side effect, allergy, or treatment failure to an angiotensin converting enzyme inhibitor (ACEI), an ACEI combination or any other angiotensin receptor blocker (ARB) or ARB combination AND if the request is for a brand name product with generic available the patient has had a documented intolerance with the generic.
ANGIOTENSIN RECEPTOR BLOCKER/CALCIUM CHANNEL BLOCKER/HCTZ COMBO		
Preferred After Clinical Criteria Are Met EXFORGE HCT® (amlodipine/valsartan/hydrochlorothiazide) § *(Quantity Limit = 1 tablet/day)* VALSARTAN/AMLODIPINE/HCTZ† (compare to Exforge HCT®) (QL = 1/day)	Tribenzor® (amlodipine/olmesartan/hydrochlorothiazide) *(QL = 1 tablet/day)*	**Valsartan/amlodipine/HCTZ, Exforge HCT, Tribenzor:** patient has had a documented side effect, allergy, or treatment failure to an angiotensin converting enzyme inhibitor (ACEI), an ACEI combination or any other angiotensin receptor blocker (ARB) or ARB combination.
ANGIOTENSIN RECEPTOR BLOCKER/MISCELLANEOUS COMBINATIONS		
Preferred Agent After Clinical Criteria Is Met ENTRESTO® (valsartan/sacubitril) (QL = 2 tabs/day)	Byvalson® (Nebivolol/Valsartan)	**Entresto®:** Diagnosis of chronic heart failure NYHA Class II-IV AND Age ≥ 18 years of age AND left ventricular ejection fraction ≤ 40% AND no history of angioedema or unacceptable side effects during receipt of ACE inhibitor or ARB AND not to be used concomitantly with aliskiren in patients with diabetes or concurrently with an ACE inhibitor or other ARB AND no severe hepatic impairment (Child-Pugh C).

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		Byvalson: The patient must have a documented side effect, allergy, or treatment failure to at least 3 preferred beta blockers and a preferred ARB used in combination AND is unable to take Bystolic and valsartan as the individual separate agents.
BETA BLOCKERS		
<u>SINGLE AGENT</u> ACEBUTOLOL† ATENOLOL† (compare to Tenormin®) BISOPROLOL FUMARATE† CARVEDILOL† (compare to Coreg®) LABETALOL† (compare to Trandate®) METOPROLOL TARTRATE† (compare to Lopressor®) METOPROLOL SUCCINATE XL† (compare to Toprol XL®) PINDOLOL† (formerly Visken®) PROPRANOLOL PROPRANOLOL ER (compare to Inderal LA®) SOTALOL† (compare to Betapace®, Betapace AF®)	Betapace®* (sotalol) Betapace AF®* (sotalol) Betaxolol Bystolic® (nebivolol) *(QL = 1 tablet/day for 2.5 mg, 5 mg and 10 mg tablet strengths, 2 tablets/day for 20 mg tab)* Coreg®* (carvedilol) Coreg CR® (carvedilol CR) *(QL = 1 tablet/day* Corgard®* (nadolol) Hemangeol® oral solution (propranolol) Inderal LA®* (propranolol ER) Inderal XL® (propranolol SR) Innopran XL® (propranolol SR) Lopressor®* (metoprolol tartrate) Nadolol Sorine® (sotalol) Tenormin®* (atenolol) Timolol† (formerly Blocadren®) Toprol XL®* (metoprolol succinate XL) Trandate®* (labetaolol)	**Non-preferred drugs (except Coreg CR and Hemangeol):** patient has had a documented side effect, allergy, or treatment failure to at least three preferred drugs. (If a medication has an AB rated generic, one trial must be the generic formulation.) **Coreg CR:** <u>Indication: Heart Failure:</u> patient has been started and stabilized on Coreg CR. (Note: Samples are not considered adequate justification for stabilization.) OR patient has had a documented side effect, allergy, or treatment failure to metoprolol SR or bisoprolol. AND patient has been unable to be compliant with or tolerate twice daily dosing of carvedilol IR. <u>Indication; Hypertension:</u> patient has been started and stabilized on Coreg CR. (Note: Samples are not considered adequate justification for stabilization.) OR patient has had a documented side effect, allergy, or treatment failure to 3(three) preferred anti-hypertensive beta-blockers. **Hemangeol:** indication for use is the treatment of proliferating infantile hemangioma
<u>BETA-BLOCKER/DIURETIC COMBINATION</u> ATENOLOL/CHLORTHALIDONE † (compare to Tenoretic®) BISOPROLOL/HYDROCHLOROTHIAZIDE† (compare to Ziac®) METOPROLOL/HYDROCHLOROTHIAZIDE† (compare to Lopressor HCT®)	Corzide®* (nadolol/bendroflumethiazide) Lopressor HCT®* (metoprolol/HCTZ) Propranolol/HCTZ† (formerly Inderide®) Tenoretic®* (atenolol/chlorthalidone) Ziac®* (bisoprolol/HCTZ) Dutoprol® (metoprolol succinate XR/hydrochlorothiazide)	

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

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
CENTRAL ALPHA AGONISTS		
ORAL **Tablet** CLONDIDNE IR† Tablets (compare to Catapress®) GUANFACINE IR† Tablets (compare to Tenex®) METHYLDOPA† Tablets	Catapres®* (clonidine) Tablet	**Catapres tablets:** Patient has a documented intolerance to the generic product. **Clonidine Patches (generic):** patient has a documented intolerance to brand Catapres-TTS patches
TRANSDERMAL CATAPRES-TTS® (clonidine) Transdermal Patch (Qty Limit = 1 patch/7 day)	Clonidine (compare to Catapres-TTS) Transdermal Patch *(Qty Limit = 1 patch/7 days)*	
GANGLIONIC BLOCKERS		
All products require a PA	Vecamyl®* (mecamylamine) Tablet	**Vecamyl tabs:** Patient has a diagnosis of moderately severe or severe hypertension AND patient has tried and failed, intolerant to, or contraindicated to at least THREE different antihypertension therapies of different mechanism of actions.
RENIN INHIBITOR		
	SINGLE AGENT Tekturna® (aliskiren) *(Quantity Limit = 1 tablet/day)* COMBINATIONS Tekturna HCT® (aliskiren/hydrochlorothiazide) *(Quantity Limit = 1 tablet/day)*	**Tekturna:** patient is NOT a diabetic who will continue on therapy with an ACEI or ARB AND patient has a diagnosis of hypertension. AND patient has had a documented side effect, allergy, or treatment failure with an angiotensin Receptor Blocker (ARB). **Tekturna HCT:** the patient must meed criteria as listed above for Tekturna and is unable to use the individual separate agents.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ANTI-INFECTIVES ANTIBIOTICS		
CEPHALOSPORINS 1ST GENERATION		
CAPSULES/TABLETS CEFADROXIL† Capsules, Tablets (formerly Duricef®) CEPHALEXIN† Capsules (compare to Keflex®) **SUSPENSION** CEFADROXIL† Suspension (formerly Duricef®) CEPHALEXIN† Suspension (formerly Keflex®) IV drugs are not managed at this time	Cephalexin® Tablets Keflex®* (cephalexin) Capsules	**Cephalexin Tabs:** patient has had a documented intolerance to cephalexin generic capsules. **Keflex:** patient has had a documented side effect, allergy, or treatment failure to generic cefadroxil and cephalexin. **Limitations:** Cephalexin and Keflex 750 mg dosage strength not covered. Use alternative strengths.
CEPHALOSPORINS 2ND GENERATION		
CAPSULES/TABLETS CEFACLOR† CAPSULE CEFPROZIL† (formerly Cefzil®) TABLET CEFUROXIME † (compare to Ceftin®) TABLET **SUSPENSION** CEFACLOR SUSPENSION CEFPROZIL† (formerly Cefzil®) SUSPENSION IV drugs are not managed at this time	Cefaclor® ER Tablet Ceftin®* (cefuroxime) tablet Ceftin® (cefuroxime) suspension	**Cefaclor ER Tabs:** patient has had a documented intolerance to cefaclor capsules. **Ceftin Tabs:** patient has had a documented side effect, allergy, or treatment failure to at least two of the following medications: cefaclor, cefprozil, and cefuroxime. One trial must be the generic formulation. **Ceftin Suspension:** patient has had a documented side effect, allergy, or treatment failure to both of the following suspensions: cefaclor and cefprozil.
CEPHALOSPORINS 3RD GENERATION		
CAPSULES/TABLETS CEFDINIR† (formerly Omnicef®) CAPSULE **SUSPENSION** CEFDINIR† (formerly Omnicef®) SUSPENSION IV drugs are not managed at this time	Cedax® (ceftibuten) capsule Cefpodoxime proxetil tablet ceftibuten†capsule (compare to Cedax®) Suprax® (cefixime) Capsule Suprax® (cefixime) Chewable Tablets Cedax® (ceftibuten) suspension Cefixime suspension Cefpodoxime proxetil suspension	**Spectracef tablet, Cedax® Capsule, Cefditoren tablet, Ceftibuten capsule, Cefpodoxime Proxetil tablets:** patient is completing a course of therapy which was initiated in the hospital. OR patient has had a documented side effect, allergy, or treatment failure to one preferred cephalosporin. **Cedax Susp, Ceftibuten Susp, Cefpodoxime Proxetil Susp, Cefixime Susp, Suprax Susp:** patient is completing a course of therapy which was initiated in the hospital. OR patient has had a documented side effect or treatment failure to cefdinir suspension.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	ceftibuten†suspension (compare to Cedax®) Suprax® (cefixime) suspension	
KETOLIDES		
	Ketek® (telithromycin)	**Ketek:** member is continuing a course of therapy initiated while an inpatient at a hospital. OR diagnosis or indication for the requested medication is community-acquired pneumonia. AND member is at least 18 years of age at the time of the request. AND member has no contraindication or a history of hypersensitivity or serious adverse event, from any macrolide antibiotic. AND Infection is due to documented Streptococcus pneumoniae (including multi-drug resistant [MDRSP*] s.pneumoniae), Haemophilus influenzae, Moraxella catarrhalis, Chlamydophila pneumoniae, or Mycoplasma pneumoniae AND member has had a documented therapeutic failure with all clinically appropriate alternatives. AND member does not have any of the following medical conditions: myasthenia gravis, hepatitis or underlying liver dysfunction, history of arrhythmias (e.g. QTc prolongation, or antiarrhythmic therapy), uncorrected hypokalemia or hypomagnasemia, clinically significant bradycardia, a history of therapy with Class IA (e.g. quinidine or procainamide) or Class III (e.g. dofetilide) antiarrhythmic medications.
MACROLIDES		
Azithromycin AZITHROMYCIN† tabs, liquid (≤ 5 day supply) (compare to Zithromax®) (Maximum 10 days therapy/30 days) **Clarithromycin** CLARITHROMYCIN† (compare to Biaxin®)	azithromycin† tablets and liquid (if > 5 day supply) (compare to Zithromax®) (Maximum 10 days therapy/30 days) Azithromycin† packet (compare to Zithromax®) *(QL = 2 grams/fill)* Zithromax®* (azithromycin) tablets and liquid *QL = 5 days supply/RX, maximum 10 days therapy/30 days* Zithromax® (azithromycin) packet *(QL=2 grams/fill)* Zmax® Suspension (azithromycin extended release for oral suspension) *QL = 5 days supply/RX, maximum 10 days therapy/30 days* Biaxin®* (clarithromycin) Clarithromycin SR† (compare to Biaxin® XL)	**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:** patient has a diagnosis of Lyme Disease AND has had a documented side effect, allergy, or treatment failure to at least two of the following: doxycycline, amoxicillin, or a 2nd generation cephalosporin. For early Lyme disease, without neurologic or rheumatologic (arthritis) complications, the length of authorization is up to 10 days. For neurologic or rheumatologic Lyme disease, the length of authorization is up to 28 days OR patient has a diagnosis of Cystic Fibrosis. (length of authorization up to 6 months) OR patient has a diagnosis of HIV/immunocompromised status and azithromycin is being used for MAC or Toxoplasmosis treatment or prevention. (length of authorization up to 6 months) OR patient has a diagnosis of bacterial sinusitis AND has had a

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
Erythromycin **Fidaxomicin** IV drugs are not managed at this time	E.E.S®† (erythromycin ethylsuccinate) ERY-TAB® (erythromycin base, delayed release) ERYTHROMYCIN BASE† ERYTHROMYCIN ETHYLSUCCINATE† (compare to E.E.S®) Eryped® (erythromycin ethylsuccinate) Erythrocin (erythromycin stearate) PCE Dispertab® (erythromycin base) Dificid® (fidaxomicin) tablet *(Quantity limit =2 tablets per day, 10 day supply per 30 days)*	documented side effect, allergy, or treatment failure to penicillin, amoxicillin, or sulfamethoxazole/trimethoprim (Bactrim). (length of authorization up to 10 days) OR patient has a diagnosis of severe bronchiectasis with frequent exacerbations (length of authorization up to 6 months) **Dificid:** patient's diagnosis or indication is Clostridium difficile associated diarrhea (CDAD) AND patient has had a side-effect, allergy, treatment failure or contraindication to metronidazole. OR prescriber provides a clinically compelling rationale why metronidazole is not appropriate for the patient. (E.g. patient has severe Clostridium difficile infection, history of recurrent infections). AND patient has had a side-effect, allergy, treatment failure or contraindication to oral vancomycin capsules (Vancocin).
OXAZOLIDINONES		
IV form of this medication not managed at this time	Sivextro® (tedizolid) (*Quantity limit = 1 tabs/day)* Zyvox® (linezolid) *(QL = 56 tablets per 28 days)* Zyvox® (linezolid) suspension (*QL = 60 ml/day, maximum 28 days supply)*	**Criteria for Approval:** patient has been started on intravenous or oral linezolid or tedizolid in the hospital and will be finishing the course of therapy in an outpatient setting OR patient has a documented blood, tissue, sputum, or urine culture that is positive for Vancomycin-Resistant Enterococcus (VRE) species. OR patient has a documented blood or sputum culture that is positive for Methicillin-Resistant Staphylococcus species OR patient has a documented tissue or urine culture that is positive for Methicillin-Resistant Staphylococcus AND patient has had a documented treatment failure with trimethoprim/sulfamethoxazole OR there is a clinically valid reason that the patient cannot be treated with trimethoprim/sulfamethoxazole.
PENICILLINS (ORAL)		
SINGLE ENTITY AGENTS **Natural Penicillins** PENICILLIN V POTASSIUM† (formerly Veetids®) tablets, oral solution **Penicillinase-Resistant Penicillins** DICLOXACILLIN† Capsules **Aminopenicillins** AMOXICILLIN† (formerly Amoxil®) capsules, tablets, chewable tablets, suspension AMPICILLIN† (formerly Principen®) capsules, suspension	Moxatag® (amoxicillin extended release) tablet *QL =1 tablet/day*	**Augmentin:** patient has had a documented intolerance to the generic formulation of the requested medication. OR patient is < 12 weeks of age and requires the 125 mg/5 mL strength of Augmentin. **Amoxicillin/Clavulanate ER, Augmentin XR, Moxatag**: prescriber must provide a clinically valid reason for the use of the requested medication. Additionally, for approval of brand Augmentin XR, the patient must have a documented intolerance to generic Amoxicillin/Clavulanate ER **Limitations:** Brand Augmentin® Chewable tablets do not offer Federal Rebate and therefore cannot be provided.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
COMBINATION PRODUCTS AMOXICILLIN/CLAVULANATE† (compare to Augmentin ®) tablets, chewable tablets, suspension AMOXICILLIN/CLAVULANATE† 600-42.9mg/5ml (formerly Augmentin ES®) suspension	Amoxicillin/clavulanate† ER (compare to Augmentin XR®) tablets Augmentin®*♣ (amoxicillin/clavulanate) tablets, suspension Augmentin XR® (amoxicillin/clavulanate) tablets PA will be granted for 125 mg/5 mL strength for patients < 12 weeks of age	
QUINOLONES		
CIPROFLOXACIN† (compare to Cipro®) tabs, oral suspension LEVOFLOXACIN † (compare to Levaquin®) tabs, sol OFLOXACIN† IV drugs are not managed at this time	Avelox® (moxifloxacin HCL) Avelox ABC PACK® (moxifloxacin HCL) Cipro® * (ciprofloxacin) tabs, oral suspension Cipro XR® (ciprofloxacin) ciprofloxacin ER† (compare to Cipro XR®) Levaquin®* (levofloxacin) tabs,sol moxifloxacin† (compare to Avelox®)	**Cipro, Cipro XR, ciprofloxacin ER:** patient has had a documented side effect, allergy, or treatment failure to generic ciprofloxacin immediate-release tablets or oral suspension. AND If the request is for Cipro XR or Cipro the patient has had a documented intolerance to the generic equivalent. **Avelox, Moxifloxacin:** patient is completing a course of therapy with the requested medication that was initiated in the hospital. OR patient has had a documented side effect, allergy, or treatment failure to levofloxacin. AND If the request is for Avelox, the patient has had a documented intolerance to generic moxifloxacin. **Levaquin (brand):** patient has a documented intolerance with the generic levofloxacin
RIFAMYCINS		
	Xifaxan ® (rifaximin) 200 mg Tablets *(Qty limit depends on indication)* Xifaxan ® (rifaximin) 550 mg Tablets *(Qty limit depends on indication)*	**Criterial for Approval: Based on Indication:** **Hepatic Encephalopathy (Xifaxan 550 mg Tablets Only):** patient has a diagnosis of hepatic encephalopathy. AND Patient has had a documented side effect, allergy, treatment failure or contraindication to lactulose. AND Quantity limit is 2 tablets/day (550 mg tablets only). **Traveller's Diarrhea (Xifaxan 200 mg Tablets Only**): patient has a diagnosis of traveller's diarrhea caused by noninvasive strains of Escherichia coli. AND Patient has had a documented side effect, allergy, treatment failure or contraindication with a fluoroquinolone. AND Quantity limit is 9 tablets/RX (200 mg tablets only). **Small Intestinal Bacterial Overgrowth (Xifaxan 550 mg or 200 mg Tablets:** patient has a diagnosis of SIBO. AND Patient has attempted dietary modification and has had a documented side effect, allergy, treatment failure or

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		contraindication to (alone or in combination) one of the following: Amoxicillin-clavulanate, cephalosporin, metronidazole, fluoroquinolone, tetracycline, and trimethoprim-sulfamethoxazole. AND Quantity limit is 800 mg to 1,200 mg/day. **Irritable Bowel Syndrome (Xifaxan 550 mg or 200 mg Tablets):** patient has a diagnosis of irritable bowel syndrome without constipation or with symptoms of bloating. AND Patient has attempted dietary modification and has had a documented side effect, allergy, treatment failure or contraindication to two of the following classes (one of which must be an antibiotic): • Antibiotics (alone or in combination: amoxicillin-clavulanate, cephalosporin, metronidazole, fluoroquinolone, tetracycline, trimethoprim-sulfamethoxazole) • SSRIs • TCAs • Antispasmodics • Antidiarrheals • Cholestyramine resin AND Quantity limit is 1,200 mg to 1,650 mg/day. **Inflammatory Bowel Disease: Crohn's Disease (Xifaxan 550 mg or 200 mg Tablets):** patient has a diagnosis of Crohn's Disease. AND Patient has had a documented side effect, allergy, treatment failure or contraindication to two of the following: 6-mercaptopurine, aminosalicylates, azathioprine, corticosteroids, fluoroquinolone and/or metronidazole. AND Quantity limit is 600 mg to 1,600 mg/day. **Inflammatory Bowel Disease: Ulcerative Colitis (Xifaxan 200 mg Tablets):** patient has a diagnosis of Ulcerative Colitis. AND Patient has had a documented side effect, allergy, treatment failure or contraindication to two of the following: 6-mercaptopurine, aminosalicylates, azathioprine, corticosteroids, fluoroquinolone and/or metronidazole. AND Quantity limit is 800 mg/day (4 x 200 mg tablets/day). **Clostridium difficile Diarrhea (Xifaxan 200 mg Tablets):** patient has a diagnosis of C. difficile diarrhea. AND Patient has had a documented side effect, allergy, treatment failure or contraindication to metronidazole. AND Quantity limit is 800 mg/day (4 x 200 mg tablets/day).
VANCOMYCIN		
IV vancomycin products are not managed at this time	Vancocin® (vancomycin) Capsules Vancomycin† (compare to Vancocin®) Capsules	**Criteria for Approval:** patient's diagnosis or indication is enterocolitis caused by Staphylococcus aureus. OR patient's diagnosis or indication is antibiotic-associated pseudomembranous colitis caused by Clostridium AND patient has had a therapeutic failure, adverse reaction or contraindication to metronidazole OR prescriber provides a clinically compelling rationale why metronidazole is not appropriate for the patient. (e.g. patient has severe Clostridium difficile infection, history of recurrent infections). AND For approval of brand Vancocin, the patient must meet the above criteria and have a documented

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

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		reason that itraconazole 100 mg generic capsules cannot be used AND meets at least 1 of the following criteria: Pain to affected area that limits normal activity, Diabetes Mellitus, Patient has significant vascular compromise **Limitations:** Coverage of Onychomycosis agents will NOT be approved solely for cosmetic purposes. **Voriconazole/Vfend:** Patient has a diagnosis of invasive aspergillosis. OR patient is completing a course of therapy with the requested medication that was initiated in the hospital. OR patient has a documented side-effect, allergy, or treatment failure to ONE of the preferred medications AND itraconazole. AND For approval of Vfend® tablets, the patient must have a documented intolerance to generic voriconazole. AND For approval of voriconazole suspenion, the patient must have a medical necessity for a liquid dosage form. For approval of Vfend® suspension, the patient must additionally have a documented intolerance to generic voriconazole suspension. **Noxafil:** patient has a diagnosis of HIV/immunocompromised status (neutropenia secondary to chemotherapy, hematopoietic stem cell transplant recipients) AND Noxafil is being used for the prevention of invasive Aspergillosis/Candida infections. OR patient is completing a course of therapy with the requested medication that was initiated in the hospital. OR Oral Suspension ONLY patient has a documented side-effect, allergy, or treatment failure to ONE of the preferred medications AND itraconazole AND the patient is being treated for oropharyngeal candidiasis. **Diflucan (brand):** For approval of Diflucan brand name product, the patient must have a documented intolerance to generic fluconazole**Oravig:** The indication for use is treatment of oropharyngeal candidiasis AND patient has had a docuemtned side effect, allergy, treatment failure/inadequate response to both nystatin suspension and clotrimazole troche. **Oravig:** The indication for use is treatment of oropharyngeal candidiasis AND patient has had a documented side effecr, allergy, or treatment failure/inadequate response to both nystatin suspension and clotrimazole troche.
ANTI-INFECTIVES ANTIMALARIALS: QUININE		
	Quinine Sulfate † (compare to Qualquin®) Qualaquin® (quinine sulfate)	**Criteria for Approval**: diagnosis or indication is for the treatment of malaria. (Use for leg cramps not permitted.) AND If the request is for brand Qualaquin, the patient has a documented intolerance to the generic equivalent.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ANTI-INFECTIVES ANTI-VIRALS		
HERPES (ORAL)		
ACYCLOVIR† (compare to Zovirax®) tablets, capsules VALACYCLOVIR † (compare to Valtrex®) ZOVIRAX® suspension (age ≤ 12 yrs)	Acyclovir suspension Famciclovir † (compare to Famvir®)§ Famvir® (famciclovir) Sitavig® (acyclovir) Buccal Tablet *QL = 2 tablets/30 days* Valtrex®* (valacyclovir) Zovirax®*(acyclovir) tablets, capsules	**Acyclovir suspension:** The patient has a medical necessity for a non-solid oral dosage form AND has a documented intolerance to brand Zovirax suspension. **Zovirax suspension (age > 12 yrs):** The patient has a medical necessity for a non-solid oral dosage form. **Famciclovir, Zovirax (tabs, caps):** patient has a documented side effect or allergy, or treatment failure (at least one course of ten or more days) with acyclovir AND valacyclovir. **Famvir:** patient has a documented side effect or allergy, or treatment failure (at least one course of ten or more days) with acyclovir AND valacyclovir. AND patient has a documented intolerance to generic famciclovir. **Sitavig:** patient has a diagnosis of recurrent herpes labialis (cold sores). AND patient is immunocompetent AND patient has a documented side effect or treatment failure with acyclovir AND valacyclovir. **Valtrex:** patient has a documented intolerance to generic valacyclovir
INFLUENZA MEDICATIONS		
Preferred After Clinical Criteria Are Met RELENZA® (zanamivir) *QL= 20 blisters / 30 days* TAMIFLU® (oseltamivir) *QL=10 capsules/30 days(45 mg & 75 mg caps) 20 capsules / 30 days (30 mg caps) 180 ml (6 mg/ml) / 30 days (suspension)*		**Tamiflu, Relenza:** Tamiflu and Relenza will NOT require prior-authorization at this time when prescribed within the following quantity limits: **Relenza:** 20 blisters per 30 days **Tamiflu:** 75mg or 45mg: 10 caps per 30 day **Tamiflu:** 30mg: 20 caps per 30 days **Tamiflu:** Suspension (6mg/ml): 180ml (3 bottles) per 30 days **Limitations:** Amantadine, Flumadine and rimantadine are not CDC recommended for use in influenza treatment or chemoprophylaxis at this time and are not covered for this indication. For information regarding amantadine see "Parkinsons Medications".
INFLUENZA VACCINES		
SEASONAL Influenza Vaccine INJECTION **Inactivated Influenza Vaccine, Trivalent (IIV3), Standard Dose (egg based)** AFLURIA® Injection	**Inactivated Influenza Vaccine, Trivalent (IIV3), Standard Dose (egg based)** Fluad™ Injection	**Flucelvax Quadrivalent:** Prescriber provides clinical rationale why one of the preferred influenza vaccines cannot be used. **Flublok:** Patient must have a documented severe reaction to egg based influenza vaccine. **Fluzone High Dose, Fluad:** Vaccine is being requested for influenza prophylaxis

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
FLUVIRIN® Injection **Inactivated Influenza Vaccine, Quadrivalent (IIV4),** **Standard Dose (egg based)** FLUARIX® QUADRIVALENT Injection FLULAVAL® QUADRIVALENT Injection FLUZONE® QUADRIVALENT Injection FLUZONE INTRADERMAL® Injection	**Inactivated Influenza Vaccine, Trivalent (IIV3), High Dose (egg based)** Fluzone High-Dose® Injection **Recombinant Influenza Vaccine, Trivalent (RIV3) (egg FREE)** Flublok® Injection **Inactivated Influenza Vaccine, Quadrivalent (ccIIV4), Standard Dose (cell culture based) (NOT egg free)** Flucelvax Quadrivalent® Injection	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 Zostavax		**Gardasil**: Covered for 19 years old to 26 years old (those under 19 should be referred to their pediatrician or PCP for state-supplied vaccine) **Zostavax:** Covered if ≥ 60 years of age Vaccines on the Advisory Committee on Immunization Practices (ACIP) list of recommended vaccines for children ≤ 18 years of age are supplied through the Vaccines for Children program administered by the Vermont Department of Health, and are not available through DVHA's pharmacy programs • Vaccines on the ACIP list of recommended vaccines for adults ≥ 19 years of age are available at many primary care provider offices and through the pharmacy programs. Vaccines are subject to the same limitations as the ACIP guideline recommendations. Providers who participate in the Blueprint for Health initiative must enroll in the Vaccines for Adults program administered by the Vermont Department of Health. The ACIP guidelines and information about enrollment in these programs can be found at 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
ANTI-MIGRAINE TRIPTANS		
Single Agent **ORAL** SUMATRIPTAN† (compare to Imitrex®) *Quantity Limit = 18 tablets/month (25 mg), 9 tablets/month (50 mg, 100 mg)* RELPAX® (eletriptan) 20 mg, 40 mg *Quantity Limit = 12 tablets/month* **After Sumatriptan Trial** RIZATRIPTAN† (compare to Maxalt®) *Quantity Limit = 12 tablets/month* RIZATRIPTAN ODT† (compare to Maxalt-MLT®) § *Quantity Limit = 12 tablets/month* **NASAL SPRAY** SUMATRIPTAN (compare to Imitrex®) *Quantity Limit =12 units/month (5 mg nasal spray),* *6 units/month (20 mg nasal spray)* **NASAL POWDER** All products require PA.	Almotriptan (compare to Axert®) 6.25mg, 12.5mg *Quantity Limit = 12 tablets/month* Amerge® (naratriptan) 1 mg, 2.5 mg *Quantity Limit = 9 tablets/month* Frova® (frovatriptan) 2.5 mg *Quantity Limit = 9 tablets/month* Frovatriptan (compare to Frova®) 2.5mg *Quantity Limit = 9 tablets/month* Imitrex®* (sumatriptan) *Quantity Limit = 18 tablets/month (25 mg), 9 tablets/month (50 mg, 100 mg),* Maxalt® (rizatriptan) 5 mg, 10 mg tablet *Quantity Limit = 12 tablets/month* Maxalt-MLT® (rizatriptan ODT) *Quantity Limit = 12 tablets/month* NARATRIPTAN† (compare to Amerge®) § (*Quantity Limit = 9 tablets/month)* Zomig® (zolmitriptan) tablets *Quantity Limit = 12 tablets/month (2.5 mg), 6 tablets/month (5 mg)* Zomig® ZMT (zolmitriptan ODT) *Quantity Limit = 12 tablets/month (2.5 mg), 6 tablets/month (5 mg)* Zolmitriptan† (compare to Zomig®) tablets *Quantity Limit = 12 tablets/month (2.5 mg), 6 tablets/month (5 mg)* Zolmitriptan† ODT (compare to Zomig® ZMT) *Quantity Limit = 12 tablets/month (2.5 mg), 6 tablets/month (5 mg)* Imitrex® (sumatriptan) *Quantity Limit =12 units/month (5 mg nasal spray),* *6 units/month (20 mg nasal spray)*	**Almotriptan, Amerge, 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. **Rizatriptan, Rizatriptan ODT:** patient has had a documented side effect, allergy, or treatment failure with Sumatriptan. **Treximet:** patient had a documented side effect, allergy or treatment failure with 2 preferred Triptans, AND patient is unable to take the individual components (sumatriptan and naproxen) separately. **Zomig Nasal Spray, Imitrex Nasal Spray, Onzetra Xsail:** patient has had a documented side effect, allergy or treatment failure with Sumatriptan Nasal Spray **Alsuma, Imitrex, Sumavel Dose Pro Injections, Zembrace**: patient has had a documented intolerance to generic sumatriptan injection. **To exceed quantity limits:** patient is taking a medication for migraine prophylaxis.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
INJECTABLE SUMATRIPTAN (compare to Imitrex®) *Quantity Limit =4 injections/month (4 or 6 mg injection)* **Combination Product (Oral)**	Zomig® (zolmitriptan) *Quantity Limit = 12 units/month (2.5 or 5 mg nasal spray)* Onzetra Xsail® (sumatriptan succinate) *Quantity Limit = 8 doses/30 days* Alsuma® (sumatriptan) 6 mg/0.5ml *Quantity Limit =4 injections/month* Imitrex® (sumatriptan) *Quantity Limit =4 injections/month (4 or 6 mg injection)* Sumavel DosePro® (sumatriptan) 6 mg/0.5ml, 4 mg/0.5 ml *Quantity Limit =4 injections/month* Zembrace® SymTouch (sumatriptan) 3mg/5ml Treximet® (sumatriptan/naproxen) *Quantity Limit = 9 tablets/month*	
ANTI-OBESITY		
Effective 10/12/2011, anti-obesity agents (weight loss agents) are no longer a covered benefit for all Vermont Pharmacy Programs. This change is resultant from Drug Utilization Review (DUR) Board concerns regarding safety and efficacy of these agents.		
ANTI-PSYCHOTIC ATYPICAL & COMBINATIONS (CHILDREN < 18 YEARS OLD)		
Preferred After Clinical Criteria Are Met **TABLETS/CAPSULES** ARIPIPRAZOLE (compare to Abilify®) FDA maximum recommended dose=30mgday, QL = 1.5 tabs/day (5mg, 10mg, & 15mg) OLANZAPINE† (compare to Zyprexa®) *FDA maximum recommended dose = 20 mg/day,*	Abilify® (aripiprazole) *FDA maximum recommended dose = 30 mg/day, Quantity limit = 1.5 tabs/day (5 mg, 10 mg & 15 mg tabs)* Clozapine† (compare to Clozaril®) *FDA maximum recommended dose = 900 mg/day*	**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;

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
Quantity limit = 1.5 tabs/day (2.5 mg, 5 mg, 7.5 mg & 10 mg tabs) RISPERIDONE† (compare to Risperdal®) *FDA maximum recommended dose = 16 mg/day* QUETIAPINE† (compare to Seroquel®) *FDA maximum recommended dose = 800 mg/day* ZIPRASIDONE† (compare to Geodon®) *FDA maximum recommended dose = 160 mg/day* ***Preferred After Clinical Criteria Are Met*** **ORAL SOLUTIONS** RISPERIDONE† (compare to Risperdal®) oral solution *FDA maximum recommended dose = 16 mg/day* **ORALLY DISINTEGRATING TABLETS**	Clozaril® *(clozapine)* *FDA maximum recommended dose = 900 mg/day* Geodon® (ziprasidone) *FDA maximum recommended dose = 160 mg/day* Invega® (paliperidone) *FDA maximum recommended dose = 12 mg/day* *Quantity limit = 1 tab/day (3mg, 9mg), 2 tabs/day (6mg)* Risperdal® (risperidone) *FDA maximum recommended dose = 16 mg/day* Seroquel® (quetiapine) *FDA maximum recommended dose = 800 mg/day* Saphris® (asenapine) *FDA maximum recommended dose = 20mg/day QL = 2 tabs/ day* Seroquel XR® (quetiapine XR) *FDA maximum recommended dose = 800 mg/day* *Quantity Limit = 1 tab/day* *(150 mg & 200 mg tablet strengths), 2 tabs/day (50 mg strength)* Zyprexa® (olanzapine) *FDA maximum recommended dose = 20 mg/day,* *Quantity limit = 1.5 tabs/day (2.5 mg, 5 mg, 7.5 mg & 10 mg tabs)* Abilify® (aripiprazole) oral solution *FDA maximum recommended dose = 25 mg/day* Risperdal® (risperidone) oral solution *FDA maximum recommended dose = 16 mg/day* Versacloz® (clozapine) Oral Suspension *FDA maximum recommended dose = 900 mg/day* *Quantity limit = 18 ml/day* Abilify® Discmelt (aripiprazole) *FDA maximum recommended dose = 30 mg/day,* *Quantity limit = 2 tabs/day (10 mg & 15 mg tabs)* clozapine orally disintegrating tablets† *(*Compare to FazaClo®)	Schizophrenia/Schizoaffective Disorder; Tourette's Syndrome. **Criteria for approval of ALL drugs:** Medication is being requested for one of the target symptoms or diagnoses listed above AND the patient is started and stabilized on the requested medication (Note: samples are not considered adequate justification for stabilization) OR patient meets additional criteria outlined below. Note: all requests for patients < 5 years will be reviewed by the DVHA medical director. **Invega/Saphris:** patient had had a documented side effect, allergy or treatment failure with at least two preferred products (typical or atypical antipsychotics) one of which is risperidone. **Abilify, Clozaril, Geodon, Risperdal, Seroquel, Zyprexa:** patient has a documented intolerance to the generic equivalent. **Clozapine:** patient has had a documented side effect, allergy or treatment failure with at least three other antipsychotic medications (typical or atypical antipsychotics), two of which must be preferred agents. **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. **Abilify Oral Solution:** patient has had a documented side effect, allergy or treatment failure with risperidone oral solution OR prescriber feels that risperidone would not be an appropriate alternative for the patient because of pre-existing medical conditions such as obesity or diabetes. **Versacloz Oral Solution:** AND patient has had a documented side effect, allergy or treatment failure with at least three other antipsychotic medications (typical or atypical antipsychotics). AND patient is unable to use clozapine orally disintegrating tablets. **Olanzapine ODT, Risperdal M-Tabs, Risperidone ODT, Zyprexa Zydis:** patient meets clinical criteria for non-orally disintegrating oral dosage forms of the same medication AND Medical necessity for a specialty dosage form has been provided AND if the request is for Risperdal M-tabs or Zyprexa Zydis, the patient has a documented intolerance to the generic equivalent. **Clozapine ODT, FazaClo:** Medical necessity for a specialty dosage form has been provided AND patient has had a documented side effect, allergy or treatment failure with at least three other antipsychotic medications (typical or atypical antipsychotics) If the request is for Fazaclo, the patient has a documented intolerance to the generic equivalent. **Abilify Discmelt** Medical necessity for a specialty dosage form has been provided AND patient has had a documented side effect, allergy or treatment failure with

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	FDA maximum recommended dose = 900 mg/day FazaClo® (clozapine orally disintegrating tablets) *FDA maximum recommended dose = 900 mg/day* Olanzapine orally disintegrating tablets† (compare to Zyprexa Zydis®) *FDA maximum recommended dose = 20 mg/day, Quantity limit = 1.5 tabs/day (5 mg & 10 mg tabs)* Risperdal® M-Tab (risperidone orally disintegrating tablets) *FDA maximum recommended dose = 16 mg/day* Risperidone† ODT (compare to Risperdal® M-Tab) *FDA maximum recommended dose = 16 mg/day* Zyprexa Zydis® (olanzapine orally disintegrating tablets) *FDA maximum recommended dose = 20 mg/day, Quantity limit = 1.5 tabs/day (5mg&10mg)*	Risperdal M-tab OR prescriber feels that risperidone would not be an appropriate alternative for the patient because of pre-existing medical conditions such as obesity or diabetes **Limitations:** Approval for use in Children < 18 years old will not be granted for the following medications or dosage forms due to no FDA approval for use in children and little or no literature to support their use in this population. Exceptions will be made for patients who have been started and stabilized on the requested medication or dosage form (Note: samples are not considered adequate justification for stabilization): Fanapt, Latuda, Rexulti, Vraylar, Geodon Im, Abilify IM, Olanzapine IM, Zyprexa IM, Abilify Maintena, Invega Sustenna, Invega Trinza, Risperdal Consta, Zyprexa Relprevv, Symbyax, Olanzapine/fluoxetine.
ANTI-PSYCHOTIC ATYPICAL & COMBINATIONS (ADULTS ≥ 18 YEARS OLD)		
TABLETS/CAPSULES ARIPIPRAZOLE (compare to Abilify®) *FDA maximum recommended dose=30mg/day, QL = 1.5 tabs/day (5mg, 10mg, & 15mg)* CLOZAPINE† (compare to Clozaril®) *FDA maximum recommended dose = 900 mg/day* OLANZAPINE† (compare to Zyprexa®) *FDA maximum recommended dose = 20 mg/day, Quantity limit = 1.5 tabs/day (2.5 mg, 5 mg, 7.5 mg & 10 mg tabs)* RISPERIDONE† (compare to Risperdal®) *FDA maximum recommended dose = 16 mg/day* QUETIAPINE† (compare to Seroquel®) > 50 mg/day *FDA maximum recommended dose = 800 mg/day* ZIPRASIDONE† (compare to Geodon®) *FDA maximum recommended dose = 160 mg/day*	Abilify® (aripiprazole) *FDA maximum recommended dose = 30 mg/day, Quantity limit = 1.5 tabs/day (5 mg, 10 mg & 15 mg tabs)* Clozaril®* *(clozapine)* *FDA maximum recommended dose = 900 mg/day* Fanapt® (iloperidone) *FDA maximum recommended dose = 24 mg/day* *Quantity limit = 2 tablets/day* Geodon®* (ziprasidone) *FDA maximum recommended dose = 160 mg/day* Invega® (paliperidone) *FDA maximum recommended dose = 12 mg/day* *Quantity limit = 1 tab/day (3mg, 9mg), 2tabs/day(6mg)* Latuda® (lurasidone) *FDA maximum recommended dose = 160 mg/day* *Quantity limit = 1 tablet/day all strengths except 80 mg = 2 tablets/day* Nuplazid™ (primavaserin) *FDA maximum recommended dose = 34mg, Quantity Limit = 2/tablets/day* Quetiapine (compare to Seroquel®) <50mg/day (adults >18 years old)	**Criteria for approval of ALL non-preferred drugs:** patient has been started and stabilized on the requested medication (Note: samples are not considered adequate justification for stabilization.) OR patient meets additional criteria outlined below. **Note**: Trazodone dosed at < 150mg/day will not be considered as a trial for adjunct treatment of MDD or any anxiety disorder. Bupropion will not be considered as a trial for adjunct treatment of any anxiety disorder. **Fanapt. Vraylar:** The indication for use is the treatment of schizophrenia/schizoaffective disorder or bipolar disorder. AND The patient has had a documented side effect, allergy or treatment failure with at least three preferred products (typical or atypical antipsychotics). **Invega, Saphris:** The indication for use is the treatment of schizophrenia/schizoaffective disorder AND The patient has had a documented side effect, allergy or treatment failure with at least three preferred products (typical or atypical antipsychotics), one of which is risperidone. Note: Prior therapy with injectable Invega Sustenna® is not considered to be started and stabilized for oral Invega. Patients transferring to oral therapy from Invega Sustenna® should transition to oral risperidone (unless patient previously failed such treatment). **Abilify, Clozaril, Geodon, Risperdal, and Zyprexa:** patient has a documented intolerance to the generic equivalent. **Latuda:**

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ORAL SOLUTIONS RISPERIDONE† (compare to Risperdal®) oral solution *FDA maximum recommended dose = 16 mg/day* **SHORT-ACTING INJECTABLE PRODUCTS** GEODON® IM (ziprasidone intramuscular injection) *FDA maximum recommended dose = 40 mg/day* **LONG-ACTING INJECTABLE PRODUCTS**	Quetiapine ER (compare to Seroquel® XR) Rexulti® (brexpiprazole) *FDA maximum recommended dose = 3mg (adjunct of MDD) or 5mg (schizophrenia)* Risperdal®* (risperidone) *FDA maximum recommended dose = 16 mg/day* Saphris® (asenapine) sublingual tablet *FDA maximum recommended dose = 20 mg/day* Seroquel® (quetiapine) *FDA maximum recommended dose = 800 mg/day* Seroquel XR® (quetiapine XR) *FDA maximum recommended dose = 800 mg/day* *Quantity Limit = 1 tab/day* *(150 mg & 200 mg tablet strengths), 2 tabs/day (50 mg strength)* Vraylar® (cariprazine) *FDA maximum recommended dose = 6mg/day,* *Quantity limit = 1 capsule/day* ZYPREXA®* (olanzapine) *FDA maximum recommended dose = 20 mg/day,* *Quantity limit = 1.5 tabs/day (2.5 mg, 5 mg, 7.5 mg & 10 mg tabs)* Abilify® (aripiprazole) oral solution *FDA maximum recommended dose = 25 mg/day* Risperdal® (risperidone) oral solution *FDA maximum recommended dose = 16 mg/day* Versacloz® (clozapine) Oral Suspension *FDA maximum recommended dose = 900 mg/day* *Quantity limit = 18 ml/day* Abilify® IM (aripiprazole intramuscular injection)	*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, one being Abilify (typical or atypical antipsychotics) OR *Indication for use is adjunct treatment of Major Depressive Disorder (MDD*): the patient has had a documented inadequate response to at least 3 different antidepressants from two different classes AND the patient has had a documented side effect, allergy or treatment failure with one preferred atypical antipsychotic product and Abilify being used as adjunctive therapy. **Quetiapine/Seroquel < or = 50mg/day:** The patient is being prescribed > 50 mg/day with combinations of tablet strengths. OR Indication for use is a mental health indication (other than the two below indications or a sleep disorder) OR *Indication for use is Adjunct treatment of Major Depressive Disorder (MDD):* the patient has had a documented inadequate response to at least 3 different antidepressants from 2 different classes OR *Indication for use is Adjunct treatment of any anxiety disorder (panic, agoraphobia, social phobia, obsessive-compulsive disorder, PTSD, Acute Stress Disorder, Generalized Anxiety Disorder):* the patient has had a documented inadequate response to at least 3 different antidepressants from 2 different classes If the request if for brand Seroquel, the patient has a documented intolerance to generic quetiapine. **NOTE:** Quetiapine in doses of < 50 mg/day will not be approved for indications of insomnia, for sleep or as a hypnotic. **Quetiapine ER, Seroquel XR:** *Indication for use is schizophrenia/schizoaffective disorder or bipolar disorder (bipolar mania, bipolar depression, and bipolar maintenance:* The patient has not been able to be adherent to a twice daily dosing schedule of quetiapine

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
All products require PA	*FDA maximum recommended dose = 30 mg/day* Olanzapine† intramuscular injection (compare to Zyprexa® IM) *FDA maximum recommended dose = 30 mg/day* Zyprexa® IM (olanzapine intramuscular injection) *FDA maximum recommended dose = 30 mg/day* Abilify Maintena® (aripiprazole monohydrate) *FDA maximum recommended dose = 400 mg/month* *Quantity limit = 1 vial/28 days* Aristada® (aripiprazole lauroxil) *Quantity Limit = 1 syringe/28 days* Invega Sustenna® (paliperidone palmitate) *FDA maximum recommended dose = 234 mg/month* Invega Trinza ®(paliperidone palmitate) *FDA maximum recommended dose = 819mg/3months* Risperdal® Consta (risperdone microspheres) *FDA maximum recommended dose = 50 mg/14 days* Zyprexa Relprevv® (olanzapine pamoate) *FDA maximum recommended dose = 600 mg/month* *Quantity limit = 1 vial/28 days (405 mg) or 2 vials/month (210 or 300 mg)*	immediate release resulting in a significant clinical impact OR *Indication for use is Adjunct treatment of Major Depressive Disorder (MDD):* the patient has had a documented inadequate response to at least 3 different antidepressants from 2 different classes AND the patient has had a documented treatment failure with quetiapine immediate release being used as adjunctive therapy. *Indication for use is Adjunct treatment of any anxiety disorder (panic, agoraphobia, social phobia, obsessive-compulsive disorder, PTSD, Acute Stress Disorder, Generalized Anxiety Disorder):* the patient has had a documented inadequate response to at least 3 different antidepressants from 2 different classes or at least 2 antidepressants and buspirone AND the patient has had a documented treatment failure with quetiapine immediate release being used as adjunctive therapy. **Abilify Oral Solutions:** The patient must meet all clinical criteria for approval of Abilify/aripiprazole as listed above AND the patient has had a documented side effect, allergy or treatment failure with preferred risperidone oral solution. **Risperdal Oral Solution:** The patient has a documented intolerance to the generic product risperidone. **Versacloz Oral Solution**: The patient has a medical necessity for a non-solid oral dosage form and is unable to use clozapine orally disintegrating tablets. **NON-PREFERRED SHORT-ACTING INJECTABLE PRODUCTS**: Medical necessity for a specialty dosage form has been provided. AND The patient has had a documented side effect, allergy, or treatment failure with Geodon IM. In addition, for approval of Zyprexa® IM, the patient must have had a documented intolerance to generic olanzapine IM. **LONG-ACTING INJECTABLE PRODUCTS:** Medical necessity for a specialty dosage form has been provided AND patient meets additional clinical criteria as outlined below. **Risperdal Consta Inj:** Tolerability has been established previously with oral risperidone. **Invega Sustenna Inj:** Tolerability has been established previously with oral/injectable risperidone or oral paliperidone. **Invega Trinza:** Tolerability has been established previously with oral/injectable risperidone or oral paliperidone AND Invega Sustenna for at least four months AND only when the dose has been stable over the prior two months. **Zyprexa Relprevv:** Medical necessity for a specialty dosage form has been provided (non-compliance with oral medications) AND Tolerability has been established previously with oral olanzapine. **Abilify Maintena:** Tolerability has been established previously with oral
ORALLY DISINTEGRATING TABLETS **All products require PA**	Abilify® Discmelt (aripiprazole) *FDA maximum recommended dose = 30 mg/day,* *Quantity limit = 2 tabs/day (10 mg & 15 mg tabs)* clozapine orally disintegrating tablets† (Compare to FazaClo®) *FDA maximum recommended dose = 900 mg/day* FazaClo® (clozapine orally disintegrating tablets) *FDA maximum recommended dose = 900 mg/day* Olanzapine orally disintegrating tablets† (compare to Zyprexa Zydis®) *FDA maximum recommended dose = 20 mg/day,* *Quantity limit = 1.5 tabs/day (5 mg & 10 mg tabs)* Risperdal® M-Tab (risperidone orally disintegrating tablets) *FDA maximum recommended dose = 16 mg/day* Risperidone† ODT (compare to Risperdal® M-Tab) *FDA maximum recommended dose = 16 mg/day* Zyprexa Zydis® (olanzapine orally disintegrating tablets)	

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
COMBINATION PRODUCTS **All products require PA**	*FDA maximum recommended dose = 20 mg/day, Quantity limit = 1.5 tabs/day (5 mg & 10 mg tabs)* olanzapine/fluoxetine† (compare to Symbyax®) *FDA maximum recommended dose = 18 mg/75 mg (per day)* Symbyax® (olanzapine/fluoxetine) *FDA maximum recommended dose = 18 mg/75 mg (per day)*	aripiprazole for at least 2 weeks. **Aristada®:** Tolerability has been established previously with oral aripiprazole for at least 2 weeks AND the patient has documented treatment failure with Abilify Maintena **ORALLY DISINTEGRATING TABLETS:** Medical necessity for a specialty dosage form has been provided. AND If the request is for FazaClo, Risperdal M-Tab or Zyprexa Zydis, the patient has a documented intolerance to the generic equivalent. **COMBINATION PRODUCTS:** The patient has had a documented side effect, allergy or treatment failure with two preferred products (ziprasidone, risperidone, and quetiapine). OR The prescriber provides a clinically valid reason for the use of the requested medication. AND If the request is for brand product, the patient has a documented intolerance to the generic product.
ANTI-PSYCHOTIC: TYPICALS		
ORAL HALOPERIDOL† (compare to Haldol®) LOXAPINE† (compare to Loxitane®) PERPHENAZINE TRIFLUOPERAZINE† **LONG ACTING INJECTABLE PRODUCTS** FLUPHENAZINE DECANOATE† HALOPERIDOL DECANOATE † (compare to Haldol® decanoate)	Chlorpromazine Fluphenazine Haldol®* (haloperidol) Loxitane®* (loxapine) 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.
BILE SALTS AND BILIARY AGENTS		
URSODIOL tablet, capsule	Actigall® (ursodiol) Chenodal® (chendiol) Cholbam® (cholic acid) Ocaliva® (obeticholic acid) Urso® (Urosiol)	**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

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Urso® Forte (ursodiol)	who are pregnanat or may become pregnant, known hepatocyte dysfunction or bile ductal abnormalities such as intrahepatic cholestasis, primary biliary cirrhosis or sclerosing cholangitis. **Cholbam:** The indication for use is the treatment of bile acid synthesis disorders due to single enzyme defects OR for the adjunctive treatment of peroxisomal disorders, including Zellweger spectrum disorders, AND the patient exhibits manifestations of liver disease, steatorrhea, or complications from decreased fat soluble vitamin absorption AND the prescriber is hepatologist or gastroenterologist. Initial approval will be granted for 3 months. For re-approval after 3 months, there must be documented clinical benefit. **Ocaliva:** The indication for use is the treatment of primary biliary cholangitis (PBC) AND the patient has had an inadequate response or is unable to tolerate ursodiol. **Urso, Urso Forte, Actigall:** The patient must have a documented treatment limiting side effect to generic ursodiol.
BONE RESORPTION INHIBITORS		
ORAL BISPHOSPHONATES **TABLETS/CAPSULES** ALENDRONATE† (compare to Fosamax®) tablets BINOSTO® (alendronate) 70 mg effervescent tablet *(Quantity Limit=4 tablets/28 days)* **INJECTABLE BISPHOSPHONATES** All products require PA	Actonel® (risedronate) Alendronate oral solution Atelvia (risedronate) Delayed Release Tablet *(Quantity Limit = 4 tablets/28 days)* Boniva® (ibandronate) *(Quantity Limit = 150 mg tablet/1 tablet per 28 days)* Etidronate Fosamax®* (alendronate) Fosamax Plus D® (alendronate/vitamin D) Ibandronate† (compare to Boniva®) *(Quantity Limit = 150 mg tablet/1 tablet per 28 days)* Risedronate† (compare to Actonel®) Boniva® Injection (ibandronate) *(QL = 3 mg/3 months (four doses)/year)* ibandronate Injection† (compare to Boniva®) *(QL=3 mg/3 months (four doses)/year)* Reclast® Injection (zoledronic acid) *(Quantity Limit = 5 mg (one dose)/year)* Zoledronic Acid Injection† (compare to Reclast®) 5mg/100ml*(QL=5 mg (one dose)/year)*	**Actonel, Atelvia, Risedronate:** patient has a diagnosis/indication of Paget's Disease, postmenopausal osteoporosis, osteoporosis in men or glucocorticoid induced osteoporosis AND patient has had a documented side effect, allergy, or treatment failure (at least a six-month trial) to generic alendronate tablets AND if the request is for brand Actonel, the patient has also had a documented intolerance to generic risedronate **Alendronate Oral Solution:** prescriber provides documentation of medical necessity for the specialty dosage form (i.e. inability to swallow tablets, dysphagia) AND the patient has a documented intolerance to Binosto. **Boniva Oral, Ibandronate:** patient has a diagnosis/indication of postmenopausal osteoporosis AND patient has had a documented side effect, allergy or treatment failure** to generic alendronate tablets. AND if the request if for brand Boniva oral, the patient has also had a documented intolerance to generic Ibandronate **Calcitonin Nasal Spray (generic), Miacalcin Nasal Spray:** patient is started and stabilized on the requested medication. If the request is for generic Calcitonin Nasal Spray, the patient has had a documented intolerance to brand Miacalcin. Note: Calcitonin Nasal Spray (brand and generic) no longer recommended for osteoporosis. **Miacalcin Injection:** patient has a diagnosis/indication of Paget's Disease **Evista Tablets:** patient has had a documented intolerance to generic raloxifene.

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ESTROGEN AGONIST/ANTAGONIST RALOXIFENE† (compare to Evista®) Tablet *(QL=1 tablet/day)* **INJECTABLE RANKL INHIBITOR** All products require PA **CALCITONIN NASAL SPRAY** All products require PA **CALCITONIN INJECTION** All products require PA **PARATHYROID HORMONE INJECTION** All products require PA	Zometa® (zoledronic acid) Injection 4mg/100ml or conc. 4mg/5ml Evista® (raloxifene) Tablet *(QL = 1 tablet/day)* Prolia® Injection (denosumab) *(QL=60 mg/6 months (two doses)/year)* Xgeva® (denosumab) *(QL=120 mg/28 days)* Calcitonin† Nasal Spray (compare to Miacalcin®) Miacalcin® (calcitonin) Nasal Spray Miacalcin® (calcitonin) Injection Forteo® (teriparatide) *(Quantity Limit = 1 pen (3 ml)/28 days)* *(Lifetime max duration of treatment = 2 years)*	**Fosamax Tablets:** patient has had a documented intolerance to generic alendronate tablets. **Fosamax Plus D:** there is a clinical reason why the patient is unable to take generic alendronate tablets and vitamin D separately. **Etidronate:** patient has a diagnosis/indication of Paget's Disease AND patient has had a documented side effect, allergy, treatment failure (at least a six-month trial) to generic alendronate and risedronate tablets **Forteo:** patient has a diagnosis/indication of postmenopausal osteoporosis in females, primary or hypogoandal osteoporosis in males or glucocorticoid induced osteoporosis AND patient has had a documented side effect, allergy, or treatment failure** to an oral bisphosphonate. AND prescriber has verified that the patient has been counseled about osteosarcoma risk **Boniva Injection, Ibandronate Injection:** patient has a diagnosis/indication of postmenopausal osteoporosis AND patient has had a documented side effect or treatment failure** to a preferred bisphosphonate. **Prolia Injection:** diagnosis or indication is osteopenia in men at high risk for fracture receiving androgen deprivation therapy for nonmetastatic prostate cancer OR diagnosis or indication is osteopenia in women at high risk for fracture receiving adjuvant aromatase inhibitor therapy for breast cancer OR patient has a diagnosis/indication of postmenopausal osteoporosis AND patient has had a documented side effect, allergy, or treatment failure** to a preferred bisphosphonate.. **Reclast Injection, Zoledronic Acid Injection (5mg):** patient has a diagnosis/indication of Paget's disease of bone OR patient has a diagnosis/indication of postmenopausal osteoporosis OR patient is male with a diagnosis of osteoporosis OR patient has a diagnosis of glucocorticoid induced osteoporosis AND patient has had a documented side effect or treatment failure** to a preferred bisphosphonate. AND if the request is for Reclast, the patient has a documented intolerance to generic zoledronic acid injection. **Zometa Injection, Zoledronic Acid Injection (4mg):** Diagnosis or indication is bone metastases from solid tumors, multiple myeloma, osteopenia or treatment of hypercalcemia of malignancy **Xgeva Injection:** diagnosis or indication is bone metastases from solid tumors (e.g. prostate, breast, thyroid, non-small lung cancer), hypercalcemia of malignancy, or giant cell tumor of bone. **Treatment failure is defined as documented continued bone loss or fracture after one or more years despite treatment with an oral bisphosphonate.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
BOTULINUM TOXINS		
	Botox® (onabotulinumtoxinA) Myobloc® (rimabotulinumtoxinB) Dysport® (abobotulinumtoxinA) Xeomin® (incobotulinumtoxinA)	**BOTOX (onabotulinumtoxinA):** The indication for use is: o Strabismus and blepharospasm associated with dystonia, including essential blepharospasm, VII cranial nerve disorders/hemifacial spasm or Focal dystonias, including cervical dystonia, spasmodic dystonia, oromandibular dystonia OR Limb spasticity (e.g., due to cerebral palsy, multiple sclerosis, or other demyelinating CNS diseases) OR Focal spasticity (e.g., due to hemorrhagic stroke, anoxia, traumatic brain injury) OR Severe Axillary Hyperhidrosis (if member has failed an adequate trial of topical therapy) OR Overactive bladder or detrusor overactivity (if member has failed an adequate trial of at least TWO urinary antispasmodics (either short- or long-acting formulations) OR Chronic migraine (>15 days per month with headache lasting 4 hours a day or longer) and the member has failed or has a contraindication to an adequate trial of at least TWO medications for migraine prophylaxis from at least two different classes (tricyclic antidepressants, SNRI's, beta-blockers, calcium channel blockers or anticonvulsants). For re-approval after 3 months, the patient must have had an improvement in symptoms. AND The patient is >12 years of age if for blepharospasm or strabismus, >16 years of age for cervical dystonia, and >18 years of age for upper or lower limb spasticity, hyperhidrosis, chronic migraine or overactive bladder/detrusor overactivity. **Dysport (abobotulinumtoxinA):** The patient has a diagnosis of cervical dystonia or upper limb spasiticity AND The patient is ≥18 years of age OR the patient has a diagnosis of lower limb spasticity and is 2 years of age or older. **Myobloc (rimabotulinumtoxinB):** The patient has a diagnosis of focal dystonia, including cervical dystonia, spasmodic dystonia, oromandibular dystonia AND The patient is >16 years of age **Xeomin (incobotulinumtoxinA):** The patient has a diagnosis of cervical dystonia, upper limb spasticity, or blepharospasm. AND The patient is ≥18 years of age **LIMITATIONS:** Coverage of botulinum toxins will not be approved for cosmetic use (e.g., glabellar lines, vertical glabellar eyebrow furrows, facial rhytides, horizontal neck rhytides, etc.). (BOTOX Cosmetic (onabotulinumtoxinA) is not covered) **IMPORTANT NOTE:** Botulinum neurotoxins are used to treat various disorders of focal muscle spasm and excessive muscle contractions, such as focal dystonias. When injected intramuscularly, botulinum neurotoxins produce a

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		presynaptic neuromuscular blockade by preventing the release of acetylcholine from the nerve endings. As a consequence of the chemistry and clinical pharmacology of each botulinum neurotoxin product, botulinum neurotoxins are not terchangeable, even among same sterotype products. Units of biological activity are unique to each preparation and cannot be compared or converted into units of another. It is important that providers recognize there is no safe dose conversion ratio—i.e., one unit of BOTOX (onabotulinumtoxinA, formerly type A) does not equal one unit of Myobloc (rimabotulinumtoxinB, formerly type B) does not equal one unit of Dysport (abobotulinumtoxinA) does not equal one unit of Xeomin (incobotulinumtoxinA). Failure to understand the unique characteristics of each formulation of botulinum neurotoxin can result in under or over dosage. It is expected that use of these products will be based on each product's individual dosing, efficacy and safety profiles.
BPH AGENTS		
<u>ALPHA BLOCKERS</u> ALFUZOSIN ER (compare to Uroxatral®) *Quanitity Limit = 1 tablet/day* DOXAZOSIN† (compare to Cardura®) TAMSULOSIN† (compare to Flomax®) *Quantity Limit = 2 capsules/day* TERAZOSIN† (formerly Hytrin®)	Cardura®* (doxazosin) Cardura XL® (doxazosin) *Quantity Limit = 1 tablet/day* Flomax®* (tamsulosin) *Quantity Limit = 2 capsules/day* Rapaflo® (silodosin) *Quantity Limit = 1 capsule/day* Uroxatral® (alfuzosin) *Quantity Limit = 1 tablet/day*	**Cardura, Cardura XL:** The patient has had a documented side effect, allergy or treatment failure with two alpha blockers, one of which must be generic doxazosin. **Flomax:** The patient has had a documented side effect, allergy or treatment failure with two preferred alpha blockers, one of which must be generic tamsulosin. **Rapaflo, Uroxatral:** The patient has had a documented side effect, allergy or treatment failure with two preferred alpha blockers. In addition, for approval of Uroxatral, the patient must have a documented intolerance to generic alfuzosin ER.
<u>ANDROGEN HORMONE INHIBITORS</u> FINASTERIDE† (compare to Proscar®) *(QL = 1 tablet/day)*	Avodart® (dutasteride) (*QL = 1 capsule/day)* Dutaseride (compare to Avodart®) *QL = 1 capsule/day* finasteride† (compare to Proscar®) females; males age < 45 *(QL = 1 tablet/day)* Proscar® *(finasteride) *(QL = 1 tablet/day)*	**Avodart, dutasteride, Proscar:** The patient has a diagnosis of BPH (benign prostatic hypertrophy) AND the patient has a documented side effect, allergy or treatment failure to generic finasteride AND for approval of brand Avodart, the patient must have a documented intolerance to generic dutasteride. **Finasteride for males age < 45:** The patient has a diagnosis of BPH (benign prostatic hypertrophy)
<u>COMBINATION PRODUCT</u>	Dutasteride/tamsulosin (compare to Jalyn®) (*QL=1 capsule/day)* Jalyn® (dutasteride/tamsulosin) (*QL = 1 capsule/day)*	**Dutasteride/tamsulosin, Jalyn:** The patient has a diagnosis of BPH (benign prostatic hypertrophy) AND the patient has a documented treatment failure/inadequate response to combination therapy with generic tamsulosin and finasteride AND is unable to take tamsulosin and dutasteride as the individual separate agents AND for approval of Jayln, the patient must have a

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		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.
CARDIAC GLYCOSIDES		
DIGOXIN† DIGOXIN† Oral Solution LANOXIN® (digoxin)		
CHEMICAL DEPENDENCY		
ALCOHOL DEPENDENCY		
ACAMPROSATE† DISULFIRAM† 250 mg, 500 mg tab (compare to Antabuse®) NALTREXONE oral † **Preferred Agent after Clinical Criteria are Met** Vivitrol® (naltexone for extended-release injectable suspension) *(QL = 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 † **Preferred Agent after Clinical Criteria are Met** SUBOXONE® sublingual FILM (buprenorphine/naloxone) *QL = 2 films per day (8 mg strength), 3 films per day (2 mg strength)or*	buprenorphine† sublingual TABLET(formerly Subutex®) *QL = 3 tablets per day (2 mg strength) or 2 tablets/day (8 mg strength)* *(Maximum Daily Dose = 16 mg/day)* Revia®* (naltrexone oral) buprenorphine/naloxone† (formerly Suboxone®)	**Suboxone, Buprenorphine/Naloxone, Buprenorphine:** Diagnosis of opiate dependence confirmed (will not be approved for alleviation of pain) AND Prescriber has a DATA 2000 waiver ID number ("X-DEA license") in order to prescribe AND A "Pharmacy Home" for all prescriptions has been selected (Pharmacy located or licensed in VT) AND Requests for Buprenorphine/Naloxone SL tablet, Bunavail or Zubsolv after documented

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1 film per day (4 mg and 12 mg strengths) *(Maximum daily Dose = 16 mg/day)* ***Maximum days supply for Suboxone is 14 days*** Note: Methadone for opiate dependency can only be prescribed through a Methadone Maintenance Clinic **<u>For Prevention of Relapse to Opioid Dependency</u>** Vivitrol® (naltrexone for extended-release injectable suspension) (QL = 1 injection (380 mg) per 30 days)	sublingual TABLET *QL = 2 tablets per day (8 mg strength) or 3 tablets per day (2 mg strength)* *(Maximum daily Dose = 16 mg/day)* Bunavail® (*QL= 1film per day(2.1/0.3mg, 6.1/1mg), 2films per day (4.2/0.7mg)* Zubsolv® *(QL=1 film per day of all strengths)* **Maximum days supply for oral buprenorphine/naloxone or buprenorphine is 14 days** Probuphine® (buprenorphine) subdermal implant *(QL = 4 implants per 6 months) Maximum length of therapy=1 year*	intolerance of Suboxone Film must include a completed MedWatch form that will be submitted by DVHA to the FDA. AND If buprenorphine (formerly Subutex) is being requested, Patient is either pregnant and history (copy of positive pregnancy test) has been submitted (duration of PA will be one 1 month post anticipated delivery date) OR Patient is breastfeeding a methadone or morphine dependent baby and history from the neonatologist or pediatrician has been submitted. **Probuphine:** Patient must have achieved and sustained prolonged clinical stability on transmucosal buprenorphine AND is currently on a maintenance dose of ≤ 8mg per day of Suboxone® or it's transmucosal buprenorphine product equivalent (defined as stable on transmucosal buprenorphine dose of ≤ 8mg for 3 months or longer without any need for supplemental dosing or adjustments) AND the provider and patient are both enrolled in the Probuphine® REMS program AND clinical justification must be provided detailing why the member cannot use a more cost effective buprenorphine formulation. **Note:** Probuphine® will be approved as a medical benefit ONLY and will NOT be approved if billed through pharmacy point of sale. Probuphine® will not be approved for new entrants to treatment. Initial approval will be granted for 6 months with extension considered for an additional 6 months (There is no clinical experience with insertion of Probuphine® beyond a single insertion in each arm). **Vivitrol:** There must be a documented trial of oral naltrexone 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.
OVERDOSE TREATMENT		
NALOXONE HCL Prefilled luer-lock needleless syringe plus intranasal mucosal atomizing device (Rescue kit) NARCAN® (naloxone hcl) Nasal Spray Quantity Limit = 4 single-use sprays/28days		

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

<u>Preferred Agents (No PA Required)</u>	**Non-preferred Agents (PA Required)**	**<u>Criteria</u>**
Constipation: Chronic, IBS_C, or Opioid-Induced (Amitiza, Linzess, & Movantik length of approval: Initial PA of 3 months and & 12 months thereafter; Relistore: 3 months		
<u>Bulk-Producing Laxatives</u> PSYLLIUM† **<u>Osmotic Laxatives</u>**	Amitiza® (lubiprostone) *(Qty Limit = 2 capsules/day)* Linzess® (linaclotide) *(Qty limit = 1 capsule/day)* Movantik (naloxegol) *(Qty limit=1 tablet/day)*	**Amitiza:** The patient has a diagnosis of chronic idiopathic constipation (CIC) (24 mcg capsules) OR The patient is a woman and has a diagnosis of irritable

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
LACTULOSE† POLYETHYLENE GLYCOL 3350 (PEG)† (**Stimulant Laxative** BISACODYL† SENNA† **Stool Softener** DOCUSATE† **Miscellaneous** DICYCLOMINE	Relistor® (methylnaltrexone) tablets (*Qty Limit = 3 tabs/day)* Relistor® (methylnatrexone) injection	bowel syndrome with constipation (IBS-C) (8 mcg capsules) OR opioid-induced constipation AND The patient has had documented treatment failure to lifestyle and dietary modification (increased fiber and fluid intake and increased physical activity). AND The patient has had documented side effect, allergy or treatment failure to a 1 week trial each of at least 2 preferred laxatives from the Bulk-Producing Laxative or Osmotic Laxative categories (see below). **Linzess:** The patient is 18 years of age or older. AND The patient has a diagnosis of chronic idiopathic constipation (CIC) (145 mcg capsules) OR The patient has a diagnosis of irritable bowel syndrome with constipation (IBS-C) (290 mcg capsules) AND The patient has had documented treatment failure to lifestyle and dietary modification (increased fiber and fluid intake and increased physical activity). AND The patient has had documented side effect, allergy or treatment failure to a 1 week trial each of at least 2 preferred laxatives from the Bulk-Producing Laxative or Osmotic Laxative categories (see below). **Movantik:** The patient is current using an opiate for at least 4 weeks AND The patient must have documented opioid-induced constipation AND The patient has had documented side effect, allergy or treatment failure to a 1 week trial of at least 2 preferred laxatives from Bulk-Producing Laxative or Osmotic Laxative categories.. **Relistor Tablets:** The patient is current using an opiate for at least 4 weeks AND has documented opioid-induced constipation AND has had a documented side effect, allergy or treatment failure to a 1 week trial of at least 2 preferred laxatives from Bulk-Producing Laxative or Osmotic Laxative categories AND has had a documented side effect, allergy, or treatment failure to Amitiza or 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 at least 2 preferred laxatives from 2 different laxative classes (see below) used in combination.
Short Bowel Syndrome (SBS) (length of approval: 6 Months)		
	Gattex® (teduglutide) Vials Maximum days' supply = 30 days	**Gattex:** Patient has a diagnosis of short bowel syndrome AND Patient is receiving specialized nutritional support administered intravenously (i.e. parenteral nutrition) AND Patient is 18 years of age or older AND Patient does not have an active gastrointestinal malignancy (gastrointestinal tract, hepatobiliary, pancreatic), colorectal cancer, or small bowel cancer. AND After preliminary review by the Clinical Call Center, the request will be forwarded to the DVHA Medical Director for final approval. Note: Re-approval requires evidence of decreased parenteral nutrition support from baseline.
Antidiarrheal: HIV/AIDs (length of approval: initial approval 3 months, subsequent 1 year)		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
DIPHENOXYLATE/ATROPINE† LOPERAMIDE†	Fulyzaq® (crofelemer) 125 mg DR Tablets *QL = 2 tablets/day*	**Fulyzaq:** 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)		
	Alosetron (compare to Lotronex®) Lotronex® (alosetron) Viberzi® (eluxadoline)	**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.
CONTRACEPTIVES		
SELECT PRODUCTS (length of approval: 1 year) **MONOPHASIC AGENTS:**		
Due to the extensive list of products, any monophasic BCP not listed as non-preferred is considered preferred.	Blisovi FE 24 (norethindrone/ethinyl estradiol/FE) Brevicon-28 (norethindrone/ethinyl estradiol) Drospirenone/ethinyl estradiol/levomefol Gildesse fe (norethindrone/ ethinyl estradiol/FE) Junel FE 24 (norethindrone/ethinyl estradiol/FE) Lo-Estrin (norethindrone/ethinyl estradiol) Lo-Estrin FE (norethindrone/ ethinyl estradiol/FE) LoMedia FE (norethindrone/ ethinyl estradiol/FE) Microgestin FE (norethindrone/ethinyl estradiol/FE) Norinyl 1/35 (norethindrone/ethinyl estradiol) Ogestrel (norgestrel/ethinyl estradiol) Ortho-Cyclen-28 (norgestimate/ethinyl estradiol)	**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
	Ovcon-35/28 (norethindrone/ethinyl estradiol) Rajani (drospirenone/ethinyl estradiol/levomefol) Taytulla (norethindrone/ethinyl estradiol/FE) Yaz (drospirenone/ ethinyl estradiol) Yasmin 28 (drospirenone/ ethinyl estradiol) Zenchent FE (norethindrone/ethinyl estradiol/FE) Zovia 1-50(ethynodiol D/ ethinyl estradiol)	
BIPHASIC AGENTS		
BEKYREE (desogestrel/ethinyl estradiol) DESOGESTREL ETHINYL ESTRADIOL KARIVA (desogestrel/ ethinyl estradiol) KIMIDESS (desogestrel/ethinyl estradiol) NORETHIDRONE/ETHINYL ESTRADIOL 0.5/1-35 PIMTREA (desogestrel/ ethinyl estradiol) VIORELE (desogestrel/ ethinyl estradiol)	Azurette (desogestrel/ ethinyl estradiol) Lo Loestrin FE(norethindrone/ ethinyl estradiol/FE) Mircette (desogestrel/ ethinyl estradiol) Necon 10/11-28 (norethindrone/ ethinyl estradiol)	**Non-preferred agents:** Trial with at least three preferred contraceptive products including the preferred formulation of the requested non-preferred agent
TRIPHASIC AGENTS		
ALYACEN (norethindrone ethinyl estradiol) ARANELLE (norethindrone/ethinyl estradiol) CAZIANT (desogestrel/ ethinyl estradiol) CYCLAFEM (norethindrone/ethinyl estradiol) DASETTA (norethindrone/ethinyl estradiol) ENPRESSE (levonorgestrel/ ethinyl estradiol) LEENA (norethindrone/ethinyl estradiol) LEVONEST (levonorgestrel/ ethinyl estradiol)) MYZILRA (levonorgestrel/ ethinyl estradiol) NATAZIA (dienogest/estradiol valerate) NECON 7/7/7 (norethindrone/ethinyl estradiol) Norgestimate ethinyl estradiol NORTREL 7/7/7 (norethindrone/ethinyl estradiol) PIRMELLA (norethindrone/ethinyl estradiol) TILIA FE (norethindrone/ethinyl estradiol/FE) TRI-ESTARYLLA (norgestimate/ ethinyl estradiol) TRI-LEGEST FE (norethindrone/ethinyl estradiol/FE) TRI-LINYAH (norgestimate/ ethinyl estradiol) TRI-LO-ESTARYLLA (norgestimate/ethinyl estradiol) TRI-LO-MARZIA (norgestimate/ethinyl estradiol) TRI-LO-SPRINTEC (norgestimate/ethinyl estradiol) TRINESSA (norgestimate/ ethinyl estradiol) TRINESSA LO (norgestimate/ethinyl estradiol) TRI-PREVIFEM (norgestimate/ ethinyl estradiol)	Cyclessa (desogestrel/ ethinyl estradiol) Estrostep FE (norethindrone/ethinyl estradiol/FE) Ortho-Novum 7/7/7 (norethindrone/ethinyl estradiol) Ortho Tri-Cyclen (norgestimate/ ethinyl estradiol) Ortho Tri-Cyclen LO (norgestimate/ ethinyl estradiol) Tri-Norinyl (norethindrone/ethinyl estradiol)	**Non-preferred agents:** Trial with at least three preferred contraceptive products including the preferred formulation of the requested non-preferred agent

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
TRI-SPRINTEC (norgestimate/ ethinyl estradiol) TRIVORA (levonorgestrel/ ethinyl estradiol) VELIVET (desogestrel/ ethinyl estradiol)		
EXTENDED CYCLE		
AMETHIA LO (levonorgestrel/ ethinyl estradiol) AMETHYST (levonorgestrel/ ethinyl estradiol) CAMRESE (levonorgestrel/ ethinyl estradiol) CAMRESE LO (levonorgestrel/ ethinyl estradiol) INTROVALE (levonorgestrel/ ethinyl estradiol 3MTH) JOLESSA (levonorgestrel/ ethinyl estradiol 3MTH) LEVONORGESTREL ETHINYL ESTRADIOL TBDSPK 3 month LEVONORGESTREL ETHESTRAD ETHINYL ESTRADIOL TBDSPK 3 month LO-SEASONIQUE (levonorgestrel/ ethinyl estradiol) QUASENSE (levonorgestrel/ ethinyl estradiol 3MTH) SEASONIQUE (levonorgestrel/ ethinyl estradiol)	Amethia (levonorgestrel/ ethinyl estradiol) Ashlyna (levonorgestrel/ ethinyl estradiol) Daysee (levonorgestrel/ ethinyl estradiol) Fayosim (levonorgestrel/ ethinyl estradiol) Quartette (levonorgestrel/ ethinyl estradiol) Rivelsa (levonorgestrel/ ethinyl estradiol)	**Non-preferred agents:** Trial with at least three preferred contraceptive products including the preferred formulation of the requested non-preferred agent
PROGESTIN ONLY CONTRACEPTIVES		
CAMILA (norethindrone) DEBLITANE (norethindrone) ERRIN (norethindrone) HEATHER (norethindrone) JENCYCLA (norethindrone) JOLIVETTE(norethindrone) LYZA (norethindrone) NORA-BE (norethindrone) NORETHINDRONE 0.35MG SHAROBEL (norethindrone)	Ortho Micronor (norethindrone)	**Non-preferred agents:** Trial with at least three preferred contraceptive products including the preferred formulation of the requested non-preferred agent
INJECTABLE CONTRACEPTIVES		
MEDROXYPROGESTERONE ACETATE 150MG (IM) VIAL/SYRINGE DEPO-PROVERA 104 (SUB-Q) SYRINGE (medroxyprogesterone acetate)	Depo-Provera (IM) (medroxyprogesterone acetate) 150mg Susp vial/syringe	
VAGINAL RING		
NUVARING® (etonogestrel/ethinyl estradiol vaginal ring)		
LONG ACTING REVERSIBLE CONTRACEPTIVES (LARCs)		
LILETTA (levonorgestrel) IUD MIRENA (levonorgestrel) IUD SKYLA (levonorgestrel) IUD	Kyleena (levonorgestrel) IUD	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.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
NEXPLANON (etonogestrel) Implant		
TOPICAL CONTRACEPTIVES		
XULANE PATCH (norelgestromin/ ethinyl estradiol)		
EMERGENCY CONTRACEPTIVES		
AFTERA (levonorgestrel) ECONTRA EZ (levonorgestrel) FALLBACK SOLO (levonorgestrel) LEVONORGESTREL MY WAY (levonorgestrel) NEXT CHOICE (levonorgestrel) OPCICON ONE-STEP (levonorgestrel) OPTION 2 (levonorgestrel) REACT (levonorgestrel) TAKE ACTION (levonorgestrel) ELLA (ulipristal)		
CORONARY VASODILATORS/ANTIANGINALS/SINUS NODE INHIBITORS		
ORAL		
ISOSORBIDE DINITRATE† tablet(compare to Isordil®) ISOSORBIDE DINITRATE† ER tablet ISOSORBIDE MONONITRATE† tablet (compare to Ismo®,Monoket®) ISOSORBIDE MONONITRATE† ER tablet (compare to Imdur®) NITROGLYCERIN† SL tablet NITROGLYCERIN† ER capsule NITROLINGUAL PUMP SPRAY® NITROGLYCERIN SPRAY LINGUAL† (compare to Nitroglycerin Pump Spray®) NITROMIST® Lingual Spray NITROQUICK® (nitroglycerin SL tablet) NITROSTAT® (nitroglycerin SL tablet) NITRO-TIME® (nitroglycerin ER capsule)	Dilatrate-SR® (isosorbide dinitrate SR capsule) Imdur®* (isosorbide mononitrate ER tablet) Ismo®* (isosorbide mononitrate tablet) Isosorbide dinitrate SL tablet Isordil®* (isosorbide dinitrate tablet) Monoket®* (isosorbide mononitrate tablet) BiDil® (isosorbide dinitrate/hydralazine) Ranexa® (ranolazine) *(Quantity Limit = 3 tablets/day (500 mg), 2 tablets/day (1000 mg)))*	**Dilatrate-SR, Imdur:** The patient has had a side effect, allergy, or treatment failure to at least two of the following medications: isosorbide dinitrate ER tablet, isosorbide mononitrate ER tablet, nitroglycerin ER capsule or Nitro-time. If a product has an AB rated generic, one trial must be the generic formulation. **Ismo, Isordil, Monoket, Isosorbide dinitrate SL tablet:** The patient has had a side effect, allergy, or treatment failure to at least two of the following medications: isosorbide dinitrate tablet or isosorbide mononitrate tablet. If a product has an AB rated generic, one trial must be the generic formulation **Bidil:** The prescriber provides a clinically valid reason why the patient cannot use isosorbide dinitrate and hydralazine as separate agents. **Ranexa:** The patient has had a diagnosis/indication of chronic angina. AND The patient has had a documented side effect, allergy, or treatment failure with at least one medication from two of the following classes: beta-blockers, maintenance nitrates, or calcium channel blockers. AND The patient does not have any of the following conditions: Hepatic insufficiency, Concurrent use of medications which may interact with Ranexa: CYP450 3A4 inducers (rifampin, rifabutin, rifapentin, phenobarbital, phenytoin, carbamazepine,

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		St.John's wort) CYP450 3A4 inhibitors (diltiazem, verapamil, ketoconazole, protease inhibitors, grapefruit juice, macrolide antibiotics) Note: doses of digoxin or drugs metabolized by CYP450 2D6 (TCAs, some antipsychotics) may need to be adjusted if used with Ranexa. AND The dose requested does not exceed 3 tablets/day (500 mg) or 2 tablets/day (1000 mg).
TOPICAL		
NITREK® (nitroglycerin transdermal patch) NITRO-BID® (nitroglycerin ointment) NITROGLYCERIN TRANSDERMAL PATCHES† (compare to Nitro-Dur®)	Nitro-Dur®* (nitroglycerin transdermal patch)	**Nitro-Dur:** patient has had a side effect, allergy, or treatment failure to Nitrek or generic nitroglycerin transdermal patches.
SINUS NODE INHIBITORS		
	Corlanor® (ivabradine) (QL=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		
CORTISONE ACETATE tablets DEXAMETHASONE† tablets, elixir, intensol, solution DEXPAK® tabs (dexamethasone taper pack) HYDROCORTISONE† tab (compare to Cortef®) MEDROL® (methylprednisolone) 2mg tablets METHYLPREDNISOLONE† (compare to Medrol®) tabs METHYLPREDNISOLONE DOSE PACK† (compare to Medrol Dose Pack®) tabs ORAPRED® ODT (prednisolone sod phosphate) (age < 12 yrs) PREDNISOLONE† 3 mg/ml oral solution, syrup (compare to Prelone®)	Celestone® (betamethasone) oral solution Cortef®* (hydrocortisone) tablets Flo-Pred® (prednisolone acetate) oral suspension Medrol®* (methylprednisolone) tablets Medrol Dose Pak®* (methylprednisolone) tabs Millipred® (prednisolone) tablets Millipred® (prednisolone sodium phos) oral solution Millipred DP® (prednisolone) dose pack tablets Orapred®* oral solution* (prednisolone sod phos) Orapred® ODT (prednisolone sod phos) (age ≥ 12 yrs) Pediapred®* (prednisolone sod phosphate) oral solution prednisolone sodium phosphate oral solution 25 mg/5ml	**Rayos:** The patient has had a trial of generic immediate release prednisone and has documented side effects that are associated with the later onset of activity of immediate release prednisone taken in the morning. **All Others:** The patient has been started and stabilized on the requested medication. OR The patient has a documented side effect, allergy, or treatment failure to at least two preferred medications. If a product has an AB rated generic, one trial must be the generic formulation.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
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	Rayos® (prednisone) Delayed Release Tablet *(Quantity limit = 1 tablet/day)* Veripred® 20 oral solution (prednisolone sodium phosphate)	
COUGH AND COLD PREPARATIONS		
All generics MUCINEX ® (guaifenesin)	Hydrocodone/chlorpheniramine (compare to Tussionex®) *(QL = 60 ml/RX)* Tussionex® (hydrocodone/chlorpheniramine) *(QL = 60 ml/RX)* TussiCaps® (hydrocodone/chlorpheniramine) *(QL = 12 capsules/RX)* All other brands	**Tussionex, TussiCaps, Hydrocodone/chlorpheniramine suspension (generic):** The patient has had a documented side effect, allergy, or treatment failure to two of the following generically available cough or cough/cold products: hydrocodone/homatropine (compare to Hycodan), promethazine/codeine (previously Phenergan with Codeine), guaifenesin/codeine (Cheratussin AC) or benzonatate. AND patient is 6 years old of age or greater. AND The quantity requested does not exceed 60 ml (Tussionex) or 12 capsules (TussiCaps). AND If the request is for Tussionex□, the patient has a documented intolerance to generic hydrocodone/chlorpheniramine suspension. **All Other Brands:** The prescriber must provide a clinically valid reason for the use of the requested medication including reasons why any of the generically available preparations would not be a suitable alternative.
CYSTIC FIBROSIS MEDICATIONS		
Preferred After Clinical Criteria Are Met: BETHKIS® (tobramycin) inhalation solution (Quantity Limit = 56 vials/56 days; maximum days' supply = 56 days) (2 vials/day for 28 days, then 28 days off) KITABIS® (tobramycin sol) (*QL= 56vials/56days; maximum days' supply = 56 days; 2 vials/day for 28 days, then 28 days off)* TOBI® (tobramycin PODHaler capsules for inhalation) (*QL = 224 capsules/56 days; maximum days' supply = 56 days) (4 capsules twice daily for 28 days, then 28 days off)*	Cayston® (aztreonam) inhalation solution (Quantity Limit = 84 vials/56 days; maximum days supply = 56 days) (3 vials/day for 28 days, then 28 days off) Kalydeco® (ivacaftor) tablets (Quantity Limit = 2 tablets/day, maximum days' supply = 30 days) Kalydeco® (ivacaftor) packets (Quantity Limit = 2 packets/day, maximum days' supply = 30 days) Orkambi® (lumacaftor/ivacaftor) (Quantity Limit= 120/30 days; max days supply=30 days)	**Bethkis, Kitabis, Pulmonzyme:** diagnosis or indication is cystic fibrosis **TOBI, tobramycin inhalation solutions:** Diagnosis or indication is cystic fibrosis and the patient has a documented failure or intolerance to Kitabis and Bethkis. **Cayston:** diagnosis or indication is cystic fibrosis and the patient has had a documented failure, intolerance or inadequate response to inhaled tobramycin therapy alone **Kalydeco:** The patient has a diagnosis of Cystic Fibrosis. AND □ Patient has one of the following mutations on at least one allele in the cystic fibrosis transmembrane conductance regulator gene(CFTR gene): A1067T, A455E, D110E, D110H, D1152H, D1270N, D579G,E193K, E56K, F1052V, F1074L, G551D, G1069R, G1244E, G1349D, G178R, G551S, K1060T, L206W, P67L, R1070Q, R1070W, R117C, R117H, R347H, R352Q, R74W, S945L, S977F, S1251N, S1255P, S549N, or S549R and who have an R117H mutation in the CFTR gene (documentation provided). AND The patient is ≥2 years old. Note:

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Pulmozyme® (dornase alfa) inhalation solution (Quantity Limit =60/30 days; maximum days supply=30 days) TOBI® (tobramycin) inhalation solution (Quantity Limit = 56 vials/56 days; maximum days supply = 56 days) (2 vials/day for 28 days, then 28 days off) Tobramycin inhalation solution† (compare to Tobi®) (Quantity Limit = 56 vials/56 days; maximum days' supply = 56 days)(2 vials/day for 28 days, then 28 days off)	Renewal of Prior Authorization will require documentation of member response. **TOBI PODHALER:** allowed after a trial of another form of inhaled tobramycin **Orkambi:** The patient has a diagnosis of Cystic Fibrosis AND Initial Criteria • ≥ 6 years of age • Patient must be determined to be homozygous for the *F508del* mutation in the CFTR gene as confirmed by an FDA-approved CF mutation test AND • Patient has a baseline forced expiratory volume in one second (FEV1) of 40 percent of the predicted normal value AND • If the patient is between the ages of 6-18, they must have undergone a baseline ophthalmic examination to monitor for lens opacities/cataracts • Prescriber is a CF specialist or pulmonologist Ongoing Approval Criteria • Patient has stable or improved FEV1 • Patient has LFTs/bilirubin monitored every 3 months for the first year of therapy and annually after the first year • ALT or AST ≤ 5 X the upper limit of normal or ALT/AST ≤ 3 X the upper limits of normal and bilirubin is ≤ 2 X the upper limit of normal • Between the ages of 12 and 18, have follow up ophthalmic exam at least annually
DERMATOLOGICAL AGENTS		
ACTINIC KERATOSIS THERAPY		
IMIQUIMOD 5% Cream EFUDEX®* (fluorouracil) 5% cream, solution FLUOROURACIL (compare to CARAC®) 0.5% 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 Picato® (ingenol mebutate) 0.015 % Gel *Qty Limit = 3 tubes* Picato® (ingenol mebutate) 0.05 % Gel *Qty Limit = 2 tubes* Solaraze® (diclofenac sodium) 3 % Gel *Qty Limit = 1 tube/30 days* 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 **Picato:** The diagnosis or indication is actinic keratosis AND The patient has had a documented side effect, allergy, contraindication or treatment failure with a generic topical fluorouracil product AND The patient has had a documented side effect, allergy, contraindication or treatment failure with generic imiquimod. **Solaraze Gel, 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.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ANTIOBIOTICS TOPICAL		
Single Agent BACITRACIN† MUPIROCIN OINTMENT† (compare to Bactroban®) **Combination Products** BACITRACIN-POLYMYXIN† NEOMYCIN-BACITRACIN-POLYMYXIN† Note: Bactroban® Nasal Ointment is not included in this managed category *C=cream, F=foam, G=gel, L=lotion, O=ointment, S=solution*	Altabax® (retapamulin) *QL = 1 tube* Bactroban® (mupirocin) Cream Bactroban®* (mupirocin) Ointment Centany® Ointment (mupirocin) Gentamicin Cream or Ointment Mupirocin cream† (compare to Bactroban®) Cortisporin® Cream (neomycin-polymyxin-hydrocortisone) Cortisporin® Ointment(bacitracin-neomycin-polymyxin-hydrocortisone) **All other branded products**	**Altabax:** The patient is being treated for impetigo. AND The patient has had a documented side effect, allergy, or treatment failure with mupirocin ointment AND MRSA (methicillin resistant staph aureus) has been ruled out by culture **Bactroban Cream or Ointment, mupirocin cream, Centany Ointment:** The patient has had a documented intolerance with generic mupirocin ointment AND If the request is for brand Bactroban Cream, the patient has also had a documented intolerance to the generic equivalent. **Cortisporin Cream or Ointment, Gentamicin Cream or Ointment:** The patient has had a documented side-effect, allergy or treatment failure with at least one preferred generic topical antibiotic
ANTIFUNGALS: ONYCHOMYCOSIS		
CICLOPIROX † 8 % solution (compare to Penlac® Nail Lacquer) QL =6.6 ml/90 days	Ciclodan® (ciclopirox 8% solution) Penlac® Nail Lacquer (ciclopirox 8 % solution) QL = 6.6 ml/90 Kerydin® Jublia® QL=48 weeks treatment	**Ciclodan, Jublia, Kerydin, Penlac Sol:** The patient meets at least 1 of the following criteria: Pain to affected area that limits normal activity, Diabetes Mellitus, Patient is immunocompromised, Patient has diagnosis of systemic dermatosis, Patient has significant vascular compromise AND Documented intolerance to generic ciclopirox 8% solution. **LIMITATIONS:** Coverage of Onychomycosis agents will NOT be approved solely for cosmetic purposes. Kits with multiple drug products or non-drug items not covered.
ANTIFUNGALS: TOPICAL		
Single Agent CICLOPIROX † (compare to Loprox®) 0.77% C, Sus, G; 1%Sh CLOTRIMAZOLE† 1% C, S KETOCONAZOLE † (compare to Kuric®, Nizoral®)	Ciclodan® (ciclopirox) C Econazole 1% C Ertaczo® (sertaconazole) 2% C Exelderm® (sulconazole) 1% C, S Extina® (ketoconazole) 2% F Ketoconazole† (compare to Extina®) 2 % Foam	**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

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
2% C, 2% Sh MICONAZOLE † all generic/OTC products NYSTATIN † O, C, P (compare to Mycostatin®, Nystop®, Nyamyc®) TOLNAFTATE † (compare to Tinactin®) 1% C, P, S **Combination Products** CLOTRIMAZOLE W/BETAMETHASONE † (compare to Lotrisone®) C, L *C=cream, F=foam, G=gel, L=lotion, P=powder, S=solution, Sh=shampoo, Sp=spray, Sus=suspension*	Lamisil RX/OTC® (terbinafine) 1% C, S, Sp, G Luzu® (luliconazole) 1% Cream Mentax®) 1% C Naftin® (naftifine) 1% & 2% C, 1%, 2% G Nizoral®* (ketoconazole) 2% Sh Nystatin w/triamcinolone C, O Nystop®, Nyamyc®* (nystatin) P Oxistat® (oxiconazole) 1% C Lotrisone®* (clotrimazole w/betamethasone) C Vusion® (miconazole w/zinc oxide) O *(QL=50 g/30 days)* **All other branded products** **Note**: Please refer to "Dermatological: Antifungals: Onychomycosis" for ciclopirox solution and Penlac® Nail Lacquer	form of a brand topical antifungal. **Vusion:** The patient has a diagnosis of diaper dermatitis complicated by documented candidiasis AND The patient is at least 4 weeks of age.AND The patient has had two trials (with two different preferred antifungal agents) used in combination with a zinc oxide diaper rash product resulting in documented side effects, allergy, or treatment failures.
ANTIVIRALS: TOPICAL		
ABREVA OTC (docosanol) 10% C *C=cream, O=ointment* Note: See Anti-Infectives: Antivirals: Herpes: Oral for Sitavig®	Acyclovir (compare to Zovirax®) 5 % O Denavir® (penciclovir) 1% C Zovirax® (acyclovir) 5% C, O Xerese® (acyclovir 5%/hydrocortisone 1%) C	**Acyclovir, Denavir, Xerese, Zovirax:** The patient has a diagnosis of oral herpes simplex infection and a failure of both oral antiviral and Abreva OTC AND for approval of generic acyclovir ointment, the patient must also have documented intolerance to brand Zovirax. ** Topical antiviral therapy offers minimal clinical benefit in the treatment of genital herpes and its use is discouraged by the CDC so topical antiviral therapy will not be approved for this indication. **
CORTICOSTEROIDS: LOW POTENCY		
ALCLOMETASONE 0.05% C, O† (compare to Aclovate®) FLUOCINOLONE 0.01% C, S, oil† (compare to Derma-Smoothe, Synalar®) HYDROCORTISONE† 0.5%, 1%, 2.5% C; 1%, 2.5% L, 0.5%, 1%, 2.5% O *C=cream, F=foam, G=gel, L=lotion, O=ointment, S=solution*	Capex® (fluocinolone) 0.01% shampoo Derma-Smoothe®* (fluocinolone 0.01%) oil Desonate® (desonide) 0.05% G Desonide† 0.05% C,L,O (compare to DesOwen®) DesOwen®* (desonide) 0.05% C, L Synalar®* (fluocinolone) 0.01% S **All other brands**	**CRITERIA FOR APPROVAL (NON-PREFERRED AGENTS):** The patient has a documented side effect, allergy, or treatment failure to at least two different preferred agents of similar potency. (If a product has an AB rated generic, one trial must be the generic.)
CORTICOSTEROIDS: MEDIUM POTENCY		
BETAMETHASONE DIPROPIONATE† 0.05% C, L, O (formerly Diprosome®)	Cloderm® (clocortolone) 0.1% C Cordran® (all products) Cutivate®(fluticasone) 0.05% L	**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

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
BETAMETHASONE VALERATE† 0.1% C, L, O (formerly Beta-Val®) BETAMETHASONE VALERATE†0.12% (compare to Luxiq®) F CLOCORTOLONE 0.1% C (compare to Cloderm®) FLUOCINOLONE† 0.025% C, O (compare to Synalar®) FLUTICASONE † 0.05% C; 0.005% O (compare to Cutivate®) HYDROCORTISONE BUTYRATE† 0.1% C, O, S MOMETASONE FUROATE† 0.1% C, L, O, S (compare to Elocon®) TRIAMCINOLONE ACETONIDE† 0.025%, 0.1% C, L, O (formerly Aristocort® or Kenalog®)	Dermatop® (prednicarbate) 0.1% C, O desoximetasone 0.05% C, O (compare to Topicort®) Elocon®* (all products) Flurandrenolide (compare to Cordran®) C, L, O Fluticasone† (compare to Cutivate®) 0.05%, L Hydrocortisone Valerate† 0.2% C,O Kenalog® (triamcinolone) Aerosol Spray Luxiq® (betamethasone valerate) F prednicarbate† (compare to Dermatop®) 0.1% C, O Sernivo® (betamethasone dipropionate) 0.05% Spray Synalar®* (fluocinolone) 0.025% C, O Topicort®* (desoximetasone) 0.05% C, O Triamcinolone Aerosol Spray Trianex®* (triamcinolone) 0.05% O **All other brands**	generic, one trial must be the generic.)
CORTICOSTEROIDS: HIGH POTENCY		
AUGMENTED BETAMETHASONE† 0.05% C, L(compare to Diprolene® AF) BETAMETHASONE VALERATE† 0.1% C, O (formerly Beta-Val®) DESOXIMETASONE† 0.05% C, G, O; 0.25% C, O (compare to Topicort®) FLUOCINONIDE† 0.05% C, G, O, S (formerly Lidex®) TRIAMCINOLONE ACETONIDE† 0.5% C, O (formerly Aristocort®) *C=cream, F=foam, G=gel, L=lotion, O=ointment, S=solution*	Amcinonide† (formerly Cyclocort®) Apexicon E® (diflorasone) 0.05% C Diflorasone diacetate† 0.05% C, O (compare to Apexicon E®) Diprolene® AF* (augmented betamethasone) 0.05% C, L Halog® (halcinonide) all products Topicort®* (desoximetasone) 0.05% G; 0.25% C, O, Spray **All other brands**	**CRITERIA FOR APPROVAL (NON-PREFERRED AGENTS):** The patient has a documented side effect, allergy, or treatment failure to at least two different preferred agents of similar potency. (If a product has an AB rated generic, one trial must be the generic.)
CORTICOSTEROIDS: VERY HIGH POTENCY		
AUGMENTED BETAMETHASONE† 0.05% C,L, O (compare to Diprolene®) 0.05% G DIFLORASONE DIACETATE† 0.05% O (compare to Apexicon®, formerly Psorcon E®) HALOBETASOL PROPRIONATE† (compare to Ultravate®) *C=cream, F=foam, G=gel, L=lotion, O=ointment, S=solution*	Clobetasol propionate† (compare to Clobex®) 0.05% L, Sh, Spray Clobetasol propionate (compare to Temovate®/Cormax®) 0.05% C,G,O,S Clobetasol 0.05% F (compare to Oulux®) clobetasol propionate emulsion† (compare to Olux E®) 0.05% F Clobex® (clobetasol propionate) 0.05% L, shampoo,	**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
	spray Diprolene®* (augmented betamethasone) 0.05% L, O Diprolene®AF 0.05% C fluocinonide † (compare to Vanos®)0.1% C Olux® * /Olux E® (clobetasol propionate) 0.05% F Temovate®* (clobetasol propionate) 0.05% C, , O, Vanos® (fluocinonide) 0.1% C Ultravate®* (halobetasol propionate) 0.05% C, O **All other brands**	
GENITAL WART THERAPY		
IMIQUIMOD 5 % (compare to Aldara®) cream PODOFILOX SOLUTION† (compare to Condylox®)	Aldara® (imiquimod) 5% cream Condylox® Gel (podofilox gel) Condylox®* solution (podofilox solution) Veregan® (sinecatechins ointment) (Quantity limit = 15 grams (1 tube)/per 30 days) Zyclara® (imiquimod 3.75%) Cream (Quantity limit = 56 packets)/per 8 weeks) Zyclara® (imiquimod 3.75%) Cream Pump (Quantity limit = 2 pumps/per 8 weeks)	**Condylox gel, Veregan:** The patient has had a documented side effect, allergy, or treatment failure with Aldara **Condylox Solution:** The patient has had a documented intolerance to generic podofilox solution. **Aldara cream:** The patient has had a documented intolerance to generic imiquimod
IMMUNOMODULATORS		
Preferred after Clinical Criteria are Met ELIDEL® (pimecrolimus) § PROTOPTIC® (tacrolimus) §	Tacrolimis Ointment† (compare to Protopic®)	**Criteria for Approval** (requests will be approved for up to 1 year): The patient has a diagnosis of atopic dermatitis (eczema). AND The patient has had a documented side effect, allergy, or treatment failure with at least one moderate to high potency topical corticosteroid within the last 6 months. AND The quantity requested does not exceed 30 grams/fill and 90 grams/6 months. AND If the request is for generic tacrolimus ointment, the patient has a documented intolerance to brand Protopic. **Note:** Use in children less than 2 years of age is not indicated. Protopic ointment 0.1% is not indicated for use in children, only the 0.03% strength.
SCABICIDES AND PEDICULOCIDES		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
SCABICIDES PERMETHRIN† 5 % (compare to Elimite®) *C* **PEDICULICIDES (lice treatment)** PERMETHRIN† 1 % *CR, L* PIPERONYL BUTOXIDE AND PYRETHRINS† *G, S, Sh* NATROBA® (spinosad 0.9 %) *Ss*§ SKLICE® (Ivermectin 0.5 %) *L* *C=cream, CR=crème rinse, G=gel, L=lotion, S=solution, Sh=shampoo, Sp=spray, Ss=suspension*	Elimite™ (permethrin 5%) C Eurax® (crotamiton 10 %) *C, L* Lindane† *L* Lindane† *Sh* Malathion †*L* (compare to Ovide®) Ovide® (malathion) *L* Spinosad† (compare to Natroba) *Ss* Ulesfia® (benzyl alcohol 5%) *L* All other brand and generic Scabicides and Pediculicides	**Non-preferred Scabicides:** The patient has had a documented side effect or allergy to permethrin cream or treatment failure with two treatments of permethrin cream. **Non-Preferred Pediculicides:** The patient has had a documented side effect or allergy to OTC permethrin and piperonyl butoxide and pyrethrins and one treatment of Natroba or Sklice OR treatment failure with two treatments of OTC permethrin and/or piperonyl butoxide and pyrethrins and one treatment of Natroba or Sklice. For approval of Ovide® Lotion, the patient must also have a documented intolerance to the generic equivalent product.
DESMOPRESSIN: INTRANASAL/ORAL		
Intranasal **Oral** DESMOPRESSIN†	DDAVP® (desmopressin) Nasal Solution or Spray 0.01% Desmopressin † Nasal Solution or Spray 0.01 % (compare to DDAVP®) Minirin † (desmopressin) Nasal Spray 0.01% Stimate® (desmopressin) Nasal Solution 1.5 mg/ml DDAVP®* (desmopressin) tablets	**CRITERIA FOR APPROVAL:** Intranasal: 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. **CRITERIA FOR APPROVAL:** non-preferred oral: The diagnosis or indication for the requested medication is (1) Diabetes Insipidus and/or (2) primary nocturnal enuresis AND The patient has had a documented intolerance to generic desmopressin tablets **LIMITATIONS:** Desmopressin intranasal formulations will not be approved for the treatment of primary nocturnal enuresis (PNE) due to safety risks of hyponatremia. Oral tablets may be prescribed for this indication.
DIABETIC TESTING SUPPLIES		
MONITORS/METERS		
Please refer to the DVHA website for covered Diabetic testing supplies.		**CRITERIA FOR APPROVAL:** The prescriber demonstrates that the patient has a medical necessity for clinically significant features that are not available on any of the preferred meters/test strips.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		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.
EPINEPHRINE: AUTO-INJECTOR		
EPINEPHRINE INJ (compare to Epipen-Jr®) (authorized generic, Mylan labeler code 49502 is the only preferred form) 0.15mg (epinephrine 0.15mg/0.15ml (1:000)) EPINEPHRINE INJ (compare to Epipen®) (authorized generic, Mylan labeler code 49502 is the only preferred form) 0.3mg (epinephrine 0.3mg/0.3ml (1:000))	Adrenaclick® 0.15MG (epinephrine 0.15mg/0.15ml (1:1000)) Adrenaclick® 0.3MG (epinephrine 0.3mg/0.3ml (1:1000)) Epinephrine Inj (compare to Adrenaclick®) 0.15mg (epinephrine 0.15mg/0.15ml (1:1000)) Epinephrine Inj (compare to Adrenaclick®) 0.3mg (epinephrine 0.3mg/0.3ml (1:1000)) Epipen® 2-PAK inj 0.3mg (epinephrine 0.3mg/0.3ml (1:1000)) Epipen-Jr® 2-PAK inj 0.15mg (epinephrine 0.15mg/0.3ml (1:1000))	**Epipen, Adrenaclick, non-authorized generics:** The patient must have a documented intolerance to the authorized generic epinephrine.
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
FIBROMYALGIA AGENTS		
	Savella® (milnacipran) tablet, titration pack *Quantity Limit = 2 tablets/day* Cymbalta® (duloxetine) Duloxetine† (compare to Cymbalta®) Lyrica® (pregabalin)	**Savella:** The diagnosis or indication is treatment of fibromyalgia AND The patient has had a documented side effect, allergy, or treatment failure to TWO drugs from the following: gabapentin, tricyclic antidepressant, SSRI antidepressant, SNRI antidepressant, miscellaneous antidepressant, cyclobenzaprine or Lyrica. **Cymbalta/Duloxetine:** The patient has had a documented side effect, allergy, or treatment failure to TWO drugs from the following: gabapentin, tricyclic antidepressant, SSRI antidepressant, SNRI antidepressant, miscellaneous antidepressant, cyclobenzaprine, Lyrica® or Savella® (this indication not processed via automated step therapy) AND if the request is for duloxetine, the patient has had a documented intolerance with brand Cymbalta. **Lyrica:** The patient has had a documented side effect, allergy, or treatment failure to TWO drugs from the following: gabapentin, tricyclic antidepressant, SSRI antidepressant, SNRI antidepressant, miscellaneous antidepressant, cyclobenzaprine or Savella®, if medication is being used for fibromyalgia (this indication not processed via automated step therapy) AND If the request is for the oral solution, the patient is unable to use Lyrica capsules (eg. swallowing disorder).
GASTROINTESTINAL		
INFLAMMATORY BOWEL DISEASE INJECTABLES (Initial approval is 3 months; renewals are 1 year)		
Preferred After Clinical Criteria Are Met HUMIRA® (adalimumab) *Quantity limit = 6 syringes/28 days for the first month (Crohn's starter kit);2 syringes/28 days subsequently* REMICADE® (infliximab)	Cimzia® (certolizumab pegol) *Quantity limit = 1 kit/28 days* Inflectra® (infliximab-dyyb) biosimilar to Remicade® Entyvio® (vedolizumab) *Quantity limit = 300mgX 3/42 days, 300mg X 1 every 56 days thereafter* Simponi® (golimumab) SC *3 of 100mg prefilled syringe or autoinjector X 1, then 100mg/28days* Stelara® (ustekinumab) Tysabri® (natalizumab)	**Clinical Criteria (Crohn's Disease)** **Humira, Remicade, Cimzia, Tysabri, Entyvio, Inflectra, Stelara:** • Patient has a diagnosis of Crohn's disease and has already been stabilized on the medication. OR • Diagnosis is moderate to severe Crohn's disease and at least 2 of the following drug classes resulted in an adverse effect, allergic reaction, inadequate response, or treatment failure (i.e. resistant or intolerant to steroids or immunosuppressants): aminosalicylates, antibiotics, corticosteroids, and immunomodulators such as azathioprine, 6-mercaptopurine, or methotrexate. Note: Humira and Cimzia have been shown to be effective in patients who have been treated with infliximab

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		but have lost response to therapy. **Cimzia additional criteria:** • Patient age > 18 years AND • The prescriber must provide a clinically valid reason why Humira cannot be used. **Inflectra additional criteria:** • The prescriber must provide a clinically valid reason why Humira and Remicade cannot be used. **Tysabri additional criteria:** • The patient has a documented side effect, allergy, treatment failure, or contraindication to BOTH, Remicade and Humira. **Entyvio, Stelara additional criteria:** • Patient age > 18 years AND • The patient has a documented side effect, allergy, treatment failure (including corticosteroid dependence despite therapy), or contraindication to BOTH Remicade and Humira • Note: Initial IV dose for Stelara will be approved through the medical benefit. All subsequent subcutaneous doses may be approved through the pharmacy benefit with quantity limit of 90mg every 8 weeks **Clinical Criteria (Ulcerative Colitis)** **Humira, Remicade:** • Patient has a diagnosis of Ulcerative Colitis and has already been stabilized on the medication. OR • The patient has a diagnosis of Ulcerative Colitis and has had a documented side effect, allergy or treatment failure with at least 2 of the following 3 agents: aminosalicylates (e.g. sulfasalazine, mesalamine, etc), corticosteroids, or immunomodulators (e.g. azathioprine, 6-mercaptopurine, cyclosporine, etc.). **Entyvio, Simponi:** • Patient has a diagnosis of ulcerative colitis and has already been stabilized on the drug OR • Age > 18 years AND a diagnosis of ulcerative colitis AND • has demonstrated corticosteroid dependence or has had an inadequate response to or failed to tolerate oral aminosalicylates, oral corticosteroids, azathioprine, or 6-mercaptopurine AND the prescriber must provide a clinically valid reason why Humira and Remicade cannot be used. **Inflectra:** • 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

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		following 3 agents: aminosalicylates (e.g. sulfasalazine, mesalamine, etc), corticosteroids, or immunomodulators (e.g. azathioprine, 6-mercaptopurine, cyclosporine, etc.) AND the prescriber must provide a clinically valid reason why Humira and Remicade cannot be used.
H.PYLORI COMBINATION THERAPY		
	Lansoprazole, amoxicillin, clarithromycin (compare to Prevpac®) *(Quantity limit = 112 caps & tabs/14 days)* Omeclamox-Pak® (omeprazole, clarithromycin, amoxicillin) *(Quantity limit = 80 caps & tabs/10 days)* Prevpac® (lansoprazole, amoxicillin, clarithromycin) *(Quantity limit = 112 caps & tabs/14 days)* Pylera® (bismuth subcitrate, metronidazole, tetracycline) capsules *(Quantity limit=120 capsules/10 days)*	**CRITERIA FOR APPROVAL:** The patient has a documented treatment failure with combinations of individual proton pump inhibitors or H2 antagonists given together with two appropriate antibiotics OR The patient has been unable to be compliant with individual agents prescribed separately. AND For approval of brand Prevpac®, the patient has a documented intolerance to the generic equivalent combination product.
H-2 BLOCKERS		
FAMOTIDINE† (compare to Pepcid®) tablet RANITIDINE† (compare to Zantac®) tablet **SYRUPS AND SPECIAL DOSAGE FORMS** CIMETIDINE † ORAL SOLUTION RANITIDNE† syrup (compare to Zantac®)	Cimetidine† (compare to Tagamet®) tablet Pepcid®* (famotidine) tablet § ranitidine† capsule § Tagamet®* (cimetidine) tablet § Zantac®* (ranitidine) tablet § famotidine† (compare to Pepcid®) oral suspension § Nizatidine †Oral Solution (compare to Axid®) Pepcid® (famotidine) Oral Suspension §	**Nizatidine capsule, Pepcid tablet, ranitidine capsule, Tagamet tablet, Zantac tablets:** The patient has had a documented side effect, allergy, or treatment failure to at least one preferred medication. If a medication has an AB rated generic, the trial must be the generic formulation. For approval of ranitidine capsules, the patient must have had a trial of ranitidine tablets. **Famotidine Oral Suspension, Nizatidine Oral Solution, Pepcid Oral Suspension:** The patient has had a documented side effect, allergy, or treatment failure to ranitidine syrup or cimetidine oral solution. If a medication has an AB rated generic, there must have been a trial of the generic formulation. **Cimetidine tablet** current users as of 05/29/2015 would be grandfathered
INFLAMMATORY BOWEL AGENTS (ORAL & RECTAL PRODUCTS)		
MESALAMINE PRODUCTS	Asacol HD® (mesalamine tablet delayed release)	**Azulfidine, Colazal:** patient has had a documented intolerance to the generic equivalent of the requested medication.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
Oral APRISO® (mesalamine capsule extended-release) ASACOL® (mesalamine tablet delayed-release) DELZICOL® (mesalamine capsule delayed-release) *(QL = 6 capsules/day)*		**Asacol HD:** The patient has had a documented side effect, allergy, or treatment failure with two (2) preferred oral mesalamine products. **Entocort EC/Uceris ER tab:** The patient had a documented intolerance to the generic budesonide 24 hr capsules.
LIALDA® (mesalamine tablet extended-release) PENTASA ER 250mg® (mesalamine cap CR)	Pentasa ER 500mg® (mesalamine cap CR) Sfrowasa® (mesalamine enema sulfite free)	**Giazo:** The diagnosis is ulcerative colitis AND The patient is male and > 18 years old. AND The patient has a documented intolerance to generic balsalazide. **Pentasa 500mg current users as of 8/7/2015 will be grandfathered** **Sfrowasa:** The patient has had a documented intolerance to mesalamine enema. **LIMITATIONS:** Kits with non-drug products are not covered.
Rectal CANASA® (mesalamine suppository) MESALAMINE ENEMA† (compare to Rowasa®)	Entocort EC®* (budesonide 24 hr cap) *QL = 3 capsules/day* Uceris® (budesonide) ER Tablet *QL = 1 tablet/day*	
CORTICOSTEROIDS **ORAL** BUDESONIDE 24HR (compare to Entocort EC®) *QL = 3 capsules/day* **RECTAL** UCERIS RECTAL FOAM (budesonide) **OTHER** BALSALAZIDE† (compare to Colazal®) DIPENTUM® (olsalazine) SULFAZINE SULFAZINE EC SULFASALAZINE† (compare to Azulfidine®) SULFASALAZINE DR	Azulfidine®* (sulfasalazine) Colazal®* (balsalazide) Giazo® (balsalazide disodium) tablet *QL = 6 tablets/day*	
PROKINETIC AGENTS		
Tablets METOCLOPRAMIDE† tabs (compare to Reglan®) **Oral Solution** METOCLOPRAMIDE† (formerly Reglan®) oral sol	Reglan®* (metoclopramide)	**Reglan:** The patient has had a documented intolerance to generic metoclopramide tablets.
Orally Disintegrating Tablets	Metozolv ODT® (metoclopramide) *(QL= 4 tabs/day)*	**Metozolv ODT:** The patient has a medical necessity for a disintegrating tablet formulation (i.e. swallowing disorder, inability to take oral medications) AND Generic metoclopramide oral solution cannot be used
PROTON PUMP INHIBITORS		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ORAL CAPULES/TABLETS OMEPRAZOLE† RX capsules (compare to Prilosec®) *(Quantity limit = 1 capsule/day)* PANTOPRAZOLE† tablets (compare to Protonix®) *(Quantity limit=1 tab/day)* LANSOPRAZOLE† generic RX capsules (compare to Prevacid®) § *(Quantity limit = 1 cap/day)*	Aciphex® (rabeprazole) tablets *(Quantity limit=1 tab/day)* Dexilant® (dexlansoprazole) capsules *(Quantity limit=1 cap/day)* Esomeprazole® Strontium capsules *(Quantity limit = 1 cap/day)* Nexium® (esomeprazole) capsules § *(Quantity limit=1 cap/day)* omeprazole † generic OTC tablets *(Quantity limit=1 tab/day)* omeprazole magnesium† generic OTC 20 mg capsules § *(Quantity limit=1 cap/day)* omeprazole/sodium bicarb capsules RX (compare to Zegerid®) § *(Quantity limit=1 cap/day)* Prevacid® RX (lansoprazole) capsules *(Quantity limit=1 cap/day)* Prevacid® 24 hr OTC (lansoprazole) capsules *(Quantity limit=1 cap/day)* Prilosec OTC® 20mg (omeprazole magnesium) tablets *(Quantity limit = 1 tablet/day)* Prilosec®* RX (brand) (omeprazole) capsules *(Quantity limit=1 cap/day)* Protonix®* (pantoprazole) tablets *(Quantity limit=1 tab/day)* rabeprazole (compare to Aciphex®) tablets *(Quantity limit = 1 tab/day)* Zegerid RX ® (omeprazole/sodium bicarb) caps, oral, suspension *(Quantity limit=1 cap/day)*hex® Sprinkle (rabeprazole) DR Capsule *(Quantity limit=1 cap/day)*	**Nexium powder for suspension, Prevacid Solutabs (for patients > 12 years old), Prilosec packet, and Protonix packet:** The patient has a requirement for a non-solid oral dosage form (e.g. an oral liquid, dissolving tablet or sprinkle). **Aciphex Sprinkle:** The patient has a requirement for a non-solid oral dosage form AND The member has had a documented side effect, allergy, or treatment failure to omeprazole capsule opened and sprinkled omeprazole or lansoprazole suspension or Prevacid solutab. **Other non-preferred medications:** The member has had a documented side effect, allergy, or treatment failure to Omeprazole RX generic capsules, Lansoprazole RX generic capsules, and Pantoprazole generic tablets. If the request is for Prevacid 24 hr OTC or Prevacid RX, the patient must also have a documented intolerance to lansoprazole generic RX capsules. If the request is for brand Zegerid RX capsules, the patient must also have a documented intolerance to the generic equivalent. **CRITERIA FOR APPROVAL (twice daily dosing):** **Gastroesophageal Reflux Disease (GERD)** – If member has had an adequate trial (e.g. 8 weeks) of standard once daily dosing for GERD, twice daily dosing may be approved. **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. Nexium 24HR OTC (esomeprazole) capsules OTC Plan Exclusion - these products are not covered.
SUSPENSION & SPECIAL DOSAGE FORMS	Nexium® (esomeprazole) powder for suspension § *(Quantity limit=1 packet/day)* Prevacid Solutabs® (lansoprazole) *(Quantity limit=1 tab/day)* Prilosec® (omeprazole magnesium) packet *(Quantity limit=2 packets/day)* Protonix® (pantoprazole) packet *(Quantity limit=1 packet/day)*	

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
GAUCHER'S DISEASE MEDICATIONS		

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

GOUT AGENTS		
SINGLE INGREDIENT COLCHICINE MITIGARE® (colchicine) capsule QL= 2 capsule/day **SINGLE INGREDIENT URICOSURIC AGENTS** PROBENECID† **XANTHINE OXIDASE INHIBITORS** ALLOPURINOL† (compare to Zyloprim®)	Colcrys® (colchicine) tablet *QL = 3 tablets/day (gout) or 4 tablets/day (FMF)* Colchicine tablets (compare to Colcrys®) Colchicine capsules Zyloprim®* (allopurinol)	**Colcrys, colchicine tablets:** *Diagnosis or indication is Familial Mediterranean Fever (FMF) or Diagnosis* OR *Diagnosis or indication is acute treatment of gout flares:* The patient has had a documented side effect or treatment failure with at least one drug from the NSAID class OR the patient is not a candidate for therapy with at least one drug form the NSAID class due to one of the following: • The patient is 60 years of ager or older • The patient has a history of GI bleed • The patient is currently taking an anticoagulant (warfarin or heparin), an oral corticosteroid, or methotrexate. OR

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
COMBINATION PRODUCTS COLCHICINE/PROBENECID† **PEG-URICASE AGENTS**	Zurampic® (lesinurad) Uloric® (febuxostat) *QL (40 mg tablets) = 1 tablet/day*	*Diagnosis or indication is prophylaxis of gout flares in adults:* the patient must have a documented intolerance to Mitigare capsules. **Colchicine capsules:** the diagnosis or indication is prophylaxis of gout flares in adults AND the patient must have a documented intolerance to Mitigare capsule. **Uloric:** The diagnosis or indication is treatment of gout AND The patient has had a documented side effect, allergy, treatment failure or a contraindication to allopurinol. NOTE: Treatment failure is defined as inability to reduce serum uric acid levels to < 6 mg/dl with allopurinol doses of 600 mg/day taken consistently. Additionally, renal impairment is not considered a contraindication to allopurinol use. **Zurampic:** The diagnosis or indication is treatment of symptomatic hyperuricemia associated with gout AND the patient has not achieved target serum uric acid levels (< 6 mg/dl) with an allopurinol dose of at least 300mg or febuxostat 80mg AND the medication is being used in combination with a xanthine oxidase inhibitor (Zurampic is not recommended for use as monotherapy). **Zyloprim:** The patient has had a documented intolerance to generic allopurinol
GROWTH STIMULATING AGENTS		
GENOTROPIN® NORDITROPIN®	Humatrope® Nutropin® AQ Omnitrope® Saizen® Zomacton® **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

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		radiological eradication of the pituitary. OR Adult Growth Hormone Deficiency confirmed by one growth hormone stimulation test (insulin, arginine, levodopa, propranolol, clonidine, or glucagon) showing results (peak level) <5ng/ml. Growth hormone deficient children must be retested after completion of growth. **LIMITATIONS:** Coverage of Growth Hormone products will not be approved for patients who have Idiopathic Short Stature. **HUMATROPE, NUTROPIN AQ, OMNITROPE, SAIZEN, ZOMACTON:** The patient has a documented side effect, allergy, or treatment failure to both preferred agents. **Increlex:** Member has growth hormone gene deletion AND neutralizing antibodies to growth hormone, OR primary insulin-like growth factor (IGF-1) deficiency (IGFD), defined by the following: o Height standard deviation score < -3 AND Basal IGF-1 standard deviation score < -3 AND Normal or elevated growth hormone level Member is ≥ 2 years old (safety and efficacy has not been established in patients younger than 2), AND Member has open epiphysis, AND Member is under the care of an endocrinologist or other specialist trained to diagnose and treat growth disorders. **Serostim:** A diagnosis of AIDS associated wasting/anorexia **Zorbtive:** A diagnosis of short bowel syndrome. Concomitant use of specialized nutritional support (specialty TPN) Prescription must be issued by gastroenterologist (specialist)
HEMOPHILIA FACTORS		
AHF-Factor VII		
NOVOSEVEN® RT		
AHF-Factor VIII		
ADVATE® HELIXATE FS® HEMOFIL® M KOATE®-DVI KOGENATE FS® MONOCLATE-P® NOVOEIGHT® OBIZUR® RECOMBINATE®	Adynovate® Afstyla® Eloctate® Nuwiq® Kovaltry®	**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.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
XYNTHA®		
AHF-Factor IX		
ALPHANINE® SD BEBULIN® BENEFIX® MONONINE®	Alprolix® Idelvion® Ixinity® Kcentra® Profilnine® Rixubis®	**All Non-Preferred Products:** The prescriber must provide a clinically compelling reason for the use of the requested medication including reasons why any of the preferred products would not be suitable alternatives.
AHF-Von Willebrand Factor		
ALPHANATE® HUMATE-P® WILATE®	Vonvendi®	**All Non-Preferred Products:** The prescriber must provide a clinically compelling reason for the use of the requested medication including reasons why any of the preferred products would not be suitable alternatives.
HEPATITIS B AGENTS		
ENTECAVIR (compare to Baraclude®) VIREAD® (tenofovir disoproxil fumarate)	Adefovir (compare to Hepsera®) Baraclude® (entecavir) Epivir-HBV® (lamivudine) Hepsera® (adefovir dipivoxil) Lamivudine HBV (compare to Epivir-HBV®) Vemlidy® (tenofovir alafenamide fumarate)	**Adefovir, Hepsera, Lamivudine HBV, Epivir-HBV:** The prescriber must provide a clinically compelling reason for the use of the requested medication including reasons why any of the preferred products would not be suitable alternatives AND for approval of brand Hepsera or Epivir-HBV, the patient has a documented intolerance to the generic. **Note:** AASLD and WHO guidelines recommend these not be utilized first line due to potential for the development of resistance. **Baraclude tabs:** the patient has a documented intolerance to generic entecavir. **Baraclude suspension:** the patient has a medical necessity for a non-solid oral dosage form. **Vemlidy:** the patient must have a diagnosis of osteoporosis, renal insufficiency (CrCl < 60ml/min), or other contraindication to Viread such as chronic steroid use.
HEPATITIS C AGENTS		
Initial PA: 3 months; subsequent maximum 3 months		
RIBASPHERE† 200 mg tabs RIBAVIRINn† 200 mg tablets ***<u>Preferred After Clinical Criteria Are Met</u>*** EPCLUSA® (sofosbuvir/velpatasvir) HARVONI® (ledipasvir/sofosbuvir) TECHNIVIE® (ombitasvir, paritaprevir, ritonavir)	***<u>Non-Preferred After Clinical Criteria Are Met</u>*** Copegus® (ribavirin 200 mg tabs) Daklinza® (daclatasvir) Moderiba® tablets,Dose Pak (ribavirin) Olysio® (simeprevir) 150 mg Capsules *(QL = 1capsule/day)(Maximum 12 weeks/lifetime)* Pegasys® (peginterferon alfa-2a)*(QL=4 vials/28 days)* Pegasys Convenience PAK®(peg-interferon alfa-	**Direct Acting Agents: Daklinza, Epclusa, Harvoni, Olysio, Sovaldi, Technivie and Viekira pak, Viekira XR, Zepatier:** • Hep C PA form must be completed and clinical documentation supplied. Combination therapy will be either approved or denied in its entirety. • Member must have Metavir fibrosis score of F2, F3, or, F4. • Prescriber is, or has consulted with, a hepatologist, gastroenterologist or infectious disease specialist, or other hepatitis specialist. Consult must be within the past year with documentation of recommended regimen. • See PA form for detailed requirements and for documentation required • For approval of a non-preferred agent, the provider must submit clinical

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
PEG-INTRON/PEG-INTRON REDIPEN (peginterferon alfa-2b) *(QL= I kit (4 pens per) 28 days)* PEG-INTRON REDIPEN PAK 4 (peginterferon alfa-2b) *(QL= I kit (4 pens per) 28 days)*	2a)*(QL=1 kit/28 days)* Pegasys Proclick (peginterferon alfa-2a) Rebetol Oral Solution® (ribavirin 40 mg/ml) Ribapak Dose Pack® (ribavirin) ribavirin † 200 mg capsules Ribasphere† 400 and 600 mg tabs(ribavirin) SOVALDI® (sofosbuvir) Viekira PAK® (ombitasvir, paritaprevir, ritonavir tablet with dasabuvir tablet) Viekira® XR (dasabuvir, ombitasvir, paritaprevir, and ritonavir) extended-release tablets Zepatier® (elbasvir/grazoprevir)	documentation detailing why the patient is not a candidate for a preferred direct acting agent regimen. **Pegasys:** Diagnosis is hepatitis C AND the patient has a documented side effect, allergy or treatment failure to Peg-Intron **Non-preferred Ribavirin Brands/strengths:** The patient is unable to use generic ribavirin 200 mg tablets
HEREDITARY ANGIOEDEMA MEDICATIONS		
	Berinert® (human C1 inhibitor) Cinryze® (human C1 inhibitor) *(QL =20 vials/30days)* Firazyr® (icatibant) *(QL = 3 syringes (9 ml)/fill)* Kalbitor® (escallantide) *(QL = 6 vials (2 packs) per fill)* Ruconest® (recombinant C1 esterase inhibitor) *(QL = 4 vials/fill)*	**Berinert, Firazyr, Kalbitor:** The diagnosis or indication is treatment of an acute Hereditary Angioedema (HAE) attack. (Approval may be granted so that 2 doses may be kept on hand for Berinert or Kalbitor and 3 doses for Firazyr). **Cinryze:** The diagnosis or indication is prophylaxis of Hereditary Angioedema (HAE) attacks. **Ruconest:** The diagnosis or indication is treatment of an acute Hereditary Angioedema (HAE) attack AND the patient has had a documented side effect, allergy, treatment failure or a contraindication to Berinert® (Approval may be granted so that 2 doses may be kept on hand)
EXONDIDIOPATHIC PULMONARY FIBROSIS (IPF)		
	Esbriet® (pirfenidone) (*QL = 270 tabs/month)* Ofev® (nintedanib) (*QL = 60 tabs/month)*	**Clinical Criteria: Esbriet, Ofev** ○ Age ≥ 18 ○ Diagnosis of idiopathic pulmonary fibrosis (IPF-ICD-9 Code 516.31 or ICD-10 code J84.112) as well as exclusion of other known causes of Interstitial Lung Disease. ○ May not be used in combination with Ofev® or Esbriet® respectively. ○ The prescriber is a pulmonologist. ○ Clinical documentation that the member is a non-smoker or has not smoked in 6 weeks. ○ FVC≥ 50% of predicted ○ AND one of the following ○ High-resolution computed tomography (HRCT) revealing IPF

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		or probable IPF. ○ Surgical lung biopsy consistent with IPF or probable IPF. **Reauthorization Criteria:** ○ Documentation the patient is receiving clinical benefit to Esbrit® or Ofev® therapy as evidenced by < 10% decline in percent predicted FVC of < 200mL decrease in FVC AND ○ There is clinical documentation that the member has remained tobacco-free.
IMMUNOLOGIC THERAPIES FOR ASTHMA		
(Initial 3 months, Renewal 1 year)		
	Xolair® (omalizumab) subcutaneous injection vial *Quantity limit = 6 vials every 28 days* Nucala® (mepolizumab) subcutaneous injection *Quantity limit = 1 vial every 28 days* Cinqair® (reslizumab) Intravenous injection	**Xolair®:** *Diagnosis of moderate to severe persistent asthma:* • The patient must be 6 years of age or older AND • The patient has had a therapeutic failure or contraindication to an inhaled corticosteroid (with or without chronic oral corticosteroid therapy), a leukotriene receptor antagonist, and a long-acting beta-agonist AND • The prescriber is a pulmonologist, allergist, or immunologist AND • Patient has tested positive to at least one perennial aerollergen by skin or blood test (i.e.: RAST, CAP, intracutaneous test) AND • Patient has a IgE level ≥ 30 and ≤ 700 IU/ml (ages 12 and older) OR IgE level ≥ 30 and ≤ 1300 IU/ml (ages 6-11) prior to beginning therapy with Xolair. *Diagnosis of chronic idiopathic urticaria:* • The patient must be 12 years of age or older AND • The patient has a therapeutic failure or contraindication to an H1 antihistamine (e.g. cetirizine, fexofenadine) at double the daily dose AND • The patient has therapeutic failure or contraindication to a leukotriene receptor antagonist. **Limitations:** Xolair use will not be approved if requested for prevention of peanut related allergic reaction or in patients with a diagnosis of moderate to severe persistent asthma who are currently smoking. **Nucala, Cinqair:** • The patient must be 12 years of age or older for Nucala or 18 years of age or older for Cinqair AND • The patient must have a diagnosis of severe persistent asthma with an eosinophilic phenotype as defined by pre-treatment blood eosinophil count of ≥ 150 cells per mcL within the previous 6 weeks or ≥ 300 cells

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		per mcL within 12 months prior to initiation of therapy AND • The patient has a history of 2 or more exacerbations in the previous year despite regular use of high dose inhaled corticosteroids (ICS) AND inadequate symptom control when given in combination with another controller medication (long-acting beta agonist {LABA} or leukotriene receptor antagonist {LTRA}) for a minimum of 3 consecutive months, with or without oral corticosteroids. Pharmacy claims will be evaluated to assess compliance with therapy. AND • The patient has a pre-treatment FEV_1 < 80% predicted AND • The prescriber is an allergist, immunologist, or pulmonologist. AND For continuation of therapy after the initial 3 month authorization, the patient must continue to receive therapy with both an ICS and a controller medication (LABA or LTRA) AND have either a decreased frequency of exacerbations OR decreased use of maintenance oral corticosteroids OR reduction in the signs and symptoms of asthma OR an increase in predicted FEV_1 from baseline. **Limitations:** Nucala® and Cinqair® will not be considered in patients who are currently smoking, in combination with omalizumab, OR for treatment of other eosinophilic conditions.
IMMUNOSUPPRESANTS, ORAL		
AZATHIOPRINE tablet CYCLOSPORINE capsule CYCLOSPORINE MODIFIED MYCOPHENOLATE MOFETIL tablet, capsule, suspension MYCOPHENOLIC ACID delayed release tablet SIROLIMUS tablet TACROLIMUS capsule ZORTRESS® (everolimus) tablet	Astagraf® XL (tacrolimus) capsule Azasan® (azathioprine) tablet Cellcept® (mycophenolate mofetil) tablet, capsule, suspension Envarsus® XR (tacrolimus) tablet Gengraf® (cyclosporine modified) capsule, solution Imuran® (azathioprine) tablet Myfortic® (mycophenolic acid) delayed release tablet Neoral® (cyclosporine modified) capsule, solution Prograf® (tacrolimus) capsule Rapamune® (sirolimus) tablet, solution Sandimmune® (cyclosporine) capsule, solution	**Criteria:** The patient has been started and stabilized on the requested product OR the patient has a documented side effect, allergy, or treatment failure to a preferred agent (if a product has and AB rated generic, there must be a trial of the generic formulation).
INTERLEUKIN (IL)-1 RECEPTOR BLOCKERS		
Preferred After Clinical Criteria Are Met ILARIS® (canakinumab)	Arcalyst® (rilonacept) *(QL = 2 vials for loading dose, then 1 vial per week)*	**Ilaris:** The diagnosis is Cryopyrin-Associated Periodic Syndrome (CAPS) OR The diagnosis is Familial Cold Autoinflammatory Syndrome (FCAS), Familial Mediterranean Fever (FMF), Hyper-IgD periodic fever syndrome (HIDS),

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		Muckle-Wells Syndrome (MWS), or Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS) AND The patient is > 4 years old OR The diagnosis is systemic juvenile idiopathic arthritis (sJIA) with active systemic features and varying degrees of synovitis with continued disease activity after initial therapy (Initial therapy defined as 1 month of anakinra (Kineret), 2 weeks of glucocorticoid monotherapy (oral or IV) or one month of NSAIDs). AND patient is > 2 years of age. **Arcalyst:** The diagnosis is Cryopyrin-Associated Periodic Syndrome (CAPS) OR The diagnosis is Familial Cold Autoinflammatory Syndrome (FCAS) OR The diagnosis is Muckle-Wells Syndrome (MWS) AND The patient is > 12 years old AND The patient must have a documented side effect, allergy, treatment failure or a contraindication to Ilaris (canakinumab) **Note:** Medical Records to support the above diagnosis must accompany the Prior Authorization request. Authorization for continued use shall be reviewed at least every 12 months to confirm patient has experienced disease stability or improvement while on therapy.
IRON CHELATING AGENTS		
EXJADE® (deferasirox) FERRIPROX® (deferiprone)	Jadenu® (deferasirox)	**Jandenu®:** patient has had a documented side effect allergy or treatment failure to Exjade®; Jadenu® will not be approved without compelling clinical reason why Exjade® cannot be used as they are different forms of the same medication
LIPOTROPICS		
BILE ACID SEQUESTRANTS		
CHOLESTYRAMINE† powder (compare to Questran®) CHOLESTYRAMINE LIGHT† powder (compare to Questran Light®) PREVALITE† powder (cholestyramine light) COLESTIPOL† tablets, granules (compare to Colestid®) WELCHOL® (colesevelam) tablets, powder packets	Questran®* powder (cholestyramine) Questran Light®* powder (cholestyramine light) Colestid®* tablets, granules (colestipol)	**Questran, Questran Light, Colestid:** The patient has had a documented intolerance to the preferred generic formulation.
FIBRIC ACID DERIVATIVES		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
GEMFIBROZIL† (compare to Lopid®) 600 mg FENOFIBRATE NANOCRYSTALIZED† (compare to Tricor®) 48 mg, 145 mg tablets *Quantity Limit = 1 tablet/day*	Antara® (fenofibrate micronized) 43 mg, 30 mg, 90 mg, 130 mg fenofibrate tablets†(compare to Lofibra® tablets) § 54 mg, 160 mg fenofibrate capsule† (compare to (Lipofen®) § 50 mg, 150 mg fenofibrate micronized capsule†(compare to Lofibra® capsules) 67 mg, 134 mg, 200 mg fenofibrate micronized† (compare to Antara®) § 43 mg, 130 mg fenofibric acid (compare to Trilipix) 45mg, 135mg delayed release capsule fenofibric acid § 35 mg, 105 mg *Quantity Limit = 1 capsule/day* Fenoglide® (fenofibrate MeltDose) 40 mg, 120 mg Fibricor® (fenofibric acid) § 35 mg, 105 mg Lipofen® (fenofibrate) 50 mg, 150 mg Lofibra® (fenofibrate micronized) Capsules 67mg, 134 mg, 200 mg Lofibra® (fenofibrate) Tablets 54 mg, 160 mg Lopid®* (gemfibrozil) 600 mg Tricor® (fenofibrate nanocrystallized) § 48 mg, 145 mg Triglide® (fenofibrate) 50 mg, 160 mg Trilipix (fenofibric acid) §45 mg, 135 mg delayed release capsule	**Lopid:** The patient has had a documented intolerance to generic gemfibrozil. **Antara, fenofibrate, fenofibrate micronized, fenofibric acid (all strengths), Fenoglide,Fibricor, Lipofen, Lofibra, Tricor, Triglide, and Trilipix:** The patient is taking a statin concurrently and has had a documented side effect, allergy, or treatment failure with preferred fenofibrate nanocrystallized. (If a product has an AB rated generic, there must have been a trial with the generic formulation.) OR The patient has had a documented side effect, allergy, or treatment failure to gemfibrozil and preferred fenofibrate nanocrystallized. (If a product has an AB rated generic, there must have been a trial with the generic formulation.)
HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMA (HoFH) AGENTS		
All products require a PA	Juxtapid® (lomitapide) Capsule *QL = 5 and 10 mg caps (1 per day), 20 mg cap (3 per day)* Kynamro® (mipomersen) Syringe for Subcutaneous Injection *QL = 4 syringes(4 ml)/28 days* Maximum days' supply per fill for all drugs is 28 days	**CRITERIA FOR APPROVAL:** Patient has a diagnosis of homozygous familial hypercholesterolemia (HoFH) AND Medication will be used as adjunct to a low-fat diet and other lipid-lowering treatments AND Patient does not have any of the following contraindications to therapy: ▪ Pregnancy (Juxtapid) ▪ Concomitant use with strong or moderate CYP3A4 inhibitors (Juxtapid) ▪ Moderate or severe hepatic impairment or active liver disease including unexplained persistent abnormal liver function tests (Juxtapid, Kynamro) AND Patient has tried and had an inadequate response, intolerance or

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		contraindication to BOTH atorvastatin and rosuvastatin. Note: Re-approval requires confirmation that the patient has responded to therapy (i.e. decreased LDL levels) AND the patient does not have any contraindications to therapy.
NICOTINIC ACID DERIVATIVES		
NIACIN† NIACOR®† (niacin) NIASPAN® (niacin extended release)	Niacin extended release† (compare to Niaspan®)	**CRITERIA FOR APPROVAL:** The patient has a documented intolerance to the branded product.
STATINS		
ATORVASTATIN (compare to Lipitor®) CRESTOR® (rosuvastin) LOVASTATIN (compare to Mevacor®) PRAVASTAIN (compare to Pravachol®) ROSUVASTATIN (compare to Crestor®) SIMVASTATIN (compare to Zocor®) **Note:** All preferred agents have a quantity limit of 1 tablet/day	Altoprev® (lovastatin SR) Fluvastatin Fluvastatin ER (compare to Lescol® XL) Lescol® XL (fluvastatin ER) Lipitor® (atorvastatin) Livalo® (pitavastatin) Mevacor® (lovastatin) Pravachol® (pravastatin) Zocor® (simvastatin) **Note:** All non-preferred agents have a quantity limit of 1 tablet/day except fluvastatin IR which has a quantity linit 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. **LIMITATIONS: Simvastatin 80 mg:** initiation of simvastatin 80 mg or titration to 80 mg is not recommended by the FDA due to the increased risk of myopathy, including rhabdomyolysis. Patients may only continue on this dose when new to Medicaid if the patient has been taking this dose for 12 or more months without evidence of muscle toxicity. If the request is for Zocor 80 mg, the patient must have met the prior treatment length requirement and have a documented intolerance to the generic equivalent
MISCELLANEOUS/COMBOS		
	Lovaza® (omega-3-acid ethyl esters) Ezetimibe (compare to Zetia®) Omega-3-acid ethyl esters† (compare to Lovaza®) Vascepa® (icosapent ethyl) *(QL = 4 capsules/day)* Ezetimibe/simvastatin (compare to Vytorin®) Vytorin® (ezetimibe/simvastatin) *(QL = 1 tablet/day)* Advicor® (lovastatin/extended release niacin) *(Qty Limit = 1 tablet/day)*	**Ezetimibe:** patient must have a documented intolerance to the brand name product. **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

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Zetia® (ezetimibe) *(Qty Limit = 1 tablet/day)*	Amlodipine/atorvastatin † (compare to Caduet®) *(Qty Limit = 1 tablet/day)* Caduet® (atorvastatin/amlodipine) *(Qty Limit = 1 tablet/day)*	separate agents AND for approval of Caduet, the patient must have also had a documented intolerance to the generic equivalent. **Advicor:** The patient is unable to take the individual drug components separately. **Vytorin, ezetimibe/simvastatin:** The patient has had an inadequate response to atorvastatin or rosuvastatin. AND If the request is for Vytorin 10/80, the patient has been taking this dose for 12 or more months without evidence of muscle toxicity.
PCSK9 INHIBITORS		

	Praluent® (alirocumab)
	QL = 2ml (75mg injection every 2 weeks or 300mg every month)/ 28 days; Max 28-day supply
	Repatha® (evolocumab) Sureclick, prefilled syringe
	QL = 2ml (2 injections)/ 28 days; Max 28-day supply
	Repatha® (evolocumab) Pushtronix™
	QL = 3.5ml (One single-use infusor and prefilled cartridge)/ 28 days; Max 28-day supply
		Criteria for approval:
		• Age > 18 years of age **or** > 13 and dx of homozygous familial hypercholesterolemia (HoFH)
		• Concurrent use with statin therapy
		• Documented adherence to prescribed lipid lowering medications for the previous 90 days
		• Recommended or prescribed by a lipidologist or cardiologist
		• Diagnosis of heterozygous familial hypercholesterolemia or clinical atherosclerotic cardiovascular disease or (Repatha only) homozygous familial hypercholesterolemia
		  ○ with additional criteria for each as outlined below
		Additional criteria for the diagnosis of heterozygous familial hypercholesterolemia (HeFH): (both are required)
		• Total cholesterol > 290 mg/dL OR LDL-C > 190 mg/dL AND one of the following
		  ○ Presence of tendon xanthomas **OR**
		  ○ In 1st or 2nd degree relative-documented tendon xanthomas, MI at age ≤ 60 years or TC > 290 mg/dL **OR**
		  ○ Confirmation of diagnosis by gene or receptor testing **AND**
		• Unable to reach goal LDL-C with maximally tolerated dose of statin and ezetimibe 10 mg daily + another concurrently administered lipid lowering agent
		  ○ A trial of 2 or more statins, at least one of which must be either atorvastatin or rosuvastatin is required.
		Additional criteria for the diagnosis of clinical atherosclerotic cardiovascular disease: (both are required)
		• History of MI, angina, coronary or other arterial revascularization, stroke, TIA, or PVD of atherosclerotic origin **AND**
		• Unable to reach goal LDL-C with maximally tolerated doses of stain + ezetimibe 10 mg daily
		  ○ A trial of 2 or more statins, at least one of which must be either atorvastatin or rosuvastatin is required.
		Additional criteria for the diagnosis of homozygous familial

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		hypercholesterolemia (Repatha only): (both are required) • Total cholesterol and LDL-C > 600 mg/dL and TG within reference range **OR** • Confirmation of diagnosis by gene testing **AND** • Unable to reach goal LDL-C with maximally tolerated dose of statin and ezetimibe 10 mg daily + another concurrently administered lipid lowering agent ○ A trial of 2 or more statins, at least one of which must be either atorvastatin or rosuvastatin is required.
MISCELLANEOUS		
Pyridostigmine bromide (Compare to Mestinon) ***PREFERRED AFTER CLINICAL CRITERIA ARE MET*** CARBAGLU® dispersible tablets (carglumic acid) *(Maximum days supply per fill = 14 days)* GLYCOPYRROLATE 1 mg, 2 mg tablets (compare to Robinul®, Robinul Forte®) ***Preferred After Clinical Criteria Are Met*** MAKENA® (hydroxyprogesterone caproate) injection 250 mg/ml 5 ml vials Maximum fill = 5 ml/fill (35 day supply) Kionex® (sodium polystyrene sulfonate) powder, suspension SPS® (sodium polystyrene sulfonate) suspension	Mestinon® Benlysta® (belimumab) Vials *(Maximum days supply per fill = 28 days)* Elaprase® (idursulfase) *(QL = calculated dose/week)* Cuvposa® oral solution (glycopyrrolate)* **Maximum days supply per fill is 30 days** Glycate® 1.5 mg tablet (glycopyrrolate) *Quantity limit = 5 tablets/day* Robinul® 1 mg tablet (glycopyrrolate) Robinul® Forte 2 mg tablet (glycopyrrolate) Hetlioz® (tasimelteon) 20 mg oral capsule *Quantity limit =1 capsule/day* * Maximum days supply per fill is 30 days* Korlym® tablets (mifepristone) *Quantity limit = 4 tablets/day* Otrexup® or Rasuvo® Single-dose auto-injector for subcutaneous use (methotrexate) *(Quantity Limit = 4 syringes/28 days)* Myalept® (metreleptin) vial for subcutaneous injection *QL = one vial/day (Maximum days' supply per fill = 30 days)* Nuedexta® capsules (dextromethorphan/quinidine) *Quantity limit = 2 capsules/day*	**Benylsta:** The diagnosis or indication is active systemic lupus erythematosus (SLE) AND The patient is positive for autoantibodies (anti-nuclear antibody (ANA) and/or anti-double-stranded DNA (anti-dsDNA). AND The patient has had a documented inadequate response or intolerance to at least TWO of the following agents: NSAIDs, hydroxychloroquine, prednisone, azathioprine, methotrexate, mycophenolate. **Note:** The efficacy of Benlysta® has not been evaluated in patients with severe active lupus nephritis or severe active central nervous system lupus. Benlysta has not been studied in combination with other biologics or intravenous cyclophosphamide. Use of Benlysta is not recommended in these situations. **Carbaglu:** The diagnosis or indication for the requested medication is hyperammonemia due to N-acetylglutamate synthetase (NAGS) deficiency AND The prescriber is a specialist in metabolic disorders (e.g., medical geneticist) or prescriber is in consultation with a specialist. Note: after preliminary review by the Clinical Call Center, the request will be forwarded to the DVHA Medical Director for final approval. **Elaprase (Hunter's Syndrome Injectable**): The diagnosis or indication for the 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. **Glycate:** The indication for use is adjunctive therapy in the treatment of peptic ulcer. AND The patient has had a documented intolerance to generic glycopyrrolate.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Samsca® tablets (tolvaptan) *Quantity limit = 15 mg tablets (1 tablet/day), 30 mg tablets (2 tablets/day)* Signifor® (pasireotide) Ampules *QL (all strengths) = 2 ml (2 amps)/day* Maximum days' supply = 30 days Solesta® submucosal injection gel 50 mg/15 ml *(Quantity Limit = 4 syringes/28 days)* Soliris® (eculizumab) *(Quantity Limit = 12 vials(360 ml) /28 days) Maximum days' supply per fill = 28 days* Somatuline® Depot Injection (lanreotide) *(Quantity Limit = 0.2 ml/28 days (60 mg syringe), 0.3 ml/28 days (90 mg syringe) and 0.5 ml/28 days (120 mg syringe))* Lysteda® tablets (tranexamic acid) *Quantity limit = 30 tablets/28 days tranexamic acid† (compare to Lysteda®)* *Quantity limit = 30 tablets/28 days* Xenazine® tablets (tetrabenazine) *(Maximum 1 month supply per fill Quantity limit = 50 mg/day at initial approval (12.5 mg tablets ONLY), up to100 mg/day at subsequent approvals (12.5 mg or 25 mg tablets)* Veltassa® (patiromer sorbitex calcium) powder packets (Q*L = 1 packet/day)* Spinraza (nusinersen) injection 12mg/5ml single-dose vial	**Robinul, Robinul Forte:** The patient has had a documented intolerance to generic glycopyrrolate. **Hetlioz:** Patient has documentation of Non-24-Hour Sleep-Wake Disorder (Non-24) AND Patient has documentation of total blindness AND Patient has had a documented side effect, allergy or treatment failure with Rozerem and at least one OTC melatonin product. **Korlym:** Patient is ≥18 years of age AND Patient has a diagnosis of endogenous Cushing's syndrome AND Patient is diagnosed with type 2 diabetes mellitus or glucose intolerance AND Patient has hyperglycemia secondary to hypercortisolism AND Patient has failed or is not a candidate for surgery AND Patient has a documented side effect, allergy, treatment failure or contraindication to at least 2 adrenolytic medications (eg. ketoconazole, etomidate) AND Patient does not have any of the following contraindications to Korlym: Pregnancy (pregnancy must be excluded before the initiation of therapy or if treatment is interrupted for >14 days in females of reproductive potential. Nonhormonal contraceptives should be used during and one month after stopping treatment in all women of reproductive potential) OR Patient requires concomitant treatment with systemic corticosteroids for serious medical conditions/illnesses (immunosuppression for organ transplant) OR Patient has a history of unexplained vaginal bleeding OR Patient has endometrial hyperplasia with atypia or endometrial carcinoma OR Patient is concomitantly taking simvastatin, lovastatin, or a CYP3A substrate with a narrow therapeutic index (e.g., cyclosporine, dihydroergotamine, ergotamine, fentanyl, pimozide, quinidine, sirolimus, or tacrolimus). Note: after preliminary review by the Clinical Call Center, the request will be forwarded to the DVHA Medical Director for final approval. **Makena:** Patient is 16 years of age or older AND Patient has a history of singleton spontaneous preterm birth AND Patient is having a singleton (single offspring) pregnancy AND Therapy will be started between 16 weeks, 0 days and 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. **Otrexup, Rasuvo:** The patient has a diagnosis of rheumatoid arthritis (RA), polyarticular juvenile idiopathic arthritis (pJIA) or psoriasis. AND The patient has been intolerant to oral methotrexate AND The patient has been unable to be compliant with a non-auto-injector form of injectable methotrexate (includes difficulty with manual dexterity). **Myalept:** Patient has a diagnosis of congenital or acquired generalized lipodystrophy AND Patient has one or more of the following metabolic

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		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. Note: after preliminary review by the Clinical Call Center, the request will be forwarded to the DVHA Medical Director for final approval. Reauthorization for continued use criteria: Patient has experienced an objective response to therapy • Sustained reduction in hemoglobin A1c (HbA1c) level from baseline OR • Sustained reduction in triglyceride (TG) levels from baseline **Nuedexta:** The 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 **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 **Signifor:** Patient has a diagnosis of (pituitary) Cushing's disease AND Patient is 18 years of age or older AND Pituitary surgery is not an option or has not been curative AND After preliminary review by the Clinical Call Center, the request will be forwarded to the DVHA Medical Director for final approval. Note: Re-approval requires confirmation that the patient has experienced an objective response to therapy (i.e., clinically meaningful reduction in 24-hour urinary free cortisol levels and/or improvement in signs or symptoms of the disease). **Solesta:** The diagnosis or indication is treatment of fecal incontinence. AND The patient is 18 years of age or older AND The patient has had an inadequate response with conservative therapy, including diet, fiber supplementation, and anti-diarrheal medication **Soliris:** The patient has a diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) documented by flow cytometry. AND The patient has received the meningococcal vaccine at least 2 weeks prior to therapy initiation. OR The patient has a diagnosis of atypical hemolytic uremic syndrome (aHUS). AND

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		The patient has received the meningococcal vaccine at least 2 weeks prior to therapy initiation. Authorization for continued use shall be reviewed to confirm that the patient has experienced an objective response to the therapy.
		Somatuline: The diagnosis or indication for the requested medication is Acromegaly.
		Lysteda, Tranexamic acid: The diagnosis or indication is clinically significant heavy menstrual bleeding AND The patient has been started and stabilized on oral tranexamic acid within the previous 360 days OR The patient does not have
		a contraindication to therapy with oral tranexamic acid (i.e., active thrombotic disease, history of thrombosis/thromboembolism, or an intrinsic risk of thrombosis/thromboembolism), and if oral tranexamic acid is to be used concomitantly with an estrogen containing hormonal contraceptive product, the 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.
		Xenazine: The diagnosis or indication for the requested medication is Huntington's disease with chorea. AND Age > 18 years.
		Veltassa: The patient requires therapy for the treatment of non-emergent hyperkalemia and has a side effect, allergy, or contraindication to one preferred sodium polystyrene sulfonate product.
		Spinraza:
		• The diagnosis is spinal muscular atrophy (SMA) type 1,2, or 3 (results of genetic testing must be submitted) AND
		• The patient has at least 2 copies of the SMN2 gene AND
		• The prescriber is a neurologist, pulmonologist, or other physician with expertise in treating SMA AND
		• The need for invasive or noninvasive ventiliation (if applicable) does not exceed more than 6 hours per 24 hour period AND
		• Baseline motor ability has been established using one of the following exams:
		  ○ Hammersmith Infant Neurological Exam (HINE)
		  ○ Hammersmith Functional Motor Scale Expanded (HFMSE)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		○ Upper Limb Module Test (non-ambulitory) ○ Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND) AND • Prior to starting therapy, and prior to each dose, the following laboroatory tests will be conducted: Platelet count, prothrombin time (PT), activated partial thromboplastin time (aPTT), and quantitative spot urine protein **Note:** Initial approval will be granted for 4 loading doses (the first 3 loading doses should be administered at 14-day intervals; the 4th loading dose should be administered 30 days after the 3rd dose). Renewal may be granted for up to 12 months with a maximum of 3 doses approved per year (12mg(5ml) every 4 months). For therapy continuation, clinical documentation must be submitted documenting improvement or maintenance of motor ability OR slower progression of disease than would otherwise be expected.
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
MUCOSAL COATING AGENTS		
ALUMINUM HYDROXIDE†(formerly Amphojel®) EPISIL® (wound barrier) GELCLAIR® (povidone sodium hyaluronate glycyrrhetinic acid gel) MYLANTA/DIPHENYDRAMINE/LIDOCAINE VISCOUS (aka "Magic Mouthwash") Or other similar single or combination products	MuGard® (mucoadhesive oral wound rinse) *(QL = 4 bottles/month)*	**MuGard:** Patient is receiving radiation and/or chemotherapy. AND The patient has had a documented side effect, allergy or treatment failure with at least one oral mucosal coating agent (e.g. aluminum hydroxide suspension, Mylanta) or a topical anesthetic (e.g. viscous lidocaine or diphenhydramine solutions) or combinations of similar agents. **Additional criteria for viscous lidocaine:** • Due to a FDA safety alert, viscous lidocaine will require prior authorization for children ≤3 years of age.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
MULTIPLE SCLEROSIS MEDICATIONS		
INJECTABLES **Interferons** AVONEX® (interferon *B*-1a) BETASERON® (interferon *B*-1b) REBIF® (interferon *B*-1a) REBIF® REBIDOSE (interferon *B*-1a) **Other** COPAXONE® 20 mg (glatiramer acetate) *(QL = 1 kit/30 days)* **ORAL** AUBAGIO® (teriflunamide) tablet *(QL = 1 tablet/day, maximum 28 day supply per fill)* TECFIDERA® (dimethyl fumarate) *(QL = 2 capsules/day, maximum 30 day supply per fill)* GILENYA® (fingolimod) capsule *(QL = 1 capsule/day, maximum 30 day supply per fill)* ***Preferred After Clinical Criteria Are Met*** AMPYRA® (dalfampridine) tablet *(QL = 2 tablets/day, maximum 30 day supply per fill)*	Extavia® (interferon beta-1b) Copaxone® 40 mg (glatiramer)*(QL = 12 syringes(12 ml)/28 days)* Plegridy® (peginterferon beta-1a) Tysabri® (natalizumab) Glatopa® 20mg (glatiramer acetate) (QL=1 carton (30 syringes/30 days) Zinbryta® (daclizumab) QL=1 syringe/30 days, Maximum 30 day supply per fill	**Ampyra:** Patient has a diagnosis of multiple sclerosis. AND Patient age > 18 years. **Copaxone 40 mg Syringe:** Patient has a diagnosis of multiple sclerosis. AND The patient has a documented side effect, allergy, treatment failure, or contraindication to at least one preferred drug (not Copaxone 20 mg). AND The patient is unable to tolerate or be compliant with Copaxone 20 mg daily dosing. **Extavia:** Patient has a diagnosis of multiple sclerosis. AND The provider provides a clinical reason why Betaseron cannot be prescribed. **Glatopa 20mg:** Patient is ≥ 18 years AND diagnosis of relapsing forms of Multiple Sclerosis AND the provider provides a clinical reason why Copaxone 20mg cannot be prescribed. **Plegridy:** Patient is ≥ 18 years. Diagnosis of relapsing form of Multiple Sclerosis. Documented side effect, allergy, treatment failure or contraindication to at least three preferred drugs including at least one preferred form of interferon. **Tysabri:** Patient has a diagnosis of relapsing multiple sclerosis and has already been stabilized on Tysabri OR Diagnosis is relapsing multiple sclerosis and the patient has a documented side effect, allergy, treatment failure, or contraindication to at least two preferred drugs. OR Diagnosis of relapsing multiple sclerosis and the patient has a documented side effect, allergy, treatment failure, or contraindication to one preferred drug and has tested negative for anti-JCV antibodies. **Zinbryta:** Patient has a diagnosis of relapsing multiple sclerosis and has already been stabilized on Zinbryta OR Patient is ≥18 years of age AND Diagnosis is relapsing multiple sclerosis and the patient has a documented side effect, allergy, treatment failure, or contraindication to at least three other MS agents, two of which must be preferred AND the patient does not have pre-existing hepatic disease or hepatic impairment (LFT monitoring is recommended prior to starting therapy, monthly during therapy, and for 6 months after stopping therapy) AND the physician, pharmacy, and patient are enrolled in the Zinbryta® REMS program.
MUSCLE RELAXANTS, SKELETAL		
Musculoskeletal Agents		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
Single Agent CHLORZOXAZONE† 500 mg tablets (compare to Parafon Forte DSC®) *(Quantity limit = 4 tablets/day)* CYCLOBENZAPRINE†5 mg, 10 mg tablets (compare to Flexeril®) *(Quantity limit = 6 tablets/day (5 mg), 3 tablets/day (10 mg))* METHOCARBAMOL† 500mg, 750 mg tablets (compare to Robaxin®) *(Quantity limit = 8 tablets/day)* ORPHENADRINE CITRATE ER† (previously Norflex®) 100 mg tablet *(Quantity limit = 2 tablets/day)* **Combination Product** *ASA = aspirin* **Maximum duration of therapy all musculoskeletal agents = 90 days** **Antispasticity Agents** BACLOFEN† (formerly Lioresal®) DANTROLENE† (compare to Dantrium®) TIZANIDINE† (compare to Zanaflex®) tablets	Amrix®(cyclobenzaprine sustained-release) 15 mg, 30 mg capsule *(Quantity limit = 1 capsule/day)* carisoprodol 250 mg tablets *(Quantity limit = 4 tablets/day)* carisoprodol†350 mg (compare to Soma®) tablets *(Quantity limit = 4 tablets/day)* cyclobenzaprine 7.5 mg† tab (compare to Fexmid®) *(Quantity limit = 3 tablets/day)* Fexmid® (cyclobenzaprine) 7.5 mg tablet *(Quantity limit = 3 tablets/day)* Lorzone® (chlorzoxazone) 375 mg, 750 mg tablets *(Quantity limit = 4 tablets/day)* metaxalone† (compare to Skelaxin®) 800 mg tablets *(Quantity limit = 4 tablets/day)* Parafon Forte DSC®* (chlorzoxazone) 500 mg tablets *(Quantity limit = 4 tablets/day)* Robaxin®* (methocarbamol) 500mg, 750 mg tablets *(Quantity limit = 8 tablets/day)* Skelaxin® (metaxalone) 800 mg tablets *(Quantity limit = 4 tablets/day)* Soma® (carisoprodol) 250 mg, 350 mg tablets *(Quantity limit = 4 tablets/day)* carisoprodol, ASA† (previously Soma Compound®) *(Quantity limit = 4 tablets/day)* carisoprodol, ASA, codeine† (previously Soma Compound with Codeine®) *(Quantity limit = 4 tablets/day)* Dantrium®* (dantrolene) tizanidine† (compare to Zanaflex®) capsules Zanaflex® (tizanidine) capsules Zanaflex®* (tizanidine) tablets	**Amrix, cyclobenzaprine 7.5 mg, Fexmid**: The prescriber must provide a clinically valid reason why a preferred generic cyclobenzaprine cannot be used. For approval of Fexmid, the patient must also have a documented intolerance to the generic equivalent. **Brand skeletal muscle relaxants with generics available (Flexeril, Parafon Forte DSC, Robaxin):** The patient has had a documented side effect, allergy or treatment failure with two different preferred musculoskeletal agents (One trial must be the AB rated generic). **carisoprodol, carisoprodol/ASA, carisoprodol/ASA/codeine, Soma, metaxolone, Skelaxin:** The patient has had a documented side effect, allergy or treatment failure with two different preferred musculoskeletal agents. Additionally, if a brand name product is requested where an AB rated generic exists, the patient must also have had a documented intolerance to the generic product. **Lorzone:** The patient has had a documented side effect, allergy or treatment failure with two different preferred musculoskeletal agents. **Dantrium, Zanaflex tablets:** The patient must have a documented intolerance with the AB rated generic product. **Tizanadine capsules, Zanaflex capsules:** The prescriber must provide a clinically valid reason why generic tizanidine tablets cannot be used. AND If the request is for Zanaflex capsules, the patient must have a documented intolerance to generic tizanadine capsules

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
MUSCULAR DYSTROPHY AGENTS		
	Exondys 51™ (eteplirsen)	**Exondys:** •The patient must have a diagnosis of Duchenne Muscular Dystrophy with a confirmed mutation of the DMD gene that is amenable to exon 51 skipping (results of genetic testing must be submitted) AND •The prescriber is, or has consulted with, a neuromuscular disorder specialist AND •The dose does not exceed 30mg/kg once weekly AND •The patient is currently on a stable corticosteroid dose for at least 6 months. •Note: Initial approval will be granted for 6 months. For re-approval after 6 months, the patient must demonstrate a response to therapy as evidenced by continued or improved clinically meaningful function.
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
NUTRITIONALS, LIQUID ORAL SUPPLEMENTS		
	ALL Note: Nutritional supplements administered via tube	**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

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

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
QUINOLONES BESIVANCE® (besifloxacin) suspension CILOXAN® (ciprofloxacin) ointment CIPROFLOXACIN HCL† (compare to Ciloxan®) solution MOXEZA® (moxifloxacin 0.5%) (preservative free) solution VIGAMOX® (moxifloxacin 0.5%) (preservative free) solution	gatifloxacin 0.5% solution (compare to Zymaxid®) levofloxacin† 0.5 % solution Ocuflox®*(ofloxacin) solution Ofloxacin† (compare to Ocuflox®) solution Zymaxid® (gatifloxacin 0.5%) solution Azasite®(azithromycin) solution All other brands	**Aminoglycosides: Single and Combination Agents:** The patient has had a documented side effect, allergy or treatment failure with TWO preferred ophthalmic aminoglycosides or aminoglycoside combination, one of wich must be Tobradex **Macrolides:** The patient has had a documented side effect, allergy or treatment failure with erythromycin **Miscellaneous: Single and Combination Agents:** The patient has had a documented side effect, allergy or treatment failure with at least TWO preferred ophthalmic antibiotics. (If a product has an AB rated generic, there must have also been a trial of the generic formulation) **Quinolones:** The patient has had a documented side effect, allergy or treatment failure with TWO preferred ophthalmic quinolones.
MACROLIDES ERYTHROMYCIN† ointment ILOTYCIN† (erythromycin) ointment	Tobramycin w/Dexamethasone† (compare to Tobradex®) suspension Tobradex ST®(tobramycin/dexamethasone) suspension Pred-G® S.O.P. (gentamicin/prednisolone) ointment	
AMINOGLYCOSIDES **Single Agent** AK-TOB† (tobramycin) solution GARAMYCIN® (gentamicin) ointment, solution GENTAK† (gentamicin) ointment, solution GENTAMICIN† ointment, solution TOBRAMYCIN † solution (compare to Tobrex®) TOBREX® ointment,solution (tobramycin)	Bacitracin ointment Bleph-10®* (sulfacetamide) solution Sulfacetamide sodium† (compare to Bleph-10®) solution Sulfacetamide sodium ointment	
Combination PRED-G® (gentamicin/prednisolone) ointment, suspension TOBRADEX®* (tobramycin/dexamethasone) suspension , ointment ZYLET® (tobramycin/loteprednol) suspension	Blephamide® (sulfacetamide/prednisolone acetate) suspension Blephamide® S.O.P. (sulfacetamide/prednisolone acetate) ointment Maxitrol®* (neomycin/polymyxin/dexamethasone) suspension, ointment Neomycin/Polymyxin w/Hydrocortisone ointment, suspension	
MISCELLANEOUS **Single Agent** All products require PA **Combination** BACITRACIN ZINC W/POLYMYXIN B†	Polytrim®* (polymyxin B/trimethoprim) soln	

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ointment NEOMYCIN/BACITRACIN/POLYMYXIN ointment NEOMYCIN/POLYMYXIN W/DEXAMETHASONE† (compare to Maxitrol®) ointment, suspension NEOMYCIN/POLYMYXIN W/GRAMICIDIN† solution (compare to Neosporin®) NEOMYCIN/POLYMYXIN/BACITRACIN/ HYDROCORTISONE† ointment NEOSPORIN®* (neomycin/polymyxin/gramicidin) solution POLYMYXIN B W/TRIMETHOPRIM† (compare to Polytrim®) solution SULFACETAMIDE W/PREDNISOLONE SOD PHOSPHATE solution		
ANTIHISTAMINES		
KETOTIFEN† 0.025 % (eg. Alaway®, Zaditor® OTC, others) (*QL=1 bottle/month)* OLOPATADINE 0.1% (compare to Patanol®) (authorized generic, labeler code 61314 is the only preferred form) (*QL=1 bottle/month)* PAZEO® (olopatadine 0.7%) *(QL= 1 bottle/month)*	Azelastine † (compare to Optivar®) *(QL = 1 bottle/month)* Bepreve® (bepotastine besilate) *(QL = 1 bottle/month)* Elestat® (epinastine) *(Quantity Limit = 1 bottle/month)* Epinastine† (compare to Elestat®) *(QL = 1 bottle/month)* Emadine® (emedastine) *(Quantity Limit = 2 bottles/month)* Lastacaft® (alcaftadine) *(QL = 1 bottle/month)* Olopatadine 0.1% (compare to Patanol®) (non-authorized generic forms) Pataday® § (olopatadine 0.2%) *(Quantity Limit = 1 bottle/month)* Patanol®§ (olopatadine 0.1%) *(Quantity Limit = 1 bottle/month)*	**Azelastine, Bepreve, Elestat, Epinastine, Olopatadine (non-authorized generics) Patanol, Pataday:** The patient has had a documented side effect, allergy, or treatment failure to Olopatadine authorized generic or Pazeo. For approved of Elestat the patient must also have had a documented intolerance to the generic equivalent. **Lastacaft, Emadine:** The patient is pregnant and the diagnosis is allergic conjunctivitis OR The patient has had a documented side effect, allergy, or treatment failure to ketotifen. AND The patient has had a documented sideeffect, allergy, or treatment failure to Pazeo.
CORTICOSTEROIDS: TOPICAL		
ALREX® (loteprednol) 0.2% suspension DUREZOL® (difluprednate) 0.05% emulsion FLAREX® (fluorometholone acetate) 0.1% suspension FLUOROMETHOLONE 0.1% suspension†	Dexamethasone sodium phosphate 0.1% solution FML Forte® (fluorometholone) 0.25% suspension FML Liquifilm® (fluorometholone) 0.1% suspension Lotemax® (loteprednol) 0.5% ointment (pres. free), gel Pred Forte®/Omnipred® (prednisolone acetate) 1%	**Non-preferred agents:** The patient has had a documented side effect, allergy, or treatment failure with TWO preferred ophthalmic corticosteroid. (If a product has an AB rated generic, there must have been a trial of the generic formulation)

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
FML® (fluorometholone) 0.1% ointment Lotemax® (loteprednol) 0.5% suspension, MAXIDEX® (dexamethasone) suspension PRED MILD® (prednisolone acetate) 0.12% suspension PREDNISOLONE ACETATE 1%suspensionS† VEXOL® (rimexolone) 1% suspension *E=emulsion, G=gel,O=ointment, S=suspension, Sol=solution*	suspension All other brands	
CYSTARAN		
	Cystaran® (cysteamine) 0.44% ophthalmic solution *(QL=4 bottles (60 ml)/ 28 days)* *Maximum days' supply/RX = 28 days*	**Cystaran:** The indication for use is corneal cystine accumulation in patients with cystinosis.
DRY EYE SYNDROME		
Generic OTC Ocular Lubricants ARTIFICIAL TEARS† Ointment ARTIFICIAL TEARS† Solution GENTEAL Solution GENTEAL P.M. Ointment LUBRIFRESH P.M.† Ointment REFRESH P.M. Ointment REFRESH Lacri-lube Ointment REFRESH PLUS Solution TEARS NATURALE† Solution	Restasis® (cyclosporine ophthalmic emulsion) 0.05% (*QL=60 vials per 30 days).* Xiidra® (lifitegrast) solution (*QL = 60 vials per 30 days)*	**Restasis:** The patient has a diagnosis of moderate to severe keratoconjunctivitis sicca (dry eye syndrome) or Sjogren syndrome with suppressed tear production due to ocular inflammation AND The member does not have any of the following contraindications or exclusions to therapy: A) An active ocular infection B) Concurrent topical anti-inflammatory drugs C) Concurrent punctal plug use AND The patient has had a documented side effect, allergy, or treatment failure to two ocular lubricants (e.g., artificial tears, lubricant gels, etc.). **Xiidra:** The patient has a diagnosis of Dry Eye Disease AND has a documented side effect, allergy or treatment failure to Restasis.
GLAUCOMA AGENTS/MIOTICS		
ALPHA-2 ADRENERGIC **Single Agent** ALPHAGAN P® 0.1 %, 0.15 % (brimonidine tartrate) BRIMONIDINE TARTRATE† 0.2 % (formerly Alphagan®) **Combination** COMBIGAN® (brimonidine tartrate/timolol maleate) SIMBRINZA® (brinzolamide 1% and brimonidine 0.2%) Suspension	apraclonidine† (compare to Iopidine®) brimonidine tartrate 0.15 % † (compare to Alphagan P®) Iopidine® (apraclonidine) Betagan®* (levobunolol) Betimol® (timolol) Betoptic S® (betaxolol suspension) Istalol®* (timolol)	**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** **Lumigan, Bimatoprost:** The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR The patient has had a documented side effect, allergy or

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
BETA BLOCKER BETAXOLOL HCL† (formerly Betoptic®) CARTEOLOL HCL† (formerly Ocupress®) LEVOBUNOLOL HCL† (compare to Betagan®) TIMOLOL MALEATE† (compare to Timoptic®)	Metipranolol (formerly Optipranolol®) Timoptic®* (timolol maleate) Timoptic XE®* (timolol maleate gel) Timolol maleate gel (compare to Timotic XE®)	treatment failure with generic latanoprost and Travatan Z. **Travoprost:** The patient has had a documented intolerance to Travatan Z. **Zioptan:** The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR The patient has had a documented side effect, allergy or treatment failure with generic latanoprost and Travatan Z. OR The patient has a sensitivity to preservatives used in ophthalmic preparations
PROSTAGLANDIN INHIBITORS LATANOPROST† (compare to Xalatan®) TRAVATAN Z® (travoprost) (BAK free)	Bimatoprost 0.3% (Lumigan®) Lumigan® 0.01 %/0.03 % (bimatoprost) Travoprost® (Xalatan®* (latanoprost) Zioptan® (tafluprost)	**Xalatan:** The patient has a documented intolerance to the generic product. AND The patient has had a documented side effect, allergy or treatment failure with Travatan Z.
CARBONIC ANHYDRASE INHIBITOR **Single Agent** DORZOLAMIDE 2 % (compare to Trusopt®)	Azopt® (brinzolamide 1%) Trusopt®* (dorzolamide 2 %)	**CARBONIC ANHYDRASE INHIBITORS** **Single Agent:** The patient has had a documented side effect, allergy or treatment failure with a preferred carbonic anhydrase inhibitor.
Combination DORZOLAMIDE w/TIMOLOL (compare to Cosopt®)	Cosopt®* (dorzolamide w/timolol) Cosopt PF® (dorzolamide w/timolol) (pres-free) Simbrinza® (brinzolamide 1% and brimonidine 0.2%) Susp	**Combination Product:** **Cosopt:** The patient has had a documented intolerance to the generic equivalent product. **Cosopt PF:** The patient has had a documented intolerance to the preservatives in the generic combination product.
MISCELLANEOUS ISOPTO® CARPINE (pilocarpine) PILOCARPINE HCL† PHOSPHOLINE IODIDE® (echothiophate)	Miochol-E® (acetylcholine)	**Miscellaneous:** The patient has had a documented side effect, allergy or treatment failure with a preferred miscellaneous ophthalmic agent. If a product has an AB rated generic, there must have also been a trial of the generic formulation)
MAST CELL STABILIZERS		
CROMOLYN SODIUM† (formerly Crolom®)	Alocril® (nedocromil sodium) Alomide® (lodoxamide)	**Criteria for Approval:** The patient has had a documented side effect, allergy, or treatment failure with generic cromolyn sodium
NON-STEROIDAL ANTI-INFLAMMATORY DRUGS (NSAIDs)		

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
ACULAR® (ketorolac 0.5% ophthalmic solution) FLURBIPROFEN † 0.03% ophthalmic solution ILEVRO® ophthalmic suspension (nepafenac 0.3%) KETOROLAC† 0.4 % ophthalmic solution (compare to Acular LS®) KETOROLAC† 0.5 % ophthalmic solution (compare to Acular®)	Acular LS ® (ketorolac 0.4% ophthalmic solution) Acuvail (ketorolac 0.45 %) Ophthalmic Solution *(Quantity Limit = 30 unit dose packets/15 days)* Bromfenac† 0.09 % ophthalmic solution BromSite™ (bromfenac 0.075%) solution Diclofenac† 0.1% ophthalmic solution Nevanac® ophthalmic suspension (nepafenac 0.1%) Ocufen®* ophthalmic solution (flurbiprofen 0.03%) Prolensa® ophthalmic solution (bromfenac 0.07%)	**Acuvail:** The patient has had a documented side effect, allergy, or treatment failure to Acular OR ketorolac 0.5% OR The patient has a documented hypersensitivity to the preservative benzalkonium chloride. **Acular LS, Bromfenac, BromSite, Diclofenac, Ocufen, Prolensa,:** The patient has had a documented side effect, allergy, or treatment failure to TWO preferred agents. In addition, if a product has an AB rated generic, there must have also been a trial of the generic formulation.
OTIC ANTI-INFECTIVES		
Anti-infective Single Agent All products require PA **Anti-infective/Corticosteroid Combination** CIPRODEX® (ciprofloxacin 0.3%/dexamethasone 0.1%) otic suspension CIPRO-HC® (ciprofloxacin 0.2%/hydrocortisone 1%) otic suspension NEOMYCIN/POLYMYXIN B SULFATE/HYDROCORTISONE† SOLUTION **Miscellaneous Agents** ACETIC ACID† Otic solution ACETIC ACID-ALUMINUM ACETATE† Otic solution	Ciprofloxacin† 0.2% (compare to Cetraxal®) otic solution *(Qty limit = 14 unit dose packages/ 7 days)* Otiprio® (ciprofloxacin 6%) otic suspension Ofloxacin† 0.3% Otic solution (formerly Floxin®) Floxin® (ofloxacin) otic solution Coly-Mycin S®/Cortisporin TC® (neomycin/colistin/thonzium/hydrocortisone) Neomycin/Polymixin B Sulfate/Hydrocortisone Suspension Otovel® (ciprofloxacin 0.3%/fluocinolone 0.025%) otic solution QL = 28 unit dose packages/7days Acetasol HC† (acetic acid 2%/hydrocortisone 1% otic solution) Acetic Acid/Hydrocortisone† Otic Solution	**All non-preferred products :** The patient has had a documented side effect, allergy, or treatment failure to two preferred products.
OVER THE COUNTER (OTC) MEDICATIONS		
Please refer to the DVHA website for covered OTC categories not already managed on the PDL. Many categories limited to generics ONLY and other categories not covered. No PA process for non-covered OTCs.		

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

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
PARKINSON'S MEDICATIONS		
DOPAMINE PRECURSOR CARBIDOPA/LEVODOPA† (compare to Sinemet®) CARBIDOPA/LEVODOPA† ER (compare to Sinemet® CR) CARBIDOPA/LEVODOPA† ODT	Rytary® (carbidopa/levodopa ER caps) Sinemet®* (carbidopa/levodopa) Sinemet CR®*(carbidopa/levodopa ER)	**Sinemet, Sinemet CR, Mirapex, Parlodel, Requip:** The patient has had a documented intolerance to the generic product. **Rytary:** The patient has a diagnosis of Parkinson's disease, post-encephalitic parkinsonism, or parkinsonism following intoxication from carbon monoxide or manganese AND the prescriber is a neurologist AND the patient is having breakthrough symptoms despite a combination of concurrent IR and ER formulations of carbidopa/levodopa
DOPAMINE AGONISTS (ORAL) BROMOCRIPTINE† (compare to Parlodel®) PRAMIPEXOLE † (compare to Mirapex®) ROPINIROLE† (compare to Requip®)	Mirapex®* (pramipexole) Mirapex ER® (pramipexole ER) *QL = 1 tab/day* Requip®* (ropinirole) Requip XL® (ropinirole XL) *QL = 1 tab/day (all strengths except 12 mg), QL = 2 tabs/day (12 mg)* ropinirole XL† (compare to Requip XL®) *QL = 1 tab/day (all strengths except 12 mg), QL = 2 tabs/day (12 mg)* Tasmar® (tolcapone) Tolcapone (compare to Tasmar®)	**Amantadine tablets:** The patient has had a documented intolerance to generic amantadine capsules. **Azilect:** The diagnosis or indication is Parkinson's disease. AND The patient has had a documented side effect, allergy, or treatment failure with selegiline. AND The dose requested does not exceed 1 mg/day **carbidopa/levodopa/entacapone**: The patient has had a documented intolerance to brand Stalevo. **Mirapex ER, Requip XL, ropinirole XL:** The diagnosis or indication is Parkinson's disease. Requests will not be approved for Restless Leg Syndrome (RLS) AND The patient has had an inadequate response (i.e. wearing off effect or "off" time) with the immediate release product. OR The patient has not been able to be adherent to a three times daily dosing schedule of the immediate release product resulting in a significant clinical impact. AND If the requested product has an AB rated generic, the patient has a documented intolerance to the generic product. **Tasmar, Tolcapone:** The diagnosis or indication is Parkinson's disease. AND The patient has had a documented side effect, allergy, or treatment failure with Comtan or entacapone. For approval of generic talcapone, the patient must have documented intolerance to brand Tasmar.
DOPAMINE AGONISTS (TRANSDERMAL) Neupro® (rotigotine) transdermal patch *(Quantity Limit = 1 patch/day)* *(2mg, 4 mg, 6 mg and 8 mg patches)*		
COMT INHIBITORS COMTAN® (entacapone) ENTACAPONE† (compare to Comtan®)	Azilect® (rasagiline) (QL = 1 mg/day) Zelapar® (selegiline ODT) *(QL = 2.5 mg/day)*	**Zelapar:** The diagnosis or indication is Parkinson's disease. AND The patient is on current therapy with levodopa/carbidopa. AND Medical necessity for disintegrating tablet administration is provided (i.e. inability to swallow tablets or drug interaction with oral selegiline). AND the dose requested does not exceed 2.5mg/day
MAO-B INHIBITORS SELEGILINE†		
OTHER AMANTADINE syrup AMANTADINE† capsules (PA required for ≤ 10 day supply) STALEVO® (carbidopa/levodopa/entacapone)	Amantadine† tablets (Quantity limit PA also required for ≤ 10 day supply) carbidopa/levodopa/entacapone† (compare to Stalevo®)	**Limitations:** To prevent the use of amantadine in influenza treatment/prophylaxis, days supply < 10 days will require PA.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
PHOSPHODIESTERASE-4 (PDE-4) INHIBITORS		
	Daliresp® tablet (roflumilast) *Quantity limit = 1 tablet/day* Otezla® tablet (apremilast) *(Starter pack – Quantity limit = 27 tablets/14 days)* *(30 mg tablets – Quantity limit = 2 tablets/day)* *** Maximum days' supply per fill = 30)**	**Daliresp:** The indication for the requested medication is treatment to reduce the risk of COPD exacerbations in patients with severe COPD associated with chronic bronchitis and a history of exacerbations. AND The patient has had a documented side effect, allergy, treatment failure, or a contraindication to at least one inhaled long-acting anticholinergic AND at least one inhaled long-acting beta-agonist AND at least one inhaled corticosteroid. **Otezla:** The patient has a diagnosis of psoriatic arthritis AND The patient is 18 years of age or older AND The patient has had inadequate response to, intolerance to, or contraindication to methotrexate.
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.		
SILDENAFIL CITRATE† (compare to Revatio®) tablet *(Quantity Limit = 3 tablets/day)*	Adcirca® (tadalafil) *(Quantity Limit = 2 tablets/day)* Revatio® (sildenafil) Tabs (*Quantity Limit = 3 tablets/day)* Revatio® (sildenafil citrate) suspension Revatio® (sildenafil citrate) vial *(Quantity Limit = 3 vials/day, maximum 14 days supply per fill)*	**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 generic sildenafil. **Revatio Suspension:** Clinical diagnosis of pulmonary hypertension AND medical necessity for a liquid formulation is provided OR the patient is unable to tolerate a 20mg dose. **Revatio IV:** Clinical diagnosis of pulmonary hypertension AND No concomitant use of organic nitrate-containing products AND The patient has a requirement for an injectable dosage form. AND Arrangements have been made for IV bolus administration outside of an inpatient hospital setting.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
PLATELET INHIBITORS		
AGGREGATION INHIBITORS BRILINTA® (ticagrelor) Tablet *QL = 2 tablets/day* CILOSTAZOL CLOPIDOGREL†75 mg (compare to Plavix®) EFFIENT® (prasugrel) Tablet *QL = 1 tablet/day* TICLOPIDINE† (formerly Ticlid®) **OTHER** AGGRENOX® (dipyridamole/Aspirin) ANAGRELIDE† (compare to Agrylin®) ASPIRIN† DIPYRIDAMOLE†	Plavix®* 75 mg (clopidogrel bisulfate) Zontivity® (vorapaxar) Tablet *QL = 1 tablet/day* Agrylin®* (anagrelide) Dipyridamole/Aspirin (compare to Aggrenox®) Durlaza® (asprin extended release) capsules Yosprala® (aspirin and omeprazole)	**Agrylin, Plavix:** The patient has had a documented intolerance to the generic formulation of the medication. **Dipyridamole/Aspirin:** The patient has had a documented intolerance to the brand formulation of the medication. **Durlaza:** The patient is ≥ 18 years of age AND the indication for use is to reduce the risk of death and myocardial infarction (MI) in patients with chronic coronary artery disease (history of MI, unstable angina pectoris, or chronic stable angina) OR to reduce the risk of death and recurrent stroke in patients who have had an ischemic stroke or transient ischemic attack AND the patient is unable to use at least 4 preferred products, one of which must be enteric coated aspirin. **Yosprala:** The patient must be at risk for developing aspirin-associated gastric ulcers (history of gastric ulcers or age ≥ 60) AND the patient must have a documented side effect, allergy, or contraindication to 3 preferred PPI's (one of which must omeprazole) used in combination with aspirin. **Zontivity:** The patient is started and stabilized on the medication. (Note: samples are not considered adequate justification for stabilization.) OR The patient has a history of myocardial infarction (MI) or peripheral arterial disease (PAD) AND The indication for use is reduction of thrombotic cardiovascular events. AND The medication is being prescribed in combination with aspirin and/or clopidogrel. **Limitations:** Plavix/clopidogrel 300mg is not an outpatient dose and is not covered in the pharmacy benefit.
POST-HERPETIC NEURALGIA AGENTS		
	Gralise® (gabapentin) tablet, starter pack *Quantity Limit = 3 tablets/day* *(Maximum 30 day supply per fill)*	**Gralise:** The patient has a diagnosis of post-herpetic neuralgia (PHN) AND The patient has had a documented side effect, allergy, contraindication or treatment failure with at least one drug from the tricyclic antidepressant class. AND The patient has had an inadequate response to the generic gabapentin immediate-release.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
PSORIASIS		
INJECTABLES (Initial approval is 3 months, renewals are 1 year)		
Preferred After Clinical Criteria Are Met COSENTYX® (secukinumab) *(Quantity limit=8 pens or vials month one, then 4 pens or vials monthly)* ENBREL® (etanercept) *Quantity limit = 8 syringes/28 days for the first 3 months; then 4 syringes/28 days(50 mg) or 8 syringes/28 days (25 mg) subsequently* HUMIRA® (adalimumab) *Quantity limit = 4 syringes/28 days for one month; 2 syringes/28 days subsequently*	Inflectra® (infliximab-dyyb) biosimilar to Remicade® Remicade® (infliximab) Stelara® (ustekinumab) *(Quantity limit = 45 mg (0.5 ml) or 90 mg (1 ml) per dose)* *(90 mg dose only permitted if pt weight > 100 kg)* Taltz® (ixekizumab) (*Quantity limit = 3 syringes/28 days for the first month, 2 syringes/28 days months 2 and 3 and 1 syringe/28 days subsequently)*	**Clinical Criteria:** **For all drugs:** The prescription must be written by a dermatologist AND The patient has a documented diagnosis of moderate to severe plaque psoriasis and has already been stabilized on the drug being requested OR The prescription must be written by a dermatologist AND The patient has a documented diagnosis of moderate to severe plaque psoriasis affecting > 10% of the body surface area (BSA) and/or has involvement of the palms, soles, head and neck, or genitalia and has had a documented side effect, allergy, inadequate treatment response, or treatment failure to at least 2 different categories of therapy [i.e. at least 2 topical agents and at least 1 oral systemic agent, (unless otherwise contraindicated)] from the following categories: Topical agents: emollients, keratolytics, corticosteroids, calcipotriene, tazarotene, etc. Systemic agents: methotrexate, sulfasalazine, azathioprine, cyclosporine, tacrolimus, mycophenolate mofetil, etc. Phototherapy: ultraviolet A and topical psoralens (topical PUVA), ultraviolet A and oral psoralens (systemic PUVA, narrow band ultraviolet B (NUVA), etc. **Additional Criteria for Cosentyx:** The prescriber must provide evidence of a trial and failure or contraindication to Humira®. **Additional Criteria for Remicade, Stelara, Taltz:** The prescriber must provide a clinically valid reason why both Humira® and Cosentyx® cannot be used. **Additional Criteria for Inflectra:** The prescriber must provide a clinically valid reason why Humira®, Cosentyx®, and Remicade® cannot be used.
NON-BIOLOGICS		
ORAL ACITRETIN† (compare to Soriatane®) capsules CYCLOSPORINE † (generic) METHOTREXATE † (all brand and generic) METHOXSALEN† (compare to Oxsoralen-Ultra®) 8-MOP® (methoxsalen) **TOPICAL** CALCIPOTRIENE† Cream, Ointment, Solution	Oxsoralen-Ultra® (methoxsalen) Soriatane® (acitretin) capsules Calcitrene® (calcipotriene) ointment calcitriol† (compare to Vectical®) Ointment	**Soriatane:** the patient has a documented intolerance to generic acitretin capsules. **Calcitrene Ointment:** The patient has a documented intolerance to Calcipotriene ointment. **Dovonex Cream:** The patient has a documented intolerance to the generic equivalent. **Oxsoralen-Ultra:** The patient has a documented intolerance to the generic equivalent. **Enstilar, Taclonex or calcipotriene/betamethasone diproprionate Ointment or Scalp Suspension:** The patient has had an inadequate response to a 24 month

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
TAZORAC® (tazarotene cream, gel)	*(Quantity Limit = 200 g (2 tubes)/week)* Calcipotriene/betamethasone ointment† (compare to Taclonex®) *(QL for initial fill = 60 grams)* Dovonex cream® (calcipotriene) Enstilar® (calcipotriene/betamethasone) foam Sorilux® (calcipotriene) foam Taclonex® (calcipotriene/betamethasone ointment/scalp suspension) *(QL for initial fill = 60 grams)* Vectical® Ointment (calcitriol) *(Quantity Limit = 200 g (2 tubes)/week)*	trial of a betamethasone dipropionate product and Dovonex (or generic calcipotriene), simultaneously. AND The patient has had a documented side effect, allergy, or treatment failure with Tazorac 0.05% or 0.1% cream or gel. Note: If approved, initial fill of Taclonex® or calcipotriene/betamethasone diproprionate will be limited to 60 grams. **Vectical Ointment, Calcitriol Ointment:** The patient ≥ 18 years of age AND The patient has a diagnosis of mild-to-moderate plaque psoriasis AND The patient has demonstrated inadequate response, adverse reaction or contraindication to calcipotriene AND If the request is for brand Vectical, the patient has had a documented intolerance to the generic product. **Sorilux:** The patient ≥ 18 years of age AND The patient has a diagnosis of plaque psoriasis AND The patient has demonstrated inadequate response or intolerance to other dosage forms of calcipotriene (brand or generic) **Limitations:** Kits with non-drug or combinations of 2 drug products are not covered.
PULMONARY AGENTS		
ANTICOLINERGICS: INHALED		
ATROVENT HFA® (ipratropium) SPIRIVA® HANDIHALER (tiotropium) *Quantity Limit = 1 capsule/day* IPRATROPIUM SOLN FOR INHALATION COMBIVENT® RESPIMAT (ipratropium/albuterol) *Quantity Limit = 1 inhaler (4 grams)/30 days* STIOLTO RESPIMAT® (tiotropium/olodaterol) *Quantity Limit = 3 inhalers/ 90 days* IPRATROPIUM/ALBUTEROL†	Incruse Ellipta® (umeclidinium bromide) *(Quantity Limit= 1 inhaler/30 days)* Tudorza® Pressair (aclidinium bromide) *Quantity Limit = 1 inhaler/30 days* Spiriva® Respimat (tiotropium) *QL = 1 inhaler/30days* Anoro® Ellipta (umeclidinium/vilanterol) *Quantity Limit = 1 inhaler (60 blisters)/30 days* Bevespi Aerosphere® (glycopyrrolate/formoterol)	**Anoro Ellipta/Bevespi Aerosphere/Utibron Neohaler:** patient has a diagnosis of COPD (not FDA approved for asthma). AND ○ Mild-Moderate COPD- failure of individual and combination therapy of one preferred Long Acting Beta Adrenergic (LABA) and a preferred Long Acting Anticholinergic OR ○ Severe COPD- failure of one preferred Inhaled Corticosteroid/LABA combination product and the preferred Long Acting Anticholinergic. **Incruse Ellipta/Tudorza:** The patient has had documented side effect, allergy or treatment failure to Spiriva® **Spiriva Respimat:** patient has a diagnosis of COPD and a compelling clinical reason why they cannot use Spiriva Handihaler.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	Quantity Limit = 1 inhaler/30days Utibron™ Neohaler® (indaceterol/glycopyrrolate) *Quantity Limit = 1 inhaler (60 blisters) 30 days*	
ANTIHISTAMINES: INTRANASAL		
	SINGLE AGENT Astelin® (azelastine) Nasal Spray *Quantity Limit = 1 bottle (30 ml)/30 days* Astepro® (azelastine 0.15 %) Nasal Spray *Quantity Limit = 1 bottle (30 ml)/30 days* azelastine (compare to Astelin®) Nasal Spray *Quantity Limit = 1 bottle (30 ml)/30 days* azelastine 0.15 % (compare to Astepro®) Nasal Spray *Quantity Limit = 1 bottle (30 ml)/30 days* Olopatadine † 0.6% (compare to Patanase®) Nasal Spray *Quantity Limit = 1 bottle (31 gm)/30 days* Patanase® (olopatadine 0.6%) Nasal Spray *Quantity Limit = 1 bottle (31 gm)/30 day* COMBO WITH CORTICOSTEROID Dymista® (azelastine/fluticasone) Nasal Spray *Quantity Limit = 1 bottle (23 gm)/30 days*	**ASTELIN, ASTEPRO, AZELASTINE, DYMISTA, OLOPATADINE,** **PATANASE:** The diagnosis or indication for the requested medication is allergic rhinitis. AND The patient has had a documented side effect, allergy, or treatment failure to loratadine (OTC) OR cetirizine (OTC) AND a preferred nasal corticosteroid used in combination. AND If the request is for Astepro, the patient has a documented intolerance to the generic equivalent.
ANTIHISTAMINES: 1ST GENERATION		
All generic antihistamines All generic antihistamine/decongestant combinations	All brand antihistamines (example: Benadryl®) All brand antihistamine/decongestant combinations (example: Deconamine SR®, Rynatan®, Ryna-12®)	**CRITERIA FOR APPROVAL:** The prescriber must provide a clinically valid reason for the use of the requested medication including reasons why any of the generically available products would not be a suitable alternative.
ANTIHISTAMINES: 2ND GENERATION		
SINGLE AGENT TABLET LORATADINE † (OTC) (Allergy Relief®, Alavert®) CETIRIZINE† OTC (formerly Zyrtec®) 5 mg, 10 mg tablets	Clarinex® (desloratadine) 5 mg tablet desloratadine† (compare to Clarinex®) 5 mg tablet Levocetirizine† (compare to Xyzal®) 5 mg tablet Xyzal® (levocetirizine) 5 mg tablet	**FEXOFENADINE 60MG/180 MG TABLETS:** The diagnosis or indication for the requested medication is allergic rhinitis or chronic idiopathic urticaria. AND The patient has had a documented side effect, allergy, or treatment failure to loratadine (OTC) AND cetirizine (OTC). **CLARINEX TABLETS, DESLORATADINE TABLETS,**

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
After loratadine OTC and cetirizine OTC trials FEXOFENADINE † 60 mg, 180 mg (OTC) tablets (formerly Allegra®) **COMBINATION WITH PSEUDOEPHEDRINE** LORATADINE/PSEUDOEPHEDRINE SR 12hr 5 mg/120 MG † (OTC) (Alavert Allergy/Sinus®) LORATADINE/PSEUDOEPHEDRINE SR 24hr 10 mg/240 MG †(OTC) **SINGLE AGENT ORAL LIQUID** LORATADINE † (OTC) syrup (Allergy Relief®) CETIRIZINE † (OTC, RX) syrup **CHEWABLE/ORALLY DISINTEGRATING TABLET** LORATADINE † (OTC) (Allergy Relief®, Alavert®) rapidly disintegrating tablet (RDT) (compare to Claritin®) 10 mg	All other brands Cetirizine/Pseudoephedrine SR 12hr 5 mg/120 mg OTC† Clarinex-D® 12 hr (desloratadine/pseudoephedrine 2.5 mg/120 mg) Clarinex Syrup® (desloratadine) Levocetirizine (compare to Xyzal®) Solution Xyzal® (levocetirizine) Solution Certirizine † OTC Chewable Tablets 5 mg, 10 mg Clarinex Reditabs®§ (desloratadine) 2.5 mg, 5 mg Desloratadine ODT (compare to Clarinex Reditabs®) 2.5 mg, 5 mg All other brands	**LEVOCETIRIZINE TABLETS, XYZALTABLETS:** The diagnosis or indication for the requested medication is allergic rhinitis or chronic idiopathic urticaria AND The patient has had a documented side effect, allergy, or treatment failure to loratadine (OTC) AND cetirizine (OTC) AND The patient has had a documented side effect, allergy, or treatment failure to fexofenadine. AND If the request is for Clarinex or Xyzal, the patient must also have a documented intolerance to the generic equivalent tablets. **CERTIRIZINE CHEWABLE TABLETS, CLARINEX REDITABS, DESLORATADINE ODT:** The diagnosis or indication for the requested medication is allergic rhinitis or chronic idiopathic urticaria AND The patient has had a documented side effect, allergy, or treatment failure to loratadine (OTC) rapidly disintegrating tablets or requires less than a 10 mg dose of loratadine. AND If the request is for Clarinex Reditabs, the patient must also have a documented intolerance to the generic equivalent tablets **CLARINEX SYRUP, LEVOCETIRIZINE SOLUTION, XYZAL SOLUTION** **ORAL LIQUID:** The diagnosis or indication for the requested medication is allergic rhinitis or chronic idiopathic urticaria AND the patient has had a documented side effect, allergy, or treatment failure to loratadine syrup AND cetirizine syrup. AND If the request is for Xyzal, the patient must also have a documented intolerance to levocetirizine solution. **CETIRIZINE D, CLARINEX-D:** The diagnosis or indication for the requested medication is allergic rhinitis. AND The patient has had a documented side effect, allergy, or treatment failure to loratadine-D (OTC). **LIMITATIONS:** Many Allegra® and Zyrtec® brand products as well as Claritin capsules are not covered as no Federal Rebate is offered. Fexofenadine suspension not covered as no Federal Rebate is offered. Fexofenadine/pseudoephedrine combination products) (brand and generic) are not covered – individual components may be prescribed separately.
BETA-ADRENERGIC AGENTS		
METERED-DOSE INHALERS (SHORT-ACTING) PROAIR® HFA (albuterol) PROVENTIL® HFA (albuterol)	Ventolin® HFA (albuterol) Xopenex® HFA (levalbuterol) ProAir® Respiclick (albuterol)	**ProAir® Respiclick**, **Ventolin HFA, Xopenex HFA**: documented side effect, allergy, or treatment failure to BOTH preferred short acting metered dose inhalers. **Serevent**: The patient has a diagnosis of asthma and is prescribed an inhaled corticosteroid (pharmacy claims will be evaluated to assess compliance with long term controller therapy) OR the patient has a diagnosis of COPD. **Arcapta, Striverdi:** The patient has a diagnosis of COPD (not FDA approved for asthma). AND The patient has a documented side effect, allergy, or treatment

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
METERED-DOSE INHALERS (LONG-ACTING) (***Preferred after clinical criteria are met)*** SEREVENT® DISKUS (salmeterol xinafoate) *Quantity Limit = 60 blisters/30 days* **NEBULIZER SOLUTIONS (SHORT-ACTING)** ALBUTEROL † neb solution (all strengths) LEVALBUTEROL neb solution (age ≤ 12 years) **NEBULIZER SOLUTIONS (LONG-ACTING)** All products require a PA **TABLETS/SYRUP (SHORT-ACTING)** ALBUTEROL † tablets/syrup **TABLETS (LONG-ACTING)** ALBUTEROL ER † tablets	Arcapta® Neohaler (indacaterol) *Quantity Limit = 1 capsule/day* Striverdi Respimat® (olodaterol) Levalbuterol † neb solution (compare to Xopenex®) (age > 12 years) Xopenex® neb solution (all ages) Brovana® (arformoterol) *QL = 2 vial/day* Perforomist® (formoterol) *QL = 2 vial/day* metaproterenol tablets/syrup † terbutaline tablets † Vospire ER®* (albuterol)	failure to Serevent. **Levalbuterol, Xopenex nebulizer solution (age > 12 years):** The patient must have had a documented side effect, allergy, or treatment failure to albuterol nebulizer. AND for approval of brand Xopenex, the patient must have had a documented intolerance to the generic. **Xopenex (age <12 years):** The patient must have a documented intolerance to generic levalbuterol nebulizer solution **Brovana or Perforomist Nebulizer Solution:** The patient must have a diagnosis of COPD. AND The patient must be unable to use a non-nebulized long-acting bronchodilator or anticholinergic (Serevent or Spiriva) due to a physical limitation **Metaproterenol tablets/syrup:** The patient has had a documented side effect, allergy or treatment failure with generic albuterol tablets/syrup. **Terbutaline tablets:** The medication is not being prescribed for the prevention/treatment of preterm labor. **Vospire ER tablets:** The patient must have had a documented side effect, allergy, or treatment failure to generic albuterol ER tablets.
CORTICOSTEROIDS/COMBINATIONS: INHALED		
METERED DOSE INHALERS (SINGLE AGENT) ASMANEX® 110 or 220 mcg/inh (mometasone furoate) *(QL =3 inhalers/90 days)* FLOVENT® DISKUS (fluticasone propionate) *(QL = 3 inhalers/90 days)* FLOVENT® HFA (fluticasone propionate) *(QL = 36 gm(3 inhalers)/90 days)*	Aerospan® (flunisolide HFA) *(QL = 6 inhalers (53.4 gm)/90 days)* Alvesco® (ciclesonide) *(QL = 18.3 gm (3 inhalers)/90 days)) (80 mcg/inh)* *(QL =36.6 gm (6 inhalers)/90 days)) (160 mcg/inh)* Arnuity Ellipta 100 or 200mcg/inh (fluticasone furoate) (QL= 90 blisters/90 days)	**Metered-dose inhalers (single agent):** The patient has had a documented side effect, allergy, or treatment failure to at least two preferred agents.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
PULMICORT FLEXHALER® (budesonide) *(QL = 6 inhalers/90 days)* QVAR® 40 mcg/inh (beclomethasone) *(QL = 17.4 gm (2 inhalers)/90 days)* QVAR® 80 mcg/inh (beclomethasone) *(QL = 58.4 gm (6 inhalers)/90 days)* **METERED DOSE INHALERS (COMBINATION PRODUCT)** ADVAIR® HFA (fluticasone/salmeterol) *(QL = 36 gm (3 inhalers)/90 days)* ADVAIR® DISKUS (fluticasone/salmeterol) *(QL = 3 inhalers/90 days)* DULERA® (mometasone/formoterol) *(QL = 39 gm (3 inhalers)/90 days)* SYMBICORT® (budesonide/formoterol) *(QL = 30.6 gm (3 inhalers)/90 days)* **NEBULIZER SOLUTIONS** PULMICORT RESPULES® (budesonide) (age ≤ 12 yrs)	Asmanex HFA 100 or 200mcg (mometasone furoate) *(QL=3 inhalers/90 days)* Breo Ellipta® (fluticasone furoate/vilanterol) *(QL = 180 blisters(3 inhalers)/90 days)* Budesonide Inh Suspension (compare to Pulmicort Respules®) (all ages) Pulmicort Respules® (budesonide) (age > 12 years)	**Breo Ellipta:** The patient has a diagnosis of COPD or Asthma AND The patient has had a documented side effect, allergy, or treatment failure to any 2 of the following: Advair, Dulera, or Symbicort. **Budesonide Inh Suspension (all ages):** The patient requires a nebulizer formulation. AND The patient has a documented intolerance to the brand product. **Pulmicort Respules (age > 12 years):** The patient requires a nebulizer formulation.
CORTICOSTEROIDS: INTRANASAL		
<u>SINGLE AGENT</u> FLUTICASONE Propionate† (compare to Flonase®) *QL = 16 gm (1 inhaler)/30 days* OMNARIS® (ciclesonide) *QL = 12.5 gm (1 inhaler)/30 days* ZETONNA® (ciclesonide) *QL = 6.1 gm (1 inhaler)/30 days*	Beconase AQ® (beclomethasone) *QL =50 gm (2 inhalers)/30 days* budesonide † (compare to Rhinocort Aqua®) *QL = 8.6 gm (1 inhaler)/30 days* Flonase®* (fluticasone propionate) *QL = 16 gm (1 inhaler)/30 days* flunisolide † 25 mcg/spray (formerly Nasalide®) *QL = 50 ml (2 inhalers)/30 days* flunisolide† 29 mcg/spray (formerly Nasarel®) *QL = 50 ml (2 inhalers)/30 days* *QL = 16.5 gm (1 inhaler)/30 days* NASONEX® (mometasone) *QL = 17 gm (1 inhaler)/30 days* QNASL® (beclomethasone diproprionate) HFA *QL = 8.7 gm (1 inhaler)/30 days* Rhinocort Aqua® (budesonide) *QL = 8.6 gm (1 inhaler)/30 days* triamcinolone † (compare to Nasacort AQ®) *QL = 16.5 gm (1 inhaler)/30 days* Veramyst® (fluticasone furoate)	**Beconase AQ, Budesonide, Flonase, Flunisolide 25 mcg/spray, Flunisolide 29 mcg/spray, Nasonex, QNASL, Rhinocort Aqua, triamcinolone, Veramyst:** The patient has had a documented side effect, allergy, or treatment failure of two preferred nasal glucocorticoids. If the request is for Rhinocort Aqua®, the patient has also had a documented intolerance to the generic equivalent. **Dymista:** The diagnosis or indication is allergic rhinitis. AND The patient has had a documented side effect, allergy, or treatment failure to loratadine (OTC) OR cetirizine (OTC) AND a preferred nasal corticosteroid used in combination. **Limitations:** Nasacort Allergy OTC not covered as no Federal Rebate is offered. Nasacort AQ RX available after PA obtained.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
	QL = 10 gm (1 inhaler)/30 days **COMBINATION WITH ANTIHISTAMINE** Dymista® (azelastine/fluticasone) *QL = 23 gm (1 inhaler)/30 days*	
LEUKOTRIENE MODIFIERS		
Preferred After Clinical Criteria Are Met MONTELUKAST SODIUM† (compare to Singulair®) tablets§ MONTELUKAST SODIUM† (compare to Singulair®) chews§ 4mg for ages 2-5, 5mg for age 6-14 MONTELUKAST SODIUM† (compare to Singulair®) granules§ ages 6months-23months	Accolate® (zafirlukast) **§** *Quantity Limit = 2 tablets/day* Singulair® (montelukast sodium) **§** tablets, chew tabs, granules *Quantity Limit = 1 tablet or packet per day* zafirlukast (compare to Accolate®) **§** Zyflo (zileuton) *Quantity Limit = 2 tablets/day* Zyflo CR® (zileuton SR) *Quantity Limit = 4 tablets/day*	**Montelukast:** • The diagnosis or indication for the requested medication is asthma. • The diagnosis or indication for the requested medication is allergic rhinitis. The patient has had a documented side effect, allergy, or treatment failure to a second generation non-sedating antihistamine and a nasal corticosteroid. • The diagnosis or indication for the requested medication is urticaria. The patient has had a documented side effect, allergy, or treatment failure to at least TWO preferred 2nd generation antihistamines (i.e. loratadine (OTC), cetirizine (OTC), fexofenadine). • If the request is for brand Singulair tablets, chew tablets or granules; the patient has a documented intolerance to the generic equivalent montelukast preparation. **Zafirlukast, Accolate:** The diagnosis or indication for the requested medication is asthma. AND If the request is for Accolate, the patient has a documented intolerance to generic zafirlukast. **Zyflo/Zyflo CR:** The diagnosis or indication for the requested medication is asthma. AND The patient has had a documented side effect, allergy, or treatment failure to Accolate or Singulair/Montelukast. **Montelukast chewable and granules:** Will only be approved for appropriate FDA approved age and indications.
SYNAGIS		
	SYNAGIS® (palivizumab) *Quantity Limit = 1 vial/month (50 mg) or 2 vials/month (100 mg)*	**CRITERIA FOR APPROVAL:** □ Infants born at 28 weeks of gestation or earlier (i.e., ≤ 28 weeks, 6 days) and under twelve months of age at the start of the RSV season (maximum 5 doses). □ Infants born at 29-32 weeks (i.e., between 29 weeks, 0 days and 31 weeks, 6 days) of gestation and under 1 year of age at the start of the RSV season who develop chronic lung disease of prematurity defined as a requirement for >21% oxygen for at least the first 28 days after birth (maximum 5 doses). □ Children under 24 months of age with chronic lung disease of prematurity defined as born at 31 weeks, 6 days or less who required >21% oxygen for at least the first 28 days after birth and continue to require medical support

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		(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:** 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 our specialty pharmacy vendor for Synagis, Wilcox Home Infusion, and processed through the DVHA POS prescription processing system using NDC values. Under no circumstances will claims processed through the medical benefit be accepted.

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
PULMONARY ARTERIAL HYPERTENSION MEDICATIONS		
ENDOTHELAN RECEPTOR ANTAGONISTS TRACLEER® (bosentan) Tablet *Quantity Limit = 2 tablets/day* **PROSTACYCLIN AGONISTS** **Injection** EPOPROSTENOL † (compare to Flolan®) REMODULIN® (treprostinil sodium injection) VELETRI® (epoprostinil) **Inhalation** TYVASO® (treprostinil inhalation solution) VENTAVIS® (iloprost inhalation solution) **Oral** ORENITRAM® (treprostinil) ER Tablet **sGC STIMULATOR** All products require a PA ****Maximum days supply for all drugs is 30 days****	Letairis® (ambrisentan) Tablet *Quantity Limit = one tablet/day* Opsumit® (macitentan) Tablet *Quantity Limit = one tablet/day* Flolan®* (epoprostenol) Uptravi® (selexipag) tablets *200mcg strength, QL = 140 tablets/30 days for the first 2 months then 2 tablets/day subsequently. All other strengths, QL = 2 tablets/day* Adempas® (riociguat) Tablets *Quantity Limit = 3 tablets/day*	**Adempas:** The patient has a diagnosis of pulmonary arterial hypertension (PAH) WHO Group I with New York Heart Association (NYHA) Functional Class II or III. OR The patient has a diagnosis of chronic thromboembolic pulmonary hypertension (CTEPH, WHO Group 4) AND the patient has persistent or recurrent disease after surgical treatment (e.g., pulmonary endarterectomy) or has CTEPH that is inoperable AND The patient is 18 years of age or older AND The patient will not use Adempas concomitantly with the following: Nitrates or nitric oxide donors (such as amyl nitrate) in any form. Phosphodiesterase (PDE) inhibitors, including specific PDE-5 inhibitors (such as sildenafil, tadalafil, or vardenafil) or non-specific PDE inhibitors (such as dipyridamole or theophylline) AND The patient is not pregnant AND Female patients are enrolled in the Adempas REMS Program **Flolan:** Clinical diagnosis of pulmonary hypertension AND The patient has had a documented intolerance to the generic epoprostenol. **Letairis, Opsumit:** Patient has a diagnosis of PAH WHO Group 1 with NYHA Functional Class II or III AND Patient is not pregnant AND Female patients have been enrolled in the REMS Program AND the patient has a documented side effect, allergy, or treatment failure with Tracleer. **Uptravi:** The patient has a diagnosis of pulmonary arterial hypertension (PAH) WHO Group I with New York Heart Association (NYHA) Functional Class II or III heart failure AND the patient is unable to tolerate or has failed 2 different preferred medications , one of which must be Orenitram
RENAL DISEASE: PHOSPHATE BINDERS		
CALCIUM ACETATE † (compare to Phos Lo®) capsule	Auryxia® (ferric citrate) *(QL= 12/day)* Eliphos® (calcium acetate) tablet Fosrenol® (lanthanum carbonate)	**Eliphos:** The patient must have a documented intolerance to the generic equivalent calcium acetate tablet or capsule. **Renvela Oral Suspension Packet:** The patient has a requirement for a liquid

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CALCIUM ACETATE † (compare to Eliphos®) tablet RENAGEL® (sevelamer) RENVELA® (sevelamer carbonate) tablets **ORAL SOLUTIONS** PHOSLYRA® (calcium acetate) oral solution	Renvela® (sevelamer carbonate) Oral Suspension Packet *(QL = 2 packs/day (0.8 g strength only)* Velphoro® (sucroferric oxyhydroxide) Chew Tablet	dosage form. **Fosrenol, Velphoro Chew Tablet/Auryxia Tablet:** The patient must have a documented side effect, allergy, or inadequate response to one preferred phosphate binder.
RESTLESS LEG SYNDROME MEDICATIONS		
DOPAMINE AGONISTS (ORAL) PRAMIPEXOLE † (compare to Mirapex®) ROPINIROLE† (compare to Requip®) **DOPAMINE AGONISTS (TRANSDERMAL)** NEUPRO® (rotigotine) transdermal patch *(Quantity Limit = 1 patch/day)* *(1mg, 2 mg and 3 mg patches ONLY)* **GAMMA-AMINOBUTYRIC ACID ANALOG** GABAPENTIN IR	Mirapex®* (pramipexole) Requip®* (ropinirole) Horizant® (gabapentin enacarbil) ER Tablet *(Quantity Limit = 1 tablet/day)*	**Mirapex, Requip:** The patient has had a documented intolerance to the generic product. **Horizant:** The patient has a diagnosis of restless legs syndrome (RLS). AND The patient has had a documented side effect, allergy, contraindication or treatment failure to two preferred dopamine agonists (pramipexole IR, ropinirole IR, Neupro) AND gabapentin IR. **Limitations:** Requests for Mirapex ER and Requip XL will not be approved for Restless Leg Syndrome (RLS).
RHEUMATOID, JUVENILE & PSORIATIC ARTHRITIS: IMMUNOMODULATORS		
Preferred After Clinical Criteria Are Met **Injectable** ENBREL® (etanercept) *(Quantity limit = 4 syringes/28 days(50 mg) and 8 syringes/28 days (25 mg))* HUMIRA® (adalimumab) (*Quantity limit = 4 syringes/28 days)*	Actemra® (tocilizumab) Intravenous Infusion *(Qty limit = 4 vials/28 days (80 mg vial), 3 vials/28 days (200 mg vial) or 2 vials/28 days (400 mg vial))* Actemra® (tocilizumab) Subcutaneous *(Qty limit = 4 prefilled syringes (3.6ml)/28 days)* Cimzia® (certolizumab pegol) *(Quantity limit = 1 kit/28 days)* Inflectra® (Infliximab-dyyb) biosimilar to Remicade® Kineret® (anakinra)	**Clinical Criteria for all drugs:** Patient has a diagnosis of rheumatoid arthritis (RA), juvenile idiopathic arthritis* or psoriatic arthritis and has already been stabilized on the drug being requested OR Diagnosis is RA, juvenile idiopathic arthritis or psoriatic arthritis, and methotrexate therapy resulted in an adverse effect, allergic reaction, inadequate response, or treatment failure. If methotrexate is contraindicated, another DMARD should be tried prior to approving therapy. Other DMARDs include leflunomide, sulfasalazine, gold, antimalarials, minocycline, D-penicillamine, azathioprine, cyclophosphamide and cyclosporine. Additional note for Humira: Approval should be granted in cases where patients have been treated with infliximab, but have lost response

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
Oral All products require PA.	*(Quantity limit = 1 syringe/day)* Orencia® (abatacept) Subcutaneous Injection *(Quantity limit = 4 syringes/28 days)* Orencia® (abatacept) Intravenous Infusion Remicade® (infliximab) Simponi® (golimumab) Subcutaneous *Qty Limit = 1 of 50 mg prefilled syringe or autoinjector/28 days)* Simponi Aria® (golimumab) 50 mg/4 ml Vial for Intravenous Infusion Stelara® (ustekinumab) *(Quantity limit = 45 mg (0.5 ml) or 90 mg (1 ml) per dose)* *(90 mg dose only permitted for pt weight > 100 kg)* Xeljanz® (tofacitinib) tablet *(Qty limit = 2 tablets/day)* *Maximum 30 days supply* Xeljanz® XR (tofacitinib) tablet (*Qty limit = 1tablet/day)*	to therapy. **Actemra Intravenous Infusion additional criteria:** The prescriber must provide a clinically valid reason why both Humira and Enbrel cannot be used. For RA, patient must have had an inadequate response to one or more TNF inhibitors. **Actemra Subcutaneous additional criteria:** The prescriber must provide a clinically valid reason why both Humira and Enbrel cannot be used. The patient must have had an inadequate response to one or more TNF inhibitors. **Cimzia additional criteria:** The prescriber must provide a clinically valid reason why both Humira and Enbrel cannot be used. **Inflectra additional criteria:** The prescriber must provide a clinically valid reason why both Humira and Enbrel cannot be used AND the patient must be unable to use Remicade. **Remicade additional criteria** The prescriber must provide a clinically valid reason why both Humira and Enbrel cannot be used. **Simponi (subcutaneous) additional criteria:** The patient must be ≥ 18 years of age AND The prescriber must provide a clinically valid reason why both Humira and Enbrel cannot be used. **Simponi Aria additional criteria :** The patient has not responded adequately to Simponi subcutaneous. AND The prescriber must provide a clinically valid reason why both Humira and Enbrel cannot be used. **Kineret additional criteria:** Note: Kineret may be used as monotherapy or concomitantly with DMARDs, other than TNF antagonists. Kineret should not be administered concomitantly with any TNF antagonists (i.e. Enbrel, Humira, or Remicade). AND The prescriber must provide a clinically valid reason why both Humira and Enbrel cannot be used. **Xeljanz, Xeljanz XR additional criteria** The patient must be ≥ 18 years of age AND The prescriber must provide a clinically valid reason why both Humira and Enbrel cannot be used. For approval of Xeljanz XR, patient has not been able to tolerate or adhere to twice daily dosing of immediate release Xeljanz, resulting in significant clinical impact. **Orencia Intravenous Infusion additional criteria:** Orencia may be used as monotherapy or concomitantly with DMARDs, other than TNF antagonists. Orencia® should not be administered concomitantly with TNFantagonists (i.e. Enbrel, Humira, or Remicade) and is not recommended for use with Kineret. AND The prescriber must provide a clinically valid reason why both Humira and Enbrel cannot be used. AND If the diagnosis is RA, there is a clinically valid reason why Orencia Subcutaneous cannot be used. **Orencia Subcutaneous additional criteria:** . Orencia should not be administered concomitantly with TNFantagonists (i.e. Enbrel, Humira, or

PREFERRED AGENTS (No PA required unless otherwise noted)	NON-PREFERRED AGENTS (PA required)	PA CRITERIA
		Remicade) and is not recommended for use with Kineret. AND The prescriber must provide a clinically valid reason why both Humira and Enbrel cannot be used. **Stelara additional criteria:** The prescriber must provide a clinically valid reason why both Humira and Enbrel cannot be used. **Patients with systemic juvenile arthritis (SJRA/SJIA)** and fever are not required to have a trial of a DMARD, including methotrexate. Patients with systemic juvenile arthritis without fever should have a trial of methotrexate, but a trial of another DMARD in the case of a contraindication to methotrexate is not required before Enbrel, Humira, Actemra, or Orencia is approved. * Patients with psoriatic arthritis with a documented diagnosis of active axial involvement should have a trial of NSAID therapy, but a trial with DMARD is not required before a TNF-blocker is approved. If no active axial skeletal involvement, then an NSAID trial and a DMARD trial are required (unless otherwise contraindicated) prior to receiving Humira, Enbrel, Remicade, Cimzia, Stelara or Simponi
SILIVA STIMULANTS		
PILOCARPINE (compare to Salagen®) CEVIMELINE† (compare to Evoxac®) EVOXAC® (cevimeline)	Salagen®* (pilocarpine)	Salagen: The patient has had a documented side effect, allergy, or treatment failure to generic pilocarpine
SEDATIVE/HYPNOTICS		
BENZODIAZEPINE		
ESTAZOLAM† (compare to Prosom®) TEMAZEPAM† 15 mg, 30 mg (compare to Restoril®)	Doral® (quazepam) flurazepam† (formerly Dalmane®) Halcion® (triazolam) Prosom®* (estazolam) Restoril®* (temazepam) temazepam† 7.5 mg, 22.5 mg (compare to Restoril®) triazolam† (compare to Halcion®)	**Criteria for Approval:** The patient has had a documented side effect, allergy, or treatment failure with two preferred benzodiazepine sedative/hypnotics. If a product has an AB rated generic, one trial must be the generic.
NON BENZODIAZEPINE, NON BARBITURATE		
ZOLPIDEM † (compare to Ambien®)*(Quantity Limit = 1 tab/day)*	Ambien®* (zolpidem) *(Quantity Limit = 1 tab/day)* Ambien CR® (zolpidem) *(Quantity Limit = 1 tab/day)* Belsomra® (suvorexant) (*Quantity Limit = 1 tab/day)*	**Ambien:** The patient has had a documented intolerance to generic zolpidem. **Ambien CR, Belsomra, Lunesta, eszopiclone, Zolpidem CR:** The patient has

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ZALEPLON † (compare to Sonata®) *(Quantity Limit = 1 cap/day (5 mg) or 2 caps/day (10 mg))*	Edluar® (zolpidem) sublingual tablet *(Quantity Limit = 1 tab/day)* eszopiclone† (compare to Lunesta®) *(Quantity Limit = 1 tab/day)* Intermezzo® (zolpidem) Sublingual Tablet *(Quantity Limit = 1 tab/day)* Lunesta® (eszopiclone) *(Quantity Limit = 1 tab/day)* Rozerem® (ramelteon) *(Quantity Limit = 1 tab/day)* Silenor® (doxepin) *(Quantity limit = 1 tab/day)* Sonata®* (zaleplon) *(Quantity Limit = 1 cap/day (5 mg) or 2 caps/day (10 mg))* Zolpidem CR† (compare to Ambien CR®) *(Quantity Limit = 1 tab/day)*	had a documented side effect, allergy or treatment failure to generic zolpidem. If the request is for brand Ambien CR, there has also been a documented intolerance to the generic. Belsomra will be available to the few patients who are unable to tolerate or who have failed on preferred medications. **Edluar:** The patient has a medical necessity for a disintegrating tablet formulation (i.e. swallowing disorder). **Intermezzo:** The patient has insomnia characterized by middle-of-the night awakening followed by difficulty returning to sleep AND The patient has had a documented inadequate response to zolpidem IR AND zaleplon. **Rozerem:** The patient has had a documented side effect, allergy, contraindication or treatment failure to generic zolpidem. OR There is a question of substance abuse with the patient or family of the patient. Note: If approved, initial fill of Rozerem will be limited to a 14 day supply. **Silenor:** The patient has had a documented side effect, allergy, contraindication or treatment failure to generic zolpidem AND The patient has had a documented intolerance with generic doxepin or there is another clinically valid reason why a generic doxepin (capsule or oral solution) cannot be used. **Sonata:** The patient has had a documented intolerance to generic zaleplon
SMOKING CESSATION THERAPIES		
NICOTINE REPLACEMENT: maximum duration is 16 weeks (2 x 8 weeks)/365 days for non-preferred. For approval of therapy beyond the established maximum duration, the prescriber must provide evidence that the patient is engaged in a smoking cessation counseling program.		
NICOTINE GUM† NICOTINE PATCH OTC† NICORETTE LOZENGE® **ORAL THERAPY** BUPROPION SR† (compare to Zyban®) CHANTIX® (varenicline) (Limited to 18 years and older, Quantity Limit = 2 tabs/day, max duration 24 weeks (2x12 weeks)/365 days)	Nicoderm CQ Patch® Nicorette Gum® nicotine lozenge† Nicotrol Inhaler® Nicotrol Nasal Spray® Zyban®* (bupropion SR) (maximum duration 24 weeks (2 x 12 weeks)/365 days)	**Nicoderm CQ patch:** The patient has had a documented intolerance to generic nicotine patch. **Nicorette gum:** The patient has had a documented intolerance to generic nicotine gum. **nicotine lozenge:** The patient has had a documented side effect or allergy to Nicorette lozenge **Nicotrol Inhaler:** The patient has had a documented treatment failure with BOTH generic nicotine patch and generic nicotine gum. **Nicotrol Nasal Spray:** The prescriber must provide a clinically valid reason for the use of the requested medication.

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		Zyban: The patient has had a documented intolerance to generic bupropion SR. *Smoking Cessation Counseling is encouraged with the use of smoking cessation therapies* *The combined prescribing of long acting (patch) and faster acting (gum or lozenge) nicotine replacement therapy is encouraged for greater likelihood of quit success. **Vermont QUIT LINE** (available free to all patients) 1-800-QUIT-NOW (1-800-784-8669) **GETQUIT™** Support Plan available free to all Chantix® patients 1-877-CHANTIX (242-6849) **Limitations:** Nicotine System Kit® not covered – prescribe multiple strengths separately
TESTOSTERONE: TOPICAL		
Nasal		
	Natesto® (testosterone) nasal (QL = 1 pump/30 days)	**Natesto:** The patient has had a documented side effect, allergy, or treatment failure to AndroGel® Gel and Androderm.
Topical		
ANDRODERM® Transdermal 2mg, 4 mg (testosterone patch) *Quantity limit = 1 patch/day/strength* ANDROGEL® GEL (testosterone 1% gel packets) *Quantity limit = 2.5 gm packet (1 packet/day)* *5 gm packet (2 packets/day)* ANDROGEL® GEL (testosterone 1.62% gel packets) *Quantity limit = 1.25 gm packet (1.62%) (1 packet/day)* *2.5 gm packet (1.62%) (2 packets/day)* ANDROGEL® PUMP (testosterone pump bottles) *Quantity limit = 1.62% (2 bottles/30 days)*	Axiron (testosterone 2% solution) 90 ml Pump Bottle *Quantity limit = 2 bottles/30 days* Fortesta® (testosterone 2 % Gel) 60 gm Pump Bottle *Quantity limit = 2 bottles/30 days* Testim® Gel 5 gm (testosterone 1% gel tube) *Quantity limit = 2 tubes/day* Testosterone 1% Gel Packets (compare to Androgel®, Vogelxo®) *Quantity Limit = 2.5gm packet (1 packet/day)* *Quantity Limit= 5gm packet (2 packets/day)* Testosterone 1% gel tube (compare to Testim® Gel 5 gm, Vogelxo®, Androgel®) *Quantity limit = 2 tubes/day* Testosterone† 1% Gel Pump (compare to Androgel®, Vogelxo®) *Quantity limit = 4 bottles/30 days*	**Axiron, Fortesta, Testim Testosterone Gel 1%, Testosterone Gel 2 %:** The patient has had a documented side effect, allergy, or treatment failure to Androgel and Androderm. **Android, Striant, Methyltesterone, Testred:** patient has a documented side effect, allergy, or treatment failure to Methitest **Limitations:** Coverage of testosterone products is limited to males.

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Oral Methitest (methyltesterone) Tablet 10mg	Testosterone 2% gel 60 gm pump bottle (compare to Fortesta®) *Quantity limit = 2 bottles/30 days* Vogelxo® 1% (testosterone 1%) gel, pump *Quantity limit = 2 tubes/day (5 gm gel tubes)* *Quantity limit = 4 bottles/30 days (gel pump bottle)* Android (methyltestoterone) capsule 10mg Methyltestosterone capsule 10mg Striant® Sr (testosterone) 30mg Testred (methyltestosterone) capsule 10mg *Maximum day supply all products is 30 days*	
THROMBOPOIETIN RECEPTOR AGONISTS		
	Nplate® (romiplostim) Promacta® (eltrombopag)	**FOR APPROVAL:** The patient is at least 18 years of age. AND The diagnosis or indication is chronic immune (idiopathic) thrombocytopenic purpura (ITP). AND The patient's platelet count is less than 30,000/µL (< 30 x 109/L) or the patient is actively bleeding. AND The patient has had a documented side effect, allergy, treatment failure or a contraindication to therapy with corticosteroids. OR The patient has a documented insufficient response following splenectomy.
URINARY ANTISPASMODICS		
SHORT-ACTING AGENTS OXYBUTYNIN† (formerly Ditropan®) **LONG-ACTING AGENTS** ***(Qty Limit = 1 per day)*** OXYBUTYNIN XL† (compare to Ditropan® XL) TOVIAZ® (fesoterodine) VESICARE® (solifenacin)	Flavoxate † (formerly Urispas®) Detrol® (tolterodine) tolterodine† (compare to Detrol®) trospium† (formerly Sanctura®) Detrol LA® (tolterodine SR)	Please note: Patients <21 years of age are exempt from all ORAL ANTIMUSCARINIC Urinary Antispasmodics PA requirements **Detrol, Detrol LA, Ditropan XL, Enablex, tolterodine (generic), tolterodine SR (generic), trospium (generic), trospium ER (generic):** The patient has had a documented side effect, allergy, or treatment failure with 2 preferred long-acting agents. If a medication has an AB rated generic, there must have also been a trial of the generic formulation. **Gelnique 3%, 10%, Oxytrol:** The patient is unable to swallow a solid oral formulation (e.g. patients with dysphagia) OR The patient is unable to be compliant with solid oral dosage forms.

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Transdermal/Topical All products require PA **BETA-3 ADRENERGIC AGONISTS** All products require PA	Ditropan XL® (oxybutynin XL) Enablex® (darifenacin) tolterodine SR† (compare to Detrol LA®) trospium ER† (formerly Sanctura XR®) Gelnique 3%® (oxybutynin topical gel) *(Qty limit = 1 pump bottle (92gm)per 30 days)* Gelnique 10%® (oxybutynin topical gel) *(Qty limit = 1 sachet/day)* Oxytrol® (oxybutinin transdermal) *(Qty Limit = 8 patches/28 days)* Myrbetriq® (mirabegron) ER Tablet *(Qty limit = 1 tablet/day)*	**Myrbetriq:** The patient has had a documented side effect, allergy, treatment failure, or contraindication with one preferred long-acting urinary antimuscarinic agent. **Limitations:** Oxytrol (for Women) OTC not covered. Oxytrol RX is available but subject to prior authorization.
VAGINAL ANTI-INFECTIVES		
CLINDAMYCIN CLEOCIN® Vaginal Ovules (clindamycin vaginal suppositories) CLINDAMYCIN VAGINAL† (clindamycin vaginal cream 2%) CLINDESSE® (clindamycin vaginal cream 2%) **METRONIDAZOLE** METRONIDAZOLE VAGINAL GEL 0.75%† VANDAZOLE† (metronidazole vaginal 0.75%)	Cleocin®* (clindamycin vaginal cream 2%) Metrogel Vaginal®* (metronidazole vaginal gel 0.75%) Nuvessa Vaginal® (metronidazole vaginal gel 1.3%) (1 pre-filled applicator/30 days)	**Cleocin:** The patient has had a documented side effect, allergy, or treatment failure to a preferred clindamycin vaginal cream. **Metrogel Vaginal, Nuvessa Vaginal:** The patient has had a documented side effect, allergy, or treatment failure to generic metronidazole vaginal gel 0.75 % or Vandazole.
VITAMINS: PRENATAL MULTIVITAMINS		
CITRANATAL HARMONY CITRANATAL 90 DHA CITRANATAL B-CALM CITRANATAL RX CITRANATAL ASSURE	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.

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CITRANATAL DHA CONCEPT OB CONCEPT DHA PRENATAL PLUS IRON PRENATAL VITAMINS PLUS PRENATE CHEW .6-.4 PREPLUS VOL-PLUS		