# North Dakota Medicaid

# Preferred Drug List (PDL)

## & Prior Authorization Criteria


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# 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 |
|---|---|---|
| Constipation – Irritable Bowel Syndrome/Opioid Induced | Motegrity added to non-preferred | |
| COPD - PDE4-Inhibitor | | Daliresp Criteria updated |
| Cytokine Modulators | Ilumya removed from PDL | |
| Digestive Enzymes | Ultresa removed from PDL | |
| Insulins | Insulin Lispro added to non-preferred | |
| Migraine Prophylaxis – CGRP Inhibitors | Aimovig moved to non-preferred | |
| Multiple Sclerosis – Oral Non-Interferons | MAVENCLAD (Cladribine) and M MAYZENT (Siponimod added to non-preferred | |
| Ophthalmic Antihistamines | Emadine removed from PDL | |
| Ophthalmic Dry Eye Syndrome | | New Category |
| Ophthalmic Glaucoma - Alpha Adrenergic | IOPIDINE (apraclonidine) 0.5% moved to brand-preferred, apraclonidine 0.5% non-preferred | |
| Ophthalmic Glaucoma - Beta Blockers | | New Category |
| Ophthalmic Glaucoma-Prostaglandin | | New Category |
| Ophthalmic Glaucoma- Rho Kinase Inhibitor | Azopt, Dozolamide, Phospholine, Pilocarpine added to preferred | Name changed to Glaucoma -Other |
| Ophthalmic Glaucoma- Rho Kinase Inhibitor | Isopto Carpine and Trusopt added to non-preferred | |
| Phosphate Binder | Sevelemer Powder Pack Labeler 43598 added to non-preferred | |
| Pulmonary Hypertension - Prostacyclins | Remodulin brand moved to non-preferred, generic preferred | |
| Pulmonary Hypertension-Endothelin Receptor Antagonists | Tracleer moved to preferred | Tracleer Criteria added |
| Ulcerative Colitis Agents - Nonsteroidal | Canasa suppository generic preferred, brand non-preferred | |
| Vaginal Anti-Infectives | clindamycin cream. GYNAZOLE 1 (butoconazole) CREAM, MICONAZOLE 3 (miconazole) suppository, terconazole suppository moved to non-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 | MOTEGRITY (prucalopride) |
| MOVANTIK (naloxegol) | RELISTOR (methylnaltrexone) TABLET |
| RELISTOR (methylnaltrexone) SYRINGE | SYMPROIC (naldemedine) |
| RELISTOR (methylnaltrexone) VIAL | TRULANCE (plecanatide) |

# COPD (Chronic Obstructive Pulmonary Disease)

## Long Acting Anticholinergics

**Group PA Criteria:**

A 30-day trial of 2 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:**
Patient must have an FDA approved indication.
Patient must also be concurrently taking a long acting anticholinergic with good compliance.

| 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) | 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 | Insulin lispro vial |
| HUMULIN R (insulin regular, human) VIAL | Insulin lispro syringe |
| HUMULIN R U-500 (insulin regular, human) VIAL | HUMALOG (insulin lispro) CARTRIDGE |
| LANTUS (insulin glargine) SOLOSTAR | HUMALOG JUNIOR KWIKPEN (insulin lispro) |
| LANTUS (insulin glargine) VIAL | HUMALOG MIX 50/50 (insulin NPL/insulin lispro) KWIKPEN |
| LEVEMIR (insulin detemir) VIAL | HUMALOG MIX 75/25 (insulin NPL/insulin lispro) KWIKPEN |
| LEVEMIR (insulin detemir) FLEXTOUCH | HUMALOG U-100 (insulin lispro) KWIKPEN |
| NOVOLIN R (insulin regular, human) VIAL | HUMALOG U-200 (insulin lispro) KWIKPEN |
| NOVOLOG (insulin aspart) CARTRIDGE | HUMULIN 70/30 (insulin NPH human/regular insulin human) KWIKPEN |
| NOVOLOG (insulin aspart) FLEXPEN | HUMULIN N (insulin NPH human isophane) KWIKPEN |
| NOVOLOG (insulin aspart) VIAL | HUMULIN R (Insulin regular, human) U-500 KWIKPEN |
| NOVOLOG MIX 70/30 (insulin aspart protamine/insulin aspart) FLEXPEN | NOVOLIN 70-30 (insulin NPH human/regular insulin human) VIAL |
| NOVOLOG MIX 70/30 (insulin aspart protamine/insulin aspart) VIAL | NOVOLIN 70-30 (insulin NPH human/regular insulin human) FLEXPEN |
| | NOVOLIN N (insulin NPH human isophane) 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) |
| | 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 |
|---|---|
| EMGALITY (Galcanazumab-gnlm) | AIMOVIG (Erenumab-aooe) |
| | AJOVY (Fremanezumab-vfrm) |

# 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) | MAVENCLAD (Cladribine) |
| GILENYA (fingolimod) | MAYZENT (Siponimod) |
| | TECFIDERA (dimethyl fumarate) |

# Ophthalmic

## Dry Eye Syndrome

| PREFERRED AGENTS | NON-PREFERRED AGENTS |
|---|---|
| RESTASIS (Cyclosporine) | RESTASIS MULTIDOSE (Cyclosporine) |
| | XIIDRA (Lifitegrast) |

Glaucoma – Alpha Adrenergic**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) | Apraclonidine 0.5% |
| ALPHAGAN P 0.15% (brimonidine) | brimonidine 0.15% |
| IOPIDINE (apraclonidine) 1% | |
| IOPIDINE (apraclonidine) 0.5% | |
| brimonidine 0.2% | |
| COMBIGAN (brimonidine/timolol) | |
| SIMBRINZA (brinzolamide/brimonidine) | |

## Glaucoma – Beta Blockers

**Group PA Criteria:**
A 30-day trial of 2 preferred ingredients will be required before a non-preferred agent will be authorized.

| PREFERRED AGENTS | NON-PREFERRED AGENTS |
|---|---|
| BETOPTIC S (Betaxolol) 0.25% | Betaxolol 0.5% |
| Carteolol | COSOPT (Dorzolamide/Timolol) |
| COMBIGAN (brimonidine/timolol) | ISTALOL (Timolol) Daily |
| Dorzolamide/Timolol | Timolol Daily |
| Levobunolol | Timolol gel forming solution |
| Timolol | TIMOPTIC (timolol) |
| TIMOPTIC OCUDOSE (timolol) | TIMOPTIC-XE (Timolol gel forming solution) |

## Glaucoma - Prostaglandin

**Group PA Criteria:**
A 30-day trial of 2 preferred ingredients will be required before a non-preferred agent will be authorized.

| PREFERRED AGENTS | NON-PREFERRED AGENTS |
|---|---|
| Latanoprost | Bimatoprost 0.03% |
| LUMIGAN (Bimatoprost) 0.01% | VYZULTA (latanoprostene) |
| TRAVATAN Z (Travoprost) | XALATAN (Latanoprost) |

| | |
|---|---|
| ZIOPTAN (Tafluprost) | XELPROS (Latanoprost) |

## –Glaucoma - Other

**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.

| PREFERRED AGENTS | NON-PREFERRED AGENTS |
|---|---|
| AZOPT (Brinzolamide) | ISOPTO CARPINE (Pilocarbine) |
| Dorzolamide | TRUSOPT (Dorzolamide) |
| PHOSPHOLINE (Echothiophate Iodide) | |
| Pilocarpine | |
| 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) | Epinastine |
| Cromolyn | Olopatadine 0.2% |
| LASTACAFT (alcaftadine) | PATANOL 0.1% (olopatadine) |
| Olopatadine 0.1% | PATADAY 0.2% (olopatadine) |
| PAZEO (olopatadine) | |

## 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 | |

## 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, 43598 |
| 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***] | tadalafil |
| Sildenafil tablet[PA] | |

## 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.

Tracleer - Patient must be less than 9 years of age for suspension and less than 18 years old for tablets.

| PREFERRED AGENTS | NON-PREFERRED AGENTS |
|---|---|
| LETAIRIS (ambrisentan) | OPSUMIT (macitentan) |
| TRACLEER (bosentan) SUSPENSION*** | |
| TRACLEER (bosentan) TABLETS*** | |

## Prostacyclins

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

# 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 |
|---|---|
| Mesalamine enema | CANASA (mesalamine) RECTAL SUPPOSITORY |
| Mesalamine rectal suppository | Mesalamine enema kit |
| | 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 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) | clindamycin cream |
| CLEOCIN (clindamycin) SUPPOSITORY | CLEOCIN (clindamycin) CREAM |
| CLINDESSE (clindamycin) CREAM | GYNAZOLE 1 (butoconazole) CREAM |
| metronidazole gel | NUVESSA (metronidazole) GEL |
| terconazole cream | METROGEL-VAGINAL (metronidazole) |
| VANDAZOLE (metronidazole) GEL | MICONAZOLE 3 (miconazole) suppository |
| | terconazole suppository |