North Dakota Medicaid

Preferred Drug List (PDL)

& Prior Authorization Criteria

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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 contraindication, 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 - Stimulants - Methylphenidates	RITALIN LA (methylphenidate LA capsules - 50-50) 20mg, 30mg, 40mg moved to brand preferred/Methylphenidate LA capsules - 50-50 20mg, 30mg, 40mg moved to non-preferred	
ADHD - Stimulants - Methylphenidates	Methylphenidate LA capsules - 50-50 60mg moved to non-preferred	
Angina		Criteria Updated
Analgesics – NSAIDS – Topical	Diclofenac 1.5% Drops added to preferred	
Analgesics – NSAIDS – Topical	Diclofenac Gel generic moved to preferred/VOLTAREN (Diclofenac) GEL moved to non-preferred	
Analgesics – NSAIDS – Topical	Diclofenac Patch moved to non-preferred	
Androgens - Topical	Natesto removed from PDL	
Anticonvulsants	FELBATOL (Felbamate) TABLET/ORAL SOLUTION moved to brand preferred/Felbamate tablet and Oral suspension moved to non-preferred, Pregabalin and Pregabalin oral solution added to non-preferred	
Antiretrovirals - Nucleoside Reverse Transcriptase Inhibitors	ZERIT (Stavudine) SOLUTION removed from PDL	
COPD - Corticosteroids - Inhaled	ASMANEX (mometasone) TWISTHALER moved to non-preferred	Asmanex Twisthaler criteria added
Cystic Fibrosis Inhaled Antibiotics	Tobramycin generic moved to non-preferred	Category PA Criteria removed; Tobramycin PA criteria added
Cytokine Modulators		Ilumya, Siliq, Taltz, Tremfya product criteria removed.
Diabetes - DPP4-Inhibitors	JENTADUETO XR (Linagliptin/metformin) moved to preferred	
Diabetes - Insulin		Fiasp criteria updated
Hematopoietic, Colony Stimulating Factors	NEULASTA (Pegfilgrastrim) moved to non-preferred	Category PA Criteria updated
Lice	ULESFIA (benzyl alcohol) removed from PDL	NATROBA (Spinosad) moved to non-preferred
Multiple Sclerosis - Injectable Non-Interferons		Group PA Criteria removed

Ophthalmic - Dry Eye Syndrome		Group and CEQUA (Cyclosporine) and RESTRASIS MULTIDOSE (Cyclosporine) Product PA criteria added
Ophthalmic - Antihistamines	Olopatadine 0.2% - Labeler 61314 moved to preferred	
Ophthalmic - Anti-infectives	GENTAK (Gentamicin Sulfate) OINTMENT	
Ophthalmic - Anti-infectives	Moxifloxacin drops – Labeler 60505, 17478, 65862, 62332, 68180 moved to non-preferred	
Ophthalmic - Anti-infectives	Neomycin SU/polymyxin B/gramicidin drops moved to non-preferred	
Opioid Analgesics – Long Acting - Abuse Deterrent Formulations/Unique Mechanisms from Full Agonist Opioids	BELBUCA (Buprenorphine) moved to preferred, Levorphanol and Tramadol ER – Labeler 13811 moved to non-preferred.	Category and Product criteria updated, Belbuca product PA criteria removed from PDL
Otic Anti-infectives/Anti-inflammatories – Fluoroquinolones	Ofloxacin drops removed from PDL, OTOVEL (Ciprofloxacin/Fluocinolone) moved to non-preferred	
PCSK9 Inhibitors		Category PA Criteria updated
Phosphate Binders	Sevelamer HCl Tablet – Labeler 00955 moved to preferred, Sevelamer HCl 400mg tablets moved to non-preferred	
Pulmonary Hypertension - PDE-5 Inhibitors		Revatio Suspension product PA criteria updated
Pulmonary Hypertension - PDE-5 Inhibitors	ALYQ (Tadalafil) added to preferred	Sildenafil/Tadalafil Product PA Criteria added
Pulmonary Hypertension - Endothelin Receptor Antagonists	Bosentan moved to non-preferred	Group PA Criteria removed, Tracleer Tablets Product PA Criteria removed
Pulmonary Hypertension - Prostacyclins	UPTRAVI (selexipag) Tablets, TYVASO (treprostinil) Inhalation moved to preferred, Treprostinil injection moved to non-preferred	
Tardive Dyskinesia		Category PA Criteria updated
Urinary Antispasmodics	ENABLEX (Darifenacin ER) moved to brand preferred, Tolterodine and Tolterodine ER moved to non-preferred	Category PA Criteria updated

ADHD Agents:

Category PA Criteria:

- **Branded non-preferred agents:** The patient must have had a 10-day trial of each pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.
- **Generic non-preferred agents:** The patient must have had a 10-day trial of a pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.

Product PA Criteria:

- *** **Clonidine ER**: Patient must have had a 30-day trial of immediate release clonidine, as evidenced by pharmacy claims or pharmacy printouts.

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Atomoxetine	Clonidine ER***
Clonidine	INTUNIV (guanfacine ER)
Guanfacine	STRATTERA (atomoxetine)
Guanfacine ER	
Stimulants - Methylphenidates	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
APTENSIO XR (methylphenidate)	Dexmethylphenidate ER
CONCERTA (methylphenidate) – *Brand Preferred*	FOCALIN (dexmethylphenidate)
COTEMPLA XR - ODT (methylphenidate)	METADATE ER (methylphenidate)
DAYTRANA (methylphenidate)	METHYLIN (methylphenidate) chew tablets
Dexmethylphenidate	Methylphenidate ER 72 mg
FOCALIN XR (dexmethylphenidate) – *Brand Preferred*	Methylphenidate ER tablet
Methylphenidate solution	Methylphenidate LA capsules - 50-50 – 20mg, 30mg, 40mg, 60mg
Methylphenidate CD 30-70	METHYLIN (methylphenidate) solution
Methylphenidate chew tablet	RELEXXII (methylphenidate)
Methylphenidate ER capsules 50-50	RITALIN (methylphenidate)
Methylphenidate LA capsules - 50-50 – 10mg	RITALIN LA (methylphenidate LA capsules - 50-50) 10mg
Methylphenidate tablet	
QUILLICHEW ER (methylphenidate)	
QUILLIVANT XR (methylphenidate)	
RITALIN LA (methylphenidate LA capsules - 50-50) 20mg, 30mg, 40mg – *Brand Preferred*	
Stimulants - Amphetamines	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
ADZENYS ER (Amphetamine) SOLUTION	ADDERALL (Dextroamphetamine/amphetamine)
ADZENYS XR - ODT (Amphetamine)	ADDERALL XR (Dextroamphetamine/amphetamine)
DESOXYN (Methamphetamine) – *Brand Preferred*	Amphetamine
Dextroamphetamine	DEXEDRINE (Dextroamphetamine)
Dextroamphetamine ER	Dextroamphetamine 5 mg/5 ml
Dextroamphetamine/amphetamine	Methamphetamine
Dextroamphetamine/amphetamine ER	ZENZEDI (Dextroamphetamine)
DYANAVEL XR (Amphetamine)	
EVEKEO (Amphetamine) – *Brand Preferred*	
MYDAYIS (Dextroamphetamine/dextroamphetamine)	
PROCENTRA (Dextroamphetamine) – *Brand Preferred*	
VYVANSE (Lisdexamfetamine)	

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
VYVANSE (lLsdexamfetamine) CHEW TABLET	

Angina:

Category PA Criteria:

- Clinical justification must be provided explaining why the patient is unable to use the preferred product (subject to clinical review).

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

Analgesics – NSAIDS – Topical:

Category PA Criteria:

- The patient must have had 30-day trials of each preferred agent, as evidenced by paid claims or pharmacy printouts.
- Clinical justification must be provided explaining why the patient is unable to use the preferred products (subject to clinical review).

PREFERRED AGENTS	NON-PREFERRED AGENTS
Diclofenac 1.5% Drops	PENNSAID (diclofenac)
Diclofenac Gel	Diclofenac Patch
FLECTOR (diclofenac) PATCH -*Brand Preferred*	VOLTAREN (diclofenac) GEL

Androgens

Category PA Criteria:

- The patient must have a diagnosis of an FDA-approved indication for use.
- The patient must have had a 30-day trial of each preferred agent, as evidenced by paid claims or pharmacy printouts.
- Clinical justification must be provided explaining why the patient is unable to use the preferred products (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

PREFERRED AGENTS	NON-PREFERRED AGENTS
ANDROGEL (testosterone)	AXIRON (testosterone) TOPICAL SOLUTION
ANDRODERM (testosterone)	FORTESTA (testosterone)

	TESTIM (testosterone)
	Testosterone gel
	Testosterone Gel MD PMP
	Testosterone topical solution
	VOGELXO (testosterone) GEL MD PMP

Anticoagulants - Oral:

Category PA Criteria:

- The patient must have a diagnosis of an FDA-approved indication.
- The patient must have had a 30-day trial of each preferred agent, as evidenced by paid claims or pharmacy printouts.

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

Anticonvulsants:

Category PA Criteria:

- **Branded non-preferred agents:** The patient must have had a 30-day trial of 2 pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.
- **Generic non-preferred agents:** The patient must have had a 30-day trial of a pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.

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	Felbamate Tablet
Divalproex sprinkle	Felbamate Oral Suspension
Divalproex tablet	KEPPRA (levetiracetam)
Ethosuximide capsule	KEPPRA (levetiracetam) ORAL SOLUTION
Ethosuximide oral solution	KEPPRA XR (levetiracetam)
FELBATOL (Felbamate) – *Brand Preferred*	LAMICTAL (lamotrigine)
FELBATOL (Felbamate) ORAL SUSPENSION – *Brand Preferred*	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	Pregabalin
LAMICTAL ODT (lamotrigine)	Pregabalin oral solution
LAMICTAL ODT (lamotrigine) DOSE PACK	TEGRETOL XR (carbamazepine)
LAMICTAL XR (lamotrigine)	TEGRETROL (carbamazepine oral suspension)
Lamotrigine chewable tablet	tiagabine
Lamotrigine dose pack	TOPAMAX (topiramate)
Lamotrigine ER	TOPAMAX (topiramate) SPRINKLE CAPSULE
Lamotrigine ODT	TRILEPTAL (oxcarbazepine)
Lamotrigine tablet	TRILEPTAL (oxcarbazepine) ORAL SUSPENSION
Levetiracetam ER	vigabatrin
Levetiracetam oral solution	vigabatrin powder pack
Levetiracetam tablet	VIGADRONE (vigabatrin)
LYRICA (pregabalin) (*Brand Preferred)*	ZARONTIN (ethosuximide)
LYRICA (pregabalin) ORAL SOLUTION (*Brand Preferred)*	ZARONTIN (ethosuximide) ORAL SOLUTION
Oxcarbazepine oral solution	ZONEGRAN (zonisamide)
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:

- **For all agents**, one of the following (A OR B) must be met:
  A. The patient must have a diagnosis of an FDA-approved indication for use
  B. The patient is greater than 30 years of age.
- **Branded non-preferred agents:** The patient must have had a 30-day trial of each pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.
- **Generic non-preferred agents:** The patient must have had a 30-day trial of a pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.

Product PA Criteria:

- ***Memantine ER**:
  - The patient must have had a 30-day trial of memantine IR, as evidenced by paid claims or pharmacy printouts.
  - The patient must not reside in facility with skilled nursing care.

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

Antiretrovirals

Integrase Strand Transfer Inhibitors

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

Antiretrovirals (continued)

Nucleoside Reverse Transcriptase Inhibitors

Category PA Criteria:

- **Branded non-preferred agents:** The patient must have had a 30-day trial of each pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.
- **Generic non-preferred agents:** The patient must have had a 30-day trial of a pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.

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)	
Zidovudine	

Antiretrovirals (continued)

Protease Inhibitor

Category PA Criteria:

- **Branded non-preferred agents:** The patient must have had a 30-day trial of each pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.
- **Generic non-preferred agents:** The patient must have had a 30-day trial of a pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.

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 an FDA-approved indication for use (meets label recommendations for diagnosis and age)
- **Branded non-preferred agents:** The patient must have had a 30-day trial of each pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.
- **Generic non-preferred agents:** The patient must have had a 30-day trial of a pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.

Product PA Criteria:

- ***Eucrisa**:
    - Patient must have had a 30 day trial of of the following within the past 180 days, as evidenced by paid claims or pharmacy printouts:
        - A topical calcineurin inhibitor (tacrolimus or pimecrolimus) OR a topical corticosteroid
- ***Dupixent**: Initial Approval: 3-months; Subsequent Approval: 12-months
    - Initial Criteria: (Duration of approval: 3-months)
        - Patient must be 12 years of age or older
        - Patient must have had a 6-week trial of at least one of the following, as evidenced by paid claims or pharmacy printouts:

- Tacrolimus OR Pimecrolimus
- One of the following must be met (A or B):
  - A. Patient must have had two 2-week trials of topical corticosteroids of medium or higher potency, as evidenced by paid claims or pharmacy printouts.
  - B. Patient must meet both of the following (1 AND 2):
    1. Affected area is on face, groin, axilla, or under occlusion
    2. Patient must have had two 2-week trials of topical corticosteroids of low or higher potency, as evidenced by paid claims or pharmacy printouts.

o Renewal Criteria: (Duration of approval: 12-months)

- Documentation from the prescriber must be provided showing that the patient has achieved a significant reduction in severity of atopic dermatitis.

- ***Protopic ointment 0.1%:** The patient must be 18 years of age or older.

A complete preferred drug list of topical corticosteroids may be found at:
http://www.hidesigns.com/assets/files/ndmedicaid/2018/Criteria/PA_Criteria.pdf

PREFERRED AGENTS	NON-PREFERRED AGENTS
DERMA-SMOOTH-FS (Fluocinolone Acetonide) OIL 0.01%	Fluocinolone Acetonide Oil 0.01%
DUPIXENT (dupilumab) PA***	Tacrolimus 0.03%
Pimecrolimus – Labeler 68682	Tacrolimus 0.1%
EUCRISA (crisaborole) OINTMENT PA***	ELIDEL (pimecrolimus) CREAM
PROTOPIC (tacrolimus) OINTMENT 0.03%	Pimecrolimus – Labeler 00591
PROTOPIC (tacrolimus) OINTMENT 0.1%***	

Atypical Antipsychotics

Oral

Category PA Criteria:

- **Branded non-preferred agents:** The patient must have had a 30-day trial of each pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.
- **Generic non-preferred agents:** The patient must have had a 30-day trial of a pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.

Product PA Criteria:

- ***Olanzapine/fluoxetine**: Clinical justification must be provided explaining why the patient is unable to use the preferred, individual products separately (subject to clinical review).

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:

- The patient must be 18 years of age or older.
- The patient must have a diagnosis of an FDA-approved indication for use.
- **Diagnosis of idiopathic constipation:**
    - The patient must have had 30-day trials of each of the following, as evidenced by paid claims or pharmacy printouts:
        - Amitiza and Linzess
- **Diagnosis of opioid-induced constipation:**
    - The patient must be currently receiving an opioid agent, as evidenced by paid claims or pharmacy printouts.
    - The patient must have had 30-day trials of each of the following, as evidenced by paid claims or pharmacy printouts:
        - Amitiza and Movantik

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.

- **For non-preferred agents:** The patient must have a diagnosis of an FDA-approved indication for use.

Product PA Criteria:

- ***Lonhala Magnair**:
    - The patient must have had a 30-day trial of Yupelri, as evidenced by paid claims or pharmacy printouts.
    - Clinical justification must be provided explaining why the patient is unable to use the preferred products (subject to clinical review).

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)	

Long Acting Beta Agonists

Group PA Criteria:

- The patient must have a diagnosis of an FDA-approved indication for use.

Product PA Criteria:

- ***Brovana**: The patient must have had a 30-day trial of Perforomist, as evidenced by paid claims or pharmacy printouts.

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:

- The patient must have a diagnosis of an FDA-approved indication for use.
- The patient must have had a 30-day trial of 2 preferred, long-acting products, as evidenced by paid claims or pharmacy printouts.

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:

- The patient must have a diagnosis of an FDA-approved indication for use.
- The patient must have had a 30-day trial of the following combinations (both 1 AND 2), as evidenced by paid claims or pharmacy printouts:
    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)

PDE4-Inhibitor

Group PA Criteria:

- The patient must have a diagnosis of an FDA-approved indication for use.
- Patient must be concurrently taking a long acting anticholinergic agent with good compliance, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS	NON-PREFERRED AGENTS
	DALIRESP (roflumilast)

Corticosteroids – Inhaled

Group PA Criteria:

- The patient must have had a 30-day trial of each preferred inhaler of a unique active ingredient, as evidenced by paid claims or pharmacy printouts.

Product PA Criteria:

- *** **Asmanex Twisthaler, Alvesco**: Patient must have had a 30-day trial of Asmanex HFA, as evidenced by pharmacy claims or pharmacy printouts.

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

Cystic Fibrosis Inhaled Antibiotics

Product PA Criteria:

- Tobramycin:
  - The patient must be stable on tobramycin, as evidenced by a paid claim or pharmacy printouts in the past 75 days
- ***Tobi Podhaler:**
  - The patient must have a diagnosis of an FDA-approved indication for use.
  - The patient must have had a 28-day trial of a preferred nebulized product, as evidenced by paid claims or pharmacy printouts.
- ***Cayston:**
  - The patient must be colonized with *Pseudomonas aeruginosa.*
  - The patient must have had a 28-day trial of TOBI Podhaler, as evidenced by paid claims or pharmacy printouts.
- ***Arikayce:**
  - The patient must be colonized with *Mycrobacterium avium* complex (MAC).
  - The 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:

- The patient must have had a 3-month trial of 2 preferred cytokine modulator agents, as evidenced by paid claims or pharmacy printouts.

Product PA Criteria:

- ***Stelara, Skyrizi:** The patient must have had a 3-month trial of 1 non-preferred agent, as evidenced by paid claims or pharmacy printouts.

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)
	SKYRIZI (risankizumab-rzaa)***
	STELARA (ustekinumab)***
	TALTZ (ixekizumab)
	TREMFYA (guselkumab)
	XELJANZ (tofacitinib)
	XELJANZ XR (tofacitinib)

Diabetes

DPP4-Inhibitors

Group PA Criteria:

- **All (preferred and non-preferred) agents require the following:**
  - The patient must have a diagnosis of an FDA-approved indication for use.
  - One of the following must be met (A OR B):
    - The requested agent is a combination product containing metformin
    - The patient is currently stable on a metformin-containing agent, with good compliance in the past 3-months, as evidenced by paid claims or pharmacy printouts (patients with GI intolerances to high dose IR metformin should trial at minimum a dose of 500mg ER).
- **All non-preferred agents ALSO require the following:**
  - The patient must have had a 30-day trial with EACH of the following agents, as evidenced by paid claims or pharmacy printouts:
    - A preferred sitagliptin product (Janumet, Janumet XR, or Januvia)
    - A preferred linagliptin preferred product (Jentadueto or Tradjenta)
    - Victoza

PREFERRED AGENTS	NON-PREFERRED AGENTS
JANUMET (sitagliptin/metformin)	alogliptan/pioglitizone
JANUMET XR (sitagliptin/metformin)	alogliptin

JANUVIA (sitagliptin)	alogliptin/metformin
JENTADUETO (linagliptin/metformin)	JUVISYNC (sitagliptin/simvastatin)
JENTADUETO XR (linagliptin/metformin)	KAZANO (alogliptin/metformin)
TRADJENTA (linagliptin)	KOMBIGLYZE XR (saxagliptin/metformin)
	NESINA (alogliptin)
	ONGLYZA (saxagliptin)
	OSENI (alogliptin/pioglitazone)

DPP4-Inhibitors/SGLT2 Inhibitors Combination

Group PA Criteria:

- Clinical justification must be provided explaining why the patient is unable to use the individual preferred products separately (subject to clinical review).

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

GLP-1 Agonists

Group PA Criteria:

- **All (preferred and non-preferred) agents require the following:**
  - The patient must have a diagnosis of an FDA-approved indication for use.
  - The patient is currently stable on a metformin-containing agent, with good compliance in the past 3-months, as evidenced by paid claims or pharmacy printouts (patients with GI intolerances to high dose IR metformin should trial at minimum a dose of 500mg ER).
- **All non-preferred agents ALSO require the following:**
  - The patient must have had a 30-day trial of each GLP-1 agonist of a unique active ingredient, as evidenced by paid claims or pharmacy printouts.

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

Insulin/GLP-1 Agonist Combination

Group PA Criteria:

- Clinical justification must be provided explaining why the patient is unable to use the individual preferred products separately (subject to clinical review).

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

Insulin

Group PA Criteria:

- **Non-preferred insulins:** Clinical justification must be provided explaining why the patient is unable to use the preferred products (subject to clinical review).
- **Syringe/Pens:** Clinical justification must be provided explaining why the patient is unable to use the preferred insulin vial/pen products (subject to clinical review).

Product PA Criteria:

- ***Fiasp:** The patient must have had a 3-month trial of one of the following agents, as evidenced by paid claims or pharmacy printouts:
    - Novolog, Humalog, or Apidra
- ***Basaglar:** Clinical justification must be provided explaining why the patient is unable to use the preferred products (subject to clinical review).
- ***Toujeo/Tresiba:**
    - **Initial Criteria:** Approval 6-months
        - The requested agent must be prescribed by or in consultation with an endocrinologist or diabetes specialist.
        - One of the following must be met (medical documentation of reported events must be provided):
            - The patient experiences 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).
            - The patient currently experiences 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.
            - Clinical justification must be provided explaining why the patient needs for a 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).
        - **If dose is >200 units of insulin per day**, clinical justification must be provided explaining why the patient is not a candidate for U-500R (Toujeo and Tresiba are not intended as replacements for U500 insulin).
    - **Renewal Criteria:** Approval 12-months
        - The patient must have experienced at least one of the following, as evidenced by provided clinical notes or labs:
            - Reduction in frequency and/or severity of hypoglycemia
            - Improved glycemic control (A1C)

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 (insulin lispro) CARTRIDGE	BASAGLAR KWIKPEN U-100 (insulin glargine)***
HUMALOG MIX 50/50 (insulin NPL/insulin lispro) VIAL	FIASP (insulin aspart) FLEXTOUCH***
HUMALOG MIX 75/25 (insulin NPL/insulin lispro) VIAL	FIASP (insulin aspart) VIAL***
HUMULIN 70/30 (insulin NPH human/regular insulin human) VIAL	Insulin lispro vial
HUMULIN N (insulin NPH human isophane) VIAL	Insulin lispro syringe

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
NOVOLIN N (insulin NPH human isophane) VIAL	HUMULIN R (Insulin regular, human) U-500 KWIKPEN
NOVOLOG (insulin aspart) CARTRIDGE	NOVOLIN 70-30 (insulin NPH human/regular insulin human) VIAL
NOVOLOG (insulin aspart) FLEXPEN	NOVOLIN 70-30 (insulin NPH human/regular insulin human) FLEXPEN
NOVOLOG (insulin aspart) VIAL	TOUJEO MAX SOLOSTAR (insulin glargine)***
NOVOLOG MIX 70/30 (insulin aspart protamine/insulin aspart) FLEXPEN	TOUJEO SOLOSTAR (insulin glargine)***
NOVOLOG MIX 70/30 (insulin aspart protamine/insulin aspart) VIAL	TRESIBA (insulin degludec) FLEXTOUCH U-100***
	TRESIBA (insulin degludec) FLEXTOUCH U-200***
	TRESIBA (insulin degludec) VIAL***

SGLT2 Inhibitors

Group PA Criteria:

- **All (preferred and non-preferred) agents require the following:**
  - The patient must have a diagnosis of an FDA-approved indication for use.
  - The patient is currently stable on a metformin-containing agent, with good compliance in the past 3-months, as evidenced by paid claims or pharmacy printouts (patients with GI intolerances to high dose IR metformin should trial at minimum a dose of 500mg ER).
- **All non-preferred agents ALSO require the following:**
  - The patient must have had a 30-day trial of an empagliflozin agent, as evidenced by paid claims or pharmacy printouts.

Product PA Criteria:

- ***Steglatro/Steglatromet:** The patient must have had a 30-day trial of each of the following, as evidenced by paid claims or pharmacy printouts: a dapagliflozin agent AND a canagliflozin agent.

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)***
	SEGLUROMET (ertugliflozin/metformin)***
	XIGDUO XR (dapagliflozin/metformin)

Diarrhea – Irritable Bowel Syndrome

Category PA Criteria:

- Patient must be 18 years of age or older.
- The patient must have had a 30-day trial of each preferred agent, as evidenced by paid claims or pharmacy printouts.

Product PA Criteria:

- ***Alosetron**: The patient must be a female.

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

Digestive Enzymes

Category PA Criteria:

- One of the following must be met:
  - The patient has had a 30-day trial of each preferred agent, as evidenced by paid claims or pharmacy printouts; OR
  - The patient is currently stable on a pancreatic enzyme (as evidenced by paid claims or pharmacy printouts), which has been prescribed 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)

Growth Hormone

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

PA Criteria:

- **For Initial or Renewal Requests:**
  - For all covered indications:
    - Patient must have a diagnosis of a **covered indication** (listed below):
      - Multiple pituitary hormone deficiencies caused by a known hypothalamic-pituitary disease or its treatment (brain surgery and/or radiation)
      - Turner's syndrome
      - SHOX syndrome
      - Noonan syndrome
      - Chronic renal insufficiency
      - Prader–Willi syndrome
      - Endogenous growth hormone deficiency
    - 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, unless one of the below exceptions is present:
      - Exceptions:
        - Patient has a diagnosis of Prader-Willi syndrome
        - Patient has a diagnosis of endogenous growth hormone deficiency - and is experiencing hypoglycemic episodes without growth hormone and growth hormone is needed to maintain proper blood glucose.
  - Diagnosis of chronic renal insufficiency (additional criteria):
    - Patient must not have received a renal transplant.
    - Patient must consult with a dietitian to maintain a nutritious diet.
  - Diagnosis of Prader–Willi syndrome (additional criteria):
    - 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 Requests:**
  - Diagnosis of endogenous growth hormone deficiency:
    - Must meet ONE of below criteria (A OR B)
      A. 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.
      B. 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

Growth Hormone (continued)

- **Additional Criteria for Subsequent Authorization**
  - For all covered indications:
    - Patient must have been compliant with growth hormone (last 6 fills must have been on time).
  - Diagnosis of Prader–Willi syndrome (additional criteria):
    - If patient is obese, BMI must have decreased. If patient is not obese, BMI must have maintained or decreased.

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:

- The patient must have a diagnosis of an FDA-approved indication for use.
- Patient must be 18 years of age or older.

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

Hematopoietic, Colony Stimulating Factors

Category PA Criteria:

- The patient must have a diagnosis of an FDA-approved indication for use.
- Clinical justification must be provided explaining why the patient is unable to use the preferred product (subject to clinical review).

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

Hematopoietic, Erythropoiesis Stimulating Agents

Category PA Criteria:

- The patient must have a diagnosis of an FDA-approved indication for use.
- The patient must have had a 4-week trial of each preferred agent, as evidenced by paid claims or pharmacy printouts.

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:

- **All agents:**
  - The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
  - Chronic Hepatitis C must be documented by one of the following:
    - **Liver fibrosis F1 and below**: 2 positive HCV RNA levels at least 6-months apart.
    - **Liver fibrosis F2 and above**: 1 positive HCV RNA test within the last 12-months.
  - The 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:
    - **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:
      - have abstained from alcohol for at least 3-months AND
      - be receiving treatment from an enrolled provider and agree to abstain from alcohol during treatment AND
      - 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
    - **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:
      - have abstained from drug use for at least 3-months AND
      - be receiving treatment from an enrolled provider and agree to abstain from said drug use during treatment AND
      - 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
  - The patient must not be receiving a known recreationally used high risk combination of drugs (e.g. “the holy trinity”) for the past 6-months.
  - Patient must attest that they will continue treatment without interruption for the duration of therapy.
  - Prescriber must be, or consult with, a hepatology, gastroenterology, or infectious disease specialist.
  - Females using ribavirin must have a negative pregnancy test in the last 30 days and receive-monthly pregnancy tests during treatment.

Hepatitis C Treatments (continued)

- 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.
- 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.
- Patient must not have life expectancy of less than 12-months due to non-liver related comorbid conditions.
- HCV RNA level must be taken on week 4 and sent with a renewal request for any duration of treatment 12 weeks or longer.
- PA approval duration will be based on label recommendation.

Product PA Criteria:

- ***Epclusa:**
  - Must be used with ribavirin for patients with decompensated cirrhosis (Child-Pugh B 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
- **All non-preferred agents**:
  - The patient must have had a trial of each preferred treatment options indicated for the patient's genotype, as evidenced by paid claims or pharmacy printouts.

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:

- The patient must have had a 28-day/2-application trial of each preferred agent, as evidenced by paid claims or pharmacy printouts (not required *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)	CROTAN (Crotamiton)
NIX 1% (Permethrin) CRÈME RINSE LIQUID	ELIMITE (Permethrin) CREAM
Permethrin 5% cream	EURAX (Crotamiton)
SKLICE (Ivermectin)	Malathion
SM LICE TREATMENT (Permethrin) 1% CRÈME RINSE LIQUID	NATROBA (Spinosad)
	OVIDE (Malathion)
	Spinosad

Migraine / Cluster Headache

Triptans - 5HT(1) Agonist

Category PA Criteria:

- **Patients able to take oral medications:**
  - Patients 18 years old or older: The patient must have had a 30-day trial of each preferred agent within the past 24-months, as evidenced by paid claims or pharmacy printouts.
  - Patients 6 to 17 years of age: The patient must have had a 30-day trial of rizatriptan within the past 24-months, as evidenced by paid claims or pharmacy printouts.
- **Patients not able to take oral medications (as evidenced by swallow study documentation):**
  - The patient must have had a 30-day trial of rizatriptan within the past 24-months, as evidenced by paid claims or pharmacy printouts.

Product PA Criteria:

- ***Sumatriptan Nasal Spray:**
  - The patient must have had a 30-day trial of each of the following agents within the past 24-months, as evidenced by paid claims or pharmacy printouts:
    - Zomig Nasal Spray 5mg
    - Onzetra Xsail 22mg
- ***Zolmitriptan tablet:**
  - The patient must have had a 30-day trial of naratriptan 2.5 mg within the past 24-months, as evidenced by paid claims or pharmacy printouts.
- ***Sumatriptan pen/syringe/cartridge, Frovatriptan, Almotriptan, Sumatriptan/naproxen:**
  - The patient must have had a 30-day trial of each available triptan agent within the past 24-months, as evidenced by paid claims or pharmacy printouts.
  - Clinical justification must be provided explaining why the patient is unable to use all other products (subject to clinical review).

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)
	Sumatriptan cartridge***
	Sumatriptan pen injctr***
	Sumatriptan spray***
	Sumatriptan syringe***

Migraine / Cluster Headache (continued)

PREFERRED AGENTS	NON-PREFERRED AGENTS
	Sumatriptan vial
	Sumatriptan/naproxen***
	ZEMBRANCE SYMTOUCH (Sumatriptan)
	Zolmitriptan***
	Zolmitriptan ODT
	ZOMIG (zolmitriptan)***
	ZOMIG (zolmitriptan) SPRAY
	ZOMIG ODT (zolmitriptan)

CGRP Inhibitors

Category PA Criteria:

- The patient must have a diagnosis of an FDA-approved indication for use.

PA Criteria for <u>Prevention of Migraine</u>: *Initial (approval duration: 3-months)*

- Patient must experience 4 or more migraine days per-month.
- The patient must have had 2-month trials of at least two of the following agents from different therapeutic classes, as evidenced by paid claims or pharmacy printouts:
  - amitriptyline, atenolol, divalproex sodium, metoprolol, nadolol, propranolol, timolol, topiramate, venlafaxine
- Prescriber must submit documentation, including clinical notes regarding failure of prior treatments to reduce migraine frequency after 2-month trial.
- The patient must have had a 3-month trial of each preferred agent, as evidenced by paid claims or pharmacy printouts.

- **Renewal:**
  - The patient must have experienced at least a 50% reduction in migraines from baseline, since starting treatment with a CGRP inhibitor.

PA Criteria for <u>Treatment of Episodic Cluster Headaches</u>: *Initial (approval duration: 3-months)*

- Prescriber must submit documentation supporting a diagnosis that meets the International Headache Society 3 – beta (IHS-3b) diagnostic criteria for cluster headache.
- A diagnosis of chronic migraine must be ruled out
- The patient must have had 2-month trials of each of the following agents, as evidenced by paid claims or pharmacy printouts:
  - Verapamil dose of at least 240mg
- Prescriber must submit documentation, including clinical notes regarding failure of prior treatments to reduce cluster headache frequency after 2-month trial.
- The patient must have had a 3-month trial of each preferred agent, as evidenced by paid claims or pharmacy printouts.

- **Renewal:**
  - The patient must have experienced at least a 50% reduction in weekly cluster headache attack frequency, since starting treatment with a CGRP inhibitor.

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

Multiple Sclerosis

Interferons

Group PA Criteria:

- The patient must have a diagnosis of an FDA-approved indication for use.
- The patient must have had a 3-month trial of at least 1 preferred agent, as evidenced by paid claims or pharmacy printouts.

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:

- The patient must have a diagnosis of an FDA-approved indication for use.
- The patient must have had a 3-month trial of each of the following, as evidenced by paid claims or pharmacy printouts.
    - Copaxone 20mg/mL, Aubagio, Gilenya, and Tecfidera
- Clinical justification must be provided explaining why the patient is unable to use the preferred products (subject to clinical review).

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:

- The patient must have a diagnosis of an FDA-approved indication for use.
- The patient must have had a 3-month trial of each preferred agent, as evidenced by paid claims or pharmacy printouts.
- One of the following must be met (A OR B):
    - **A.** The patient must have had a 3-month trial of Copaxone, as evidenced by paid claims or pharmacy printouts.
    - **B.** If patient has a documented intolerance, hypersensitivity, or labeled contraindication to Copaxone, the patient must have had a 3-month trial interferon beta-1, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS	NON-PREFERRED AGENTS
AUBAGIO (teriflunomide)	MAVENCLAD (Cladribine)

GILENYA (fingolimod)	MAYZENT (Siponimod)
	TECFIDERA (dimethyl fumarate)

Ophthalmic

Dry Eye Syndrome

Group PA Criteria:

- The patient must have had a 30-day trial of the preferred agent, as evidenced by paid claims or pharmacy printouts.

Product PA Criteria (Cequa, Restasis Multidose):

- The patient must have had a 30-day trials of Xiidra, as evidenced by paid claims or pharmacy printouts.
- Clinical justification must be provided explaining why the patient is unable to use all other products (subject to clinical review).

PREFERRED AGENTS	NON-PREFERRED AGENTS
RESTASIS (Cyclosporine)	CEQUA (Cyclosporine)***
	RESTASIS MULTIDOSE (Cyclosporine)***
	XIIDRA (Lifitegrast)

Glaucoma – Alpha Adrenergic

Group PA Criteria:

- **Branded non-preferred agents:** The patient must have had a 30-day trial of each pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.
- **Generic non-preferred agents:** The patient must have had a 30-day trial of a pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.

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:

- The patient must have had a 30-day trial of at least 2 preferred ophthalmic beta blocker products of a unique active ingredient, as evidenced by paid claims or pharmacy printouts.

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 Maleate	TIMOPTIC (Timolol Maleate)
TIMOPTIC OCUDOSE (timolol)	TIMOPTIC-XE (Timolol gel forming solution)

Glaucoma - Prostaglandin

Group PA Criteria:

- The patient must have had a 30-day trial of at least 2 preferred ophthalmic prostaglandin products of a unique active ingredient, as evidenced by paid claims or pharmacy printouts.

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:** The patient must have had a 30-day trial of each pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.
- **Generic non-preferred agents:** The patient must have had a 30-day trial of a pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS	NON-PREFERRED AGENTS
AZOPT (Brinzolamide)	ISOPTO CARPINE (Pilocarbine)
Dorzolamide	TRUSOPT (Dorzolamide)
PHOSPHOLINE (Echothiophate Iodide)	
Pilocarpine	
RHOPRESSA (Netarsudil)	
ROCKLATAN (Netarsudil/Latanoprost)	

Antihistamines

Group PA Criteria:

- The patient must have had 30-day trials of at least 3 preferred agents, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS	NON-PREFERRED AGENTS
ALOMIDE (lodoxamide)	ALOCRIL (nedocromil)
Azelastine	ELESTAT (epinastine)
BEPREVE (bepotastine)	Epinastine
Cromolyn	Olopatadine 0.2% - Labeler 17478, 00093, 60505
LASTACAFT (alcaftadine)	PATANOL 0.1% (olopatadine)
Olopatadine 0.1%	PATADAY 0.2% (olopatadine)
Olopatadine 0.2% - Labeler 61314	
PAZEO (olopatadine)	

Anti-infectives

Group PA Criteria:

- The patient must have had 3-day trials of at least 3 preferred agents, as evidenced by paid claims or pharmacy printouts.

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
GENTAK (gentamicin sulfate) OINTMENT	Levofloxacin drops
Gentamicin sulfate drops	Moxifloxacin drops – Labeler 60505, 17478, 65862, 62332, 68180
Gentamicin sulfate ointment	Neomycin SU/bacitracin/polymyxin B ointment
MOXEZA (moxifloxacin) DROPS	Neomycin SU/polymyxin B/gramicidin drops
Moxifloxacin drops – Labeler 00781	NEO-POLYCIN (neomycin SU/bacitracin/polymyxin B) OINTMENT
Neomycin SU/polymyxin B/gramicidin drops	NEOSPORIN (neomycin SU/polymyxin B/gramicidin) DROPS
Ofloxacin drop	OCUFLOX (ofloxacin) DROPS
Polymyxin B/trimethoprim drops	POLYCIN (bacitracin/polymyxin) OINTMENT
Sulfacetamide drops	POLYTRIM (polymyxin B/trimethoprim) DROPS
Tobramycin drops	Sulfacetamide ointment
TOBREX (tobramycin) OINTMENT	TOBREX (tobramycin) DROPS
	VIGAMOX (moxifloxacin) DROPS
	ZYMAXID (gatifloxacin) DROPS

Anti-infectives/Anti-inflammatories

Group PA Criteria:

- The patient must have had 7-day trials of at least 2 preferred agents, as evidenced by paid claims or pharmacy printouts.

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:

- The patient must have had 5-day trials of at least 2 preferred agents, as evidenced by paid claims or pharmacy printouts.

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 SM (Loteprednol)
ketorolac tromethamine 0.4%	Loteprednol eye drops
Ketorolac tromethamine 0.5%	OCUFEN (flurbiprofen)
LOTEMAX (loteprednol) GEL DROPS	OMNIPRED 1% (prednisolone acetate)
LOTEMAX (loteprednol) OINTMENT	PRED FORTE 1% (prednisolone acetate)
MAXIDEX (dexamethasone)	PROLENSA (bromfenac)
NEVANAC (nepafenac)	
PRED MILD 0.12% (prednisolone acetate)	
Prednisolone acetate 1%	
Prednisolone sodium phosphate 1%	

Opioid Analgesics – Long Acting

Category PA Criteria:

- **Initial Criteria:**
  - The patient must have required around-the-clock pain relief for the past 90 days, as evidenced by paid claims or pharmacy printouts.
  - The prescriber must attest that they have reviewed the past 3-months of the patient's North Dakota PDMP reports.
  - The 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.).
  - The prescription must be written by or in consultation with an 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:
    - Cumulative daily dose of narcotics exceeds 90 MED/day
    - Patient is using benzodiazepine concurrently with narcotic medication
- **Renewal Criteria:**
  - Documentation noting progress toward therapeutic goal must be included with request (including pain level and function).

Product PA Criteria:

- **For ALL non-preferred agents:** The patient must have had a 30-day trials of 3 of the following long-acting products, as evidenced by paid claims or pharmacy printouts.:
  - Tapentadol
  - Fentanyl
  - Morphine

  - Oxycodone
- *** **Additional criteria for Fentanyl 12 mcg/hr**: Patient must meet one of the following:
  - The patient must be receiving a total daily opioid dose less than or equal to 60 Morphine Equivalent Dose (MED), as evidenced by paid claims or pharmacy printouts
  - The patient must be continuously tapering off opioids from a higher strength Fentanyl patch
- ***Additional criteria for hydromorphine ER and oxymorphine ER - 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, as evidenced by paid claims or pharmacy printouts
- *** **Additional criteria for Methadone, Arymo ER, Morphabond ER, Oxycontin 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 provided explaining why the patient is unable to use other products (subject to clinical review).

Abuse Deterrent Formulations/Unique Mechanisms from Full Agonist Opioid

PREFERRED AGENTS	NON-PREFERRED AGENTS
butorphanol[PA]	ARYMO ER (morphine)***
BELBUCA (Buprenorphine)	buprenorphine patches
BUTRANS (buprenorphine) PATCHES [PA]	CONZIP (tramadol ER)
EMBEDA (morphine/naltrexone)[PA]	HYSINGLA ER (hydrocodone)
NUCYNTA ER (tapentadol)[PA]	Levorphanol
pentazocine-naloxone[PA]	Methadone***
Tramadol ER - Labeler 00378, 47335, 68180, 10370[PA]	MORPHABOND ER (morphine)***
XTAMPZA ER (oxycodone)[PA]	OXYCONTIN (oxycodone)***
	Tramadol ER – Labeler 13811
	ULTRAM ER (tramadol ER)

Full Agonist Opioids Without Abuse Deterrent Formulations

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:

- **For ALL agents:**
  - The patient must be 16 years of age or older.
  - The patient must not be taking other opioids, tramadol, or carisoprodol concurrently.
  - The prescriber must be registered to prescribe under the Substance Abuse and Mental Health Services Administration (SAMHSA) and provide his/her DEA number.
  - The prescriber and patient must have a contract, or a prescriber developed a treatment plan.
  - The prescriber must perform routine drug screens.
  - The prescriber must routinely check the PDMP and attest that the last 3-months of North Dakota PDMP reports must have been reviewed by the prescriber.
  - The prescriber must be enrolled with ND Medicaid.
- **For ALL non-preferred agents:**
  - The patient must have had a 30-day trial of each preferred agent, as evidenced by paid claims or pharmacy printouts.
    - FDA MedWatch forms for each failed product must be faxed to the FDA and submitted with the request.
  - Clinical justification must be provided explaining why the patient is unable to use the preferred products (subject to clinical review).

Oral Agents

Product PA Criteria:

- ***** Buprenorphine tablets**: The patient must be pregnant or breastfeeding, and estimated delivery date/duration of need for breastfeeding must be provided.

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/Anti-inflammatories – Fluoroquinolones

Category PA Criteria:

- The patient must have had a 7-day trial of a preferred agent, as evidenced by paid claims or pharmacy printouts.

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

PCSK9 Inhibitors

Category PA Criteria:

- **For ALL agents:**

- Patient's LDL must have remained greater than 70 mg/dL after an 8 week trial of Rosuvastatin 20-40 mg or Atorvastatin 40-80 mg with good compliance, as evidenced by paid claims or pharmacy printouts.

- **For ALL non-preferred agents:**
  - Clinical justification must be provided explaining why the patient is unable to use the preferred products (subject to clinical review).

PREFERRED AGENTS	NON-PREFERRED AGENTS
Praluent Pen	Repatha Sureclick
Repatha Pushtronex	Repatha Syringe

Phosphate Binders

Category PA Criteria:

- The patient must have had 30-day trials of at least 3 preferred agents of a unique active ingredient, as evidenced by paid claims or pharmacy printouts.
- The patient must have a diagnosis of end-stage renal disease or chronic kidney disease.

PREFERRED AGENTS	NON-PREFERRED AGENTS
Calcium acetate	AURYXIA (ferric citrate) TABLET
FOSRENOL (lanthanum) CHEWABLE TABLET *– brand preferred*	FOSRENOL (lanthanum) POWDER PACK
PHOSLYRA (calcium acetate) ORAL solution	Lanthanum chew tab
RENAGEL (Sevelamer HCl) TABLET	RENVELA (sevelamer carbonate) TABLET
RENVELA (sevelamer) POWDER PACK	Sevelamer HCl 400mg Tablet
Sevelamer Carbonate Tablet	Sevelamer HCl 800mg Tablet - Labeler 65862
Sevelamer HCl 800mg Tablet – Labeler 00955	Sevelamer Powder Pack - Labeler 65862, 43598
Sevelamer Powder Pack - Labeler 00955	VELPHORO (Sucroferric oxyhydroxide)

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:

- The patient must have a diagnosis of an FDA-approved indication for use.
- The patient must have had 30-day trials of at least 2 preferred agents, as evidenced by paid claims or pharmacy printouts.

Product PA Criteria:

- ***Yosprala DR/Durlaza**: Clinical justification must be provided explaining why the patient is unable to use the preferred products (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:

- The patient must have a diagnosis of an FDA-approved indication for use.
- The patient must have had a 30-day trial of each preferred agent, as evidenced by paid claims or pharmacy printouts.

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

Pulmonary Hypertension

Category PA Criteria:

- The patient must have a diagnosis of an FDA-approved indication for use.
- The patient must have had a 30-day trial of each preferred agent, as evidenced by paid claims or pharmacy printouts.

PDE-5 Inhibitors

Group PA Criteria:

- The patient cannot be taking nitrates of any form.

Product PA Criteria:

- ***Revatio Suspension (one of the following must be met):**
  - The patient must be less than 9 years of age.
  - The provider must submit clinical documentation of the patient's inability to ingest a solid dosage form.

- *** Sildenafil/Tadalafil (one of the following must be met):**
  - The patient must be less than 12 years of age
  - The provider must submit clinical documentation to support patient's diagnosis

PREFERRED AGENTS	NON-PREFERRED AGENTS
ALYQ (Tadalafil)	ADCIRCA (tadalafil) TABLET
REVATIO (sildenafil) SUSPENSIONPA***	REVATIO (sildenafil) TABLET
Sildenafil tablet PA***	
Tadalafil tablet PA***	

Soluble Guanylate Cyclase Stimulators

Group PA Criteria:

- The patient must not be using ANY of the following agents concurrently with the requested agent:
  - Nitrates of any form
  - Specific (sildenafil or tadalafil) or non-specific (dipyridamole or theophylline) PDE-5 inhibitors.
- 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
ADEMPAS (riociguat)	

Endothelin Receptor Antagonists

Product PA Criteria:

- **Tracleer Suspension:** Patient must be less than 9 years of age.

PREFERRED AGENTS	NON-PREFERRED AGENTS
Ambrisentan	Bosentan
TRACLEER (bosentan) SUSPENSION***	LETAIRIS (ambrisentan)
TRACLEER (bosentan) TABLETS - *Brand Preferred*	OPSUMIT (macitentan)

Prostacyclins

PREFERRED AGENTS	NON-PREFERRED AGENTS
ORENITRAM ER (treprostinil) TABLET	REMODULIN (treprostinil) INJECTION
UPTRAVI (selexipag) TABLET	Treprostinil Injection
TYVASO (treprostinil) INHALATION	
VENTAVIS (iloprost) INHALATION	

Tardive Dyskinesia

Category PA Criteria

- The patient must be 18 years of age or older.
- The prescription must be written by/in consultation with a specialist (neurologist or psychiatrist).
- The patient must have a diagnosis of tardive dyskinesia, including the following:
  - Involuntary athetoid or choreiform movements
  - History of treatment with dopamine receptor blocking agent (DRBA)
  - Symptom duration lasting longer than 4-8 weeks
- The patient must not be taking monoamine oxidase inhibitor (MAOI)
- The patient is not pregnant or breastfeeding

Product PA Criteria:

- ***** Austedo/tetrabenazine:**
  - The patient must have a diagnosis of Huntington's disease or Tardive Dyskinesia.
  - The 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:

- The patient must have had a 30-day trial of each preferred agent, as evidenced by paid claims or pharmacy printouts.
- The patient must have a diagnosis of an FDA-approved indication for use.

Oral

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

- The patient must have a diagnosis of an FDA-approved indication for use.
- The patient must have had a 30-day trial of 2 preferred agents, as evidenced by paid claims or pharmacy printouts.

Product PA Criteria:

- ***** Trospium ER:** The patient must have had a 30-day trial of each of the following, as evidenced by paid claims or pharmacy printouts:
    - Trospium and tolterodine ER

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

Vaginal Anti-Infectives

Category PA Criteria:

- The patient must have a diagnosis of an FDA-approved indication for use.
- The patient must have had 30-day trials of 3 preferred agents, as evidenced by paid claims or pharmacy printouts.

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