North Dakota Medicaid

Preferred Drug List (PDL)

& Prior Authorization Criteria

Published By:

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March 2019

Version 2019.2

Effective: April 1, 2019

Contents

Guiding Rules of the Preferred Drug List (PDL):

- This is NOT an all-inclusive list of medications covered by ND Medicaid. Please use the NDC Drug Lookup tool at to view coverage status, quantity limits, copay, and prior authorization information for all medications. Visit http://www.hidesigns.com/ndmedicaid for more information on medications not found in this list.

- This is NOT an all-inclusive list of medications that require prior authorization. Please visit for PA criteria for medications not found on the PDL.

- Prior authorization criteria apply in addition to the general Drug Utilization Review policy that is in effect for the entire pharmacy program. Refer to http://www.hidesigns.com/ndmedicaid for applicable drug utilization management and coverage rules and therapeutic duplication edits.

- Prior authorization for a non-preferred agent with a preferred brand/generic equivalent in any category will be given only if an authorized generic is not available and all other criteria is met, including all DAW criteria, clinical criteria, and step therapy specific to that category.

- The use of pharmaceutical samples will not be considered when evaluating the member's medical condition or prior prescription history for drugs that require prior authorization.

- Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC drugs are not covered unless specified.

- A trial will be considered a failure if a product was not effective at maximum tolerated dose with good compliance, as evidenced by paid claims or pharmacy print outs or patient has a documented intolerance or adverse reaction to an ingredient.

- Length of prior authorizations is a year unless otherwise specified.

- Rational of inability to swallow a solid dosage form must be provided after age 9 for all non-solid oral dosage forms.

- Acronyms
  PA – Indicates preferred agents that require clinical prior authorization.
  *** - Indicates that additional PA criteria applies as indicated in the Product PA Criteria

Changes Since Last Version:

Category	Product Status Changes	Criteria Changes
ADHD Agents	Brand Adderall XR moved to non-preferred, all generics are now preferred	
Androgens	Testosterone cypionate injection and Testosterone enanthate injection moved to preferred. Android, Striant, Testred, Xyosted added to non-preferred	Injectable/Implantable and Oral groups added
Angina	Ranolazine ER added to non-preferred	
Anticonvulsants	Vigabatrin and VIGADRONE (Vigabatrin) added to non-preferred	
COPD (Chronic Obstructive Pulmonary Disease)	INCRUSE ELLIPTA (umeclidinium), ARCAPTA NEOHALER (indacaterol), and SEEBRI Neohaler (glycopyrrolate) moved to preferred	PDE4-Inhibitor Group updated
Corticosteroids – Inhaled		New Category
Cystic Fibrosis Inhaled Antibiotics		Category PA Criteria updated. Drug category criteria updated for Cayston. Drug category criteria added for Tobi Podhaler and Arikayce.
Epinephrine Autoinjectors	Symjepi added to non-preferred	
Growth Hormone		Category PA Criteria updated
Hepatitis C	Daklinza removed from PDL	
Migraine Prophylaxis – CGRP Inhibitors	Emgality and Aimovig moved to preferred	Category PA Criteria updated
Ophthalmic - Anti-inflammatories	DUREZOL (difluprednate) moved to non-preferred. INVELTYS (Loteprednol) and LOTEMAX SM (Loteprednol) Added to non-preferred	
Opioid Analgesics – Long Acting	Butrans 7.5mcg/hr, 15 mcg/hr moved to preferred, 20mcg/hr moved to non-preferred	
Pulmonary Hypertension - PDE-5 Inhibitors	Sildenafil suspension added to non-preferred	
Urinary Antispasmodics	Tolterodine ER moved to preferred	

ADHD Agents:

Category PA Criteria:

Branded non-preferred agents: A 10-day trial of all accessible pharmaceutically equivalent preferred agents will be required before a non-preferred agent will be authorized.

Generic non-preferred agents: A 10-day trial of a pharmaceutically equivalent preferred agent will be required before a non-preferred agent will be authorized.

Product PA Criteria:

*** Clonidine ER: require a 1-month trial of immediate release clonidine.

PREFERRED AGENTS	NON-PREFERRED AGENTS
ADZENYS XR - ODT (amphetamine)	ADDERALL (dextroamphetamine/amphetamine)
ADZENYS ER (amphetamine) SOLUTION	ADDERALL XR (dextroamphetamine/amphetamine)
APTENSIO XR (methylphenidate)	amphetamine
Atomoxetine	DEXEDRINE (dextroamphetamine)
Clonidine	Dexmethylphenidate ER
Clonidine ER[PA***]	Dextroamphetamine
CONCERTA (methylphenidate)	Dextroamphetamine 5 mg/5 ml
COTEMPLA XR - ODT (methylphenidate)	FOCALIN (dexmethylphenidate)
DAYTRANA (methylphenidate)	INTUNIV (guanfacine ER)
DESOXYN (methamphetamine)	METADATE ER (methylphenidate)
Dexmethylphenidate	METHYLIN (methylphenidate) chew tablets
Dextroamphetamine ER	Methamphetamine
Dextroamphetamine/amphetamine	Methylphenidate ER 72 mg
Dextroamphetamine/amphetamine ER	Methylphenidate ER tablet
DYANAVEL XR (amphetamine)	Methylphenidate solution
EVEKEO (amphetamine)	RELEXXII (methylphenidate)
FOCALIN XR (dexmethylphenidate)	RITALIN (methylphenidate)
Guanfacine ER	RITALIN LA (methylphenidate LA capsules - 50-50)
KAPVAY (clonidine ER) [PA***]	STRATTERA (atomoxetine)
Methamphetamine	
METHYLIN (methylphenidate) solution	
Methylphenidate CD 30-70	
Methylphenidate chew tablet	
Methylphenidate ER capsules 50-50	
Methylphenidate LA capsules - 50-50	
Methylphenidate tablet	
MYDAYIS (amphetamine/dextroamphetamine)	
PROCENTRA (dextroamphetamine)	
QUILLICHEW ER (methylphenidate)	
QUILLIVANT XR (methylphenidate)	
VYVANSE (lisdexamfetamine)	
VYVANSE (lisdexamfetamine) CHEW TABLET	
ZENZEDI (dextroamphetamine)	

Angina:

PREFERRED AGENTS	NON-PREFERRED AGENTS
RANEXA (ranolazine)	Ranolazine ER

Analgesics – NSAIDS – Topical:

Category PA Criteria:
A 30-day trial of all preferred agents will be required before a non-preferred agent will be authorized. A medical reason must be provided why preferred agents do not work.

PREFERRED AGENTS	NON-PREFERRED AGENTS
FLECTOR (diclofenac) PATCH	diclofenac gel
PENNSAID (diclofenac)	
VOLTAREN (diclofenac) GEL	

Androgens

Category PA Criteria:
A 30-day trial of all preferred agents will be required before a non-preferred agent will be authorized. All agents require an FDA-approved indication. Medical justification must be provided why patient can't use a preferred product (subject to clinical review).

Injectable/Implantable

PREFERRED AGENTS	NON-PREFERRED AGENTS
Testosterone cypionate injection	AVEED (testosterone undecanoate)
Testosterone enanthate injection	TESTOPEL (testosterone)
	XYOSTED (testosterone enanthate)

Oral

PREFERRED AGENTS	NON-PREFERRED AGENTS
	ANDROID (methyltestosterone)
	Methyltestosterone
	METHITEST (methyltestosterone)
	STRIANT (testosterone)
	TESTRED (methyltestosterone)

Topical/Nasal

PREFERRED AGENTS	NON-PREFERRED AGENTS
ANDROGEL (testosterone)	AXIRON (testosterone) TOPICAL SOLUTION
ANDRODERM (testosterone)	FORTESTA (testosterone)
	TESTIM (testosterone)
	NATESTO (testosterone)
	Testosterone gel
	Testosterone Gel MD PMP

	Testosterone topical solution
	VOGELXO (testosterone) GEL MD PMP

Anticoagulants - Oral:

Category PA Criteria:
A 30-day trial of all preferred agents will be required before a non-preferred agent will be authorized. All agents will require an FDA indication.

PREFERRED AGENTS	NON-PREFERRED AGENTS
BEVYXXA (Betrixaban)	SAVAYSA (edoxaban)
ELIQUIS (Apixaban)	
PRADAXA (dabigatran)	
XARELTO (rivaroxaban)	

Anticonvulsants:

Category PA Criteria:
Branded non-preferred agents: A 30-day trial of 2 pharmaceutically equivalent preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present.

Generic non-preferred agents: A 30-day trial of a pharmaceutically equivalent preferred agent will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present.

PREFERRED AGENTS	NON-PREFERRED AGENTS
APTIOM (eslicarbazepine)	CARBATROL (carbamazepine)
BANZEL (rufinamide) ORAL SUSPENSION	DEPAKENE (valproic acid) CAPSULE
BANZEL (rufinamide) TABLET	DEPAKENE (valproic acid) ORAL SOLUTION
BRIVIACT (brivaracetam)	DEPAKOTE (divalproex sodium) TABLET
Carbamazepine chewable tablet	DEPAKOTE ER (divalproex sodium)
Carbamazepine ER capsule	DEPAKOTE SPRINKLE (divalproex sodium)
Carbamazepine oral suspension	DILANTIN (phenytoin) CHEWABLE TABLET
Carbamazepine tablet	DILANTIN (phenytoin) ORAL SUSPENSION
Carbamazepine XR tablet	DILANTIN ER (phenytoin)
CELONTIN (methsuximide)	EPITOL (carbamazepine)
Divalproex ER	FELBATOL (felbamate)
Divalproex sprinkle	FELBATOL (felbamate) ORAL SUSPENSION
Divalproex tablet	KEPPRA (levetiracetam)
Ethosuximide capsule	KEPPRA (levetiracetam) ORAL SOLUTION
Ethosuximide oral solution	KEPPRA XR (levetiracetam)
Felbamate tablet	LAMICTAL (lamotrigine)
Felbamate oral suspension	LAMICTAL (lamotrigine) CHEWABLE TABLET
FYCOMPA (perampanel)	LAMICTAL (lamotrigine) DOSE PACK
FYCOMPA (perampanel) ORAL SUSPENSION	MYSOLINE (primidone)
Gabapentin capsule	NEURONTIN (gabapentin) CAPSULE
Gabapentin oral solution	NEURONTIN (gabapentin) ORAL SOLUTION

Gabapentin tablet	NEURONTIN (gabapentin) TABLET
GABITRIL (tiagabine)	QUDEXY XR (topiramate)
LAMICTAL ER (lamotrigine) DOSE PACK	TEGRETOL XR (carbamazepine)
LAMICTAL ODT (lamotrigine)	TEGRETROL (carbamazepine oral suspension)
LAMICTAL ODT (lamotrigine) DOSE PACK	tiagabine
LAMICTAL XR (lamotrigine)	TOPAMAX (topiramate)
Lamotrigine chewable tablet	TOPAMAX (topiramate) SPRINKLE CAPSULE
Lamotrigine dose pack	TRILEPTAL (oxcarbazepine)
Lamotrigine ER	TRILEPTAL (oxcarbazepine) ORAL SUSPENSION
Lamotrigine ODT	vigabatrin
Lamotrigine tablet	vigabatrin powder pack
Levetiracetam ER	VIGADRONE (vigabatrin)
Levetiracetam oral solution	ZARONTIN (ethosuximide)
Levetiracetam tablet	ZARONTIN (ethosuximide) ORAL SOLUTION
LYRICA (pregabalin)	ZONEGRAN (zonisamide)
LYRICA (pregabalin) ORAL SOLUTION	
Oxcarbazepine oral solution	
Oxcarbazepine tablet	
OXTELLAR XR (oxcarbazepine)	
PEGANONE (Ethotoin)	
Phenobarbital elixir	
Phenobarbital tablet	
PHENYTEK (phenytoin)	
Phenytoin chewable tablet	
Phenytoin ER capsule	
Phenytoin suspension	
Primidone	
SABRIL (vigabatrin)	
SABRIL (vigabatrin) POWDER PACK	
SPRITAM (levetiracetam)	
TEGRETOL (carbamazepine)	
Topiramate ER	
Topiramate sprinkle capsule	
Topiramate tablet	
TROKENDI XR (topiramate)	
Valproic acid capsule	
Valproic acid oral solution	
VIMPAT (lacosamide)	
VIMPAT (lacosamide) ORAL SOLUTION	
Zonisamide	

Antidementia

Category PA Criteria:

All agents will require an FDA indication for patients younger than 30 years old.

Branded non-preferred agents: A 30-day trial of all accessible pharmaceutically equivalent preferred agents will be required before a non-preferred agent will be authorized.

Generic non-preferred agents: A 30-day trial of a pharmaceutically equivalent preferred agent will be required before a non-preferred agent will be authorized.

Product PA Criteria:
***Memantine ER: A 30-day trial of memantine IR will be required before Namenda XR will be authorized. Patient must not reside in nursing home.

PREFERRED AGENTS	NON-PREFERRED AGENTS
Donepezil 5mg, 10mg	ARICEPT (donepezil)
Donepezil ODT	Donepezil 23mg
EXELON (rivastigmine)	NAMENDA (memantine)
EXELON (rivastigmine) PATCH	NAMZARIC (memantine/donepezil)
Galantamine	RAZADYNE (galantamine)
Galantamine ER	RAZADYNE ER (galantamine)
Galantamine oral solution	Rivastigmine patch
Memantine	NAMENDA XR (memantine)
Memantine oral solution	
Memantine ER***	
Rivastigmine	

Antiretrovirals

Integrase Strand Transfer Inhibitors

PREFERRED AGENTS	NON-PREFERRED AGENTS
BIKTARVY (bictegravir/Emtricitabine/Tenofovir)	
GENVOYA (elvitegravir/cobicistat/emtricitabine/tenofovir)	
ISENTRESS (raltegravir)	
JULUCA (dolutegravir/rilpivirine)	
STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir)	
TIVICAY (dolutegravir)	
TRIUMEQ (abacavir/dolutegravir/lamivudine)	

Nucleoside Reverse Transcriptase Inhibitors

Category PA Criteria:
Branded non-preferred agents: A 30-day trial of all accessible pharmaceutically equivalent preferred agents will be required before a non-preferred agent will be authorized.

Generic non-preferred agents: A 30-day trial of a pharmaceutically equivalent preferred agent will be required before a non-preferred agent will be authorized.

PREFERRED AGENTS	NON-PREFERRED AGENTS
Abacavir	COMBIVIR (lamivudine/zidovudine)
Abacavir/lamivudine	EPIVIR (lamivudine)
Abacavir/lamivudine/zidovudine	EPZICOM (abacavir)
ATRIPLA (efavirenz/emtricitabine/tenofovir)	RETROVIR (zidovudine)
BIKTARVY (bictegravir/Emtricitabine/Tenofovir)	TRIZIVIR (abacavir/lamivudine)
CIMDUO (lamivudine/tenofovir)	VIDEX EC (didanosine)
COMPLERA (emtricitabine/rilpivirine/tenofovir)	VIREAD (tenofovir)
DELSTRIGO (doravirine/lamivudine/tenofovir)	ZERIT (stavudine) CAPSULE
DESCOVY (emtricitabine/tenofovir)	ZIAGEN (abacavir)
Didanosine	
EMTRIVA (emtricitabine)	

GENVOYA (elvitegravir/cobicistat/emtricitabine/tenofovir)	
Lamivudine	
Lamivudine/zidovudine	
ODEFSEY (emtricitabine/rilpivirine/tenofovir)	
SYMFI (efavirenz/lamivudine/tenofovir)	
SYMFI LO (efavirenz/lamivudine/tenofovir)	
Stavudine	
STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir)	
SYMTUZA (darumavir/cobicistat/emtricitabine/tenofovir)	
Tenofovir	
TRIUMEQ (abacavir/dolutegravir/lamivudine)	
TRUVADA (emtricitabine/tenofovir)	
VIDEX (didanosine)	
ZERIT (stavudine) SOLUTION	
Zidovudine	

Protease Inhibitor

Category PA Criteria:
Branded non-preferred agents: A 30-day trial of all accessible pharmaceutically equivalent preferred agents will be required before a non-preferred agent will be authorized.

Generic non-preferred agents: A 30-day trial of a pharmaceutically equivalent preferred agent will be required before a non-preferred agent will be authorized.

PREFERRED AGENTS	NON-PREFERRED AGENTS
APTIVUS (tipranavir)	KALETRA (lopinavir/ritonavir) SOLUTION
atazanavir	LEXIVA (Fosamprenavir)
CRIXIVAN (indinavir)	REYATAZ (atazanavir) CAPSULE
EVOTAZ (atazanavir/cobicistat)	ritonavir
Fosamprenavir	
INVIRASE (saquinavir)	
KALETRA (lopinavir/ritonavir) TABLET	
lopinavir/ritonavir solution	
NORVIR (ritonavir)	
PREZCOBIX (darunavir/cobicistat)	
PREZISTA (darunavir)	
REYATAZ (atazanavir) POWDER PACK	
SYMTUZA (darumavir/cobicistat/emtricitabine/tenofovir)	
VIRACEPT (nelfinavir)	

Atopic Dermatitis

Category PA Criteria:
Patient must have a FDA approved indication and age.
A complete preferred drug list of topical corticosteroids may be found at:
http://www.hidesigns.com/assets/files/ndmedicaid/2018/Criteria/PA_Criteria.pdf

Generic non-preferred agents: A 30-day trial of a pharmaceutically equivalent preferred agent will be required before a non-preferred agent will be authorized.

Product PA Criteria:
***Eucrisa: Patient must have had a 30 day trial within the past 180 days of either a topical calcineurin inhibitor (tacrolimus or pimecrolimus) or corticosteroid

***Dupixent: Patient must have had both a 6 week trial of a topical calcineurin inhibitor (tacrolimus or pimecrolimus) and a 30 day trial of at least a medium strength topical corticosteroid (or low strength if area is on face, groin, axilla, or under occlusion)

***Protopic: 0.1% strength is covered for adults only

PREFERRED AGENTS	NON-PREFERRED AGENTS
DERMA-SMOOTH-FS (Fluocinolone Acetonide) OIL 0.01%	Fluocinolone Acetonide Oil 0.01%
DUPIXENT (dupilumab) PA***	Tacrolimus 0.03%
ELIDEL (pimecrolimus) CREAM	Tacrolimus 0.1%
EUCRISA (crisaborole) OINTMENT PA***	
PROTOPIC (tacrolimus) OINTMENT 0.03%	
PROTOPIC (tacrolimus) OINTMENT 0.1%***	

Atypical Antipsychotics

Oral

Category PA Criteria:
Branded non-preferred agents: A 30-day trial of all accessible pharmaceutically equivalent preferred agents will be required before a non-preferred agent will be authorized.

Generic non-preferred agents: A 30-day trial of a pharmaceutically equivalent preferred agent will be required before a non-preferred agent will be authorized.

Product PA Criteria:
***Olanzapine/fluoxetine: Plan prefers individual drugs prescribed separate

PREFERRED AGENTS	NON-PREFERRED AGENTS
aripiprazole solution	ABILIFY (aripiprazole)
Aripiprazole	ABILIFY DISCMELT (aripiprazole)
Aripiprazole ODT	CLOZARIL (clozapine)
Clozapine	FAZACLO (clozapine) RAPDIS
Clozapine ODT	GEODON (ziprasidone)
FANAPT (iloperidone)	INVEGA ER (paliperidone)
LATUDA (lurasidone)	Olanzapine/Fluoxetine***
Olanzapine	RISPERDAL (risperidone)
Olanzapine ODT	RISPERDAL (risperidone) ORAL SOLUTION
Paliperidone ER	RISPERDAL M-TAB (risperidone)
Quetiapine	SEROQUEL (quetiapine)
Quetiapine ER	SEROQUEL XR (quetiapine)
REXULTI (brexpiprazole)	SYMBYAX (olanzapine/fluoxetine) ***
Risperidone	ZYPREXA (olanzapine)
Risperidone ODT	ZYPREXA ZYDIS (olanzapine)
Risperidone oral solution	
SAPHRIS (asenapine)	
VRAYLAR (cariprazine)	
Ziprasidone	

Long Acting Injectable

PREFERRED AGENTS	NON-PREFERRED AGENTS
ABILIFY MAINTENA (aripiprazole)	
ARISTADA (aripiprazole lauroxil)	
ARISTADA INITIO (aripiprazole lauroxil)	
INVEGA SUSTENNA (paliperidone)	
INVEGA TRINZA (paliperidone)	
PERSERIS (risperidone)	
RISPERDAL CONSTA (risperidone)	
ZYPREXA RELPREVV (olanzapine)	

Constipation – Irritable Bowel Syndrome/Opioid Induced

Category PA Criteria:

Patients must be 18 years old. All medications will require an FDA indication.

For idiopathic constipation:

- A 30 day trial of both Amitiza and Linzess will be required before a non-preferred agent will be authorized.

For opioid-induced constipation:

- A paid claim for an opioid must be on patient's profile
- A 30 day trial of Amitiza and Movantik will be required before a non-preferred oral agent will be authorized.

PREFERRED AGENTS	NON-PREFERRED AGENTS
AMITIZA (lubiprostone)	LINZESS (linaclotide) 72 mcg
LINZESS (linaclotide) 145 mcg, 290 mcg	RELISTOR (methylnaltrexone) TABLET
MOVANTIK (naloxegol)	SYMPROIC (naldemedine)
RELISTOR (methylnaltrexone) SYRINGE	TRULANCE (plecanatide)
RELISTOR (methylnaltrexone) VIAL	

COPD (Chronic Obstructive Pulmonary Disease)

Long Acting Anticholinergics

Group PA Criteria:

A 30-day trial of all preferred agents will be required before a non-preferred agent will be authorized. Either single ingredient or combination products will count toward trials. All non-preferred agents indicated only for COPD will require verification of FDA-approved indication.

Product PA Criteria:

***Lonhala Magnair - Patients must have both of the following:

- A failure of a 30 day trial of Yupelri will be required before Lonhala Magnair will be authorized.

-Clinical justification must be given for why another product will not work in addition to Category PA Criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
INCRUSE ELLIPTA (umeclidinium)	LONHALA MAGNAIR (glycopyrrolate)***
SEEBRI NEOHALER (glycopyrrolate)	YUPELRI (revefenacin)
SPIRIVA HANDIHALER (tiotropium)	
SPIRIVA RESPIMAT 2.5 MG (tiotropium)	
TUDORZA PRESSAIR (aclidinium)	

COPD continued:

Long Acting Beta Agonists

Group PA Criteria:
All agents indicated only for COPD will require verification of FDA-approved indication.

Product PA Criteria:
***Brovana will require a 30 day trial of Perforomist in addition to Category PA Criteria

PREFERRED AGENTS	NON-PREFERRED AGENTS
ARCAPTA NEOHALER (indacaterol)	BROVANA (arformoterol)***
PERFOROMIST (formoterol)	
SEREVENT DISKUS (salmeterol)	
STRIVERDI RESPIMAT (olodaterol)	

Combination Anticholinergics/Beta Agonists

Group PA Criteria:
A 30-day trial of 2 long acting preferred products will be required before a non-preferred agent (short or long acting) will be authorized. All agents indicated only for COPD will require verification of FDA-approved indication.

PREFERRED AGENTS	NON-PREFERRED AGENTS
Albuterol/ipratropium	COMBIVENT RESPIMAT (albuterol/ipratropium)
ANORO ELLIPTA (umeclidinium/vilanterol)	DUONEB (albuterol/ipratropium)
BEVESPI AEROSPHERE (glycopyrrolate/formoterol)	STIOLTO RESPIMAT (tiotropium/olodaterol)
UTIBRON NEOHALER (glycopyrrolate/indacaterol)	

Combination Steroid/Anticholinergics/Long Acting Beta Agonists

Group PA Criteria:
In addition to the category PA criteria, patient must have an FDA approved indication and a 30 day trial of the following combinations:
1. Steroid/Long Acting Beta Agonist (LABA) Combination Inhalers + Long Acting Anticholinergics
2. Combination Anticholinergics/Long Acting Beta Agonist + Inhaled Steroid

PREFERRED AGENTS	NON-PREFERRED AGENTS
	TRELEGY ELLIPTA (Fluticasone Furoate/Umeclidinium/Vilanterol)

COPD Continued:

PDE4-Inhibitor

Group PA Criteria:
In addition to the category PA criteria, patient must have an FDA approved indication, a history of exacerbations treated with corticosteroids within the last year for initial requests.
Patient must also have had a 30 day trial with a medication in each of the following therapeutic classes from either single ingredient or combination products:

1. Long acting anticholinergic
2. Long acting beta agonist
3. Inhaled Steroid

PREFERRED AGENTS	NON-PREFERRED AGENTS
	DALIRESP (roflumilast)

Corticosteroids – Inhaled

Category PA Criteria:
Patient must have failed a 30-day trial of all preferred inhalers will be required before a non-preferred agent will be authorized.

Preferred	Non-Preferred
ASMANEX (mometasone) TWISTHALER	ALVESCO (ciclesonide)
budesonide suspension	ARMONAIR RESPICLICK (fluticasone)
FLOVENT DISKUS (fluticasone)	ARNUITY ELLIPTA (fluticasone)
FLOVENT HFA (fluticasone)	ASMANEX HFA (mometasone)
PULMICORT FLEXHALER (budesonide)	PULMICORT RESPULES (budesonide)
QVAR REDIHALER (beclomethasone)	

Cystic Fibrosis Inhaled Antibiotics

Category PA Criteria:
Branded non-preferred agents: A 10-day trial of all accessible pharmaceutically equivalent preferred agents will be required before a non-preferred agent will be authorized.

Generic non-preferred agents: A 10-day trial of a pharmaceutically equivalent preferred agent will be required before a non-preferred agent will be authorized.

Product PA Criteria:
***Tobi Podhaler - Patient must have a 28 day trial of preferred nebulized product. All agents will require an FDA-approved indication

***Cayston – Patient must also have had 28 day trial of TOBI Podhaler in addition to Category PA Criteria. Patient must be colonized with *Pseudomonas aeruginosa.*

***Arikayce – Patient must be colonized with *Mycrobacterium avium* complex (MAC). Patient must have not achieved negative sputum cultures after a minimum duration of 6 consecutive months of background treatment with a macrolide, a rifamycin, and ethambutol.

PREFERRED AGENTS	NON-PREFERRED AGENTS
BETHKIS (Tobramycin)	ARIKAYCE (Amikacin/Nebulizer) ***
KITABIS PAK (Tobramycin/Nebulizer)	CAYSTON (Aztreonam)***
TOBI PODHALER (Tobramycin) PA***	TOBI (Tobramycin)
Tobramycin	Tobramycin/Nebulizer

Cytokine Modulators

Category PA Criteria:
A 3-month trial of 2 preferred agents will be required before a non-preferred agent will be authorized. All agents will require an FDA-approved indication.

Product PA Criteria:
***Stelara - For the diagnosis of Chron's disease, Category PA Criteria must be met. Remicade can be given and billed on the medical side. For all other indications, patient must fail a 3-month trial of one non-preferred agent in addition to Category PA Criteria.

***Ilumya, Siliq, Taltz, Tremfya - Patient must fail a 3-month trial of one non-preferred agent in addition to Category PA Criteria

***Kevzara, Orencia, Olumiant - Patient must fail a 3-month trial of 2 non-preferred agents in addition to all preferred agents

PREFERRED AGENTS	NON-PREFERRED AGENTS
COSENTYX (secukinumab)	ACTEMRA (tocilizumab)
ENBREL (etanercept)	CIMZIA (certolizumab)
HUMIRA (adalimumab)	ILUMYA (tildrakizumab-asmn)
	KEVZARA (sarilumab)***
	KINERET (anakinra)
	OLUMIANT (baricitinib)***
	ORENCIA (abatacept)***
	OTEZLA (apremilast)
	SILIQ (brodalumab)***
	SIMPONI (golimumab)
	STELARA (ustekinumab)***
	TALTZ (ixekizumab)***
	TREMFYA (guselkumab)***
	XELJANZ (tofacitinib)
	XELJANZ XR (tofacitinib)

Diabetes

DPP4-Inhibitors

Category PA Criteria:
All agents will require:

1. A diagnosis of an FDA-approved indication for use
2. One of the following:
   A: The requested agent is a combination product containing metformin
   B: Metformin use with good compliance in the past 3 months before and concurrently with requested agent (patients with GI intolerances to high dose IR metformin should trial at minimum a dose of 500mg ER)

In addition, non-preferred agents will require a failed trial of each of the following:

1. 30 days of 1 sitagliptin preferred product (Janumet, Janumet XR, or Januvia)
2. 30 days of 1 linagliptin preferred product (Jentadueto or Tradjenta)
3. 30 days of Victoza

PREFERRED AGENTS	NON-PREFERRED AGENTS
JANUMET (sitagliptin/metformin)	alogliptan/pioglitizone
JANUMET XR (sitagliptin/metformin)	alogliptin
JANUVIA (sitagliptin)	alogliptin/metformin
JENTADUETO (linagliptin/metformin)	JENTADUETO XR (linagliptin/metformin)
TRADJENTA (linagliptin)	JUVISYNC (sitagliptin/simvastatin)
	KAZANO (alogliptin/metformin)
	KOMBIGLYZE XR (saxagliptin/metformin)
	NESINA (alogliptin)
	ONGLYZA (saxagliptin)
	OSENI (alogliptin/pioglitazone)

DPP4-Inhibitors/SGLT2 Inhibitors Combination

Category PA Criteria: The prescriber must provide medical justification explaining why the patient cannot use individual preferred products separately

PREFERRED AGENTS	NON-PREFERRED AGENTS
	GLYXAMBI (Empagliflozin/linagliptin)
	STEGLUJAN (Ertugliflozin/Sitagliptin)
	QTERN (Dapagliflozin/Saxagliptin)

GLP-1 Agonists

Category PA Criteria:

All agents will require:

1. A diagnosis of an FDA-approved indication for use
2. Metformin use with good compliance in the past 3 months before and concurrently with requested agent (patients with GI intolerances to high dose IR metformin should trial at minimum a dose of 500mg ER)

Non-preferred agents will require:

1. A 30-day trial of 2 preferred agents.

PREFERRED AGENTS	NON-PREFERRED AGENTS
VICTOZA (liraglutide)	ADLYXIN (lixisenatide)
BYDUREON (exenatide microspheres)	BYDUREON BCISE (exenatide microspheres)
BYETTA (exenatide)	OZEMPIC (semaglutide)
	TANZEUM (albiglutide)
	TRULICITY (dulaglutide)

Insulin/GLP-1 Agonist Combination

Category PA Criteria: The prescriber must provide medical justification explaining why the patient cannot use individual preferred products separately

PREFERRED AGENTS	NON-PREFERRED AGENTS
	SOLIQUA (Insulin glargine/lixisenatide)
	XULTOPHY (insulin degludec/liraglutide)

Insulin

Category PA Criteria:

Non-preferred insulin:

•The prescriber must submit medical justification explaining why the patient cannot use the preferred product (subject to clinical review).

Syringe/Pens:

• Prescriber must provide a reason why patient needs to use a syringe/pen instead of a vial, subject to clinical review

Product PA Criteria:

***Fiasp

•Patient must have had 3 month trial with Novolog, Humalog, and Apidra

***Basaglar:

•The prescriber must submit medical justification explaining why the patient cannot use the preferred product (subject to clinical review).

***Toujeo/Tresiba -

Initial Criteria: Approval 6 months

1. Patient must have one of the following:
    a. Recurrent episodes of hypoglycemia on Insulin glargine U100, insulin detemir U100, or U-500R despite adjustments to current regimen (prandial insulin, interacting drugs, meal and exercise timing)
    b. Inconsistent blood sugars with a basal insulin requirement of a minimum of 100 units/day for a minimum of 3 months with good compliance, as evidenced by paid claims or pharmacy print outs.
2. Must be prescribed by or in consultation with a endocrinologist or diabetes specialist
3. Patient must provide clinical explanation for the following:
    a. If dose is greater than 200 units of insulin per day, why patient is not a candidate for U-500R (Toujeo and Tresiba are not intended as replacements for U500 insulin
    b. Need for smaller volume of insulin (max is 80 units/injection for both Insulin glargine 300 units/mL and 100 units/mL. Patients using Insulin glargine 300 unit/mL may require more basal insulin than those receiving 100 units/mL)

Renewal Criteria: Approval 12 months

One of the following, evidenced by clinical notes or labs:

1. Improvement in frequency and/or severity of hypoglycemia
2. Improved glycemic control (A1C)

Insulin Continued:

PREFERRED AGENTS	NON-PREFERRED AGENTS
APIDRA (insulin glulisine) VIAL	ADMELOG (insulin lispro) VIAL
APIDRA SOLOSTAR (insulin glulisine) INSULIN PEN	ADMELOG SOLOSTAR (insulin lispro) INSULIN PEN
HUMALOG (insulin lispro) VIAL	AFREZZA (insulin regular, human)
HUMALOG MIX 50/50 (insulin NPL/insulin lispro) VIAL	BASAGLAR KWIKPEN U-100 (insulin glargine)***
HUMALOG MIX 75/25 (insulin NPL/insulin lispro) VIAL	FIASP (insulin aspart) FLEXTOUCH***
HUMULIN 70/30 (insulin NPH human/regular insulin human) VIAL	FIASP (insulin aspart) VIAL***
HUMULIN N (insulin NPH human isophane) VIAL	HUMALOG (insulin lispro) CARTRIDGE
HUMULIN R (insulin regular, human) VIAL	HUMALOG JUNIOR KWIKPEN (insulin lispro)
HUMULIN R U-500 (insulin regular, human) VIAL	HUMALOG MIX 50/50 (insulin NPL/insulin lispro) KWIKPEN
LANTUS (insulin glargine) SOLOSTAR	HUMALOG MIX 75/25 (insulin NPL/insulin lispro) KWIKPEN
LANTUS (insulin glargine) VIAL	HUMALOG U-100 (insulin lispro) KWIKPEN
LEVEMIR (insulin detemir) VIAL	HUMALOG U-200 (insulin lispro) KWIKPEN
LEVEMIR (insulin detemir) FLEXTOUCH	HUMULIN 70/30 (insulin NPH human/regular insulin human) KWIKPEN
NOVOLIN R (insulin regular, human) VIAL	HUMULIN N (insulin NPH human isophane) KWIKPEN
NOVOLOG (insulin aspart) CARTRIDGE	HUMULIN R (Insulin regular, human) U-500 KWIKPEN
NOVOLOG (insulin aspart) FLEXPEN	NOVOLIN 70-30 (insulin NPH human/regular insulin human) VIAL
NOVOLOG (insulin aspart) VIAL	NOVOLIN 70-30 (insulin NPH human/regular insulin human) FLEXPEN
NOVOLOG MIX 70/30 (insulin aspart protamine/insulin aspart) FLEXPEN	NOVOLIN N (insulin NPH human isophane) VIAL
NOVOLOG MIX 70/30 (insulin aspart protamine/insulin aspart) VIAL	TOUJEO MAX SOLOSTAR (insulin glargine)***
	TOUJEO SOLOSTAR (insulin glargine)***
	TRESIBA (insulin degludec) FLEXTOUCH U-100***
	TRESIBA (insulin degludec) FLEXTOUCH U-200***
	TRESIBA (insulin degludec) VIAL***

SGLT2 Inhibitors

Category PA Criteria:

All agents will require:

1. A diagnosis of an FDA-approved indication for use
2. One of the following:
   A: The requested agent is a combination product containing metformin
   B: Metformin use with good compliance in the past 3 months before and concurrently with requested agent (patients with GI intolerances to high dose IR metformin should trial at minimum a dose of 500mg ER)

In addition, non-preferred agents will require:

3. A 30 day trial of a empagliflozin agent, as evidenced by paid claims or pharmacy print-outs

Product PA Criteria:

***Steglatro/Steglatromet - Patient must have a 30 day trial of a dapagliflozin and canagliflozin agent in addition to Category PA Criteria

PREFERRED AGENTS	NON-PREFERRED AGENTS
JARDIANCE (empagliflozin)	FARXIGA (dapagliflozin)
SYNJARDY (empagliflozin/metformin)	INVOKAMET (canagliflozin)
SYNJARDY XR (empagliflozin/metformin)	INVOKAMET XR (canagliflozin/metformin)
	INVOKANA (canagliflozin)
	STEGLATRO (ertugliflozin)***
	STEGLATROMET (ertugliflozin/metformin)***
	XIGDUO XR (dapagliflozin/metformin)

Diarrhea – Irritable Bowel Syndrome

Category PA Criteria: Patient must be 18 years of age or older. A 30-day trial of all preferred agents will be required before a non-preferred medication will be approved.

Product PA Criteria:

***Alosetron– Patient must be a female.

PREFERRED AGENTS	NON-PREFERRED AGENTS
loperamide	alosetron***
LOTRONEX (alosetron)***	
VIBERZI (eluxadoline)	
XIFAXIN (rifaximin) 550 mg tablet	

Digestive Enzymes

Category PA Criteria: A 30-day trial of all preferred agents will be required before a non-preferred agent will be authorized unless patient stable on a pancreatic enzyme written by a gastroenterologist or pancreas disease specialist

PREFERRED AGENTS	NON-PREFERRED AGENTS
CREON (lipase/protease/amylase)	PANCREAZE (lipase/protease/amylase)
ZENPEP (lipase/protease/amylase)	PANCRELIPASE (lipase/protease/amylase)
	PERTZYE (lipase/protease/amylase)
	ULTRESA (lipase/protease/amylase)
	VIOKACE (lipase/protease/amylase)

Epinephrine Autoinjectors

Category PA Criteria: Medical justification must be provided for why the preferred product will not work.

PREFERRED AGENTS	NON-PREFERRED AGENTS
epinephrine - labeler 49502	ADRENACLICK (epinephrine)
	AUVI-Q (epinephrine)
	epinephrine - labelers 00115, 54505
	EPIPEN (epinephrine)
	EPIPEN JR (epinephrine)
	SYMJEPI (epinephrine)

Growth Hormone

PA Criteria:

1. Patients new to GH therapy must meet the criteria below and be started on a preferred growth hormone.
2. Patients continuing GH therapy and having met the criteria listed below must be switched to a preferred growth hormone.

Covered Indications:

1. Multiple pituitary hormone deficiencies caused by a known hypothalamic-pituitary disease or its treatment (brain surgery and/or radiation)
2. Turner's syndrome
3. SHOX syndrome
4. Noonan syndrome
5. Chronic renal insufficiency
6. Prader–Willi syndrome
7. Endogenous growth hormone deficiency

For Initial or Subsequent Authorization:

For any indication:

- Patient must not have active malignancy
- Prescriber must be an endocrinologist or nephrologist or

prescriber must have at least one annual consultation about the patient with the pediatric specialty

- Patient must not have epiphyseal closure and must still be growing:
    - Exceptions:
        - Prader-Willi syndrome
        - Endogenous growth hormone deficiency - if patient is experiencing hypoglycemic episodes without growth hormone and growth hormone is needed to maintain proper blood glucose

For Chronic renal insufficiency:

- Patient must not have received a renal transplant
- Patient must consult with a dietitian to maintain a nutritious diet

For Prader–Willi syndrome:

- Sleep apnea must be ruled out by sleep study in obese patients
- Patient must consult with a dietitian to maintain a nutritious diet

Additional Criteria for Initial Authorization

For Endogenous growth hormone deficiency:

- Must meet ONE of below criteria
    - Patients with multiple pituitary hormone deficiencies caused by a known hypothalamic-pituitary disease or its treatment (brain surgery and/or radiation) must have an IGF-1 or IGFBP-3 level of less than SDS 1.3.
    - Patient must have had two GH stimulation tests by insulin, levodopa, L-arginine, propranolol, clonidine, or glucagon with a maximum peak of < 10ng/mL after stimulation no more than 6 months apart

Additional Criteria for Subsequent Authorization

For any indication:

- Patient must have been compliant with growth hormone (last 6 fills must have been on time).

For Prader-Willi:

- If patient is obese, BMI must have decreased. If patient is not obese, BMI must have maintained or decreased.

Growth Hormone Continued:

PREFERRED AGENTS	NON-PREFERRED AGENTS
NORDITROPIN FLEXPRO (somatropin)PA	GENOTROPIN (somatropin)
	GENOTROPIN MINIQUICK (somatropin)
	HUMATROPE (somatropin)
	NUTROPIN AQ (somatropin)
	OMNITROPE (somatropin)
	SAIZEN (somatropin)
	ZOMACTON (somatropin)

Heart Failure – Neprilysin Inhibitor/Angiotensin Receptor Blocker

Category PA Criteria:

1. Patient must have FDA approved diagnosis
2. Patient must be 18 years or older

PREFERRED AGENTS	NON-PREFERRED AGENTS
ENTRESTO (sacubitril/valsartan) PA	

Hematopoietic, Colony Stimulating Factors

Category PA Criteria: All agents will require an FDA indication. A 4-week trial of all preferred products will be required before non-preferred agents will be authorized.

PREFERRED AGENTS	NON-PREFERRED AGENTS
GRANIX (TBO-Filgrastim)	FULPHILA (Pegfilgrastrim-JMDB)
LEUKINE (Sargramostim)	NIVESTYM (Figrastim-AAFI)
NEULASTA (Pegfilgrastim)	UDENYCA (pegfligrastim-CBQV)
NEUPOGEN (Filgrastim)	ZARXIO (Filgrastim-SNDZ)

Hematopoietic, Erythropoiesis Stimulating Agents

Category PA Criteria: All agents will require an FDA indication. A 4-week trial of all preferred products will be required before non-preferred agents will be authorized.

PREFERRED AGENTS	NON-PREFERRED AGENTS
ARANESP (darbepoetin alfa)PA	EPOGEN (epoetin alfa)
PROCRIT (epoetin alfa)PA	MIRCERA (methoxy polyethylene glycol-epoetin beta)
	RETACRIT (epoetin alfa - EPBX)

Hepatitis C Treatments

Category PA Criteria: Non-preferred agents will require a failed trial of all preferred treatment options indicated for the patient's genotype and be labeled for failure of previous treatment.

1. Patient must have a documented FDA-approved diagnosis. Chronic Hepatitis C must be documented by one of the following:
    a. Liver fibrosis F1 and below: 2 positive HCV RNA levels at least 6 months apart
    b. Liver fibrosis F2 and above: 1 positive HCV RNA test within the last 12 months
2. Patient must be an FDA-approved age
3. Patient must be drug (illicit use of drugs by injection) and alcohol free as documented by 2 drug and alcohol tests dated at least 3 months apart and meet criteria as outlined below:
    a. If the patient has a history of alcohol use disorder, the patient must have abstained from alcohol for at least 12 months OR patient must:
        i. have abstained from alcohol for at least 3 months AND
        ii. be receiving treatment from an enrolled provider and agree to abstain from alcohol during treatment AND
        iii. be under the care of an addiction medicine/chemical dependency treatment provider and the provider attests the patient has abstained from alcohol use for at least 3 months
    b. If the patient has a history of illicit use of drugs by injection, the patient must have abstained from drug use for at least 12 months OR patient must:
        i. have abstained from drug use for at least 3 months AND
        ii. be receiving treatment from an enrolled provider and agree to abstain from said drug use during treatment AND
        iii. be under the care of an addiction medicine/chemical dependency treatment (or buprenorphine waived provider) provider and the provider attests the patient agrees to abstain from drug use for at least 3 months
4. Patient must not be receiving a known recreationally used high risk combination of drugs (e.g. “the holy trinity”) for the past 6 months
5. Patient must attest that they will continue treatment without interruption for the duration of therapy.
6. Prescriber must be, or consult with, a hepatologist, gastroenterologist, or infectious disease specialist.
7. HCV RNA level must be taken on week 4 and sent with a renewal request for any duration of treatment 12 weeks or longer.
8. Females using ribavirin must have a negative pregnancy test in the last 30 days and receive monthly pregnancy tests during treatment.
9. Patient must have established compliant behavior including attending scheduled provider visits (defined as 1 or less no-shows) and filling maintenance medications on time as shown in the prescription medication history for the past 6 months.
10. Patient must be tested for hepatitis B, and if the test is positive, hepatitis B must either be treated or closely monitored if patient does not need treatment.
11. Patient must not have life expectancy of less than 12 months due to non-liver related comorbid conditions.
12. PA approval duration will be based on label recommendation.

Hepatitis C Continued:

Product PA Criteria:

***Epclusa:

• Must be used with ribavirin for patients with decompensated cirrhosis (Child-Pugh B or Child-Pugh C).

***Mavyret/Vosevi:

• Patient must not have decompensated cirrhosis (Child-Pugh B or Child-Pugh C)

***Zepatier:

• Patient must not have decompensated cirrhosis (Child-Pugh B or Child-Pugh C)

• Genotype 1a - must test for presence of virus with NS5A resistance-associated polymorphisms

PREFERRED AGENTS	NON-PREFERRED AGENTS
EPCLUSA (sofosbuvir/velpatasvir)PA***	HARVONI (ledipasvir/sofosbuvir)
MAVYRET (glecaprevir/pibrentasvir)PA***	Ledipasvir/sofosbuvir
ZEPATIER (elbasvir/grazoprevir)PA***	Sofosbuvir/velpatasvir
	SOVALDI (sofosbuvir)
	VIEKIRA PAK (dasabuvir/ombitasvir/paritaprevir/ritonavir)
	VOSEVI (sofosbuvir/velpatasvir/voxilaprevir)

Lice

Category PA Criteria: A 28-day/2-application trial of each of the preferred agents will be required before a non-preferred agent will be authorized. This requirement will be waived in the presence of a documented community breakout of a resistant strain that is only susceptible to a non-preferred agent.

PREFERRED AGENTS	NON-PREFERRED AGENTS
LICE KILLING SHAMPOO (piperonyl butoxide/pyrethrins)	ELIMITE (permethrin) CREAM
NATROBA (spinosad)	EURAX (crotamiton)
NIX 1% (Permethrin) CRÈME RINSE LIQUID	Malathion
Permethrin 5% cream	OVIDE (malathion)
SKLICE (ivermectin)	Spinosad
SM LICE TREATMENT (Permethrin) 1% CRÈME RINSE LIQUID	
ULESFIA (benzyl alcohol)	

Migraine

Treatment – 5HT(1) Agonist

Category PA Criteria:

Patients able to take oral medications:

-Patients 18 years old or older: A 30-day trial of all preferred agents in the past 24 months will be required before a non-preferred agent will be authorized.

-Patients 6 to 17 years of age: A 30-day trial of rizatriptan mg in the past 24 months will be required before a non-preferred agent will be authorized.

Patients not able to take oral medications (as evidenced by swallow study documentation):

-A 30-day trial of rizatriptan ODT in the past 24 months will be required before a non-preferred agent will be authorized.

Product PA Criteria:

***Sumatriptan Nasal Spray:

- Patient must fail a 30 day trial of all of the following within the past 24 months, as evidenced by paid claims or pharmacy print outs:
    - o Zomig Nasal Spray 5mg
    - o Onzetra Xsail 22mg

***Zolmitriptan tablet:

- Patient must fail a 30 day trial of naratriptan 2.5mg within the past 24 months, as evidenced by paid claims or pharmacy print outs

***Sumatriptan pen/syringe/cartridge, Frovatriptan, Almotriptan, Treximet:

- Medical justification must be provided as to why another triptans won't work
- Patient must fail a 30 day trial of all other available triptans within the past 24 months, as evidenced by paid claims or pharmacy print outs

PREFERRED AGENTS	NON-PREFERRED AGENTS
RELPAX (eletriptan)	Almotriptan***
Rizatriptan	ALSUMA (sumatriptan) PEN INJCTR***
Rizatriptan ODT	AMERGE (naratriptan)
Sumatriptan tablet	Eletriptan
	FROVA (frovatriptan)***
	Frovatriptan***
	IMITREX (sumatriptan) CARTRIDGE***
	IMITREX (sumatriptan) PEN INJCTR***
	IMITREX (sumatriptan) SPRAY***
	IMITREX (sumatriptan) TABLET
	IMITREX (sumatriptan) VIAL***
	MAXALT (rizatriptan)
	MAXALT MLT (rizatriptan)
	Naratriptan
	ONZETRA XSAIL (sumatriptan)

Migraine Treatment – 5HT(1) Agonist Continued:

PREFERRED AGENTS	NON-PREFERRED AGENTS
	Sumatriptan cartridge***
	Sumatriptan pen injctr***
	Sumatriptan spray***
	Sumatriptan syringe***
	Sumatriptan vial
	TREXIMET (sumatriptan/naproxen)***
	ZEMBRANCE SYMTOUCH (Sumatriptan)
	Zolmitriptan***
	Zolmitriptan ODT
	ZOMIG (zolmitriptan)***
	ZOMIG (zolmitriptan) SPRAY
	ZOMIG ODT (zolmitriptan)

Prophylaxis – CGRP Inhibitors

Category PA Criteria:

Initial: Approval for 3 months

- Patient must experience 4 or more migraine days per month.
- Prescriber must submit documentation of treatment failure of a 2 month trial of two of the following agents from different therapeutic classes: amitriptyline, atenolol, divalproex sodium, metoprolol, nadolol, propranolol, timolol, topiramate, venlafaxine
  - Documentation must include clinical notes regarding failure to reduce migraine frequency.
- A 3 month trial of each preferred agent will be required before a non-preferred agent will be authorized, as evidenced by paid claims or pharmacy print outs.
- Renewal:
  Patient must experience a reduction in migraines of at least 50%

PREFERRED AGENTS	NON-PREFERRED AGENTS
AIMOVIG (Erenumab-aooe)	AJOVY (Fremanezumab-vfrm)
EMGALITY (Galcanazumab-gnlm)	

Multiple Sclerosis

Interferons

Group PA Criteria: A 3-month long trial of a preferred agent will be required before a non-preferred agent will be authorized. An FDA indication is required.

PREFERRED AGENTS	NON-PREFERRED AGENTS
AVONEX (interferon beta-1A) PEN	EXTAVIA (interferon beta-1B)
AVONEX (interferon beta-1A) SYRINGE	PLEGRIDY (peginterferon beta-1A) PEN
AVONEX (interferon beta-1A) VIAL	PLEGRIDY (peginterferon beta-1A) SYRINGE
BETASERON (interferon beta-1B)	REBIF (interferon beta-1A)
	REBIF REBIDOSE (interferon beta-1A)

Injectable Non-Interferons

Group PA Criteria: A 3-month long trial of all preferred agents and 3-month trials of Aubagio, Tecfidera, and Gilenya will be required before a non-preferred agent will be authorized. An FDA indication is required. Clinical justification must be provided why preferred product will not work.

PREFERRED AGENTS	NON-PREFERRED AGENTS
COPAXONE (glatiramer) 20 MG/ML	COPAXONE (glatiramer) 40 MG/ML***
	glatiramer 20mg/ml***
	glatiramer 40mg/ml***
	Glatopa (glatiramer)***

Oral Non-Interferons

Group PA Criteria: Non-preferred agents: A 3-month long trial of all preferred agents and Copaxone will be required before a non-preferred agent will be authorized. If patient has a documented intolerance, hypersensitivity, or labeled contraindication to Copaxone, a 3-month trial of interferon beta-1 is required for non-preferred agents. An FDA indication is required.

PREFERRED AGENTS	NON-PREFERRED AGENTS
AUBAGIO (teriflunomide)	TECFIDERA (dimethyl fumarate)
GILENYA (fingolimod)	

Ophthalmic

Alpha Adrenergic – Glaucoma

Group PA Criteria:
Branded non-preferred agents: A 30-day trial of all accessible pharmaceutically equivalent preferred agents will be required before a non-preferred agent will be authorized.

Generic non-preferred agents: A 30-day trial of a pharmaceutically equivalent preferred agent will be required before a non-preferred agent will be authorized.

PREFERRED AGENTS	NON-PREFERRED AGENTS
ALPHAGAN P 0.1% (brimonidine)	brimonidine 0.15%
ALPHAGAN P 0.15% (brimonidine)	IOPIDINE (apraclonidine)
apraclonidine	
brimonidine 0.2%	
COMBIGAN (brimonidine/timolol)	
SIMBRINZA (brinzolamide/brimonidine)	

Rho Kinase Inhibitor - Glaucoma

PREFERRED AGENTS	NON-PREFERRED AGENTS
RHOPRESSA (netarsudil)	

Antihistamines

Group PA Criteria:
A 30-day trial of 3 preferred agents will be required before a non-preferred agent will be authorized.

PREFERRED AGENTS	NON-PREFERRED AGENTS
ALOMIDE (lodoxamide)	ALOCRIL (nedocromil)
Azelastine	ELESTAT (epinastine)
BEPREVE (bepotastine)	EMADINE (emedastine)
Cromolyn	Epinastine
LASTACAFT (alcaftadine)	Olopatadine 0.2%
Olopatadine 0.1%	PATANOL 0.1% (olopatadine)
PAZEO (olopatadine)	PATADAY 0.2% (olopatadine)

Ophthalmic Continued:

Anti-infectives

Group PA Criteria:

A 3-day trial of 3 preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present.

PREFERRED AGENTS	NON-PREFERRED AGENTS
Bacitracin/polymyxin B ointment	AZASITE (azithromycin)
BESIVANCE (besifloxacin) DROPS	Bacitracin ointment
CILOXAN (ciprofloxacin) OINTMENT	BLEPH-10 (sulfacetamide) DROPS
Ciprofloxacin drops	CILOXAN (ciprofloxacin) DROPS
Erythromycin ointment	Gatifloxacin drops
Gentamicin sulfate drops	GENTAK (gentamicin sulfate) OINTMENT
Gentamicin sulfate ointment	Levofloxacin drops
MOXEZA (moxifloxacin) DROPS	moxifloxacin drops
Neomycin SU/polymyxin B/gramicidin drops	Neomycin SU/bacitracin/polymyxin B ointment
Ofloxacin drop	NEO-POLYCIN (neomycin SU/bacitracin/polymyxin B) OINTMENT
Polymyxin B/trimethoprim drops	NEOSPORIN (neomycin SU/polymyxin B/gramicidin) DROPS
Sulfacetamide drops	OCUFLOX (ofloxacin) DROPS
Tobramycin drops	POLYCIN (bacitracin/polymyxin) OINTMENT
TOBREX (tobramycin) OINTMENT	POLYTRIM (polymyxin B/trimethoprim) DROPS
	Sulfacetamide ointment
	TOBREX (tobramycin) DROPS
	VIGAMOX (moxifloxacin) DROPS
	ZYMAXID (gatifloxacin) DROPS

Anti-infectives/Anti-inflammatories

Group PA Criteria:

A 7-day trial of 2 preferred agents will be required before a non-preferred agent will be authorized unless 1 of the exceptions on the PA form is present.

PREFERRED AGENTS	NON-PREFERRED AGENTS
Neomycin/bacitracin/polymyxin b/hydrocortisone ointment	BLEPHAMIDE S.O.P. (sulfacetamide/prednisolone) ointment
BLEPHAMIDE (sulfacetamide/prednisolone) DROPS	MAXITROL (neomycin/polymyxin b/dexamethasone) DROPS
Neomycin/polymyxin b/dexamethasone drops	MAXITROL (neomycin/polymyxin b/dexamethasone) OINTMENT
Neomycin/polymyxin b/dexamethasone ointment	Neomycin/polymyxin b/hydrocortisone drops
Neomycin/polymyxin b/hydrocortisone ointment	NEO-POLYCIN HC (neomycin SU/bacitracin/polymyxin B/hydrocortisone) OINTMENT
PRED-G (gentamicin/prednisol ac) DROPS	TOBRADEX ST (tobramycin/dexamethasone) DROPS
PRED-G (gentamicin/prednisol ac) OINTMENT	Tobramycin/dexamethasone
Sulfacetamide/prednisolone drops	
TOBRADEX (tobramycin/dexamethasone) DROPS	
TOBRADEX (tobramycin/dexamethasone) OINTMENT	
ZYLET (tobramycin/lotepred etab) DROPS	

Ophthalmic Continued:

Anti-inflammatories

Group PA Criteria:
A 5-day trial of 2 preferred agents will be required before a non-preferred agent will be authorized.

PREFERRED AGENTS	NON-PREFERRED AGENTS
ACUVAIL (ketorolac)	ACULAR (ketorolac)
ALREX (loteprednol)	ACULAR LS (ketorolac)
Diclofenac sodium	Bromfenac sodium
FLAREX (fluorometholone)	BROMSITE (bromfenac sodium)
Fluorometholone	Dexamethasone sodium phosphate
Flurbiprofen sodium	DUREZOL (difluprednate)
FML FORTE (fluorometholone)	INVELTYS (Loteprednol)
FML S.O.P. (fluorometholone)	FML (fluorometholone)
ILEVRO (nepafenac)	LOTEMAX (loteprednol) GEL DROPS
ketorolac tromethamine 0.4%	LOTEMAX (loteprednol) OINTMENT
Ketorolac tromethamine 0.5%	LOTEMAX SM (Loteprednol)
LOTEMAX (loteprednol) DROPS	OCUFEN (flurbiprofen)
MAXIDEX (dexamethasone)	OMNIPRED 1% (prednisolone acetate)
NEVANAC (nepafenac)	PRED FORTE 1% (prednisolone acetate)
PRED MILD 0.12% (prednisolone acetate)	PROLENSA (bromfenac)
Prednisolone acetate 1%	
Prednisolone sodium phosphate 1%	

Opioid Analgesics – Long Acting

Category PA Criteria:

1. Patient must have required around-the-clock pain relief for the past 90 days
2. The past 3 months of North Dakota PDMP reports must have been reviewed by the prescriber.
3. Patient must be in consult with oncologist or pain management specialist with a pain management contract (with treatment plan including goals for pain and function, and urine and/or blood screens) if one of the following:
    a. Cumulative daily dose of narcotics exceeds 90 MED/day
    b. Patient is using benzodiazepine concurrently with narcotic medication
4. Patient must have not achieved therapeutic goal with non-narcotic medication (NSAIDs, TCAs, SNRIs, Corticosteroids, etc.) and non-medication alternatives (Weight Loss, Physical Therapy, Cognitive Behavioral Therapy, etc.)
5. Renewal Criteria: Documentation noting progress toward therapeutic goal must be included with request (including pain level and function).

Abuse Deterrent Formulations/Unique Mechanisms from Full Agonist Opioids

Group PA Criteria: A 30 day trial of tapentadol, morphine, and oxycodone products will be required in addition to Category PA Criteria before a non-preferred agent will be authorized.

Product PA Criteria:

*** Belbuca, Methadone, Arymo ER, Morphabond ER, and Oxycontin - Clinical justification must be given for why another product will not work in addition to Category PA Criteria.

PREFERRED AGENTS	NON-PREFERRED AGENTS
butorphanol[PA]	ARYMO ER (morphine)***
BUTRANS (buprenorphine) PATCHES 5mcg/hr, 7.5 mcg/hr, 10 mcg/hr, 15 mcg/hr [PA]	BELBUCA (buprenorphine)***
EMBEDA (morphine/naltrexone)[PA]	BUTRANS (buprenorphine) PATCHES , 20 mcg/hr
levorphanol[PA]	buprenorphine patches
NUCYNTA ER (tapentadol)[PA]	CONZIP (tramadol ER)
pentazocine-naloxone[PA]	HYSINGLA ER (hydrocodone)
Tramadol ER[PA]	Methadone***
XTAMPZA ER (oxycodone)[PA]	MORPHABOND ER (morphine)***
	OXYCONTIN (oxycodone)***
	ULTRAM ER (tramadol ER)

Full Agonist Opioids Without Abuse Deterrent Formulations

Group PA Criteria: The 90-day around-the-clock pain relief requirement must be met by an equianalgesic dose of 60 mg oral morphine daily, 25 mcg transdermal fentanyl/hour, 30 mg oxycodone daily, 8 mg of oral hydromorphone daily, or another opioid daily. Patient must have failed 30-day trials of fentanyl, morphine, and oxycodone products in addition to Category PA Criteria before a non-preferred agent will be authorized.

Product PA Criteria:
*** Fentanyl Patch 37.5 mcg/hr, 62.5 mcg/hr, 87.5 mcg/hr, morphine ER capsules, morphine ER tablets 60mg, 100mg, and 200mg and oxycodone ER - Clinical justification must be given for why another product will not work in addition to Category PA Criteria.

*** Fentanyl 12 mcg/hr – The total daily opioid dose must be less than 60 Morphine Equivalent Dose (MED) in additional to Category PA Criteria

PREFERRED AGENTS	NON-PREFERRED AGENTS
Fentanyl 12 mcg/hr[PA]	EXALGO (hydromorphone)
Fentanyl 25 mcg/hr, 50 mcg/hr, 75 mcg/hr, 100 mcg/hr[PA]	Fentanyl patch 37.5 mcg/hr, 62.5 mcg/hr, 87.5 mcg/hr***
Morphine ER tablets 15mg, 30mg[PA]	Hydromorphone ER tablets
	KADIAN (morphine)***
	Morphine ER capsules
	Morphine ER tablets 60mg, 100mg, 200mg
	MS CONTIN (morphine)
	Oxycodone ER
	Oxymorphone ER tablets
	ZOHYDRO ER (hydrocodone)

Opioid Antagonist – Opioid and Alcohol Dependence

PREFERRED AGENTS	NON-PREFERRED AGENTS
VIVITROL (Naltrexone Microspheres)	

Opioid Partial Antagonist – Opioid Dependence

Category PA Criteria:
A 30-day trial of all preferred agents will be required before a non-preferred agent will be authorized. The prescriber must submit medical justification explaining why the patient cannot use the preferred products (subject to clinical review). A FDA MedWatch form for the failed product must be faxed to the FDA and submitted with request for all non-preferred buprenorphine/naloxone products.

1. Patient must be 16 years of age or older.
2. Patient must not be taking other opioids, tramadol, or carisoprodol concurrently.
3. The prescriber must be registered to prescribe under the Substance Abuse and Mental Health Services Administration (SAMHSA) and provide his/her DEA number.
4. The prescriber and patient must have a contract, or the prescriber must have developed a treatment plan.
5. The prescriber must perform routine drug screens.
6. The prescriber must routinely check the PDMP and the last 3 months of North Dakota PDMP reports must have been reviewed by the prescriber.
7. The prescriber must be enrolled with ND Medicaid.

Oral Agents

Product PA Criteria:
*** Buprenorphine tablets will be allowed during a period that a patient is pregnant or breastfeeding.

PREFERRED AGENTS	NON-PREFERRED AGENTS
Buprenorphine-naloxone tablets[PA]	BUNAVAIL FILM (buprenorphine/naloxone)
ZUBSOLV (buprenorphine/naloxone)[PA]	Buprenorphine tablets***
	buprenorphine/naloxone film
	SUBOXONE FILM (buprenorphine/naloxone)

Non-Oral Agents

PREFERRED AGENTS	NON-PREFERRED AGENTS
SUBLOCADE (buprenorphine) [PA]	
PROBUPHENE (buprenorphine) [PA]	

Otic Anti-infectives – Fluoroquinolones

Category PA Criteria: A 7-day trial of 1 preferred product in the past 3 months is required before a non-preferred product will be approved.

PREFERRED AGENTS	NON-PREFERRED AGENTS
CIPRO HC (ciprofloxacin/hydrocortisone)	Ciprofloxacin drops
CIPRODEX (ciprofloxacin/dexamethasone)	
Ofloxacin drops	
OTOVEL (ciprofloxacin/fluocinolone)	

PCSK9 Inhibitors

Category PA Criteria:

- Patient must have one of the following diagnosis:
  - Heterozygous or homozygous familial hypercholesterolemia
  - Clinical atherosclerotic cardiovascular disease
- Patient's LDL must have remained greater than 100 mg/DL or greater after the following 3-month trials with good compliance:
  - Rosuvastatin 20-40mg or Atorvastatin 40-80mg
  - Rosuvastatin or Atorvastatin combined with another lipid lowering agent

Preferred	Non-Preferred
Praluent Pen	Repatha Sureclick
Repatha Pushtronex	Repatha Syringe

Phosphate Binders

Category PA Criteria:

The following criteria will be required before a non-preferred agent will be authorized:

1. Patient must have had a 3-month trial of 3 preferred different chemical entities.
2. Patient must have end stage renal disease or chronic kidney disease.

PREFERRED AGENTS	NON-PREFERRED AGENTS
Calcium acetate capsule	AURYXIA (ferric citrate) TABLET
Calcium acetate tablet	ELIPHOS (calcium acetate) TABLET
FOSRENOL (lanthanum) CHEWABLE TABLET	FOSRENOL (lanthanum) POWDER PACK
PHOSLYRA (calcium acetate) ORAL solution	Lanthanum chew tab
RENAGEL (sevelamer) TABLET	RENVELA (sevelamer carbonate) TABLET
RENVELA (sevelamer) POWDER PACK	sevelamer powder pack - labeler 65862
sevelamer tablet	VELPHORO (sucroferric oxyhydroxide)
sevelamer powder pack - labeler 00955	

Pituitary Suppressants

PREFERRED AGENTS	NON-PREFERRED AGENTS
ELIGARD (leuprolide)	
LUPRON DEPOT (leuprolide)	
SUPPRELIN LA (histrelin)	
SYNAREL (nafarelin)	
TRESTAR (triptorelin)	
TRIPTODUR (triptorelin)	
VANTAS (histrelin)	
ZOLADEX (goserelin)	

Platelet Aggregation Inhibitors

Category PA Criteria: A 30 day trial of 2 preferred agents will be required before a non-preferred agent will be authorized. Patient must have FDA indication.

Product PA Criteria:
***Yosprala DR/Durlaza – The prescriber must submit medical justification explaining why the patient cannot use the preferred product (subject to clinical review).

PREFERRED AGENTS	NON-PREFERRED AGENTS
AGGRENOX (aspirin/dipyridamole)	Aspirin/dipyridamole ER
Aspirin	Clopidogrel 300mg
BRILINTA (ticagrelor)	DURLAZA (aspirin ER)***
Clopidogrel 75 mg	EFFIENT (prasugrel)
Dipyridamole	PLAVIX (clopidogrel)
Prasugrel	YOSPRALA DR (aspirin/omeprazole)***
	ZONTIVITY (vorapaxar)

Progesterone

Category PA Criteria: All medications require an FDA-approved indication. Non-preferred agents will require a 30-day trial of all preferred medications.

PREFERRED AGENTS	NON-PREFERRED AGENTS
MAKENA (hydroxyprogesterone caproate)[PA]	hydroxyprogesterone caproate

Pulmonary Hypertension

Category PA Criteria: A 30-day trial of all preferred agents will be required before a non-preferred agent will be authorized. All medications require an FDA-approved indication.

PDE-5 Inhibitors

Group PA Criteria: Patient cannot be taking nitrates of any form.

Product PA Criteria:
***Revatio Suspension – Patients 7 years and older will be required to submit documentation of their inability to ingest a solid dosage form.

PREFERRED AGENTS	NON-PREFERRED AGENTS
ADCIRCA (tadalafil)[PA]	REVATIO (sildenafil) TABLET
REVATIO (sildenafil) SUSPENSION[PA***]	Sildenafil suspension
Sildenafil tablet[PA]	tadalafil

Soluble Guanylate Cyclase Stimulators

Group PA Criteria: Patients of childbearing potential must not be pregnant, be taking a reliable form of birth control, and have a pregnancy test before initiation and monthly during therapy. Patient may not

be taking with nitrates of any form or specific (sildenafil or tadalafil) or non-specific (dipyridamole or theophylline) PDE-5 inhibitors.

PREFERRED AGENTS	NON-PREFERRED AGENTS
ADEMPAS (riociguat)	

Endothelin Receptor Antagonists

Group PA Criteria: Patients of childbearing potential must not be pregnant, be taking a reliable form of birth control, and have a pregnancy test before initiation and monthly during therapy.

PREFERRED AGENTS	NON-PREFERRED AGENTS
LETAIRIS (ambrisentan)	OPSUMIT (macitentan)
	TRACLEER (bosentan)

Prostacyclins

PREFERRED AGENTS	NON-PREFERRED AGENTS
ORENITRAM ER (treprostinil)	TYVASO (treprostinil)
REMODULIN (treprostinil)	UPTRAVI (selexipag)
VENTAVIS (iloprost)	

Tardive Dyskinesia

Category PA Criteria

1. Patient is 18 years of age or older
2. Patient must have a specialist (neurologist or physiatrist) involved in therapy
3. Patient has been diagnosed with tardive dyskinesia including the following
    a. Involuntary athetoid or choreiform movements
    b. History of treatment with dopamine receptor blocking agent (DRBA)
    c. Symptom duration lasting longer than 4-8 weeks
4. Patient must not be taking monoamine oxidase inhibitor (MAOI)
5. Patient is not pregnant or breastfeeding

Product PA Criteria:

*** Austedo/tetrabenazine:

1. Patient must have chorea associated with Huntington's disease or Tardive Dyskinesia
2. Patient must not have hepatic impairment

PREFERRED AGENTS	NON-PREFERRED AGENTS
INGREZZA (valbenazine) PA	AUSTEDO (deutetrabenazine)***
tetrabenazine PA***	

Ulcerative Colitis Agents - Nonsteroidal

Category PA Criteria: A 30-day trial of each of the preferred agents will be required before a non-preferred agent will be authorized. Non-preferred agents will require an FDA indication.

Oral

PREFERRED AGENTS	NON-PREFERRED AGENTS
APRISO (mesalamine) CAPSULE	ASACOL HD (mesalamine)
Balsalazide capsule	AZULFIDINE (sulfasalazine)
DELZICOL (mesalamine) CAPSULE	AZULFIDINE DR (sulfasalazine)
DIPENTUM (olsalazine)	COLAZAL (balsalazide)
LIALDA (mesalamine) TABLET	Mesalamine DR
PENTASA (mesalamine)	SULFAZINE (sulfasalazine)
Sulfasalazine DR tablet	
Sulfasalazine tablet	

Rectal

PREFERRED AGENTS	NON-PREFERRED AGENTS
CANASA (mesalamine) RECTAL SUPPOSITORY	Mesalamine enema kit
Mesalamine enema	ROWASA (mesalamine) ENEMA KIT
	SF ROWASA (mesalamine) ENEMA

Urinary Antispasmodics

Category PA Criteria: A 30-day trial of 3 preferred agents will be required before a non-preferred agent will be authorized. Non-preferred agents require an FDA-approved indication.

Product PA Criteria:
*** Trospium ER will require two of the a 1-month trials to be with trospium and tolterodine ER.

PREFERRED AGENTS	NON-PREFERRED AGENTS
Flavoxate	Darifenacin ER
GELNIQUE (oxybutynin)	DETROL (tolterodine)
Oxybutynin ER	DETROL LA (tolterodine)
Oxybutynin syrup	DITROPAN XL (oxybutynin)
Oxybutynin tablet	ENABLEX (darifenacin)
OXYTROL (oxybutynin) PATCH	MYRBETRIQ (mirabegron)
Tolterodine	SANCTURA (trospium)
Tolterodine ER	SANCTURA ER (trospium)***
TOVIAZ (fesoterodine)	Trospium ER***
Trospium	
VESICARE (solifenacin)	

Vaginal Anti-Infectives

Category PA Criteria: A 30-day trial of 3 preferred agents will be required before a non-preferred agent will be authorized. Non-preferred agents require an FDA-approved indication.

PREFERRED AGENTS	NON-PREFERRED AGENTS
AVC (sulfanilamide)	CLEOCIN (clindamycin) CREAM
CLEOCIN (clindamycin) SUPPOSITORY	NUVESSA (metronidazole) GEL
clindamycin cream	METROGEL-VAGINAL (metronidazole)
CLINDESSE (clindamycin) CREAM	

GYNAZOLE 1 (butoconazole) CREAM	
metronidazole gel	
MICONAZOLE 3 (miconazole) suppository	
terconazole cream	
terconazole suppository	
VANDAZOLE (metronidazole) GEL	