Preferred Drug List (PDL)

& Prior Authorization Criteria

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Please use the NDC Drug Lookup to find Prior Authorization (PA) Forms

Guiding Rules of the Preferred Drug List (PDL):

THIS LIST REFERS TO MEDICATIONS PROCESSED BY PHARMACY POINT OF SALE SYSTEMS.

For Clinic Administered Drugs - Prior authorization criteria for medication claims processed by physician/clinic billing using 837P codes can be found at the end of this document or by using this link:
Clinic Administered Drugs - Prior Authorization Criteria.
For medications not on this list, FDA or compendia supported indications are required.

- Prior authorization criteria apply in addition to the general Drug Utilization Review policy that is in effect for the entire pharmacy program
    - Other documents explaining coverage rules can be found at www.hidesigns.com/ndmedicaid:
        - Preferred Diabetic Supply List (PDSL)
        - Coverage Rules on Medications
        - Therapeutic Duplication Edits

- Please use the NDC Drug Lookup tool to access PA form, view coverage status, quantity limits, copay, and prior authorization information for all medications.

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

- 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.

- Prior authorization for a non-preferred agent with a preferred brand/generic equivalent in any category will be given only if all other criteria is met, including all DAW criteria, clinical criteria, and step therapy specific to that category.

- 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

- 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.

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

- Clinical justification must be provided for combination products that are comprised of components available and more cost effective when prescribed separately

*** - Indicates that additional PA criteria applies as indicated in the Product PA Criteria

Contents

Please use the NDC Drug Lookup to find Prior Authorization (PA) Forms

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General

Dispense as Written (DAW1)

Prior Authorization Form - Dispense As Written (DAW1)
MedWatch Form

Criteria for ALL DAW requests (must meet one of the following (A or B):

A. Primary insurance requires a ND Medicaid non-preferred branded product
B. All of the following are met (1-3):

Please use the NDC Drug Lookup to find Prior Authorization (PA) Forms

1. The requested brand-name product must not have an authorized generic available
2. The patient must have failed a 30-day trial of each pharmaceutically equivalent generic product from each available manufacturer, as evidenced by paid claims or pharmacy print outs
    a. A failure is defined as product was not effective at maximum tolerated dose or caused adverse reaction where the branded product is expected to have a different result and other alternatives (e.g. medications in same class) are not an option for the patient
    b. The patient or prescriber preference is NOT criteria considered for approval
3. A MedWatch form for each trial of each product from the available manufacturer(s) must be filled out and attached to request

Medications that cost over $3000/month

General Prior Authorization Form

Group Criteria:

- The patient must have a diagnosis of an FDA-approved indication for use in line with label recommendations

PA REQUIRED
GATTEX (teduglutide)
INCRELEX (mecasermin)
OXERVATE (cenegermin-bkbj)

Non-solid dosage preparations

General Prior Authorization Form

Group Criteria:

- The patient must have failed treatment with a more cost-effect dosage form in the last 30 days, as evidenced by paid claims or pharmacy printouts

  OR
- The patient must be unable to ingest solid dosage form as evidenced by swallow study documentation

Preferred Dosage Forms List:

Prior Authorization Form - Non-Preferred Dosage Form

See Preferred Dosage Forms List

Cardiology

Angina:

Non-Preferred Agents Criteria:

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

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
RANEXA (ranolazine)	Ranolazine ER

Blood Modifying Agents

Anticoagulants - Oral:

General Prior Authorization Form

Group Criteria:

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

Non-Preferred Agents Criteria:

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

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
ELIQUIS (Apixaban)	SAVAYSA (edoxaban)
PRADAXA (dabigatran)	
XARELTO (rivaroxaban)	

Anticoagulants - Injectable

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- One of the following must be met (A or B)
    A. The patient must have had a 30-day trial of enoxaparin, as evidenced by paid claims or pharmacy printouts.
    B. The request must be for fondaparinux and the patient must have a diagnostic history of heparin-induced thrombocytopenia (HIT)

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
enoxaparin	ARIXTRA (fondaparinux)
	fondaparinux
	FRAGMIN (dalteparin)
	LOVENOX (enoxaparin)

Antihemophilic Factor Products

Prior Authorization Form - Antihemophilic Factors

Group Criteria:

- The provider must attest that the patient visits an accredited Hemophilia Treatment Center once per year
- The date of the patient's last appointment with treatment center must be provided
- Contact information for treatment center must be provided

Non-Preferred Agents Criteria:

- Clinical justification must be provided explaining why the patient is unable to use the PREFFERED AGENTS (subject to clinical review).
- The patient may qualify for non-preferred product if they are stable on current therapy (have had a paid claim for requested therapy in the past 45 days)

FACTOR VIIa	
PREFFERED AGENTS (CLINICAL PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
NOVOSEVEN RT (Coagulation Factor VIIa recombinant)	
FACTOR VIII – HEMOPHILIA A	
PREFFERED AGENTS (CLINICAL PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
ADVATE (factor VIII recombinant)	ADYNOVATE (factor VIII recombinant, PEGylated)
HEMOFIL M (factor VIII plasma derived; mAb-purified)	AFSTYLA (factor VIII recombinant, single chain)

KOATE (factor VIII plasma derived, chromatography purified)	ELOCTATE (factor VIII recombinant, Fc fusion protein)
KOGENATE FS (factor VIII recombinant)	JIVI (factor VIII recombinant, pegylated-aucl)
NOVOEIGHT (factor VIII recombinant)	KOVALTRY (factor VIII recombinant)
NUWIQ (factor VIII recombinant)	OBIZUR (recombinant, B domain-deleted porcine factor VIII)
RECOMBINATE (factor VIII recombinant)	
XYNTHA (factor VIII recombinant)	
XYNTHA SOLOFUSE (factor VIII recombinant)	
FACTOR VIII:C – HEMOPHILIA A	
PREFFERED AGENTS (CLINICAL PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
MONOCLATE-P (Antihemophilic Factor VIII:C (human))	
FACTOR VIII – HEMOPHILIA A/vWF	
PREFFERED AGENTS (CLINICAL PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
ALPHANATE (Antihemophilic Factor/Von Willebrand Factor Complex (Human))	
HUMATE-P (Factor VIII/von Willebrand Factor (human))	
WILATE (Factor VIII/von Willebrand Factor (human))	
FACTOR VIII – VON WILLEBRAND FACTOR - RECOMBINANT	
PREFFERED AGENTS (CLINICAL PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
	VONVENDI (Recombinant human vWF)
FACTOR IX – HEMOPHILIA B	
PREFFERED AGENTS (CLINICAL PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
ALPHANINE SD (factor IX, plasma-derived)	ALPROLIX (factor IX recombinant, Fc fusion)
BENEFIX (factor IX recombinant)	IDELVION (factor IX recombinant, albumin fusion)
IXINITY (factor IX recombinant)	REBINYN (factor IX recombinant, glycol-PEGylated)
MONONINE (factor IX, plasma-derived mAb purified)	
PROFILNINE (factor IX complex)	
RIXUBIS (factor IX recombinant)	
FACTOR IXa/IX	
PREFFERED AGENTS (CLINICAL PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
HEMLIBRA (Emicizumab-kxwh)	
FACTOR X	
PREFFERED AGENTS (CLINICAL PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
COAGADEX (Coagulation Factor X (Human))	
FACTOR X	
PREFFERED AGENTS (CLINICAL PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
CORIFACT (Factor XIII Concentrate (Human))	
FACTOR XIII A – SUBUNIT, RECOMBINANT	
PREFFERED AGENTS (CLINICAL PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
TRETTEN (Factor XIII A-Subunit, recombinant)	
ANTI-INHIBITOR COAGULANT COMPLEX	
PREFFERED AGENTS (CLINICAL PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
FEIBA NF (Anti-Inhibitor Coagulant Complex)	

Hematopoietic, Colony Stimulating Factors

General Prior Authorization Form

Group Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).

Non-Preferred Agents Criteria:

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

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
FULPHILA (Pegfilgrastrim-JMDB)	GRANIX (TBO-Filgrastim)
LEUKINE (Sargramostim)	NEULASTA (Pegfilgrastim)
NEUPOGEN (Filgrastim)	NIVESTYM (Figrastim-AAFI)
UDENYCA (Pegfligrastim-CBQV)	ZARXIO (Filgrastim-SNDZ)
ZIEXTENZO (Pegfligrastim-BMEZ)	

Platelet Aggregation Inhibitors

General Prior Authorization Form

Group Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).

Non-Preferred Agents Criteria:

- The patient must have had 30-day trials of at least 2 preferred agents, as evidenced by paid claims or pharmacy printouts.

Product Specific Criteria:

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

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
AGGRENOX (aspirin/dipyridamole)	Aspirin/Dipyridamole ER
Aspirin	Aspirin/Omeprazole DR
BRILINTA (ticagrelor)	Clopidogrel 300mg
Clopidogrel 75 mg	DURLAZA (aspirin ER)***
Dipyridamole	EFFIENT (prasugrel)
Prasugrel	PLAVIX (clopidogrel)
	YOSPRALA DR (aspirin/omeprazole)***
	ZONTIVITY (vorapaxar)

Thrombocytopenia

General Prior Authorization Form

Group Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- Documentation of the patient's current platelet count must be attached to the request

Non-Preferred Agents Criteria:

- The patient must have had trials with each preferred agent (at the recommended dose and duration) with each preferred agent, as evidenced by paid claims or pharmacy Printouts.

Diagnosis Specific Criteria: Chronic immune thrombocytopenia (ITP):

- Criteria for coverage of **Promacta, Doptelet, Nplate, Tavalisse**:
    - **Initial Criteria:**
        - The provider must attest that the patient's degree of thrombocytopenia and clinical condition increase the risk for bleeding
            - The patient must have experienced an inadequate response after one of the following (A or B):
                A. The patient must have failed a trial of appropriate duration of a corticosteroid or immunoglobulins as evidenced by paid claims or pharmacy print outs
                B. The patient must have undergone a splenectomy

- **Renewal Criteria:**
  - The patient must be experiencing a significant increase in platelet count and bleeding reduction risk on therapy (supported by documentation)
  - If on maximum dose: The patient's platelet count must have increased to a level sufficient to avoid clinically important bleeding after the recommended duration for the product*
    *Promacta, Nplate, Doptelet: 4 weeks
    *Tavalisse: 12 weeks

PREFFERED AGENTS (CLINICAL PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
PROMACTA (Eltrombopag)	DOPTELET (Avatrombopag)
TAVALISSE (Fostamatinib)	NPLATE (Romiplostim)

Diagnosis Specific Criteria: Chronic liver disease-associated thrombocytopenia

- Criteria for coverage of **Doptelet** and **Mulpleta**
  - The patient must have a diagnosis of chronic liver disease
  - The patient must be scheduled to undergo a procedure that puts the patient at risk of bleeding
    - The prescriber must include documentation of the name and scheduled date of the procedure
  - The provider must indicate the date therapy will be initiated and discontinued*
    *Doptelet: given from 10-13 to 5-8 days prior to procedure
    *Mulpleta: given from 8-14 to 2-8 days prior to procedure

PREFFERED AGENTS (CLINICAL PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
DOPTELET (Avatrombopag)	MULPLETA (Lusutrombopag)

Diagnosis Specific Criteria: Chronic hepatitis C infection-associated thrombocytopenia

- Criteria for coverage of **Promacta**
  - The patient must have a diagnosis of hepatitis C and be currently receiving or planning to initiate interferon-based treatment
    - Prescriber must attest that the patient's degree of thrombocytopenia prevents continuation or initiation of interferon

Diagnosis Specific Criteria: Aplastic Anemia

- Criteria for coverage of **Promacta**
  - One of the following must be met (A or B):
    A. The patient must be receiving Promacta as first-line treatment in combination with standard immunosuppressive therapy (e.e. corticosteroid, Atgam, cyclosporin)
    B. The patient must have had an insufficient response to treatment with prior immunosuppressive therapy

Hypertension

ARBs (Angiotensin Receptor Blockers)

General Prior Authorization Form

Non-Preferred Agents Criteria:

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

Product Specific Criteria:

- **Combination agents:**
  - Clinical justification must be provided explaining why the patient is unable to use a preferred combination product or the individual agents separately (subject to clinical review).

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Amlodipine-olmesartan	Amlodipine-Valsartan-Hydrochlorothiazide
Amlodipine-valsartan	ATACAND (Candesartan)

Candesartan 4mg, 32mg	ATACAND HCT (Candesartan-Hydrochlorothiazide)
EDARBI (azilsartan)	AVALIDE (Irbesartan-Hydrochlorothiazide)
EDARBYCLOR (azilsartan/chlorothalidone)	AVAPRO (irbesartan)
Irbesartan	AZOR (Amlodipine/Olmesartan)
Irbesartan-hydrochlorothiazide	BYVALSON (Nebivolol/Valsartan)
Losartan	Candesartan 8mg, 16mg
Losartan-hydrochlorothiazide	Candesartan-hydrochlorothiazide
Olmesartan	COZAAR (Losartan)
Olmesartan-hydrochlorothiazide	DIOVAN HCT (Valsartan-Hydrochlorothiazide)
Telmisartan	Eprosartan
Valsartan	EXFORGE (Amlodipine-Valsartan)
Valsartan-hydrochlorothiazide	EXFORGE HCT (Amlodipine-Valsartan-Hydrochlorothiazide)
	HYZAAR (Losartan-Hydrochlorothiazide)
	Telmisartan-Amlodipine
	Telmisartan-Hydrochlorothiazide
	TRIBENZOR (Olmesartan-Amlodipine-Hydrochlorothiazide)

Renin Inhibitors

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have had 30-day trials of 2 different ACE-inhibitors and 2 different ARBs, each at the highest tolerable therapeutic dose, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS	NON-PREFERRED AGENTS
TEKTURNA (aliskiren)	aliskirin
	TEKTURNA HCT (aliskiren-hydrochlorothiazide)

Vecamyl

General Prior Authorization Form

Group Criteria:

- The patient must have documented history of failure to achieve blood pressure goals (using maximum tolerated doses) of all first- and second-line agents as defined by the most recent JNC report.

Heart Failure

Edecrin

General Prior Authorization Form

Product Specific Criteria:

- **Ethacrynic acid**: One of the following must be met (A or B)
  - A. The patient must have a documented sulfa allergy
  - B. The patient must have failed a 30-day trial of all preferred agents, as evidenced by paid claims or pharmacy print outs.

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
furosemide	ethacrynic acid
bumetanide	
torsemide	

Entresto

Product Specific Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
ENTRESTO (sacubitril/valsartan)	

Lipid-Lowering Agents

Juxtapid

Prior Authorization Form - Juxtapid

Product Specific Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The patient must have LDL levels of >130 mg/dL after a 90-day trial of the following, as evidenced by paid claims or pharmacy printouts:
    A. A lipid lowering agent other than a statin combined with either Crestor (rosuvastatin) ≥20 mg or Lipitor (atorvastatin) ≥ 40 mg
- The patient must meet one of the following (A, B, or C):
    A. The patient must have genetic confirmation of two mutant alleles at the LDLR, APOB, PCSK9, or LDLRAP1 gene locus
    B. The patient's current untreated LDL and total cholesterol level is > 500 mg/dl or >300 mg/dl with cutaneous or tendon xanthoma before 10 years of age
    C. The patient has a current untreated LDL level consistent with Heterozygous Familial Hypercholesterolemia (HeFH) in both parents

PCSK9 Inhibitors

PCSK9 Inhibitors Prior Authorization Form

Group Criteria:

- 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.
- Clinical documentation of the patient's LDL during prior trials must be provided with the request.

Non-Preferred Agents Criteria:

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

PREFFERED AGENTS (CLINICAL PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
PRALUENT PEN (Alirocumab)	REPATHA SURECLICK (Evolocumab)
REPATHA PUSHTRONEX (Evolocumab)	REPATHA SYRINGE (Evolocumab)

Statins

General Prior Authorization Form

Product Specific Criteria:

- **Livalo**:
    - Statin intensity treatment goal must be "moderate" or "low"
    - The patient must have failed 3-month trials of one of the below drug regimens (based on their intensity treatment goal), as evidenced by paid claims or pharmacy print outs:
        - "Moderate" treatment goal
            - atorvastatin 10-20mg, rosuvastatin 5-10mg, and one of the following:
                - Simvastatin 20 - 40mg a day
                - Pravastatin 40 - 80mg a day
                - Lovastatin 40mg a day
                - Fluvastatin XL 80mg a day
                - Fluvastatin 40mg twice a day
        - "Low" treatment goal

- Two of the following:
    - Simvastatin 10mg a day
    - Pravastatin 10 - 20mg a day
    - Lovastatin 20mg a day
    - Fluvastatin 20 - 40mg a day

- **Altoprev (lovastatin) ER/Fluvastatin/Fluvastatin ER/Zypitamag:**
    - Clinical justification must be provided explaining why the patient is unable to use the preferred agents (subject to clinical review).

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
atorvastatin	ALTOPREV (lovastatin)
lovastatin	ALTOPREV (lovastatin) ER
pravastatin	Amlodipine-atorvastatin
rosuvastatin	CRESTOR (rosuvastatin)
simvastatin	EZALLOR SPRINKLE (rosuvastatin)
	Ezetimibe-simvastatin
	fluvastatin
	fluvastatin ER
	LESCOL XL (fluvastatin)
	LIPITOR (atorvastatin)
	LIVALO (pitavastatin)
	PRAVACHOL (pravastatin)
	ZOCOR (simvastatin)
	ZYPITAMAG (pitavastatin)

Pulmonary Hypertension

General Prior Authorization Form

PDE-5 Inhibitors

Group Criteria:

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

Product Specific Criteria:

- **Sildenafil/Tadalafil:**
    - One of the following must be met (A or B):
        A. The patient must be less than 12 years of age
        B. The provider must submit clinical documentation to support patient's diagnosis
- **Revatio Suspension:**
    - The provider must submit clinical documentation to support patient's diagnosis
    - One of the following must be met (A or B):
        A. The patient must be less than 9 years of age.
        B. The provider must submit clinical documentation of the patient's inability to ingest a solid dosage form.

PREFFERED AGENTS (PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
ALYQ (Tadalafil)	ADCIRCA (Tadalafil) TABLET
REVATIO (Sildenafil) SUSPENSION*** - *Brand Required*	REVATIO (Sildenafil) TABLET
Sildenafil tablet***	Sildenafil Suspension
Tadalafil tablet***	

Soluble Guanylate Cyclase Stimulators

Group Criteria:

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

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
ADEMPAS (riociguat)	

Endothelin Receptor Antagonists

Group Criteria:

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

Product Specific Criteria:

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

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Ambrisentan	Bosentan
TRACLEER (bosentan) SUSPENSION***	LETAIRIS (ambrisentan)
TRACLEER (bosentan) TABLETS - *Brand Preferred*	OPSUMIT (macitentan)

Prostacyclins

Group Criteria:

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

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
ORENITRAM ER (Treprostinil) TABLET	REMODULIN (Treprostinil) INJECTION
UPTRAVI (Selexipag) TABLET	
Treprostinil injection	
TYVASO (Treprostinil) INHALATION	
VENTAVIS (Iloprost) INHALATION	

Dermatology

Acne

General Prior Authorization Form

Group Criteria:

- The patient must be between 12 and 35 years of age

Non-Preferred Agents Criteria:

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

CLINDAMYCIN-BENZOYL PEROXIDE	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
Clindamycin-benzyl peroxide 1.2%-5%	ACANYA (Clindamycin-benzoyl peroxide) 1.2%-2.5%
Clindamycin/benzoyl peroxide 1%-5% without pump	BENZACLIN (Clindamycin/benzoyl peroxide without pump) 1%-5%
ONEXTON (Clindamycin/benzoyl peroxide) 1.2%-3.75%	BENZACLIN (Clindamycin/benzoyl peroxide with pump) 1%-5%
	Clindamycin/benzoyl peroxide 1%-5% with pump
	Clindamycin-benzoyl peroxide 1.2%-2.5%
	DUAC (lindamycin/benzoyl peroxide) 1.2%-5%
	NEUAC (Clindamycin/benzoyl peroxide) 1.2%-5%
RETINOID	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
ALTRENO (tretinoin) LOTION	ATRALIN (Tretinoin) 0.05% GEL
AVITA (tretinoin) CREAM *(brand preferred)*	Clindamycin-tretinoin 1.2%-0.025%
RETIN-A (tretinoin) CREAM *(brand preferred)*	FABIOR (tazarotene) 0.1% FOAM
RETIN-A MICRO PUMP (Tretinoin Microsphere) 0.06%	RETIN-A MICRO (Tretinoin Microsphere) GEL WITHOUT PUMP
RETIN-A MICRO PUMP (Tretinoin Microsphere) 0.08%	RETIN-A MICRO PUMP (Tretinoin Microsphere) 0.04%
Tretinoin gel 0.01%, 0.03%	RETIN-A MICRO PUMP (Tretinoin Microsphere) 0.10%
ZIANA (Clindamycin-tretinoin 1.2%-0.025%) *(brand preferred)*	tretinoin microsphere without pump
	tretinoin microsphere with pump
	Tretinoin cream
	Tretinoin gel 0.05%
ADAPALENE	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
DIFFERIN (adapalene) CREAM (*brand preferred*)	Adapalene 0.1% cream
Adapalene gel	Adapalene 0.3% gel with pump
DIFFERIN (adapalene) GEL W/ PUMP *(brand preferred)*	Adapalene/Benzoyl Peroxide 0.1%-2.5%
DIFFERIN (adapalene) LOTION	
EPIDUO (adapalene/benzoyl peroxide) 0.1%-2.5% *(brand preferred)*	
EPIDUO FORTE (adapalene/benzoyl peroxide) 0.3%-2.5%	
OTHER	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
ACZONE (Dapsone) GEL WITH PUMP 7.5%	ACZONE (Dapsone) GEL WITHOUT PUMP 5%
AZELEX (Azelaic Acid)	AKLIEF (Trifarotene) CREAM 0.005%
Clindamycin capsule	CLEOCIN T (Clindamycin) GEL
Clindamycin gel	CLEOCIN T (Clindamycin) LOTION
Clindamycin lotion	CLEOCIN T (Clindamycin) MED SWAB
Clindamycin solution	CLINDACIN P (Clindamycin) MED SWAB
Clindamycin med. swab	CLINDACIN ETZ (Clindamycin) MED SWAB
Sulfacetamide suspension	CLINDAGEL (Clindamycin) GEL DAILY
	Clindamycin Gel Daily
	Clindamycin foam
	Dapsone gel without pump 5%

Please use the NDC Drug Lookup to find Prior Authorization (PA) Forms

	EVOCLIN (Clindamycin) FOAM
TETRACYCLINES	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
Doxycycline hyclate capsule	AMZEEQ (Minocycline) Foam
Doxycycline hyclate tablet 20mg, 100mg	Demeclocycline
Doxycycline monohydrate 25 mg/5mL suspension	DORYX (Doxycycline hyclate) TABLET DR
Doxycycline monohydrate tablet 50 mg, 75mg, 100mg	DORYX MPC (Doxycycline hyclate) TABLET DR
Doxycycline monohydrate capsule 50 mg, 100mg	Doxycycline monohydrate capsule 75mg, 150mg
Minocycline capsule	Doxycycline hyclate tablet 75mg, 150 mg
Minocycline tablet	Doxycycline monohydrate tablet 75mg, 150 mg
VIBRAMYCIN (Doxycycline) 25mg/5mL SUSPENSION	Doxycycline hyclate tablet DR
VIBRAMYCIN (Doxycycline calcium) 50 mg/5mL SYRUP	MINOCIN (Minocycline) CAPSULE
	Minocycline Tablet ER
	MINOLIRA ER (Minocycline) TABLET
	MORGIDOX (Doxycycline hyclate) CAPSULE
	SEYSARA (Sarecycline)
	SOLODYN ER (Minocycline) TABLET
	Tetracycline
	XIMINO (Minocycline) CAPSULE ER

Actinic Keratosis

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The patient must have had a 6-month trial of each preferred agent of a unique active ingredient, as evidenced by paid claims or pharmacy printouts.

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
CARAC (Fluorouracil) 0.5% CREAM	Fluorouracil 0.5% cream
Diclofenac 3% sodium gel	Imiquimod 3.75% cream pump
Imiquimod 5% cream packet	PICATO (ingenol mebutate)
Fluorouracil 5% cream	ZYCLARA (imiquimod) 3.75% CREAM PUMP
TOLAK (Fluorouracil) 4% CREAM	ZYCLARA (imiquimod) 3.75% CREAM PACKET
	ZYCLARA (imiquimod) 2.5% CREAM PUMP

Antifungals – Topical

General Prior Authorization Form

Diagnosis Specific Criteria:

- **Onychomycosis:** *Approval Duration = 12 months*
  - A. The patient must have a diagnosis of an FDA approved indication for use
    - Diagnosis must be confirmed by potassium hydroxide (KOH) preparation
  - B. The patient must have had a trial of one oral agent (terbinafine, fluconazole, or itraconazole), for the length of recommended treatment time for patient's particular infection, as evidenced by paid claims or pharmacy printouts
  - C. Adequate time must have passed since treatment cessation to accurately assess healthy toenail outgrow (at least 6 months)
  - D. One of the following must be met (A or B):

A. Clinical justification must be provided explaining why the patient is unable to use the preferred agents (subject to clinical review)
B. The active ingredient of the requested product is not available in a preferred formulation

- **Other diagnoses:** *Approval Duration = 12 months*
    A. The patient must have had a trial of 3 preferred agents, for the length of recommended treatment time for patient's particular infection, as evidenced by paid claims or pharmacy printouts
    B. One of the following must be met (A or B):
        A. Clinical justification must be provided explaining why the patient is unable to use the preferred agents (subject to clinical review)
        B. The active ingredient of the requested product is not available in a preferred formulation

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Ciclopirox cream	CICLODAN (Ciclopirox) CREAM
Ciclopirox gel	CICLODAN (Ciclopirox) SOLUTION
Ciclopirox shampoo	EXTINA (Ketoconazole) FOAM
Ciclopirox solution	JUBLIA (efinaconazole) SOLUTION
Clotrimazole cream	KERYDIN (tavaborole) SOLUTION
Clotrimazole solution	Ketoconazole foam
Econazole cream	LOPROX (Ciclopirox) CREAM
ERTACZO (sertraconazole) CREAM	LOPROX (Ciclopirox) SHAMPOO
EXELDERM CREAM (sulconazole)	LOPROX (Ciclopirox/Skin Cleanser) KIT
EXELDERM SOLUTION (sulconazole)	LOPROX (Ciclopirox) SUSPENSION
Ketoconazole cream	LUZU (Luliconazole) Cream
Ketoconazole shampoo	Naftifine Cream
Luliconazole cream	Natfifine Gel
MENTAX (butenafine) CREAM	NAFTIN (Naftifine) CREAM
Miconazole	NAFTIN (Naftifine) GEL
Miconazole/zinc oxide/white petrolatum ointment	NIZORAL (Ketoconazole) SHAMPOO
Nystatin cream	NYAMYC (Nystatin) POWDER
Nystatin ointment	NYSTOP (Nystatin) POWDER
Nystatin powder	Oxiconazole cream
Nystatin – triamcinolone cream	OXYSTAT (Oxiconazole) CREAM
Nystatin – triamcinolone ointment	OXISTAT (oxiconazole) LOTION
	PENLAC (Ciclopirox) SOLUTION
	VUSION (Miconazole/Zinc/White Petrolatum) OINTMENT

Antipsoriatics – Topical

General Prior Authorization Form

Non-Preferred Agents Criteria:

- **For Foams and Sprays:**
    A. Patient must have failed 30-day trials of the preferred solution and shampoo formulations, as evidenced by paid claims or pharmacy print outs
- **For Lotions:**
    A. Patient must have failed a 30-day trial of a preferred agent, as evidenced by paid claims or pharmacy print outs
- **For Ointments:**
    A. Patient must have failed 30-day trials of the preferred ointment formulations, as evidenced by paid claims or pharmacy print outs

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
calcipotriene ointment	calcipotriene/betamethasone ointment
calcipotriene solution	Calcitriol ointment
calcipotriene cream	DOVONEX (Calcipotriene) CREAM
SORILUX (calcipotriene) FOAM	DUOBRII (halobetasol/tazarotene) LOTION
TACLONEX (calcipotriene/betamethasone) SUSPENSION	ENSTILAR (calcipotriene/betamethasone) FOAM
TAZORAC (Tazarotene) CREAM 0.05%	TACLONEX (calcipotriene/betamethasone) OINTMENT
TAZORAC (Tazarotene) GEL	Tazarotene cream
VECTICAL (Calcitriol) OINTMENT	TAZORAC (Tazarotene) CREAM 0.1%

Eczema / Atopic Dermatitis

Prior Authorization Form - Eczema

Topical Corticosteroids: Please see the Preferred Drug List of Topical Corticosteroids at the end of this document

Category PA Criteria:

- Patient must meet FDA label recommendations for indication and age

Product Specific Criteria (Initial): *Approval Duration = 3 months*

- **Eucrisa**:
  - Patient must have had a 30-day trial of at least one 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**
  - 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.

Product Specific Criteria (Renewal): *Approval Duration = 3 months*

- **Eucrisa and Dupixent:**
  - The prescriber must submit documentation showing that the patient has achieved a significant reduction in severity of atopic dermatitis since treatment initiation

PREFFERED AGENTS (CLINICAL PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
DUPIXENT (dupilumab)***	Tacrolimus 0.03%
EUCRISA (crisaborole) OINTMENT***	Tacrolimus 0.1%
Pimecrolimus – Labeler 68682	ELIDEL (pimecrolimus) CREAM
PROTOPIC (tacrolimus) OINTMENT 0.03%	Pimecrolimus – Labeler 00591
PROTOPIC (tacrolimus) OINTMENT 0.1%***	

Hemangeol

Prior Authorization Form - Hemangeol

Please use the NDC Drug Lookup to find Prior Authorization (PA) Forms

Product Specific Criteria:

- The patient must have a diagnosis of proliferating infantile hemangioma requiring systemic therapy
- The patient must be between 5 weeks and 1 year of age
- The patient must weigh at least 2 kg
- The provider must attest that the patient does not have any of the following contraindications to treatment:
    A. Asthma or history of bronchospasm
    B. Bradycardia (<80 beats per minute)
    C. Greater than first-degree heart block
    D. Decompensated heart failure
    E. Blood pressure <50/30 mmHg
    F. Pheochromocytoma

Lice

General Prior Authorization Form

Category 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).*

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
LICE KILLING SHAMPOO (piperonyl butoxide/pyrethrins)	CROTAN (Crotamiton)
NATROBA (spinosad)	ELIMITE (permethrin) CREAM
NIX 1% (Permethrin) CRÈME RINSE LIQUID	EURAX (crotamiton)
Permethrin 5% cream	Malathion
SM LICE TREATMENT (Permethrin) 1% CRÈME RINSE LIQUID	OVIDE (malathion)
	SKLICE (ivermectin)
	Spinosad

Steroids - Topical

General Prior Authorization Form

Non-Preferred Agents Criteria:

- **Non-preferred Step 1 agents (not labeled as "STEP 2"):**
    G. The patient must have failed a 2-week trial of all preferred drug entities within the same potency category and dosage form group within the last 3 months, as evidenced by paid claims or pharmacy printouts
- **Non-preferred agents labeled as "STEP 2":**
    A. The patient must have failed a 2-week trial of all preferred and non-preferred drug entities within the same potency category and dosage form group within the last 3 months.

See Topical Corticosteroids Preferred Medication List

Endocrinology

Diabetes

DPP4-Inhibitors

General Prior Authorization Form

Group Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- One of the following must be met (A OR B):
    A. The requested agent is a combination product containing metformin
    B. 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).

Non-Preferred Agents Criteria:

- 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

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
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

General Prior Authorization Form

Group Criteria:

- The prescriber must provide medical justification explaining why the patient cannot use individual preferred products separately

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
	GLYXAMBI (Empagliflozin/linagliptin)
	STEGLUJAN (Ertugliflozin/Sitagliptin)
	QTERN (Dapagliflozin/Saxagliptin)

GLP-1 Agonists

General Prior Authorization Form

Group Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).

- 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).

Non-Preferred Agents Criteria:

- 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.

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
VICTOZA (liraglutide)	ADLYXIN (lixisenatide)
BYDUREON (exenatide microspheres)	BYDUREON BCISE (exenatide microspheres)
BYETTA (exenatide)	OZEMPIC (semaglutide)
	RYBELSUS (semaglutide)
	TRULICITY (dulaglutide)

Insulin/GLP-1 Agonist Combination

General Prior Authorization Form

Group Criteria:

- The prescriber must provide medical justification explaining why the patient cannot use individual preferred products separately

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS:
	SOLIQUA (Insulin glargine/lixisenatide)
	XULTOPHY (insulin degludec/liraglutide)

Insulin

Insulin Prior Authorization Form

Group 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 Specific 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).

o **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)
-

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
APIDRA (insulin glulisine) VIAL	ADMELOG (insulin lispro) VIAL
APIDRA SOLOSTAR (insulin glulisine) INSULIN PEN	ADMELOG SOLOSTAR (insulin lispro) INSULIN PEN
HUMALOG MIX 50/50 (insulin NPL/insulin lispro) VIAL	AFREZZA (insulin regular, human)
HUMALOG MIX 75/25 (insulin NPL/insulin lispro) VIAL	BASAGLAR KWIKPEN U-100 (insulin glargine)***
HUMULIN R (insulin regular, human) VIAL	FIASP (insulin aspart) FLEXTOUCH***
HUMULIN R U-500 (insulin regular, human) VIAL	FIASP (insulin aspart) VIAL***
Insulin lispro vial	HUMALOG (insulin lispro) VIAL
Insulin lispro syringe	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) VIAL
NOVOLOG (insulin aspart) FLEXPEN	HUMULIN 70/30 (insulin NPH human/regular insulin human) KWIKPEN
NOVOLOG (insulin aspart) VIAL	HUMULIN N (insulin NPH human isophane) VIAL
NOVOLOG MIX 70/30 (insulin aspart protamine/insulin aspart) FLEXPEN	HUMULIN N (insulin NPH human isophane) KWIKPEN
NOVOLOG MIX 70/30 (insulin aspart protamine/insulin aspart) VIAL	HUMULIN R (Insulin regular, human) U-500 KWIKPEN
	NOVOLIN 70-30 (insulin NPH human/regular insulin human) 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)***

Please use the NDC Drug Lookup to find Prior Authorization (PA) Forms

	TRESIBA (insulin degludec) FLEXTOUCH U-100***
	TRESIBA (insulin degludec) FLEXTOUCH U-200***
	TRESIBA (insulin degludec) VIAL***

Rosiglitazone

General Prior Authorization Form

Product Specific Criteria:

- The patient must have failed a 30-day trial of pioglitazone, as evidenced by paid claims or pharmacy printouts
- Clinical justification must be provided explaining why the patient is unable to use the preferred agents and other classes of medication (subject to clinical review)

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Pioglitazone	Rosiglitazone

SGLT2 Inhibitors

General Prior Authorization Form

Group PA Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- 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).

Non-Preferred Agents Criteria:

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

Product Specific 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.

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
JARDIANCE (empagliflozin)	FARXIGA (dapagliflozin)
SYNJARDY (empagliflozin/metformin)	INVOKANA (canagliflozin)
SYNJARDY XR (empagliflozin/metformin)	INVOKAMET (canagliflozin)
	INVOKAMET XR (canagliflozin/metformin)
	STEGLATRO (ertugliflozin)***
	STEGLATROMET (ertugliflozin/metformin)***
	XIGDUO XR (dapagliflozin/metformin)

Sulfonylureas

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have failed a 30-day trial of glipizide, as evidenced by paid claims or pharmacy printouts.
- Clinical justification must be provided explaining why the patient is unable to use the preferred agents and other classes of medication (subject to clinical review).

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Glimepiride	Glyburide
Glipizide	Glyburide/Metformin
Glipizide/Metformin	
Glipizide ER	

Growth Hormone

Prior Authorization Form - Growth Hormone

Group Criteria:

- 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.
- **For Initial or Renewal Requests:**
    - 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
    - For all covered indications:
        - 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
- **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.

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

Serostim

Prior Authorization Form - Growth Hormone

Product Specific Criteria (Initial):

- Patient must have a diagnosis of treatment of HIV with wasting cachexia
- Patient must not have an active malignancy
- Prescriber must be experienced in the diagnosis and management of HIV infection
- Patient must be on concomitant antiretroviral therapy
- Patient must have failed a 3-month trial with Megace, as evidenced by paid claims or pharmacy Printouts

Product Specific Criteria (Renewal):

- Lean body mass and body weight must have increased in the past 12 weeks
- Physical endurance must have increased in past 12 weeks
- Patient must not have completed 48 weeks of continuous treatments

Zorbtive

Prior Authorization Form - Growth Hormone

Product Specific Criteria:

- Patient must not have active malignancy
- Patient must have diagnosis of short bowel syndrome
- Patient must be receiving specialized nutritional support
- Treatment duration must not be longer than 4 weeks

Pituitary Suppressants

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
ELIGARD (leuprolide)	
LUPRON DEPOT (leuprolide)	
SUPPRELIN LA (histrelin)	
SYNAREL (nafarelin)	
TRESTAR (triptorelin)	
TRIPTODUR (triptorelin)	
VANTAS (histrelin)	
ZOLADEX (goserelin)	

Gastrology

Constipation – Irritable Bowel Syndrome/Opioid Induced

Category PA Criteria:

- The patient must be 18 years of age or older.
- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).

Idiopathic Constipation

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have had 30-day trials of each of the following, as evidenced by paid claims or pharmacy printouts:
    - Amitiza and Linzess

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
AMITIZA (lubiprostone)	LINZESS (linaclotide) 72 mcg
LINZESS (linaclotide) 145 mcg, 290 mcg	MOTEGRITY (prucalopride)
	TRULANCE (plecanatide)
	ZELNORM (Tegaserod)

Opioid-Induced Constipation:

General Prior Authorization Form

Non-Preferred Agents Criteria:

- 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

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
AMITIZA (lubiprostone)	RELISTOR (methylnaltrexone) TABLET
MOVANTIK (naloxegol)	SYMPROIC (naldemedine)
RELISTOR (methylnaltrexone) SYRINGE	
RELISTOR (methylnaltrexone) VIAL	

Diarrhea – Irritable Bowel Syndrome

General Prior Authorization Form

Non-Preferred Agents 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 Specific Criteria:

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

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS:
Dicyclomine Capsule	Alosetron***
Dicyclomine Tablet	Dicyclomine Oral Syrup
LOTRONEX (alosetron)***	
VIBERZI (eluxadoline)	
XIFAXIN (rifaximin) 550 mg tablet	

Digestive Enzymes

General Prior Authorization Form

Non-Preferred Agents Criteria:

- A 30-day trial of all PREFFERED AGENTS (no PA required) 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

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
CREON (lipase/protease/amylase)	PANCREAZE (lipase/protease/amylase)
ZENPEP (lipase/protease/amylase)	PANCRELIPASE (lipase/protease/amylase)
	PERTZYE (lipase/protease/amylase)
	VIOKACE (lipase/protease/amylase)

Nausea/Vomiting

Chemo Induced

Prior Authorization Form - Nausea/Vomiting

Non-Preferred Agents Criteria: *Approval Duration = 6 months or until last day of chemotherapy*

- The patient must have diagnosis of nausea and/or vomiting
- Prescriber must be an oncologist
- The patient must be receiving a moderately or highly emetogenic chemotherapy
- The final date of chemotherapy treatment must be provided with the request
- Patient must have failed a 3-day trial of each preferred product(s) in the same class within the last 6 months as evidenced by paid claims or pharmacy print outs
- Patient must not have failed preferred chemical entity with same active ingredient as requested product due to side effects

Product Specific Criteria:

- **Syndros**

  A. The patient must have one of the following diagnoses and meet required trial for their diagnosis:
  - Loss of appetite due to HIV/AIDS:
    - The patient must have tried and failed a 3-month trial with Megace, as evidenced by paid claims or pharmacy printouts
  - Chemotherapy-induced nausea and vomiting:
    - The patient must have tried and failed a 3-day trial of ondansetron ODT in combination with aprepitant suspension and a glucocorticoid, as evidenced by paid claims or pharmacy printouts

NK1 RECEPTOR ANTAGONISTS	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
VARUBI (Rolapitant) TABLET	AKYNZEO (Netupitant/Palonosetron)
	Aprepitant Capsule
	EMEND (Aprepitant) CAPSULE
	EMEND (Aprepitant) SUSPENSION
5-HT3 RECEPTOR ANTAGONISTS	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
Granisetron tablet	AKYNZEO (Netupitant/Palonosetron)
Ondansetron ODT	SANCUSO (Granisetron) PATCH

Ondansetron solution	ZOFRAN (Ondansetron) TABLET
Ondansetron tablet	ZUPLENZ (Ondansetron) FILM
CANNABINOIDS	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
Dronabinol Capsule	CESAMET (Nabilone) CAPSULE
	MARINOL (Dronabinol) CAPSULE
	SYNDROS (Dronabinol) SOLUTION

Pregnancy

Prior Authorization Form - Nausea/Vomiting

Non-Preferred Agents Criteria: *Approval Duration = 3 months or until due date*

- Patient must have diagnosis of nausea and vomiting of pregnancy
- Patient must have failed a 3-day trial of all preferred products
- Patient's due date must be provided
- Bonjesta: The prescriber must submit medical justification explaining why the patient cannot use a preferred product (subject to clinical review)

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
DICLEGIS (doxylamine/vitamin B6) – *Brand Required*	BONJESTA (doxylamine/vitamin B6)
meclizine	Doxylamine/Vitamin B6
metoclopramide	
ondansetron	

Proton Pump Inhibitor

Solid Dosage Forms

General Prior Authorization Form

Group Criteria: *Approval Duration = 6 months*

Non-Preferred Agents Criteria: Step 1 Agents (Esomeprazole Magnesium, Lansoprazole 15mg, rabeprazole):

- Patient must have failed a 25-day trial of at least one of the preferred or Step 1 Solid Dosage Form agents in the past 90 days, as evidenced by paid claims or pharmacy printouts

Non-Preferred Agents Criteria: Step 2 Agents (Esomeprazole strontium, Esomeprazole magnesium/glycerin, Omeprazole-sodium bicarbonate):

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

SOLID DOSAGE FORMS		
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED STEP 1 AGENTS (ELECTRONIC STEP)**	**NON-PREFERRED STEP 2 AGENTS (PA REQUIRED)**
DEXILANT (dexlansoprazole)	Esomeprazole magnesium	Esomeprazole magnesium/glycerin
Lansoprazole 30mg	Lansoprazole 15mg	Esomeprazole strontium
omeprazole	Rabeprazole	NEXIUM (esomeprazole)
pantoprazole		Omeprazole-Sodium bicarbonate
		PREVACID (Lansoprazole)
		PRILOSEC (Omeprazole)
		PROTONIX (Pantoprazole)

Non-Solid Dosage Forms

General Prior Authorization Form

Please use the NDC Drug Lookup to find Prior Authorization (PA) Forms

Group Criteria: *Approval Duration = 6 months*

Non-Preferred Agents Criteria:

- The patient must have feeding tube in place
- The patient must have failed a 30-day trial of all Preferred Non-Solid Dosage form agents (Nexium Packet and Protonix Packet) in the past 2 years, as evidenced by paid claims or pharmacy printouts

Product Specific Criteria:

- **Prilosec Packet:**
  - The patient must have had a 30-day trial of lansoprazole ODT in the past 2 years, as evidenced by paid claims or pharmacy printouts
- **Omeprazole-sodium bicarbonate packet/Aciphex Sprinkle:**
  - Clinical justification must be provided explaining why the patient is unable to use the other proton-pump inhibitor agents (subject to clinical review)

NON-SOLID DOSAGE FORMS		
PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED STEP 1 AGENTS (PA REQUIRED)	NON-PREFERRED STEP 2 AGENTS (PA REQUIRED)
NEXIUM (esomeprazole) PACKET	Lansoprazole 15mg ODT	ACIPHEX SPRINKLE (rabeprazole)
PROTONIX (pantoprazole) PACKET	PRILOSEC PACKET (omeprazole)	Lansoprazole 30mg ODT
		Omeprazole-sodium bicarbonate packet
		PREVACID (Lansoprazole) SOLUTAB

Vancomycin - Oral

General Prior Authorization Form

Non-Preferred Agents Criteria: *Approval Duration = 5 days*

- The patient must have diagnosis of *Clostridium difficile*-associated diarrhea (CDAD)
- The patient must be 18 years of age or older
- The patient must have failed a 10-day trial with vancomycin, as evidenced by paid claims or pharmacy printouts
- Request must be for treatment of the first recurrence for a patient whose initial episode was treated with Dificid

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
FIRVANQ (vancomycin) SOLUTION	DIFICID (fidaxomicin) TABLET
Vancomycin capsule	VANCOCIN (vancomycin) CAPSULE

Genetic and Rare Disease

Cystic Fibrosis Inhaled Antibiotics

General Prior Authorization Form

Product Specific 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 an FDA-approved indication for use (meets label recommendations for diagnosis and age).
  - 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.

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
BETHKIS (Tobramycin)	ARIKAYCE (Amikacin/Nebulizer) ***
KITABIS PAK (Tobramycin/Nebulizer) (*Brand Preferred)*	CAYSTON (Aztreonam)***
TOBI PODHALER (Tobramycin) ***	TOBI (Tobramycin)
	Tobramycin***
	Tobramycin/Nebulizer

Hereditary Angioedema

General Prior Authorization Form

Category Criteria:

- The patient must have diagnosis of hereditary angioedema, confirmed by a specialist.

PREFFERED AGENTS (CLINICAL PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
BERINERT (C1 Esterase Inhibitor)	
CINRYZE (C1 Esterase Inhibitor)	
FIRAZR (Icatibant)	
HAEGARDA (C1 Esterase Inhibitor)	
KALBRITOR (Ecallantide)	
RUCONEST (C1 Esterase Inhibitor)	
TAKHZYRO (Lanadelumab-FLYO)	

Idiopathic Pulmonary Fibrosis

Prior Authorization Form - Idiopathic Pulmonary Fibrosis

Category Criteria:

- The patient must be 18 years of age or older
- The patient must have documented diagnosis of idiopathic pulmonary fibrosis
- The patient must have a specialist involved in therapy
- The patient must have forced vital capacity (FVC) ≥ 50% of predicted within prior 60 days

Product Specific Criteria

- **Alternative Ofev Products:**
  - The patient must have documented diagnosis of systemic sclerosis-associated interstitial lung disease

PREFFERED AGENTS (CLINICAL PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
ESBRIET (Pirfenidone)	
OFEV (Nintedanib)	

Phenylketonuria

Kuvan:

Prior Authorization Form - Phenylketonuria

Criteria for initial requests: *Approval Duration = 2 months*

- The patient must have a diagnosis of hyperphenylalaninemia
- The patient must be following a PHE restricted diet
- The patient's weight must be provided
- The patient must be 4 years of age or older
- The patient must not have been known to have two null mutations in TRANS
- Baseline PHE levels must be attached
    A. For females of child bearing potential: PHE levels must be above 360 micromoles/liter
    B. For males or females unable to bear children: PHE levels must be above 600 micromoles/liter
- Requested initial dose must be 10 mg/kg or less

Criteria for renewal requests: *Approval Duration = 12 months*

- The patient's weight must be provided
- If dose is the same or less than previous trial:
    A. PHE level must be between 60 and 360 micromoles per liter
- For a dose increase from previous trial:
    A. PHE levels must be attached that were taken after 1 month of previous trial
    B. The patient's PHE level must be greater than 360 micromoles per liter
    C. For increase > 10 mg/kg - patient must have failed a trial of 1 month of 10 mg/kg

Palynziq:

Prior Authorization Form - Phenylketonuria

Criteria for initial requests: *Approval Duration = 6 months*

- The patient must have a diagnosis of hyperphenylalaninemia
- The patient must be following a PHE restricted diet
- The patient must be 18 years of age or older
- PHE levels must be above 600 micromoles/liter
- The patient must have been compliant with diet and medication management for past 6 months.

Criteria for renewal requests: *Approval Duration = 12 months*

- **If dose is the same or less than previous trial:**
    A. PHE level must be between 60 and 360 micromoles per liter
- **For a dose increase to 40 mg:**
    A. PHE levels must be attached that were taken after 24 weeks of 20 mg
    B. The patient's PHE level must be greater than 360 micromoles per liter

Immunology

Biosimilar Agents

General Prior Authorization Form

Group Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- Clinical justification must be provided explaining why the patient is unable to use the preferred agents (subject to clinical review)

Cytokine Modulators

General Prior Authorization Form

Non-Preferred Agents 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 Specific 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.

ANKYLOSING SPONDYLITIS	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
COSENTYX (secukinumab)	CIMZIA (certolizumab)
ENBREL (etanercept)	SIMPONI (golimumab)
HUMIRA (adalimumab)	TALTZ (ixekizumab)
BEHCET'S SYNDROME	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
HUMIRA (adalimumab)	OTEZLA (apremilast)
CHRONIC INFANTILE NEUROLOGICAL, CUTANEOUS AND ARTICULAR SYNDROME	
PREFFERED AGENTS (PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
KINERET (anakinra)	
CROHN'S DISEASE	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
HUMIRA (adalimumab)	CIMZIA (certolizumab)
	STELARA (ustekinumab)***
CYTOKINE RELEASE SYNDROME	
PREFFERED AGENTS (PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
ACTEMRA (tocilizumab)	
GIANT CELL ARTERITIS	
PREFFERED AGENTS (PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
ACTEMRA (tocilizumab)	
HIDRADENITIS SUPPURATIVA	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
HUMIRA (adalimumab)	
NON-RADIOGRAPHIC AXIAL SPONDYLARTHRITIS	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
HUMIRA (adalimumab)	CIMZIA (certolizumab)
PLAQUE PSORIASIS	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
COSENTYX (secukinumab)	CIMZIA (certolizumab)
ENBREL (etanercept)	OTEZLA (apremilast)
HUMIRA (adalimumab)	SILIQ (brodalumab)***
	SKYRIZI (risankizumab-rzaa)***
	STELARA (ustekinumab)***
	TALTZ (ixekizumab)***
	TREMFYA (guselkumab)***
PSORIATIC ARTHRITIS	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**

COSENTYX (secukinumab)	CIMZIA (certolizumab)
ENBREL (etanercept)	ORENCIA (abatacept)
HUMIRA (adalimumab)	OTEZLA (apremilast)
	SIMPONI (golimumab)
	STELARA (ustekinumab)***
	TALTZ (ixekizumab)***
	XELJANZ (tofacitinib)
	XELJANZ XR (tofacitinib)
RHEUMATOID ARTHRITIS	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
COSENTYX (secukinumab)	ACTEMRA (tocilizumab)
ENBREL (etanercept)	CIMZIA (certolizumab)
HUMIRA (adalimumab)	KEVZARA (sarilumab)
	KINERET (anakinra)
	OLUMIANT (baricitinib)
	ORENCIA (abatacept)
	RINVOQ (upadacitinib)
	SIMPONI (golimumab)
	XELJANZ (tofacitinib)
	XELJANZ XR (tofacitinib)
SCHNITZLER SYNDROME	
PREFFERED AGENTS (PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
KINERET (anakinra)	
ULCERATIVE COLITIS	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
HUMIRA (adalimumab)	SIMPONI (golimumab)
	STELARA (ustekinumab)
	XELJANZ (tofacitinib)
	XELJANZ XR (tofacitinib)
UVEITIS	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
HUMIRA (adalimumab)	

Dupixent

Prior Authorization Form - Dupixent

Asthma

Click to Jump to Criteria

Eczema

Click to Jump to Criteria

Chronic Rhinosinusitis

General Prior Authorization Form

Initial Criteria: *Approval Duration = 3 months*

- The patient must meet label recommendations for indication and age.
- Diagnosis has been confirmed by anterior rhinoscopy, nasal endoscopy, or computed tomography (CT)

- The patient must still be experiencing inflammation of paranasal sinuses after 12 weeks of treatment with intranasal or oral corticosteroids and nasal saline irrigations, as evidenced by paid claims or pharmacy printouts.

Renewal Criteria: *Approval Duration = 9 months*

- The prescriber must provide documentation showing that the patient has achieved a significant reduction in systemic or intranasal corticosteroids and reduction in inflammation.

Eosinophilic Asthma

Prior Authorization Form – Eosinophilic Asthma

Category Criteria (Initial): *Approval Duration = 3 months*

- The patient must meet label recommendations for indication and age.
- The patient must have had 2 or more asthma exacerbations in previous year despite continued compliant use of a moderate to high dose inhaled steroid in combination with a long-acting beta agonist (LABA) or long-acting muscarinic antagonist (LAMA) as evidenced by paid claims or pharmacy printouts

Category Criteria (Renewal): *Approval Duration = 3 months*

- The prescriber must provide documentation showing that the patient has achieved a significant reduction in asthma exacerbations and utilization of rescue medications since treatment initiation

PREFERRED AGENTS	NON-PREFERRED AGENTS
DUPIXENT (Dupilumab)	
FASENRA (Benralizumab)	
NUCALA (Mepolizumab)	

Epinephrine

General Prior Authorization Form

PREFFERED AGENTS (CLINICAL PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Epinephrine – Labeler 49502	Epinephrine – Labeler 00935
SYMJEPI (Epinephrine)	Epinephrine – Labeler 11516
	EPIPEN (Epinephrine)
	EPIPEN (Epinephrine) JUNIOR

Gout

General Prior Authorization Form

Category 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 Specific Criteria:

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

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Allopurinol Tablet	COLCRYS (Colchicine) TABLETS
Colchicine Capsules	Febuxostat
Colchicine Tablets	GLOPERBA (Colchicine) ORAL SOLUTION
Probenecid-Colchicine Tablets	MITIGARE (Colchicine) CAPSULE
Probenecid Tablets	ULORIC (Febuxostat) TABLET
	ZYLOPRIM (Allopurinol) TABLET

Please use the NDC Drug Lookup to find Prior Authorization (PA) Forms

Immune Globulins

Prior Authorization Form - Immune Globulins

Non-Preferred Agents Criteria:

- If the patient's BMI > 30, adjusted body weight must be provided along with the calculated dose
- The patient must have a diagnosis of an FDA-approved indication for use
- The patient may qualify for non-preferred product if they are stable on current therapy (have had a paid claim for requested therapy in the past 45 days)

Product Specific Criteria:

- **Gammagard S/D:**
  - The patient must be intolerant to IgA (i.e., treatment of an autoimmune process in a patient with undetectable levels of IgA)
- **Cutaquig, Cuvitru, Hizentra, Hyqvia or Xembify:**
  - The patient must be unable to tolerate IV administration
  - The patient must have failed a trial of at least two of the following, as evidenced by paid claims or pharmacy printouts:
    - Gamunex-C
    - Gammaked
    - Gammagard
- **Other Products:**
  - The patient must have failed a trial of at least two of the following, as evidenced by paid claims or pharmacy printouts:
    - Gammagard
    - Gamunex-C
    - Privigen

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
BIVIGAM (human immunoglobulin gamma)	ASCENIV (human immune globulin G slra)
FLEBOFAMMA DIF (human immunoglobulin gamma)	CUTAQUIG (human immune globulin G solution)
GAMANEX-C (human immunoglobulin gamma)	CUVITRU (human immunoglobulin gamma)
GAMASTAN S-D (human immunoglobulin)	GAMMAGARD S-D (human immunoglobulin gamma)
GAMMAGARD LIQUID (human immunoglobulin gamma)	HIZENTRA (human immunoglobulin gamma)
GAMMAKED (human immunoglobulin gamma)	HYQVIA (human immune globulin G and hyaluronidase)
GAMMAPLEX (human immunoglobulin gamma)	XEMBIFY (human immune globulin-klhw)
OCTAGAM (human immunoglobulin gamma)	
PANZYGA (Immune Globulin- IFAS)	
PRIVIGEN (human immunoglobulin gamma)	

Steroids - Nasal

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have failed a 30-day trial (within the past 2 years) of 1 preferred agent, as evidenced by paid claims or pharmacy printouts

Product Specific Criteria:

- ***Xhance (fluticasone) and Zetonna (ciclesonide):**

A. Clinical justification must be provided explaining why the patient is unable to use another product with the same active ingredient (subject to clinical review)

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
BECONASE AQ (beclomethasone)	flunisolide
Fluticasone	mometasone
QNASL (beclomethasone)	OMNARIS (ciclesonide)
	QNASL CHILDREN'S (beclomethasone)
	XHANCE (fluticasone)***
	ZETONNA (ciclesonide)***

Ulcerative Colitis Agents

General Prior Authorization Form

Category PA Criteria:

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

Oral

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
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

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Mesalamine enema	CANASA (mesalamine) RECTAL SUPPOSITORY
Mesalamine rectal suppository	Mesalamine enema kit
	ROWASA (mesalamine) ENEMA KIT
	SF ROWASA (mesalamine) ENEMA
	UCERIS (budesonide) RECTAL FOAM

Infectious Disease

Antimalarial Agents

General Prior Authorization Form

Group Criteria:

- The request must be for TREATMENT of malaria (*NOT covered for prophylaxis)*

Non-Preferred Agents Criteria:

- The patient must have had a trial of a generic quinine in the last 30 days, as evidenced by paid claims or pharmacy print outs
- The patient must be less than 18 years old to qualify for atovaquone/proguanil 62.5-25 MG

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
daraprim	ARAKODA (tafenoquine)
hydroxychloroquine	atovaquone/proguanil
quinine	chloroquine
	COARTEM (artemether/lumefantrine)
	KRINTAFEL (tafenoquine)
	MALARONE (atovaquone/proguanil)
	mefloquine
	primaquine
	QUALAQUIN (Quinine)

Human Immunodeficiency Virus (HIV)

Serostim - Wasting Cachexia

Dronabinol/Syndros - Loss of Appetitie

Antiretrovirals

Category 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.

Integrase Strand Transfer Inhibitors

PREFFERED AGENTS (NO PA REQUIRED)	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)	

Non-Nucleoside Reverse Transcriptase Inhibitors

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
ATRIPLA (Efavirenz/Emtricitabine/Tenofovir)	SUSTIVA (Efavirenz)
COMPLERA (Emtricitabine/Rilpivirine/tenofovir)	VIRAMUNE (Nevirapine)
EDURANT (Rilpivirine)	VIRAMUNE XR (Nevirapine)
Efavirenz	
Etravirine	
INTELENCE (Etravirine)	
JULUCA (dolutegravir/rilpivirine)	
Nevirapine	
Nevirapine ER	
ODEFSEY (Emtricitabine/Rilpivirine/Tenofovir)	
PIFELTRO (Doravirine)	
Rilpivirine	
SYMFI (efavirenz/lamivudine/tenofovir)	
SYMFI LO (efavirenz/lamivudine/tenofovir)	

Nucleoside Reverse Transcriptase Inhibitors

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
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	
TEMIXYS (Lamivudine/Tenofovir)	
TRIUMEQ (abacavir/dolutegravir/lamivudine)	
TRUVADA (emtricitabine/tenofovir)	
VIDEX (didanosine)	
Zidovudine	

Post-Attachment Inhibitor

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
TROGARZO (Ibalizumab-uiyk)	

Protease Inhibitor

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
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)	

Lipodystrophy – Growth Hormone-Releasing Hormone Analogue

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
EGRIFTA (Tesamorelin)	

Hepatitis C Treatments

Prior Authorization From – Hepatitis C

Category Criteria:

Please use the NDC Drug Lookup to find Prior Authorization (PA) Forms

- 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.
- 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 Specific 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).

Non-Preferred Agents Criteria:

- 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.

PREFFERED AGENTS (CLINICAL PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
EPCLUSA (sofosbuvir/velpatasvir) *Brand Preferred****	HARVONI (ledipasvir/sofosbuvir)
MAVYRET (glecaprevir/pibrentasvir)***	Ledipasvir/sofosbuvir
	Sofosbuvir/velpatasvir
	SOVALDI (sofosbuvir)

Please use the NDC Drug Lookup to find Prior Authorization (PA) Forms

	VIEKIRA PAK (dasabuvir/ombitasvir/paritaprevir/ritonavir)
	VOSEVI (sofosbuvir/velpatasvir/voxilaprevir)***
	ZEPATIER (elbasvir/grazoprevir)

Antibiotics - Resistance Prevention

Prior Authorization Form – Antibiotics – Resistance Prevention

Non-Preferred Agents Criteria:

- **Initial Criteria:** *Approval Duration = 5 days*
  - Patient must have an FDA-approved indication for use (meets label recommendations for diagnosis & age)
    - Diagnosis must be proven to be caused by a susceptible microorganism by culture and susceptibility testing
  - Medication must be prescribed by an infection disease specialist, an antibiotic stewardship program, or protocol.
  - One of the following criteria must be met (A or B)
    - A. Prescriber must provide evidence-based medical justification for use, explaining why a preferred antibiotic is not an option due to susceptibility, previous failed trials, or other contraindications (subject to clinical review)
    - B. The patient is continuing treatment upon discharge from an acute care facility
- **Renewal Criteria:** *Approval Duration = 5 days*
  - Prescriber must attest that the patient's condition is improving and that it is medically necessary to continue treatment course after re-evaluation of the patient's condition.
  - The total requested duration of use must not be greater than manufacturer labeling or treatment guideline recommendations (whichever is greater).

Community-Acquired Pneumonia

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Amoxicillin	BAXDELA (Delafloxacin)
Amoxicillin-Clavulanate	FACTIVE (Gemifloxacin)
Azithromycin	XENLETA (Lefamulin)
Cefpodoxime	
Cefuroxime	
Clarithromycin	
Doxycycline	
Levofloxacin	
Linezolid	
Moxifloxacin	

Methicillin-Resistant *Staphylococcus aureus* (MRSA):

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Clindamycin	BAXDELA (Delafloxacin)
Doxycycline	NUZYRA (Omadacycline)
Linezolid	SIVEXTRO (Tedizolid)
Minocycline	
Trimethoprim-Sulfamethoxazole	

Antifungals - Aspergillius and Candidiasis Infections

General Prior Authorization Form

Non-Preferred Agents Criteria: *Approval Duration = Per label recommendations*

- The request must be for use as prophylaxis of invasive Aspergillus and Candida infections or Oropharyngeal Candidiasis
- The patient must meet one of the following (A or B):
    A. The patient must have documented history of failure to all preferred agentsas evidenced by paid claims or pharmacy printouts
    B. Prescriber must provide evidence-based medical justification for use, explaining why preferred antifungals are not an option due to susceptibility, previous failed trials, or other contraindications (subject to clinical review)

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Clotrimazole	DIFLUCAN (Fluconazole)
CRESEMBA (Isavuconazonium)	NOXAFIL (posaconazole)
Fluconazole	SPORANOX (Itraconazole)
Itraconazole	TOLSURA (itraconazole)
Nystatin	VFEND (Voriconazole)
ORAVIG (miconazole)	
Voriconazole	

Men's Health

Androgens

General Prior Authorization Form

Group Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- 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

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS:
Testosterone Cypionate injection	AVEED (Testosterone Undecanoate)
Testosterone Enanthate injection	DEPO-TESTOSTERONE (Testosterone Cypionate)
	TESTOPEL (Testosterone)
	XYOSTED (Testosterone Enanthate)

Oral

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS:
	ANDROID (Methyltestosterone)
	Methyltestosterone
	METHITEST (Methyltestosterone)
	STRIANT (Testosterone)
	TESTRED (Methyltestosterone)

Topical

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
ANDRODERM (testosterone) PATCH	ANDROGEL (testosterone)
Testosterone 1% gel packet	AXIRON (testosterone) TOPICAL SOLUTION

Testosterone 1% gel tube	FORTESTA (testosterone) 2% Gel MD PMP CANISTER
Testosterone 12.5/1.25G gel MD PMP Bottle	TESTIM (testosterone) GEL TUBE
	Testosterone 2% Gel MD PMP Canister
	Testosterone 20.25/1.25G Gel MD PMP Bottle
	Testosterone 1.25G-1.62% Gel Packet
	Testosterone 2.5G-1.62% Gel Packet
	VOGELXO (Testosterone)

Benign Prostatic Hyperplasia

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have diagnosis of benign prostatic hyperplasia (BPH)
- The patient must have had a 30-day trial of each preferred agent, as evidenced by paid claims or pharmacy printouts

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
alfuzosin ER	AVODART (Dutasteride)
CARDURA XL (doxazosin)	CARDURA (Doxazosin)
doxazosin	FLOMAX (Tamsulosin)
dutasteride	MINIPRESS (Prazosin)
finasteride	PROSCAR (Finasteride)
prazosin	sildenafil
RAPAFLO (silodosin) – *brand required*	tadalafil
tamsulosin	
terazosin	

Nephrology/Urology

Hematopoietic, Erythropoiesis Stimulating Agents

General Prior Authorization Form

Non-Preferred Agents Criteria:

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

PREFFERED AGENTS (PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
ARANESP (darbepoetin alfa)	EPOGEN (epoetin alfa)
PROCRIT (epoetin alfa)	MIRCERA (methoxy polyethylene glycol-epoetin beta)
	RETACRIT (epoetin alfa - epbx)

Hyperkalemia (Chronic)

Prior Authorization Form - Hyperkalemia

Group Criteria:

- **Initial criteria**: *Approval Duration = 3 months*
  - . The patient must be 18 years of age or older.
  - A. Medication must be prescribed by, or in consultation with, a nephrologist

B. The patient's current serum potassium level must be exceeding the upper limit of normal, as evidenced by documentation from at least two separate lab values, submitted with the request
C. The patient must not have gastrointestinal motility disorders (e.g. severe constipation, bowel obstruction or impaction, abnormal postoperative bowel motility disorders)
D. One of the following criteria must be met:
    - The patient must have failed 30-day trials with at least two of the following products
        - ❖ Bumetanide, Chlorothiazide, Fludrocortisone, Furosemide, Hydrochlorothiazide, Indapamide, Metolazone, Torsemide
E. The patient must not be receiving the medications known to cause hyperkalemia listed below, OR medical justification must be provided explaining why discontinuation of these agents would be clinically inappropriate in this patient:
    - angiotensin-converting enzyme inhibitor
    - angiotensin II receptor blocker
    - aldosterone antagonist
    - nonsteroidal anti-inflammatory drugs (NSAIDs)

- **Renewal Criteria:** *Approval Duration = 6 months*
    . The patient's current serum potassium level is within normal limits or has been significantly reduced from baseline, as evidenced by lab documentation submitted with the request

PREFFERED AGENTS (CLINICAL PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
LOKELMA (Sodium Zirconium Cyclosilicate)	VELTASSA (Patiromer)

Interstitial Cystitis

General Prior Authorization Form

Non-Preferred Agents Criteria:

- **Initial Criteria:** *Duration of Approval = 3 Months*
    A. The prescriber must attest that all other potential causes for bladder pain/discomfort have been ruled out.
    B. The patient must have a diagnosis of pain or discomfort due to interstitial cystitis.
    C. The patient must be 16 years of age or older.
    D. The patient must have not experienced adequate symptom relief after implementing self-care practices and behavior modification (e.g. avoiding food/beverages and activities that exacerbate symptoms, fluid management, etc).
    E. The patient must have failed a 30-day trial of amitriptyline, as evidenced by paid claims or pharmacy printouts.
- **Renewal Criteria:** *Duration of Approval = 12 months*
    A. The patient must have experienced a significant reduction in bladder pain/discomfort since initiating therapy (supported by clinical documentation).

PREFFERED AGENTS (PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Amitriptyline	ELMIRON (Pentosan Polysulfate Sodium)

Phosphate Binders

General Prior Authorization Form

Category 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.

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Calcium acetate	AURYXIA (ferric citrate) TABLET
FOSRENOL (lanthanum) CHEWABLE TABLET *– brand preferred*	FOSRENOL (lanthanum) POWDER PACK
PHOSLYRA (calcium acetate) ORAL solution	Lanthanum chew tab
RENVELA (sevelamer) POWDER PACK	RENAGEL (Sevelamer HCl) TABLET
Sevelamer Carbonate Tablet	RENVELA (sevelamer carbonate) TABLET
Sevelamer Powder Pack - Labeler 00955	Sevelamer HCl 400mg Tablet
	Sevelamer HCl 800mg Tablet
	Sevelamer Powder Pack - Labeler 65862, 43598
	VELPHORO (Sucroferric oxyhydroxide)

Urinary Antispasmodics

General Prior Authorization Form

Non-Preferred Agents Criteria:

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

Product Specific 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

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
ENABLEX (darifenacin ER)	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)***
Solifenacin	Tolterodine
TOVIAZ (fesoterodine)	Tolterodine ER
Trospium	Trospium ER***
	VESICARE (solifenacin)

Neurology

Anticonvulsants

Group 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.

PREFFERED AGENTS (NO PA REQUIRED)	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) (*Brand Preferred)*	Pregabalin
LAMICTAL ER (Lamotrigine) DOSE PACK	Pregabalin oral solution
LAMICTAL ODT (Lamotrigine)	QUDEXY XR (Topiramate)
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) (*Brand Preferred)*	
SABRIL (Vigabatrin) POWDER PACK (*Brand Preferred)*	
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	

Please use the NDC Drug Lookup to find Prior Authorization (PA) Forms

Dementia

General Prior Authorization Form

Category PA Criteria:

- 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.
- **Non-Preferred Agents 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.
  - **Non-Solid Dosage Forms:** The patient must be unable to ingest solid dosage form as evidenced by swallow study documentation

Product Specific 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.

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Donepezil 5mg, 10mg Tablet	ARICEPT (donepezil)
Galantamine Tablet	Donepezil ODT
Galantamine ER	Donepezil 23mg Tablet
Memantine	EXELON (rivastigmine) PATCH
Rivastigmine Capsule	Galantamine oral solution
	Memantine oral solution
	Memantine ER
	NAMENDA (memantine)
	NAMENDA XR (memantine)
	NAMZARIC (memantine/donepezil)
	RAZADYNE (galantamine)
	RAZADYNE ER (galantamine)
	Rivastigmine patch

Emflaza

Prior Authorization Form - Emflaza

Initial Criteria: *Approval Duration = 6 months*

- The patient must be 2 years of age or older
- The patient must have diagnosis of Duchenne muscular dystrophy (DMD) confirmed by the documented presence of abnormal dystrophin or a confirmed mutation of the dystrophin gene
- Onset of weakness must have occurred before 2 years of age
- The medication must be prescribed by or in consultation with a physician who specializes in the treatment of Duchenne Muscular Dystrophy (DMD) and/or neuromuscular disorders
- The patient must have serum creatinine kinase activity of at least 10 times the upper limit of normal (ULN) prior to initiating treatment
- The patient must have failed a 6-month trial of prednisone due to inadequate treatment response, intolerance, or contraindication, as evidenced by paid claims or pharmacy printouts
- The provider must submit baseline motor milestone score results from at least ONE the following assessments:
  i. 6-minute walk test (6MWT)
  ii. North Star Ambulatory Assessment (NSAA)

iii. Motor Function Measure (MFM)
iv. Hammersmith Functional Motor Scale (HFMS)

- The patient must have ONE of the following significant intolerable adverse effects supported by documentation:
  i. Cushingoid appearance
  ii. Central (truncal) obesity
  iii. Undesirable weight gain (>10% of body weight gain increase over 6-month period)
  iv. Diabetes and/or hypertension that is difficult to manage
  v. Severe behavioral adverse effect

Renewal Criteria: *Approval Duration = 12 months*

- The patient must have ONE of the following (A or B)
  A. Improvement in motor milestone score from baseline from ONE the following assessments:
     i. 6MWT – improvement of 20 meters from baseline
     ii. NSAA – improvement of 2 points from baseline
     iii. MFM – improvement of 2 points from baseline
     iv. HFMS – improvement of 2 points from baseline
  B. The patient must have had improvement of adverse effects experienced on prednisone supported by documentation:
     i. Cushingoid appearance
     ii. Central (truncal) obesity
     iii. Undesirable weight gain (>10% of body weight gain increase over 6-month period)
     iv. Diabetes and/or hypertension that is difficult to manage
     v. Severe behavioral adverse effect

Headache/Migraine

Prophylaxis of Migraine – CGRP Inhibitors

Prior Authorization Form – CGRP Inhibitors

Group Criteria:

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

Non-Preferred Agents Criteria:

- The patient must have had a 3-month trial of each preferred agent, as evidenced by paid claims or pharmacy printouts.

PREFFERED AGENTS (CLINICAL PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
AIMOVIG (Erenumab-aooe)	AJOVY (Fremanezumab-vfrm)
EMGALITY (Galcanazumab-gnlm)	

Cluster Headache – Emgality

Prior Authorization Form – CGRP Inhibitors

Initial PA Criteria: *Approval Duration: 3 months*

- Patient must meet ICHD-3 criteria for diagnosis of cluster headache

- Patient must use medication as preventative treatment during episodic cluster headache episodes, as medication is not indicated for chronic use

Renewal PA Criteria: *Approval Duration: 9 months*

- Prescriber must submit documentation indicating that the members' cluster headaches have been reduced in frequency and/or severity as a result of therapy per patient headache journal

Treatment of Migraine - Triptans - 5HT(1) Agonist

General Prior Authorization Form

Non-Preferred Agents 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 Specific Criteria:

Cambia Powder Pack -Migraine Treatment

- ***Sumatriptan/Tosymra 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).

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
RELPAX (eletriptan) – *Brand Preferred*	Almotriptan Tablet***
Rizatriptan	ALSUMA (sumatriptan) PEN INJCTR***
Rizatriptan ODT	AMERGE (naratriptan) TABLET
Sumatriptan tablet	Eletriptan Tablet
	FROVA (frovatriptan) TABLET***
	Frovatriptan Tablet***
	IMITREX (sumatriptan) CARTRIDGE***
	IMITREX (sumatriptan) PEN INJCTR***
	IMITREX (sumatriptan) SPRAY***
	IMITREX (sumatriptan) TABLET
	IMITREX (sumatriptan) VIAL***
	MAXALT (rizatriptan) TABLET
	MAXALT MLT (rizatriptan)
	Naratriptan Tablet
	ONZETRA XSAIL (sumatriptan)
	Sumatriptan Cartridge***

	Sumatriptan Pen Injctr***
	Sumatriptan Spray***
	Sumatriptan Syringe***
	Sumatriptan Vial
	Sumatriptan/Naproxen Tablet***
	TOSYMRA (Sumatriptan) NASAL SPRAY***
	TREXIMET (Sumatriptan/Naproxen) TABLET
	ZEMBRANCE SYMTOUCH (Sumatriptan)***
	Zolmitriptan Tablet***
	Zolmitriptan ODT
	ZOMIG (zolmitriptan) TABLET***
	ZOMIG (zolmitriptan) SPRAY
	ZOMIG ODT (zolmitriptan)

Dihydroergotamine

General Prior Authorization Form

Non-Preferred Agents Criteria:

- **Non-preferred step 1 agents:**
  - A. The patient must have a diagnosis of migraine or cluster headache
  - B. Within the past 2 years, the patient must have had 30-day trials of at least two 'Preferred Agents', as evidenced by paid claims or pharmacy printouts
- **Non-preferred step 2 agents:**
  - A. The patient must meet criteria for Step 1 agents
  - B. Within the past 2 years, the patient must have had 30-day trials of at least two 'Non-Preferred Step 1 Agents', as evidenced by paid claims or pharmacy printouts

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED STEP 1 AGENTS (PA REQUIRED)	NON-PREFERRED STEP 2 AGENTS (PA REQUIRED)
RELPAX (eletriptan)	ONZETRA XSAIL (sumatriptan) NASAL SPRAY	CAFERGOT (ergotamine/caffeine) TABLET
Rizatriptan Tablets	ZOMIG (zolmitriptan) NASAL SPRAY	D.H.E.45 (dihydroergotamine) INJECTION
Rizatriptan ODT	zolmitriptan ODT	Dihydroergotamine Injection
Sumatriptan Tablets		Dihydroergotamine Nasal Spray
		ERGOMAR (ergotamine) SL TABLET
		MIGERGOT (ergotamine/caffeine) RECTAL SUPPOSITORY
		MIGRANAL (dihydroergotamine) SPRAY

Multiple Sclerosis

General Prior Authorization Form

Interferons

Non-Preferred Agents Criteria:

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

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
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

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- 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).

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
COPAXONE (glatiramer) 20 MG/ML – *Brand Preferred*	COPAXONE (glatiramer) 40 MG/ML
	glatiramer 20mg/ml
	glatiramer 40mg/ml
	Glatopa (glatiramer)

Oral Non-Interferons

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- 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.

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
AUBAGIO (teriflunomide)	MAVENCLAD (Cladribine)
GILENYA (fingolimod)	MAYZENT (Siponimod)
	TECFIDERA (dimethyl fumarate)
	VUMERITY (Diroximel Fumarate)

Narcolepsy

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age)

Diagnosis Specific Criteria:

- **Narcolepsy:**
    - A. The patient must have failed 30-day trials of each preferred agent and at least 1 additional CNS stimulant indicated for treatment of narcolepsy, as evidenced by paid claims or pharmacy printouts
    - B. Provider must submit documentation of prior treatment failure, as evidenced by documentation of one of the following, while on prior treatments:
        - Multiple Sleep Latency Test (MSLT) <8 minutes
        - EPWORTH sleepiness scale score ≥10

- **Obstructive Sleep Apnea:**
    A. The requested agent must be Sunosi
    B. The patient must have failed 30-day trials of each preferred agent, as evidenced by paid claims or pharmacy printouts
    C. Provider must submit documentation of prior treatment failure, as evidenced by documentation of one of the following, while on prior treatments:
        - Multiple Sleep Latency Test (MSLT) <8 minutes
        - EPWORTH sleepiness scale score ≥10

Renewal Criteria:

- Provider must submit documentation of symptom improvement, as evidenced by documentation of one of the following, while on prior treatments:
    A. Multiple Sleep Latency Test (MSLT) <8 minutes
    B. EPWORTH sleepiness scale score ≥10

PREFERRED AGENTS	NON-PREFERRED AGENTS
Modafinil	Armodafinil
NUVIGIL (Armodafinil) – *Brand Preferred*	PROVIGIL (Modafinil)
	SUNOSI (Solriamfetol)
	WAKIX (Pitolisant)
	XYREM (Sodium Oxybate)

Nuedexta

Prior Authorization Form - Nuedexta

Group Criteria (Initial): *Approval Duration = 3 months*

- The patient must be 18 years of age or older
- The patient must not have a diagnosis of any of the following: prolonged QT interval, heart failure, or complete atrioventricular (AV) block
- The prescriber must provide the following information:
    A. Baseline Center for Neurological Studies lability (CNS-LS) score
    B. Baseline weekly PBA episode count
- The patient must have diagnosis of pseudobulbar affect (PBA) due to one of the following neurologic conditions and meet additional criteria for diagnosis:
    A. Amytrophic Lateral Sclerosis (ALS)
    B. Multiple Sclerosis (MS)
    C. Alzheimer's Disease
    D. Stroke
- **Additional initial criteria for a diagnosis of PBA due to Alzheimer's disease or stroke:**
    A. Neurologic condition must have been stable for at least 3 months
    B. Patient must have failed** a 3-month trial of at least one medication from each of the classes listed below (A and B), as evidenced by paid claims or pharmacy print outs:
        A. **SSRIs**: sertraline, fluoxetine, citalopram and paroxetine
        B. **Tricyclic Antidepressants**: nortriptyline and amitriptyline
    - A PBA episode count and CNS-LS score must be provided for before and after each trial

***A failure is defined as one of the following:*

- *PBA count decreased less than 75 percent, stayed the same, or increased from baseline in each trial*

- *CHS-LS score decreased less than 7 points, stayed the same, or increased from baseline in each trial*

Group Criteria (Renewal): *Approval Duration = 6 months*

- Benefit of continued therapy must be assessed
- Baseline and current PBA episode count must be included with request
- Current PBA episode must be reduced by at least 75% from baseline
- **Additional initial criteria for a diagnosis of PBA due to Alzheimer's disease or stroke:**
    A. Baseline and current Center for Neurological Studies lability (CNS-LS) must be included with request
    B. Current CNS-LS score must be reduced by at least 30% from baseline

Parkinson's disease

General Prior Authorization Form

Product Specific Criteria:

- **Gocovri, Osmolex ER, Rytary, and Pramipexole ER:**
    - The patient must have a diagnosis of an FDA-approved indication for use
    - The patient is must not currently be residing in a facility with skilled nursing care
    - Clinical justification must be provided explaining why the patient is unable to use the preferred agents (subject to clinical review).
- **Inbrija, Apokyn, Duopa:**
    - The patient must have a diagnosis of an FDA-approved indication for use
    - Medication must be prescribed by, or in consultation with, a psychiatrist or neurologist
    - The patient must be currently taking an extended release formulation of carbidopa – levodopa, as evidenced by paid claims or pharmacy printouts, and will continue taking carbidopa – levodopa concurrently with requested agent
    - Documentation of intermittent hypomobility or "off" episodes (number and frequency) must be provided
    - The patient must have had inadequate response to medications in two of the following classes to reduce number and frequency of OFF episodes, as evidenced by paid claims or pharmacy printouts
        - A monoamine oxidase-B (MAO-B) inhibitor (e.g. rasagiline and selegiline)
        - A dopamine agonist (e.g. pramipexole IR, ropinirole IR)
        - A catechol-O-methyltransferase (COMT) inhibitor (e.g. entacapone)
- **Xadago and Nourianz:**
    - The patient must have a diagnosis of an FDA-approved indication for use
    - Medication must be prescribed by, or in consultation with, a psychiatrist or neurologist
    - The patient must be currently experiencing intermittent hypomobility or "off" episodes
    - The patient must be currently taking an extended release formulation of carbidopa – levodopa, as evidenced by paid claims or pharmacy printouts, and will continue taking carbidopa – levodopa concurrently with requested agent
    - The patient must be exhibiting deterioration in quality of response to during levodopa/carbidopa therapy for intermittent hypomobility, or "off" episodes
    - The patient must have had inadequate response to rasagiline and selegiline, as evidenced by paid claims or pharmacy printouts
- **Nuplazid**:
    - The patient must have a diagnosis of an FDA-approved indication for use
    - Medication must be prescribed by, or in consultation with, a psychiatrist or neurologist

- The patient must be experiencing recurrent or continuous hallucinations and/or delusions for the past 30 days
- The patient must have experienced an inadequate response to a 30-day trial of quetiapine or clozapine, as evidenced by paid claims or pharmacy printouts
- The patient must not have experienced a reduction in symptoms of psychosis, despite documented medication dosage reduction and discontinuation trials (with a goal of levodopa monotherapy)

- **Tolcapone**
  - The patient must have failed a 30-day trial of entacapone, as evidenced by paid claims or pharmacy printouts
- **Rasagiline and Emsam**
  - The patient must have failed a 30-day trial of selegiline, as evidenced by paid claims or pharmacy printouts

Non-Preferred Agents Criteria (Renewal):

- Documentation of disease stabilization or improvement in disease since initiation of treatment must be provided

PREFERRED AGENTS	NON-PREFERRED AGENTS
Amantadine IR	APOKYN (Apomorphine)
AZILECT (Rasagiline)	Carbidopa-Levodopa ODT
Benztropine	DUOPA (Levodopa/Carbidopa)
Bromocriptine	EMSAM (Selegiline) PATCH
Carbidopa-levodopa-entacapone	GOCOVRI (Amantadine ER)
Carbidopa-Levodopa Capsules	INBRIJA (Levodopa)
Carbidopa-Levodopa ER	NOURIANZ (Istradefylline)
Entacapone	NUPLAZID (Pimavanserin)
Levodopa	OSMOLEX ER (Amantadine ER)
NEUPRO (Rotigotine) PATCH	Pramipexole ER
Pramipexole IR	Rasagiline
Ropinirole	RYTARY (Levodopa/Carbidopa)
Ropinirole ER	Tolcapone
Selegiline	XADAGO (Safinamide)
Trihexyphenidyl	

Tardive Dyskinesia

Prior Authorization Form – Tardive Dyskinesia

Category 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 Specific Criteria:

- ***** Austedo/tetrabenazine:**
  - The patient must have a diagnosis of Huntington's disease or Tardive Dyskinesia.
  - The patient must not have hepatic impairment

PREFFERED AGENTS (CLINICAL PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
AUSTEDO (deutetrabenazine)***	

INGREZZA (valbenazine)	
tetrabenazine***	

Ophthalmic

Antihistamines

General Prior Authorization Form

Non-Preferred Agents Criteria:

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

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
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

General Prior Authorization Form

Non-Preferred Agents Criteria:

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

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
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	Neomycin SU/bacitracin/polymyxin B ointment
Gentamicin sulfate ointment	Neomycin SU/polymyxin B/gramicidin drops
Moxifloxacin drops	NEO-POLYCIN (neomycin SU/bacitracin/polymyxin B) OINTMENT
MOXEZA (moxifloxacin) 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

General Prior Authorization Form

Non-Preferred Agents Criteria:

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

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
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

General Prior Authorization Form

Non-Preferred Agents Criteria:

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

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
ACUVAIL (ketorolac)	ACULAR (ketorolac)
ALREX (loteprednol)	ACULAR LS (ketorolac)
Diclofenac sodium	Bromfenac sodium
DUREZOL (Difluprednate)	BROMSITE (bromfenac sodium)
FLAREX (fluorometholone)	Dexamethasone sodium phosphate
Fluorometholone	INVELTYS (Loteprednol)
Flurbiprofen sodium	FML (fluorometholone)
FML FORTE (fluorometholone)	ILEVRO (nepafenac)
FML S.O.P. (fluorometholone)	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%	

Dry Eye Syndrome

General Prior Authorization Form

Non-Preferred Agents Criteria:

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

Product Specific 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).

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
RESTASIS (Cyclosporine)	CEQUA (Cyclosporine)***
	RESTASIS MULTIDOSE (Cyclosporine)***
	XIIDRA (Lifitegrast)

Glaucoma

Alpha Adrenergics

General Prior Authorization Form

Non-Preferred Agents 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.

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
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)	

Beta Blockers

General Prior Authorization Form

Non-Preferred Agents 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.

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
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)

Prostaglandins

General Prior Authorization Form

Non-Preferred Agents 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.

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)

Latanoprost	Bimatoprost 0.03%
LUMIGAN (Bimatoprost) 0.01%	VYZULTA (latanoprostene)
TRAVATAN Z (Travoprost)	XALATAN (Latanoprost)
ZIOPTAN (Tafluprost)	XELPROS (Latanoprost)

Other

Non-Preferred Agents 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.

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
AZOPT (Brinzolamide)	ISOPTO CARPINE (Pilocarbine)
Dorzolamide	TRUSOPT (Dorzolamide)
PHOSPHOLINE (Echothiophate Iodide)	
Pilocarpine	
RHOPRESSA (Netarsudil)	
ROCKLATAN (Netarsudil/Latanoprost)	

Otic

Anti-infectives/Anti-inflammatories – Fluoroquinolones

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have had a 7-day trial of one preferred product in the past 3 months, as evidenced by paid claims or pharmacy printouts.

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
CIPRO HC (ciprofloxacin/hydrocortisone)	Ciprofloxacin/Fluocinolone
CIPRODEX (ciprofloxacin/dexamethasone)	OTOVEL (ciprofloxacin/fluocinolone)

Pain

Lidocaine topical cream

Prior Authorization Form - Anesthetics - Topical

Group Criteria:

- The request must be for patient home use of cream, prior to injection pain from a medically necessary procedure

NSAIDS

Prior Authorization Form - NSAIDs

Solid Oral Dosage Forms

Prior Authorization Form - NSAIDs

Non-Preferred Agents Criteria:

- The patient must have failed a 30-day trial of 3 different oral generic NSAIDs including a COX-2 inhibitor with GI intolerances, as evidenced by paid claims or pharmacy print outs

Product Specific Criteria:

- **Mefanemic acid:**
  A. The patient must have diagnosis of dysmenorrhea
- **Branded NSAIDs and non-preferred strengths**:
  A. Clinical justification must be provided explaining why the patient is unable to use other NSAID agents (subject to clinical review)

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Celecoxib 50mg, 100mg, 200mg	ARTHROTEC (Diclofenac/Misoprostol)
Diclofenac potassium	Celecoxib 400mg
Diclofenac sodium 50mg, 75mg	CELEBREX (Celecoxib)
Etodolac	DAYPRO (Oxaprozin)
Fenoprofen 600mg	Diclofenac sodium ER 100mg
Flurbiprofen	Diclofenac sodium 25mg
Ibuprofen	Diclofenac/Misoprostol
Indomethacin	DUEXIS (Famotidine/Ibuprofen)
Indomethacin ER	Etodolac ER
Ketoprofen 50mg, 75mg	FELDENE (Piroxicam)
Ketorolac	Fenoprofen 400mg
Meloxicam	INDOCIN (Indomethacin)
Nabumetone	Ketoprofen 25mg
Naproxen 220mg, 250mg, 500mg	Ketoprofen ER 200mg
Piroxicam	Meclofenamate
Sulindac	Mefenamic acid
Tolmetin 200mg, 400mg	MOBIC (Meloxicam)
ZIPSOR (diclofenac)	NALFON (Fenoprofen)
	NAPRELAN (Naproxen)
	Naproxen ER 375 mg
	Naproxen 275mg, 550mg
	Oxaprozin
	RELAFEN DS (Nabumetone)
	TIVORBEX (indomethacin, submicronized)
	Tolmetin 600mg
	VIMOVO (Naproxen/Esomeprazole)
	VIVLODEX (meloxicam, submicronized)
	ZORVOLEX (diclofenac, submicronized)

Non-Solid Oral Dosage Forms

Prior Authorization Form - NSAIDs

Product Specific Criteria:

- **Indomethacin oral solution**:
  A. The patient must be unable to ingest solid dosage form as evidenced by swallow study documentation
  B. The patient must have failed a 30-day trial of naproxen oral solution, as evidenced by paid claims or pharmacy print outs

PREFERRED AGENTS	NON-PREFERRED AGENTS
Ibuprofen	CAMBIA (Diclofenac Potassium) POWDER PACK

Naproxen	Indomethacin
	QMIIZ ODT (meloxicam)

Nasal

Prior Authorization Form - NSAIDs

Product Specific Criteria:

- **Sprix**:
  A. The patient must be 18 years of age or older
  B. The patient must have a diagnosis of postoperative nausea and vomiting
  C. The patient must not have a documented history of gastric or duodenal ulcer or comorbidities of GI bleed, perforation, or obstruction

Topical:

Prior Authorization Form - NSAIDs

Non-Preferred Agents 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).

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Diclofenac 1.5% Topical Solution	Diclofenac Patch
Diclofenac Gel	PENNSAID (Diclofenac) 2% PUMP
FLECTOR (diclofenac) PATCH *(Brand Preferred)*	VOLTAREN (diclofenac) GEL

Opioid Analgesics – Long Acting

Category Criteria (initial):

- 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

Category Criteria (renewal):

- Documentation noting progress toward therapeutic goal must be included with request (including pain level and function).

Partial Agonist/Antagonist Opioids

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
BELBUCA (Buprenorphine)	buprenorphine patches
Butorphanol	
BUTRANS (buprenorphine) PATCHES	

Abuse Deterrent Formulations/Unique Mechanisms from Full Agonist Opioids

Prior Authorization Form – Opioid Analgesics

Additional Group Criteria:

- The patient must have had 30-day trials of both an NSAID and an immediate release opioid, as evidenced by paid claims or pharmacy printouts

Non-Preferred Agents Criteria:

- Clinical justification must be provided explaining why the patient is unable to use other opioid and non-opioid analgesic agents (subject to clinical review).

PREFFERED AGENTS (CLINICAL PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
NUCYNTA ER (tapentadol)	ARYMO ER (morphine)
OXYCONTIN (oxycodone)	CONZIP (tramadol ER) CAPSULES
Tramadol ER Tablets	HYSINGLA ER (hydrocodone)
	Levorphanol
	Methadone
	MORPHABOND ER (morphine)
	Tramadol ER Capsules
	ULTRAM ER (tramadol ER) TABLETS
	XTAMPZA ER (oxycodone)

Full Agonist Opioids Without Abuse Deterrent Formulations

Prior Authorization Form – Opioid Analgesics

Product Specific Criteria:

- **Fentanyl Patch:**
  - Patient must meet one of the following criteria:
    - The patient has an indication of cancer pain or palliative care pain
    - The patient requires a long acting narcotic and cannot tolerate an oral dosage form
  - Patient must have a BMI ≥17
  - **Fentanyl Patch 12 mcg/hr**:
    - Patient must meet one of the following (A or B):
    A. 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
    B. The patient must be continuously tapering off opioids from a higher strength Fentanyl patch
- **Morphine ER Tablets:**
  - Patients have reached the max dose of Oxycontin and are switching to Morphine ER Tablets for an Opioid Rotation strategy

Non-Preferred Agents Criteria:

- Clinical justification must be provided explaining why the patient is unable to use other opioid and non-opioid analgesic agents (subject to clinical review).

Full Agonist Opioids Without Abuse Deterrent Formulations	
PREFFERED AGENTS (CLINICAL PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Fentanyl 12 mcg/hr	DURAGESIC (Fentanyl) Patch
Fentanyl 25 mcg/hr, 50 mcg/hr, 75 mcg/hr, 100 mcg/hr	EXALGO (hydromorphone)
Morphine ER tablets	Fentanyl patch 37.5 mcg/hr, 62.5 mcg/hr, 87.5 mcg/hr
	Hydromorphone ER tablets
	KADIAN (morphine)
	Morphine ER capsules
	MS CONTIN (morphine)
	Oxycodone ER
	Oxymorphone ER tablets
	ZOHYDRO ER (hydrocodone)

Opioid Analgesic – Short Acting

Prior Authorization Form – Opioid Analgesics

Product Specific Criteria:

- **Subsys, Fentanyl Citrate Buccal Tablet, Lazanda, Actiq, and Abstral:**
  A. The patient's age must be within label recommendations
  B. The patient must have a diagnosis of cancer pain

C. The patient must currently be on around the clock opioid therapy for at least a week, as evidenced by paid claims or pharmacy printouts
    - The around the clock opioid therapy must be equivalent to 60 mg oral morphine daily, 25 mcg transdermal fentanyl/hour, 30mg oxycodone daily, 8 mg of oral hydromorphone daily, or equianalgesic dose of another opioid daily

- **ALL Other Non-Preferred Short-Acting Opioid Analgesics (Initial):**
    A. The patient must have required around-the-clock pain relief for the past 90 days, as evidenced by paid claims or pharmacy printouts
    B. The prescriber must attest that they have reviewed the past 3 months of the patient's North Dakota PDMP reports
    C. 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.)
    D. 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)
- **Oxycodone IR**
    A. The above Initial Criteria must be met
    B. The patient must currently be on a long-acting opioid analgesic that provides a daily Morphine Equivalent Dose (MED) which meets requirements below (based on requested strength), as evidenced by paid claims or pharmacy printouts (Please use an Opioid Dose Calculator to find the MED for specific products):
        - **Oxycodone 15 mg tablet:** long-acting opioid must provide ≥150 mg MED per day
        - **Oxycodone 20 mg tablet:** long-acting opioid must provide ≥200 mg MED per day
        - **Oxycodone 30 mg tablet:** long-acting opioid must provide ≥300 mg MED per day
- **Meperidine, butalbital-codeine products:**
    A. The above Initial Criteria must be met
    B. Clinical justification must be provided explaining why the patient is unable to use other opioid and non-opioid analgesic products (subject to clinical review).
- **ALL Other Non-Preferred Short-Acting Opioid Analgesics (Renewal):**
    A. Documentation noting progress toward therapeutic goal must be included with request (including pain level and function).

PREFFERED AGENTS (CLINICAL PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Acetaminophen/Codeine Solution	ABSTRAL (Fentanyl) SUBLINGUAL TABLET
Acetaminophen/Codeine Tablets	ACTIQ (Fentanyl) LOZENGE
Benzhydrocodone/Acetaminophen	Butalbital-Codeine
Codeine Tablets	CONZIP (Tramadol)
Hydrocodone/Acetaminophen 7.5-325/15ml Solution	DEMEROL (Meperidine)
hydrocodone-acetaminophen 5-325 MG	DILAUDID (Hydromorphone)
hydrocodone-acetaminophen 7.5-325 MG	ENDOCET (Oxycodone/Acetaminophen)
hydrocodone-acetaminophen 10-325 MG	FENTORA (Fentanyl) EFFERVESCENT TABLET
Hydrocodone/Ibuprofen	Fentanyl Citrate Buccal Tablet
Hydromorphone Liquid	Fentanyl Lozenge
Hydromorphone Tablet	Hydrocodone/Acetaminophen 5-163mg/7.5mL Solution
Morphine Tablets	hydrocodone-acetaminophen 2.5-325 MG
Morphine Solution	hydrocodone-acetaminophen 10MG-300MG
NUCYNTA (Tapentadol) TABLETS	hydrocodone-acetaminophen 5 MG-300MG
Oxycodone 5mg, 10mg Tablets	hydrocodone-acetaminophen 7.5-300 MG
Oxycodone Solution	LAZANDA (Fentanyl) SPRAY
oxycodone-acetaminophen 5-325 MG	LORCET (Hydrocodone/Acetaminophen)

Please use the NDC Drug Lookup to find Prior Authorization (PA) Forms

oxycodone-acetaminophen 10 -325 MG	LORTAB (Hydrocodone/Acetaminophen) SOLUTION
Oxymorphone Tablets	Meperidine
Tramadol Tablets	NALOCET (Oxycodone/Acetaminophen)
Tramadol/Acetaminophen Tablets	NORCO (Hydrocodone/Acetaminophen)
	OPANA (Oxymorphone)
	OXAYDO (Oxycodone)
	Oxycodone 15mg, 20mg, 30mg
	oxycodone-acetaminophen 2.5-325 MG
	oxycodone-acetaminophen 7.5-325 MG
	PERCOCET (Oxycodone/Acetaminophen)
	PRIMLEV (Oxycodone/Acetaminophen)
	ROXICODONE (Oxycodone)
	ROXYBOND (Oxycodone)
	SUBSYS (Fentanyl) SPRAY
	ULTRACET (Tramadol/Acetaminophen)
	ULTRAM (Tramadol)
	VICODIN (Hydrocodone/Acetaminophen)

Skeletal Muscle Relaxants

General Prior Authorization Form

Non-Preferred Agents Criteria: *Approval Duration = 3 months*

- The patient must have failed two 30-day trials of other skeletal muscle relaxants, as evidenced by paid claims or pharmacy printouts.

Product Specific Criteria

- **Metaxalone:** *Approval Duration = 3 months*
  - **A.** One of the required 30-day trials must be methocarbamol, as evidenced by paid claims or pharmacy printouts.
- **Carisoprodol:** *Approval Duration = 1 week*
  - A. Clinical justification must be provided explaining why the patient is unable to use the preferred agents (subject to clinical review)

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Baclofen	AMRIX (Cyclobenzaprine)
Chlorzoxazone 500mg	Chlorzoxazone 375mg and 750mg
Cyclobenzaprine 5mg and 10mg	Cyclobenzaprine 7.5mg
Dantrolene	Cyclobenzaprine ER
Methocarbamol	Carisoprodol
Orphenadrine ER	Carisoprodol-aspirin
Tizanidine tablets	Carisoprodol-aspirin-codeine
	DANTRIUM (Dantrolene)
	FEXMID (Cyclobenzaprine)
	LORZONE (Chlorzoxazone)
	METAXALL (Metaxalone)
	Metaxalone
	NORGESIC FORTE (orphenadrine/aspirin/caffeine)
	OZOBAX (Baclofen) SOLUTION
	ROBAXIN (Methocarbamol)
	SKELAXIN (Metaxalone)
	SOMA (Carisoprodol)

	Tizanidine capsules
	ZANAFLEX (Tizanidine)

Psychiatry

ADHD Agents

Non-Preferred Agents 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 Specific Criteria:

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

Non-Stimulants	
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)**
ADHANSIA XR (methylphenidate)	Dexmethylphenidate ER
APTENSIO XR (methylphenidate)	FOCALIN (dexmethylphenidate)
CONCERTA (methylphenidate) – *Brand Preferred*	METADATE ER (methylphenidate)
COTEMPLA XR - ODT (methylphenidate)	METHYLIN (methylphenidate) chew tablets
DAYTRANA (methylphenidate)	Methylphenidate ER 72 mg
Dexmethylphenidate	Methylphenidate ER tablet
FOCALIN XR (dexmethylphenidate) – *Brand Preferred*	Methylphenidate LA capsules - 50-50 – 20mg, 30mg, 40mg, 60mg
Methylphenidate solution	METHYLIN (methylphenidate) solution
Methylphenidate CD 30-70	RELEXXII (methylphenidate)
Methylphenidate chew tablet	RITALIN (methylphenidate)
Methylphenidate ER capsules 50-50	RITALIN LA (methylphenidate LA capsules - 50-50) 10mg
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*	

Non-Stimulants	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
EVEKEO ODT (Amphetamine)	
MYDAYIS (Dextroamphetamine/dextroamphetamine)	
PROCENTRA (Dextroamphetamine) – *Brand Preferred*	
VYVANSE (Lisdexamfetamine)	
VYVANSE (lLsdexamfetamine) CHEW TABLET	

Atypical Antipsychotics

Oral

Non-Preferred Agents 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 Specific 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).

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
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

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
ABILIFY MAINTENA (aripiprazole)	
ARISTADA (aripiprazole lauroxil)	
ARISTADA INITIO (aripiprazole lauroxil)	
INVEGA SUSTENNA (paliperidone)	
INVEGA TRINZA (paliperidone)	
PERSERIS (risperidone)	
RISPERDAL CONSTA (risperidone)	
ZYPREXA RELPREVV (olanzapine)	

Sedatives/Hypnotics

Prior Authorization Form - Sedative/Hypnotics

Product Specific Criteria (Initial): *Approval Duration = 1 month*

- **Zolpidem 10mg** (prior authorization required for females only):
  - The patient must have failed a 25-day trial of zolpidem 5 mg within the last 30 days, as evidenced by paid claims or pharmacy print outs
- **Zolpidem ER:**
  - The patient's insomnia must be characterized by difficulty with sleep maintenance
  - The patient must have failed a 25-day trial of eszopiclone within the last 30 days, as evidenced by paid claims or pharmacy printouts
- **Belsomra:**
  - The patient's insomnia must be characterized by difficulty with sleep onset and maintenance
  - The patient must have had the following 25-day trials with the most recent failure within the last 30 days, as evidenced by paid claims or pharmacy printouts
    - Silenor (doxepin)
    - Eszopiclone
    - Zolpidem ER
- **Temazepam, zolpidem SL:**
  - The patient's insomnia must be characterized by difficulty with sleep onset and maintenance
  - The patient must have had the following 25-day trials with the most recent failure within the last 30 days, as evidenced by paid claims or pharmacy printouts
    - Zolpidem ER
    - Eszopiclone
    - Silenor (doxepin)
    - Belsomra
- **Edluar (Zolpidem):**
  - The patient's insomnia must be characterized by difficulty with sleep onset
  - The patient must have had the following 25-day trials with the most recent failure within the last 30 days, as evidenced by paid claims or pharmacy printouts
    - Zolpidem IR
    - Zaleplon
    - Eszopiclone
- **Triazolam, fluazepam, estazolam, Seconal sodium, Zolpimist:**
  - Clinical justification must be provided explaining why the patient is unable to use the preferred agents (subject to clinical review)

Product Specific Criteria (Renewal): *Approval Duration = 6 months (2 weeks for b*enzodiazepines)

- **ALL Agents:**
  - The prescriber has provided confirmation that other conditions causing sleep issues have been ruled out
- **benzodiazepines (temazepam, triazolam, flurazepam, estazolam):**
  - The patient must be undergoing dose tapering

NON - DEA SCHEDULED (NON-ADDICTIVE) MEDICATION:	
PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Mirtazapine	Ramelteon
ROZEREM (ramelteon)	
SILENOR (doxepin)	

Trazodone	
DEA SCHEDULED MEDICATIONS	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
Eszopiclone	AMBIEN (Zolpidem)
Zaleplon	AMBIEN CR (Zolpidem)
Zolpidem 5mg	BELSOMRA (Suvorexant)
Zolpidem 10mg (for males)	EDLUAR (Zolpidem)
	Estazolam
	Flurazepam
	LUNESTA (Eszopiclone)
	SECONAL SODIUM (Secobarbital)
	Temazepam
	Triazolam
	Zolpidem ER
	Zolpidem 10mg (for females)
	ZOLPIMIST (Zolpidem)
	Zolpidem SL tab

Respiratory

Albuterol/Levalbuterol Rescue Inhalers

General Prior Authorization Form
MedWatch Form

Product Specific Criteria

- **Albuterol HFA, ProAir Respiclick:**
  - The patient must currently be receiving an inhaled corticosteroid product, as evidenced by paid claims or pharmacy printouts (see Coverage Rules for Medications).

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Albuterol HFA – Labeler 66993***	Albuterol HFA – Labeler 00933 and 00254
PROAIR (albuterol) HFA – *Brand Preferred*	ProAir Digihaler
PROAIR RESPICLICK (albuterol)***	PROVENTIL (albuterol) HFA
XOPENEX (levalbuterol) HFA - *Brand Preferred*	VENTOLIN (albuterol) HFA***

Anticholinergics/Beta Agonists Combinations

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The patient must have had a 30-day trial of 2 preferred, combination anticholinergic/long-acting beta agonist products, as evidenced by paid claims or pharmacy printouts.

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Albuterol/ipratropium	DUAKLIR PRESSAIR (Aclidinium/Formoterol)
ANORO ELLIPTA (umeclidinium/vilanterol)	DUONEB (albuterol/ipratropium)
BEVESPI AEROSPHERE (glycopyrrolate/formoterol)	STIOLTO RESPIMAT (tiotropium/olodaterol)
COMBIVENT RESPIMAT (albuterol/ipratropium)	
UTIBRON NEOHALER (glycopyrrolate/indacaterol)	

Corticosteroids – Inhaled

General Prior Authorization Form

Non-Preferred Agents 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 Specific Criteria:

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

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Budesonide Suspension	ALVESCO (ciclesonide)***
FLOVENT DISKUS (fluticasone)	ARMONAIR RESPICLICK (fluticasone)
FLOVENT HFA (fluticasone)	ARNUITY ELLIPTA (fluticasone)
PULMICORT FLEXHALER (budesonide)	ASMANEX HFA (mometasone)
	ASMANEX (mometasone) TWISTHALER***
	PULMICORT RESPULES (budesonide)
	QVAR REDIHALER (beclomethasone)

Long Acting Anticholinergics

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have had a 30-day trial of at least 2 preferred long-acting anticholinergic agents, as evidenced by paid claims or pharmacy printouts.
    - Either single ingredient or combination products will count toward trials.
- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).

Product Specific 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).

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
SPIRIVA HANDIHALER (tiotropium)	INCRUSE ELLIPTA (umeclidinium)
SPIRIVA RESPIMAT 2.5 MG (tiotropium)	LONHALA MAGNAIR (glycopyrrolate)***
TUDORZA PRESSAIR (aclidinium)	SEEBRI NEOHALER (glycopyrrolate)
	YUPELRI (revefenacin)

Spiriva Respimat 1.25 mcg

General Prior Authorization Form

Criteria for coverage:

- The patient must have a diagnosis of asthma
- The patient must have failed a 30-day trial of a steroid inhaler and a long acting beta agonist

Long Acting Beta Agonists

General Prior Authorization Form

Group Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).

Product Specific Criteria:

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

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)

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

Steroid/Long Acting Beta Agonist (LABA) Combination Inhalers

General Prior Authorization Form

Criteria for coverage:

- The patient must have had 30-day trials 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 and meet the criteria for that diagnosis
    - **For COPD diagnosis: one of the following must be met (A or B):**
        - A. The patient must have failed 30-day trials of at least 1 agent from each of the below lists (I and II)
            - I. Tudorza Pressair, Spiriva, Spiriva Respimat, Incruse Ellipta, or Seebri Neohaler
            - II. Brovana, Arcapta Neohaler, Striverdi Respimat, Perforomist, or Serevent.
        - B. The patient must have failed 30-day trials of at least 1 of the following agents below:
            - Anoro Ellipta, Stiolto Respimat, Utibron NeoHaler, Bevespi Aerosphere, or Trelegy Ellipta
    - **For asthma diagnosis:**
        - The patient must have been reviewed for step down therapy for all renewal requests.

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
ADVAIR HFA (Fluticasone/Salmeterol)	ADVAIR DISKUS (Fluticasone/Salmeterol)
DULERA (Mometasone/Formoterol)	AIRDUO RESPICLICK (Fluticasone/Salmeterol)
Fluticasone/Salmeterol – Labeler 66993	BREO ELLIPTA (Fluticasone/Vilanterol)
SYMBICORT (Budesonide/Formoterol)	Fluticasone/Salmeterol – Labeler - 00093
	WIXELA INHUB (Fluticasone/Salmeterol)

Steroid/Anticholinergics/Long Acting Beta Agonists Combinations

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- 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

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
	TRELEGY ELLIPTA (Fluticasone Furoate/Umeclidinium/Vilanterol)

Substance Use

Nicotine / Tobacco Dependence Treatment

General Prior Authorization Form

A total of 24 consecutive weeks of Chantix will be covered, every 2 years.

A total of 12 consecutive weeks will be covered for all other products, every 2 years.

Non-Preferred Agents 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.

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)

Bupropion SR	NICODERM CQ (Nicotine) PATCH
CHANTIX (Varenicline)	NICORETTE (Nicotine Polacrilex) GUM
Nicotine Lozenge	ZYBAN (Bupropion SR)
Nicotine Patch	
Nicotine Polarcrilex Gum	
NICOTROL (Nicotine Polacrilex) INHALER	
NICOTROL (Nicotine Polacrilex) SPRAY	

Opioid Dependence Treatment

Lucemyra

General Prior Authorization Form

Group 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 agents (subject to clinical review)

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Clonidine	LUCEMYRA (Lofexidine)
Guanfacine	

Naloxone Rescue Medications

General Prior Authorization Form

Group Criteria (Initial):

- Narcan Nasal Spray does NOT require prior authorization for the initial dose

Group Criteria (Renewal):

- The provider must attest that it is known that the previous dose was taken by the patient (and not diverted or given to another patient)
- One of the following criteria must be met (A, B, or C)
    A. The previous dose has expired
    B. The dose was used by patient for illicit drug use
    C. The patient is currently taking opioids and meets one of the following criteria:
        - The opioid dose must have been decreased
        - The provider has provided medical justification why the opioid dose as not been decreased

Opioid Antagonist

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
VIVITROL (Naltrexone Microspheres)	

Opioid Partial Agonist

General Prior Authorization Form

Product Specific Criteria:

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

Non-Preferred Agents Criteria:

- 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).
- DAW (Dispense As Written) Criteria must be met in addition to Opioid Partial Agonist Group PA Criteria.
- For all non-preferred agents OTHER than Zubsolv (buprenorphine/naloxone):
    - The patient must have failed a 30-day trial of Zubsolv (buprenorphine/naloxone)
    - Clinical justification must be provided explaining why the patient is unable to use Zubsolv (subject to clinical review).
    - DAW (Dispense As Written) Criteria must be met in addition to Opioid Partial Agonist Group PA Criteria.

ORAL AGENTS	
PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Buprenorphine-naloxone tablets	BUNAVAIL FILM (buprenorphine/naloxone)
Buprenorphine tablets***	buprenorphine/naloxone film
	SUBOXONE FILM (buprenorphine/naloxone)
	ZUBSOLV (buprenorphine/naloxone)
NON-ORAL AGENTS	
PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
SUBLOCADE (buprenorphine)	
PROBUPHINE (buprenorphine)	

Women's Health

Estrogens

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have failed 30-day trials of at least two preferred products, as evidenced by paid claims or pharmacy printouts.

PREFFERED AGENTS (CLINICAL PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
CLIMARA PRO (estradiol-levonorgestrel) PATCH	ALORA (Estradiol) PATCH TWICE WEEKLY
COMBIPATCH (Estradiol- Norethindrone)	CLIMARA (Estradiol) PATCH WEEKLY
ELESTRIN (estradiol) GEL	DELESTROGEN (Estradiol Valerate) INJECTION
Estradiol Tablet	DEPO-ESTRADIOL (Estradiol Cypionate) INJECTION
ESTRING (estradiol)	DIVIGEL (estradiol) GEL
EVAMIST (estradiol) SPRAY	Estradiol Valerate Injection
MENOSTAR (estradiol) PATCH	Estradiol- Norethindrone Tablet
Norethindrone-Ethinyl Estradiol tablet	Estradiol Patch Twice Weekly
PREMARIN (estrogens, conjugated) INJECTION	Estradiol Patch Weekly
PREMARIN (estrogens, conjugated) TABLET	Estradiol Vaginal Cream
PREMARIN (estrogens, conjugated) VAGINAL CREAM	Estradiol Vaginal Tablet
PREMPHASE (estrogen, conj.,m-progest) TABLET	FEMRING (estradiol)
PREMPRO (estrogen, conj.,m-progest) TABLET	MENEST (estrogens, esterified) TABLET
VAGIFEM (estradiol) VAGINAL TABLET	MINIVELLE (Estradiol) PATCH TWICE WEEKLY
YUVAFEM (estradiol) VAGINAL TABLET	PREFEST (estradiol-norgestimate) TABLET

	VIVELLE-DOT (Estradiol) PATCH

Mifepristone

Prior Authorization Form - Mifeprex

Criteria for coverage: *Approval Duration = 1 month*

- Gestational age must be less than or equal to 70 days
- One of the following criteria must be met (A or B):
    A. **Pregnancy must have resulted from an act of rape or incest, and one of the following (I or II)**
        I. The provider has provided a signed written statement indicating that the rape or act of incest has been reported to the appropriate law enforcement agency, or in the case of a minor who is a victim of incest, to an agency authorized to receive child abuse and neglect reports. The statement must indicate to whom the report was made.
        II. The provider has provided written statement signed by the recipient and the provider that the recipient's pregnancy resulted from rape or incest and by professional judgement, the provider agrees with the woman's statement.
    B. **Both of the following must be met (I and II)**
        I. The woman must suffer from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would as certified by a provider, place the woman in danger of death unless an abortion is performed
        II. The provider must provide a signed written statement indicating why, in the provider's professional judgement, the life of a woman would be endangered if the fetus were carried to term

Orilissa

Prior Authorization Form - Orilissa

Initial Criteria: *Approval Duration = 6 months*

- The patient must be 18 years of age or older
- The patient must have a diagnosis of moderate to severe pain associated with endometriosis
- The patient must not have osteoporosis or severe liver disease (Child-Pugh Class C).
- The patient must have failed the following trials (A and B), as evidenced by paid claims or pharmacy printouts:
    A. A 3-cycle trial of mefenamic acid (or similar fenamate Non-Steroidal Anti-Inflammatory agent (NSAIDs))
    B. A 3-cycle trial of an oral estrogen-progestin or progestin contraceptives

Renewal Criteria: *Approval Duration = 18 months*

- Prescriber must submit documentation of improvement in pain score from baseline
- Request must be for maintenance dosing (150 mg strength).

Osteoporosis

Prior Authorization Form - Osteoporosis

Non-Preferred Agents Criteria (Initial): *Approval Duration = 2 years*

- The patient must have a diagnosis of an FDA-approved indication for use
- The patient must have a current BMD T-score ≤ -2.5 OR new fracture after a 6-month trial of each of the following, as evidenced by paid claims or pharmacy printouts:
    A. Alendronate or Risedronate

B. Denosumab

- Patient must be at high risk of fracture, confirmed by at least one of the following:
  A. The patient with a history of hip or vertebral fracture
  B. The patient with a T-score of −2.5 or lower at the femoral neck or spine
  C. The patient who have a T-score of between −1.0 and −2.5 at the femoral neck or spine and a ten-year hip fracture risk of ≥3% as assessed with the FRAX
  D. 10-year risk of a major osteoporosis-related fracture of ≥20% as assessed with the FRAX

Product Specific Criteria:

- ***Forteo and Miacalcin:**
  A. The patient must have a current BMD T-score ≤ -2.5 OR new fracture after a 6-month trial of Tymlos (Abaloparatide), as evidenced by paid claims or pharmacy printouts
- ***Binosto and alendronate oral solution:**
  A. The patient must be unable to ingest solid dosage form as evidenced by swallow study documentation

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Alendronate	Alendronate oral solution
Calcitonin, Salmon Nasal Spray	BINOSTO (Alendronate) EFFERVESCENT TAB
Ibandronate	FORTEO (Teriparatide)***
PROLIA (Denosumab)	MIACALCIN (Calcitonin, Salmon)***
Risedronate	TYMLOS (Abaloparatide)

Progesterone

Prior Authorization Form - Makena

Non-Preferred Agents Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- 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 medication is medically necessary

PREFFERED AGENTS (CLINICAL PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
MAKENA (hydroxyprogesterone caproate)	hydroxyprogesterone caproate

Vaginal Anti-Infectives

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The patient must have had 30-day trials of 3 preferred agents, as evidenced by paid claims or pharmacy printouts.

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
AVC (sulfanilamide)	Clindamycin cream
CLEOCIN (Clindamycin) SUPPOSITORY	CLEOCIN (Clindamycin) CREAM
CLINDESSE (Clindamycin) CREAM	METROGEL-VAGINAL (Metronidazole)
GYNAZOLE 1 (butoconazole) CREAM	MICONAZOLE 3 (miconazole) suppository
Metronidazole gel	terconazole suppository
NUVESSA (Metronidazole) GEL	
terconazole cream	
VANDAZOLE (Metronidazole) GEL	

Preferred Dosage Forms List:

Prior Authorization Form - Non-Preferred Dosage Form

Criteria for coverage:

- Clinical justification must be provided explaining why the patient is unable to use the preferred agents (subject to clinical review).
- The patient must have a diagnosis of an FDA-approved indication for use
- The patient must not have any contraindication to the requested product
- The patient must have failed* a therapeutic course** of each preferred agent (listed in boxes below) within the past 2 years, as evidenced by paid claims or pharmacy printouts.

**: A failure is defined as product was not effective at maximum tolerated dose or patient has a documented intolerance or adverse reaction to inactive ingredients where the non-preferred product is expected to have a different result and other alternatives (e.g. medications in same class) are not an option for the patient*

***: Trials must have been at least 30 days in duration unless otherwise indicated*

Amoxicillin ER

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Amoxicillin IR	Amoxicillin ER

Antihistamines

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Cetirizine Chew Tablet	Desloratadine ODT
Cetirizine Solution	Levocetirizine solution
Cetirizine Tablet	
Desloratadine Tablet	
Levocetirizine Tablet	
Loratadine Solution	
Loratadine Tablet	

Bactroban

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Bactroban ointment	Bactroban cream

Belladonna Alkaloids/Phenobarbital

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Belladonna Alkaloids/Phenobarbital Tablets	Belladonna Alkaloids/Phenobarbital Elixir

Bowel Prep Agents

Required trial duration: 1 complete dose

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
GAVILYTE-G	CLENPIQ
GOLYTELY 227.1-21.5	COLYTE
GOLYTELY 236-22.74G	GAVILYTE-C
MOVIPREP	GAVILYTE-N
OSMOPREP	NULYTELY
PEG-3350 AND ELECTROLYTES 236-22.74G	PEG 3350-ELECTROLYTE 240-22.72G

Please use the NDC Drug Lookup to find Prior Authorization (PA) Forms

	PEG 3350-ELECTROLYTE 420 G
	PLENVU
	PREPOPIK
	SUPREP
	TRILYTE

Brisdelle (Paroxetine)

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Paroxetine tablets	Paroxetine Mesylate 7.5mg capsules

Butalbital-Acetaminophen-Caffeine

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Butalbital-Acetaminophen-Caffeine Tablets	Butalbital-Acetaminophen-Caffeine Capsules
	ESGIC (Butalbital-Acetaminophen-Caffeine) CAPSULES
	VANATOL LQ (Butalbital-Acetaminophen-Caffeine) SOLUTION
	VANATOL S (Butalbital-Acetaminophen-Caffeine) SOLUTION
	ZEBUTAL (Butalbital-Acetaminophen-Caffeine) CAPSULES

Daxbia (Cephalexin)

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Cephalexin	Daxbia (Cephalexin)

Gabapentin

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Gabapentin	GRALISE (gabapentin)
Gabapentin	HORIZANT (gabapentin)
Pramipexole	
Ropinirole	

Jadenu (Deferasirox)

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Deferasirox tablet for suspension	JADENU (deferasirox)

Kits

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
FDA approved products prescribed separately	CAMPHOTREX 4%-10% ROLL-ON G (menthol/camphor)
	DERMACINRX ARM PAK (lidocaine/dimethacone)
	DERMACINRX CINLONE-I CPI (triamcinolone/lidocaine/prilocaine)
	DERMACINRX PHN PAK (lidocaine/emollient cmb No. 102)
	DERMACINRX SILAZONE (triamcinolone/silicones)
	DERMACINRX LEXITRAL PHARMAP (diclofenac/capsicum oleoresin)
	DERMACINRX PHN PAK (lidocaine/emollient cmb no.102)
	DERMACINRX SILAPAK (triamcinolone/dimeth/silicone)
	DERMACINRX SURGICAL PHARMAP (mupirocin/chlorhexidine/dimeth)

Please use the NDC Drug Lookup to find Prior Authorization (PA) Forms

	DERMACINRX THERAZOLE PAK (clotrimazole/betameth dip/zinc)
	DERMACINRX ZRM PAK (lidocaine/dimethicone)
	ESOMEP-EZS KIT (esomeprazole mag/glycerin)
	TRIXYLITRAL (diclofenac/lidocaine/tape)
	ELLZIA PAK (triamcinolone/dimethicone)
	INFAMMACIN (diclofenac/capsicum)
	LOPROX (ciclopirox/skin cleanser No. 40)
	MIGRANOW KIT(sumatriptan/menthol/camphor)
	MORGIDOX (Doxycycline/skin cleanser No. 19)
	PRO DNA MEDICATED COLLECTION (lidocaine/glycerin)
	QUTENZA (capsaicin/skin cleanser)
	SILAZONE-II KIT (triamcinolone aceton/silicones)
	TICANASE KIT (fluticasone/sodium chloride/sodium bicarbonate)
	XRYLIX 1.5% KIT (diclofenac/kinesiology tape)
	GABACAINE KIT (gabapentin/lidocaine)
	LIDOPURE PATCH 5% COMBO PAC (lidocaine/kinesiology tape)
	NUVAKAAN KIT (lidocaine/prilocaine/silicone)
	ZILACAINE PATCH 5% COMBO PA (lidocaine/silicone, adhesive)
	PRILO PATCH KIT (lidocaine/prilocaine)

Metformin

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Metformin ER	FORTAMET (Metformin)
	GLUMETZA (Metformin)
	RIOMET (Metformin) ORAL SOLUTION

Methotrexate

Required trial duration: 6 weeks

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
methotrexate	OTREXUP (methotrexate)
	RASUVO (methotrexate)
	TREXALL (methotrexate)

Mupirocin

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Mupirocin Ointment	Mupirocin Calcium Cream

Nascobal (Cyanocobalamin) Nasal Spray

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Cyanocobalamin Injection	NASCOBAL (Cyanocobalamin) NASAL SPRAY

Nitroglycerin Spray

Required trial duration: 1 dose while on preventative medication

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Nitroglycerin sublingual tablets	GONITRO (Nitroglycerin) SUBLINGUAL PACKET

	Nitroglycerin Spray
	NITROLINGUAL (Nitroglycerin) SPRAY

Nocdurna (desmopressin)

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Desmopressin	Nocdurna (desmopressin)

Onmel (itraconazole)

Required trial duration: 12 weeks with 6 months outgrow following treatment for onychomycosis

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Itraconazole capsule	ONMEL (itraconazole) tablet
Terbinafine	

Potassium

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Potassium tablets	Potassium Solution
	Potassium Powder for Solution

Procysbi (cysteamine)

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
CYSTAGON (cysteamine)	PROCYSBI (cysteamine)

Ribavirin

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
RIBASPHERE (ribavirin)	RIBASPHERE RIBAPAK (ribavirin)
Ribavirin	

Siklos (Hydroxyurea)

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
DROXIA (Hydroxyurea capsule)	SIKLOS (Hydroxyurea tablet)
Hydroxyurea capsule	

Steroids - Oral

Additional Criteria for coverage of Emflaza: See Emflaza Criteria on this document

Rayos required trial duration: 12 weeks with 2AM dosing of prednisone

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Budesonide 3mg EC Capsules	Budesonide 9 mg ER Tablet
Cortisone	DEXPAK (dexamethasone)
Dexamethasone	DXEVO (dexamethasone)
Hydrocortisone	EMFLAZA (deflazacort)
Methylprednisone	MILLIPRED (Prednisolone)
Prednisolone sodium phosphate 5mg/5ml, 15mg/5ml, 25mg/5ml	Prednisone Intensol
Prednisone Solution	Prednisolone sodium phosphate ODT
Prednisone Tablets	Prednisolone sodium phosphate 10mg/5ml, 20mg/5ml solution
	RAYOS (prednisone)

Please use the NDC Drug Lookup to find Prior Authorization (PA) Forms

	TAPERDEX (dexamethasone)
	UCERIS (budesonide)

Tacrolimus

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Tacrolimus	ASTAGRAF XL (Tacrolimus)
	ENVARSUS ER (Tacrolimus)

Tirosint (levothyroxine)

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
levothyroxine	TIROSINT (levothyroxine)

Tussicaps

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Hydrocodone/chlorpheniramine ER suspension	TUSSICAPS (hydrocodone/chlorpheniramine)
Promethazine/codeine	
ZODRYL AC (chlorpheniramine/codeine)	

Topical Corticosteroids Preferred Medication List

Potency	Dosage Form	Preferred		Non-Preferred	
Class 1 - Very High Potency	**Class 1 - Very High Potency**				
	Cream	Clobetasol Propionate	0.05%	Clobetasol Emollient	0.05%
				Halobetasol Propionate	0.05%
				STEP2* Fluocinonide	0.10%
	Ointment	Betamethasone, augmented	0.05%	Halobetasol Propionate	0.05%
		Clobetasol Propionate	0.05%		
	Foam, Gel, Lotion, Shampoo, Solution, Spray, Tape	Clobetasol Propionate Solution	0.05%	Betamethasone, augmented lotion	0.05%
		Clobetasol Propionate Lotion	0.05%	Betamethasone, augmented gel	0.05%
		Clobex (*Brand Required*) Shampoo	0.05%	Clobetasol emulsion foam	0.05%
		Clobex (*Brand Required*) Spray	0.05%	Clobetasol propionate foam	0.05%
		Clobetasol Propionate Gel	0.05%	Lexette (Halobetasol) foam	0.05%
				Desoximetasone spray	0.25%
				STEP2* Cordran (Flurandrenolide) Tape	4MCG/SQ CM
				STEP 2* Ultravate (Halobetasol) lotion	0.05%
Class 2 - High	**Class 2 - High Potency**				
	Cream	Betamethasone, augmented	0.05%	Apexicon E	0.05%
		Desoximetasone	0.25%	Fluocinonide-E	0.05%
		Diflorasone Diacetate	0.05%	STEP2* Amcinonide	0.10%

Please use the NDC Drug Lookup to find Prior Authorization (PA) Forms

		Fluocinonide	0.05%		
		Halog-*brand required*	0.10%		
		Triamcinolone Acetonide	0.50%		
		Betamethasone Dipropionate	0.05%	Diflorasone Diacetate	0.05%
	Ointment	Betamethasone Valerate	0.10%		
		Desoximetasone	0.25%		
		Fluocinonide	0.05%		
		Fluticasone Propionate	0.01%		
		Halog	0.10%		
		Mometasone Furoate	0.10%		
		Triamcinolone Acetonide	0.50%		
	Gel, Lotion Solution	Fluocinonide gel	0.05%	Desoximetasone gel	0.05%
		Fluocinonide solution	0.05%	Bryhali (halobetasol)	0.01%
				STEP2* Amcinonide Lotion	0.10%

Class 3 - Medium Potency	**Class 3 - Medium Potency**				
	Cream	Betamethasone Valerate	0.10%	Betamethasone Dipropionate	0.05%
		Fluticasone Propionate	0.05%	Clocortolone Pivalate	0.10%
		Mometasone Furoate	0.10%	Fluocinolone Acetonide	0.025%
		Synalar	0.025%	Pandel	0.10%
		Triamcinolone Acetonide	0.10%	Prednicarbate	0.10%
				STEP2* Desoximetasone	0.05%
				STEP2* Flurandrenolide	0.05%
				STEP2* Hydrocortisone Butyrate	0.10%
				STEP2* Hydrocortisone Butyrate Emollient	0.10%
				STEP2* Hydrocortisone Valerate	0.20%
	Ointment	Fluocinolone Acetonide	0.025%	Desoximetasone	0.05%
		Desonide	0.05%	Hydrocortisone Valerate	0.20%
		Hydrocortisone Butyrate	0.10%	Trianex	0.05%
		Prednicarbate	0.10%	STEP2* Flurandrenolide	0.05%
		Triamcinolone Acetonide	0.10%		
		Triamcinolone Acetonide	0.025%		
	Aerosol, Foam, Lotion, Solution, Spray	Mometasone Furoate Solution	0.10%	Betamethasone Valerate Foam	0.12%
		Betamethasone Dipropionate Lotion	0.05%	Triamcinolone Acetonide Aerosol	0.147MG/G
		Hydrocortisone Butyrate Solution	0.10%	STEP2* Flurandrenolide Lotion	0.05%
		Triamcinolone Acetonide Lotion	0.10%	STEP2* Fluticasone Propionate Lotion	0.05%
				STEP2* Sernivo spray (Betamethasone)	0.05%
Class 4 -	**Class 4 - Low Potency**				
	Cream	Alclometasone Dipropionate	0.05%		

Please use the NDC Drug Lookup to find Prior Authorization (PA) Forms

		Desonide	0.05%		
		Fluocinolone Acetonide	0.01%		
		Hydrocortisone	2.50%		
		Hydrocortisone	1.00%		
		Triamcinolone Acetonide	0.025%		
	Ointment	Alclometasone Dipropionate	0.05%		
		Hydrocortisone	1.00%		
		Hydrocortisone	2.50%		
	Oil, Lotion, Shampoo, Solution	Capex Shampoo	0.01%	Betamethasone Valerate Lotion	0.10%
		Desonide Lotion	0.05%		
		Fluocinolone Acetonide Oil	0.01%		
		Fluocinolone Acetonide Solution	0.01%		
		Hydrocortisone Lotion	2.50%		
		Texacort Solution	2.50%		
		Triamcinolone Acetonide Lotion	0.025%		

Clinic Administered Drugs

Brineura

Prior Authorization Form - Brineura

Initial Criteria: *Approval Duration = 6 months*

- Patient must be between 3 and 8 years of age.
- The patient must have diagnosis of late infantile neuronal ceroid lipofuscinosis type 2 (CLN2), also known as tripeptidyl peptidase 1 (TPP1) deficiency confirmed by the following:
    - A genetic test confirming CLN2 disease
    - An enzyme assay confirming deficiency of tripeptidyl peptidase 1 (TPP1)
- Brineura must be prescribed by or in consultation with a metabolic specialist, geneticist, or pediatric neurologist.
- Patient must not have ventriculoperitoneal shunts
- Baseline results of motor and language domains of the Hamburg CLN2 Clinical Rating Scale must be submitted and meet the following parameters
    - Results must show a combined score of less than 6 in the motor and language domains
    - Results must show a score of at least 1 in each of these domains

Renewal Criteria: *Approval Duration = 12 months*

- The patient must not have acute, unresolved localized infection on or around the device insertion site or suspected or confirmed CNS infection
- Patient maintains at a score of at least 1 in the motor domain on the Hamburg CLN2 Clinical Rating Scale
- The patient has responded to therapy compared to pretreatment baseline with stability/lack of decline* in motor function/milestones

**: Decline is defined as having an unreversed (sustained) 2-category decline or an unreversed score of 0 in the Motor domain of the CLN2 Clinical Rating Scale*

Spinraza

Prior Authorization Form - Spinraza

Criteria: *Approval Duration = 12 months*

- For a diagnosis of Spinal Muscular Atrophy (SMA) Type 1, 2, or 3:
    A. The patient must not have respiratory insufficiency (need for invasive or noninvasive ventilation for more than 6 hours per 24-hour period)
    B. The patient must not require gastric feeding tubes for the majority of feeds
    C. The patient must not have severe contractures or severe scoliosis
    D. The patient must not have wasting or cachexia
- For a diagnosis of Spinal Muscular Atrophy (SMA) Type 3:
    A. The patient must be less than 2 years of age
    B. The patient must be experiencing issues with ambulating (falls, trouble climbing stairs, unable to walk independently)

Synagis

Prior Authorization Form - Synagis

Criteria: *Approval Duration = 5 months (allows for 5 monthly doses between October 19th through April 21st)*

- Patient must have one of the following diagnoses (A, B, or C) and the additional criteria outlined for diagnosis:
    A. Prematurity:
        - < 29 weeks, 0 days gestational age
        - ≤12 months of age at start of RSV season
    B. Chronic Lung Disease of Prematurity (CLD)
        - ≤12 months of age at start of RSV season
            - < 32 weeks, 0 days gestational age
            - Requires supplemental oxygen > 21% for at least the first 28 days after birth
        - 13-24 months of age at start of RSV season
            - < 32 weeks, 0 days gestational age
            - Requires supplemental oxygen > 21% for at least the first 28 days after birth
            - Continues to receive medical support within six months before the start of RSV season with supplemental oxygen, diuretic, or chronic corticosteroid therapy
    C. Congenital Heart Disease
        - ≤12 months of age at start of RSV season
            - Hemodynamically significant cyanotic or acyanotic congenital heart disease with medical therapy required