The West Virginia Bureau for Medical Services
Office of Pharmacy Services

Preferred Drug List
and
Prior Authorization Criteria

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this Preferred Drug List (PDL).

- Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. A current listing of all covered over-the-counter (OTC) products may be found at the BMS Website by clicking the hyperlink.
- Prior authorization (PA) of any non-preferred agent requires that class criteria, and in some cases drug-specific criteria, be followed unless documentation is provided indicating that the use of these agents would be medically contraindicated. "Exceptions" to the PA criteria should be detailed on the PA form for consideration; these include relative contraindications, such as potential drug-drug interactions, adverse effects, intolerance, and drug-disease interactions.
- Required trials of preferred agents are defined as "failed" or otherwise satisfied only when efficacy has not been observed despite patient adherence to a dose and duration which should have produced therapeutic effects.
- Unless otherwise specified, all requests to "grandfather" existing drug therapy will require clinical reasoning from the prescriber detailing why the patient cannot be transitioned to a preferred agent from the Medicaid PDL. Please note that this requirement includes therapy that may have been previously preferred on the Medicaid PDL but has since changed to non-preferred status.
- 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.
- Other drug utilization review restrictions may apply, including, but not limited to, therapeutic duplication, drug-drug interaction, ingredient duplication, etc.
- Quantity limits may apply. Refer to the Drug Limits list on the Bureau for Medical Services (BMS) website by clicking the hyperlink.
- Unless otherwise indicated, non-preferred combination products require medical reasoning beyond convenience or enhanced compliance as to why the clinical need cannot be met with a preferred agent or combination of preferred single-ingredient agents containing the same, or similar, active ingredient.
- Acronyms
    - Clinical (CL) – Requires clinical PA. For detailed clinical criteria, please refer to the PA Criteria page by clicking the hyperlink.
    - Non-Reviewed (NR) – Denotes a new drug which has not yet been reviewed by the Pharmaceutical and Therapeutics (P&T) Committee. **These agents are available only on appeal to the BMS medical director.**
    - Automatic PA (AP) – Non-preferred and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA Criteria column.

CLASSES CHANGING	Status Changes	PA Criteria Changes	New Drugs
ANDROGENIC AGENTS			X
ANGIOTENSIN MODULATORS	X		
ANTIBIOTICS INHALED	X		
ANTICOAGULANTS	X		
ANTICONVULSANTS			X
ANTIEMETICS	X		
ANTIMIGRAINE AGENTS, ACUTE	X		
ANTIPARASITICS, TOPICAL	X		X
ANTIPSYCHOTICS, ATYPICAL AND COMBINATION	X		
ANTIRETROVIRALS			X
ANTIVIRALS			X
BETA BLOCKERS			X
BONE RESORPTION SUPRESSION AND RELATED AGENTS			X
BRONCHODILATORS, BETA AGONIST	X		
COPD AGENTS			X
CYTOKINE AND CAM ANTAGONISTS			X
DIABETES AGENTS, DPP-4 INHIBITOR			X
DIABETES AGENTS, SGLT2 INHIBITOR	X		
DRY EYE PRODUCTS	X		
DUCHENNE MUSCULAR DYSTROPHY CORTICOSTEROIDS			X
HEART FAILURE TREATMENTS	X		X
IMMUNOMODULATORS, ATOPIC DERMATITIS	X		
OPHTHALMICS ALLERGIC CONJUNCTIVITIS	X		
OPIATE DEPENDENCE TREATMENTS	X		
ORAL AND TOPICAL CONTRACEPTIVES	X		
PAH AGENTS			X
PLATELET AGGREGATION INHIBITORS	X		
POTASSIUM REMOVING AGNETS	X		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ACNE AGENTS, TOPICAL[AP]		
CLASS PA CRITERIA: Non-preferred agents require a 30-day trial of one preferred retinoid and two unique chemical entities in two other subclasses, including the generic version of the requested non-preferred product, before they will be approved, unless one of the exceptions on the PA form is present. In cases of pregnancy, a trial of retinoids will not be required. For members 18 years of age or older, a trial of retinoids will not be required. Acne kits are non-preferred. **Specific Criteria for subclass will be listed below. NOTE:** Non-preferred agents in the Rosacea subclass are available only on appeal and require at least a 30-day trial of all preferred agents in that subclass.		
ANDROGEN RECEPTOR INHIBITORS		
	WINLEVI CREAM (clascoterone)	
ANTI-INFECTIVE		
clindamycin lotion, pledget, solution erythromycin gel, solution	AMZEEQ FOAM (minocycline) CLEOCIN-T (clindamycin) CLINDACIN ETZ KIT, PLEDGET (clindamycin) CLINDACIN P (clindamycin) CLINDACIN PAC (clindamycin) clindamycin foam, gel dapsone ERYGEL (erythromycin) erythromycin pledget EVOCLIN (clindamycin) FABIOR (tazarotene) OVACE PLUS (sulfacetamide) sodium sulfacetamide 10% cleansing gel sulfacetamide	
RETINOIDS		
adapalene gel tretinoin cream	adapalene cream, lotion ATRALIN (tretinoin) AVITA (tretinoin) tazarotene cream, foam, gel tretinoin gel tretinoin microsphere gel	**In addition to the Class Criteria:** PA required for members 18 years of age or older.
KERATOLYTICS		
benzoyl peroxide cleanser (Rx, OTC) benzoyl peroxide 10% cream (OTC) benzoyl peroxide gel (Rx, OTC) benzoyl peroxide lotion (OTC) benzoyl peroxide wash (OTC)	BENZEFOAM (benzoyl peroxide) BP 10-1 (benzoyl peroxide) BPO (benzoyl peroxide)	
COMBINATION AGENTS		
clindamycin phosphate/benzoyl peroxide gel (generic DUAC only) clindamycin phosphate/benzoyl peroxide gel (generic ACANYA) sulfacetamide/sulfur suspension	ACANYA (clindamycin phosphate/benzoyl peroxide) adapalene/benzoyl peroxide* AVAR-E (sulfacetamide/sulfur) AVAR LS (sulfacetamide/sulfur) benzoyl peroxide/erythromycin	**In addition to the Class Criteria:** Non-preferred combination agents require 30-day trials of the corresponding preferred single agents before they will be approved.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	benzoyl peroxide/urea clindamycin/benzoyl peroxide gel (all generics other than DUAC) clindamycin/tretinoin gel* clindamycin phosphate/benzoyl peroxide (generic ONEXTON) NEUAC (clindamycin phosphate/benzoyl peroxide) SSS 10-4 (sulfacetamide/sulfur) SSS 10-5 foam (sulfacetamide/sulfur) sulfacetamide sodium/sulfur cleanser, cloths, lotion, pads, wash, wash kit sulfacetamide/sulfur/urea SUMADAN XLT (sulfacetamide/sulfur) SUMAXIN TS (sulfacetamide/sulfur) ZMA CLEAR (sulfacetamide/sulfur)	*PA required for combination agents with retinoid products for members 18 years of age or older.
ROSACEA AGENTS		
azelaic acid gel metronidazole cream metronidazole 0.75% gel (NDCs 00713-0637-37, 51672-4116-06 only)	FINACEA FOAM (azelaic acid) ivermectin METROGEL (metronidazole) metronidazole gel (all other NDCs) metronidazole lotion RHOFADE (oxymetazoline) ROSADAN (metronidazole)	**Subclass criteria:** Non-preferred agents are available only on appeal and require evidence of 30-day trials of all chemically unique preferred agents in the subclass.
ALZHEIMER'S AGENTS[AP]		
CLASS PA CRITERIA: Non-preferred agents require a 30-day trial of a preferred agent in the same subclass before they will be approved, unless one of the exceptions on the PA form is present. Prior authorization is required for members up to 45 years of age if there is no diagnosis of Alzheimer's disease.		
CHOLINESTERASE INHIBITORS		
donepezil 5 mg and 10 mg donepezil ODT EXELON PATCHES (rivastigmine) galantamine tablets galantamine ER capsules rivastigmine capsules	ADLARITY PATCHES (donepezil) ARICEPT (donepezil) donepezil 23 mg* galantamine solution rivastigmine patches ZUNVEYL (benzgalantamine gluconate)	*Donepezil 23 mg tablets will be authorized if the following criteria are met: 1. There is a diagnosis of moderate-to-severe Alzheimer's Disease; AND 2. There has been a trial of donepezil 10 mg daily for at least three months and donepezil 20 mg daily for an additional one month.
NMDA RECEPTOR ANTAGONIST		
memantine memantine ER	memantine solution NAMENDA SOLUTION, TITRATION PACK (memantine)	
CHOLINESTERASE INHIBITOR/NMDA RECEPTOR ANTAGONIST COMBINATIONS		
	NAMZARIC (donepezil/memantine)	Combination agents require 30-day trials of each corresponding preferred single agent.
ANALGESICS, NARCOTIC LONG-ACTING (Non-parenteral)[AP]		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
CLASS PA CRITERIA: Non-preferred agents require six-day trials of three chemically distinct preferred agents (excluding fentanyl) **AND** a six-day trial of the generic form of the requested non-preferred agent (if available) before they will be approved, unless one of the exceptions on the PA form is present. If no generic form is available for the requested non-preferred brand agent, then another generic non-preferred agent must be trialed instead. **NOTE: All long-acting opioid agents require prior authorization for children under 18 years of age.** Requests must be for a Food and Drug Administration (FDA) approved age and indication and specify previous opioid and non-opioid therapies attempted.		
BUTRANS (buprenorphine) fentanyl 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr and 100 mcg/hr patches[CL/PA] morphine ER tablets tramadol ER tablets (generic ULTRAM ER)	ARYMO ER (morphine sulfate) BELBUCA (buprenorphine buccal films)* buprenorphine patches (all labelers including 00093) CONZIP ER (tramadol) fentanyl 37.6 mcg/hr, 62.5 mcg/hr and 87.5 mcg/hr patches hydrocodone ER capsules, tablets hydromorphone ER HYSINGLA ER (hydrocodone) KADIAN (morphine) methadone** MORPHABOND ER (morphine sulfate) morphine ER capsules (generic AVINZA) morphine ER capsules (generic KADIAN) MS CONTIN (morphine) oxycodone ER OXYCONTIN (oxycodone) oxymorphone ER tramadol ER (generic CONZIP ER)*** ULTRAM ER (tramadol) ZOHYDRO ER (hydrocodone)	*Belbuca prior authorization requires manual review. Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. **Methadone will be authorized without a trial of the preferred agents if a diagnosis of cancer is submitted. ***Tramadol ER (generic ConZip) requires a manual review and may be authorized for 90 days with submission of a detailed treatment plan including anticipated duration of treatment and scheduled follow-ups with the prescriber.
ANALGESICS, NARCOTIC SHORT-ACTING (Non-parenteral)[AP]		
CLASS PA CRITERIA: Non-preferred agents require six-day trials of at least four chemically distinct preferred agents (based on the narcotic ingredient only), including the generic formulation of the requested non-preferred agent, before they will be approved, unless one of the exceptions on the PA form is present. **NOTE: All tramadol and codeine products require prior authorization for children under 18 years of age**. Requests must be for an FDA approved age and indication and specify non-opioid therapies attempted.		
APAP/codeine butalbital/APAP/caffeine/codeine 50/325/30 mg codeine hydrocodone/APAP 2.5/325 mg, 5/325 mg, 7.5/325 mg, and 10/325 mg hydrocodone/APAP solution hydromorphone tablets meperidine oral solution morphine oxycodone capsules, solution, tablets oxycodone/APAP oxycodone/ASA tramadol tablets** tramadol/APAP**	ABSTRAL (fentanyl)* ACTIQ (fentanyl)* butalbital/APAP/caffeine/codeine 50/300/30 mg butalbital/ASA/caffeine/codeine butorphanol DEMEROL (meperidine) dihydrocodeine/APAP/caffeine DILAUDID (hydromorphone) fentanyl* FENTORA (fentanyl)* FIORICET/CODEINE (butalbital/APAP/caffeine/codeine) FIORINAL/CODEINE (butalbital/ASA/caffeine/codeine)	**Limits:** Unless the patient has escalating cancer pain or another diagnosis supporting increased quantities of short-acting opioids, all short-acting solid forms of the narcotic analgesics are limited to 120 tablets per 30 days. Longer-acting medications should be maximized to prevent unnecessary breakthrough pain in chronic pain therapy. *Fentanyl buccal, nasal, and sublingual products will only be authorized for a diagnosis of cancer and as an adjunct to a long-acting agent. These dosage forms will not be authorized for monotherapy.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	hydrocodone/APAP 5/300 mg, 7.5/300 mg and 10/300 mg hydrocodone/ibuprofen hydromorphone liquid, suppositories levorphanol LORCET (hydrocodone/APAP) LORTAB (hydrocodone/APAP) LORTAB SOLUTION (hydrocodone/APAP) meperidine tablets morphine rectal suppository NORCO (hydrocodone/APAP) oxycodone concentrate oxycodone/ibuprofen oxymorphone pentazocine/naloxone PERCOCET (oxycodone/APAP) QDOLO SOLUTION (tramadol) ROXICODONE (oxycodone) ROXYBOND (oxycodone) SEGLENTIS (celecoxib/tramadol)*** tramadol solution ULTRACET (tramadol/APAP)** VICOPROFEN (hydrocodone/ibuprofen)	**Immediate release tramadol is limited to 240 tablets per 30 days. ***Seglentis requires medical reasoning beyond convenience or enhanced compliance as to why the clinical need cannot be met with a preferred agent or combination of preferred single ingredient agents.
ANALGESICS, NON-NARCOTIC SHORT ACTING		
CLASS PA CRITERIA: Non-preferred agents require a 30-day trial of a preferred agent before they will be approved, unless one of the exceptions on the PA form is present.		
SODIUM CHANNEL BLOCKER (Nav 1.8)		
JOURNAVX (suzetrigine)		
ANDROGENIC AGENTS		
CLASS PA CRITERIA: A non-preferred agent will only be authorized if one of the exceptions on the PA form is present.		
ANDROGEL PUMP (testosterone)CL/PA* TESTIM (testosterone) testosterone 1.62% gel testosterone cypionate vialCL/PA* testosterone enanthate vialCL/PA*	ANDROGEL PACKETS (testosterone) ANDROID (methyltestosterone) AVEED (testosterone undecanoate) AZMIRO INJECTION (testosterone cypionate) FORTESTA (testosterone) JATENZO (testosterone undecanoate) METHITEST (methyltestosterone) methyltestosterone capsules NATESTO (testosterone) testosterone gel testosterone solution pump TESTRED (methyltestosterone) TLANDO (testosterone undecanoate) UNDECATREX (testosterone undecanoate) VOGELXO (testosterone)	*Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	XYOSTED (testosterone enanthate)	
ANESTHETICS, TOPICAL[AP]		
CLASS PA CRITERIA: Non-preferred agents require 10-day trials of each preferred agent before they will be approved, unless one of the exceptions on the PA form is present.		
lidocaine lidocaine/prilocaine xylocaine	lidocaine/hydrocortisone LIDOTRAL CREAM (lidocaine) LIDOZION LOTION (lidocaine) SYNERA (lidocaine/tetracaine)	
ANGIOTENSIN MODULATORS[AP]		
CLASS PA CRITERIA: Non-preferred agents require 14-day trials of each preferred agent in the same subclass, with the exception of the Direct Renin Inhibitors, before they will be approved, unless one of the exceptions on the PA form is present.		
ACE INHIBITORS		
benazepril captopril enalapril fosinopril lisinopril ramipril trandolapril	ACCUPRIL (quinapril) ALTACE (ramipril) captopril/HCTZ enalapril solution EPANED SOLUTION (enalapril)* LOTENSIN (benazepril) moexipril perindopril PRINIVIL (lisinopril) QBRELIS SOLUTION (lisinopril)** quinapril ZESTRIL (lisinopril)	*Epaned solution (enalapril solution) will be authorized with a diagnosis of hypertension, symptomatic heart failure or asymptomatic left ventricular dysfunction provided that the patient is less than (<) 7 years of age **OR** is unable to ingest a solid dosage form due to documented oral-motor difficulties or dysphagia. **Qbrelis solution may be authorized for children 6 to 10 years of age who are unable to tolerate a solid dosage form. Qbrelis may also be authorized for older patients with clinical documentation indicating oral-motor difficulties or dysphagia.
ACE INHIBITOR COMBINATION DRUGS		
benazepril/amlodipine benazepril/HCTZ captopril/HCTZ enalapril/HCTZ fosinopril/HCTZ lisinopril/HCTZ	ACCURETIC (quinapril/HCTZ) LOTENSIN HCT (benazepril/HCTZ) LOTREL (benazepril/amlodipine) quinapril/HCTZ TARKA (trandolapril/verapamil) trandolapril/verapamil ZESTORETIC (lisinopril/HCTZ)	
ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs)		
irbesartan losartan olmesartan telmisartan valsartan	ATACAND (candesartan) AVAPRO (irbesartan) BENICAR (olmesartan) candesartan COZAAR (losartan) DIOVAN (valsartan) EDARBI (azilsartan) MICARDIS (telmisartan)	
ARB COMBINATIONS		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
irbesartan/HCTZ losartan/HCTZ olmesartan/amlodipine olmesartan/amlodipine/HCTZ olmesartan/HCTZ valsartan/amlodipine valsartan/HCTZ	ATACAND-HCT (candesartan/HCTZ) AVALIDE (irbesartan/HCTZ) AZOR (olmesartan/amlodipine) BENICAR-HCT (olmesartan/HCTZ) candesartan/HCTZ DIOVAN-HCT (valsartan/HCTZ) EDARBYCLOR (azilsartan/chlorthalidone) EXFORGE (valsartan/amlodipine) EXFORGE HCT (valsartan/amlodipine/HCTZ) HYZAAR (losartan/HCTZ) MICARDIS-HCT (telmisartan/HCTZ) telmisartan/amlodipine telmisartan/HCTZ TRIBENZOR (olmesartan/amlodipine/HCTZ) valsartan/amlodipine/HCTZ	
DIRECT RENIN INHIBITORS		
	aliskiren TEKTURNA (aliskiren) TEKTURNA HCT (aliskiren/HCTZ)	**Substitute for Class Criteria:** Tekturna requires a 30-day trial of one preferred ACE, ARB, or combination agent, at the maximum tolerable dose, before it will be authorized unless one of the exceptions on the PA form is present.
ANTIANGINAL & ANTI-ISCHEMIC		
CLASS PA CRITERIA: Agents in this class may only be authorized for patients with angina who are also taking a calcium channel blocker, a beta blocker, or a nitrite as single agents or a combination agent containing one of these ingredients.		
ranolazine[AP]	ASPRUZYO SPRINKLE ER (ranolazine) RANEXA	
ANTIBIOTICS, GI & RELATED AGENTS		
CLASS PA CRITERIA: Non-preferred agents require a 14-day trial of a preferred agent before they will be approved, unless one of the exceptions on the PA form is present.		
metronidazole tablets neomycin tinidazole VANCOCIN (vancomycin) vancomycin capsules	AEMCOLO TABLETS (rifamycin) DIFICID (fidaxomicin)* fidaxomicin FIRVANQ SOLUTION (vancomycin)*** FLAGYL (metronidazole) LIKMEZ (metronidazole)** metronidazole capsules paromomycin vancomycin solution*** VOWST CAPSULES (fecal microbiota spores)*	*Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. **Likmez may be authorized for those who are unable to ingest solid dosage forms of metronidazole due to documented oral-motor difficulties or dysphagia. ***Vancomycin solution and Firvanq solution may be authorized for children up to 9 years of age who are unable to ingest solid dosage forms of vancomycin. Therapy may be authorized for older patients with clinical documentation indicating oral-motor difficulties or dysphagia.
ANTIBIOTICS, INHALED		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
CLASS PA CRITERIA: Non-preferred agents require a 28-day trial of a preferred agent and documentation of therapeutic failure before they will be approved, unless one of the exceptions on the PA form is present.		
BETHKIS 300 mg/4 ml (tobramycin) tobramycin 300 mg/5 ml (generic KITABIS) tobramycin 300 mg/5 ml (generic TOBI)	CAYSTON (aztreonam) KITABIS PAK 300 mg/5 ml (tobramycin) TOBI (tobramycin) TOBI PODHALER (tobramycin)	
ANTIBIOTICS, TOPICAL		
CLASS PA CRITERIA: Non-preferred agents require 10-day trials of at least one preferred agent, including the generic formulation of the requested non-preferred agent, before they will be approved, unless one of the exceptions on the PA form is present.		
bacitracin (Rx, OTC) gentamicin sulfate mupirocin ointment	CENTANY (mupirocin) CORTISPORIN (bacitracin/neomycin/polymyxin/HC) mupirocin cream neomycin/polymyxin/pramoxine XEPI CREAM (ozenoxacin)	
ANTIBIOTICS, VAGINAL		
CLASS PA CRITERIA: Non-preferred agents require trials of each chemically unique preferred agent at the manufacturer's recommended duration, before they will be approved, unless one of the exceptions on the PA form is present.		
CLEOCIN CREAM (clindamycin) CLEOCIN OVULE (clindamycin) metronidazole gel	clindamycin cream CLINDESSE (clindamycin) NUVESSA (metronidazole) SOLOSEC (secnidazole) VANDAZOLE (metronidazole) XACIATO GEL (clindamycin)	
ANTICOAGULANTS		
CLASS PA CRITERIA: Non-preferred agents require a trial of each preferred agent in the same subclass, unless one of the exceptions on the PA form is present.		
INJECTABLE[CL/PA]		
enoxaparin	ARIXTRA (fondaparinux) fondaparinux FRAGMIN (dalteparin) LOVENOX (enoxaparin)	
ORAL		
dabigatran ELIQUIS (apixaban) warfarin XARELTO TABLETS (rivaroxaban)	PRADAXA (dabigatran) PRADAXA ORAL PELLETS (dabigatran etexilate) SAVAYSA (edoxaban) XARELTO SUSPENSION (rivaroxaban)	*Xarelto 2.5 mg tablets may be approved for a diagnosis of chronic Coronary Artery Disease (CAD) or Peripheral Artery Disease (PAD) AND being used concurrently with aspirin.
ANTICONVULSANTS		
CLASS PA CRITERIA: For a diagnosis of seizure disorder, non-preferred agents require a 14-day trial of a preferred agent in the same subclass before they will be approved, unless one of the exceptions on the PA form is present; patients currently on established therapies shall be grandfathered. For all other diagnoses, non-preferred agents require a 30-day trial of a preferred agent in the same subclass before they will be approved, unless one of the exceptions on the PA form is present. In situations where AB-rated generic equivalent products are available, "Brand Medically Necessary" must be hand-written by the prescriber on the prescription for the brand name product to be reimbursed.		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ADJUVANTS		
BRIVIACT (brivaracetam) carbamazepine carbamazepine ER CARBATROL (carbamazepine) DEPAKOTE SPRINKLE CAPSULES (divalproex) divalproex divalproex sprinkle capsules divalproex ER EPITOL (carbamazepine) lacosamide solution, tablets LAMICTAL (lamotrigine) LAMICTAL CHEWABLE TABLETS (lamotrigine) LAMICTAL XR (lamotrigine) lamotrigine lamotrigine ODT levetiracetam ER levetiracetam IR levetiracetam IR suspension oxcarbazepine tablets QUDEXY XR (topiramate ER) TEGRETOL SUSPENSION (carbamazepine) TEGRETOL XR (carbamazepine) topiramate ER* topiramate ER sprinkle capsules (generic QUDEXY) topiramate IR sprinkle capsules topiramate IR tablets TRILEPTAL SUSPENSION (oxcarbazepine) valproic acid zonisamide	APTIOM (eslicarbazepine) BANZEL (rufinamide) carbamazepine oral suspension DEPAKOTE (divalproex) DEPAKOTE DR (divalproex) DEPAKOTE ER (divalproex) DIACOMIT CAPSULES, POWDER PACK (stiripentol)** ELEPSIA XR (levetiracetam) EPRONTIA SOLUTION (topiramate)**** EQUETRO (carbamazepine) felbamate FELBATOL (felbamate) FINTEPLA SOLUTION (fenfluramine)***** FYCOMPA (perampanel) KEPPRA (levetiracetam) KEPPRA SOLUTION (levetiracetam) KEPPRA XR (levetiracetam) LAMICTAL ODT (lamotrigine) lamotrigine dose pack lamotrigine ER methsuximide MOTPOLY XR (lacosamide)******* oxcarbazepine suspension OXTELLAR XR (oxcarbazepine) rufinamide oral suspension, tablets SABRIL (vigabatrin) SPRITAM (levetiracetam) TEGRETOL TABLETS (carbamazepine) tiagabine TOPAMAX SPRINKLE CAPSULES (topiramate) TOPAMAX TABLETS (topiramate) TRILEPTAL TABLETS (oxcarbazepine) TROKENDI XR (topiramate)*** vigabatrin powder pack, tablets VIGAFYDE (vigabatrin solution) VIMPAT SOLUTION, TABLETS (lacosamide) XCOPRI (cenobamate) ZONISADE SOLUTION (zonisamide)****** ZTALMY (ganaxolone)	*Topiramate ER will be authorized after a 30-day trial of topiramate IR. **Diacomit may only be approved as adjunctive therapy for a diagnosis of Dravet Syndrome when prescribed by, or in consultation with, a neurologist **AND** requires a 30-day trial of valproate and clobazam unless one of the exceptions on the PA form is present. Diacomit must be used concurrently with clobazam. ***Trokendi XR is available only on appeal. ****Eprontia requires medical reasoning, beyond convenience or enhanced compliance, as to why the medical need cannot be met by using the preferred Topamax sprinkle capsules. *****Full PA criteria for Fintepla may be found on the PA Criteria page by clicking the hyperlink. ******Zonisade solution may only be authorized for those who are unable to ingest solid dosage forms due to documented oral-motor difficulties or dysphagia **AND** have had a 14-day trial with a preferred agent available in a non-solid dosage form resulting in an inadequate treatment response. *******Motpoly XR requires medical reasoning, beyond convenience or enhanced compliance, as to why the clinical need cannot be met by using the preferred lacosamide agent.
BARBITURATES[AP]		
phenobarbital primidone	MYSOLINE (primidone)	
BENZODIAZEPINES[AP]		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
clonazepam diazepam rectal gel diazepam tablets NAYZILAM NASAL SPRAY (midazolam) VALTOCO NASAL SPRAY (diazepam)	clobazam* clonazepam ODT KLONOPIN (clonazepam) LIBERVANT BUCCAL FILMS (diazepam)** ONFI (clobazam)* ONFI SUSPENSION (clobazam)* SYMPAZAN (clobazam films)*	*Clobazam will be authorized as adjunctive therapy with any chronic anti-seizure medication, with the exception of other benzodiazepines. **NOTE:** Generic clobazam is preferred over brand Onfi. **Libervant requires review by the Medical Director and is available only on appeal.
CANNABINOIDS		
EPIDIOLEX SOLUTION (cannabidiol)[AP]*		*Epidiolex may be authorized after 14-day trials of two of the following agents within the past 12 months: clobazam, levetiracetam, valproate, lamotrigine, topiramate, rufinamide or felbamate.
HYDANTOINS[AP]		
DILANTIN CAPSULES (phenytoin sodium extended) DILANTIN INFATAB, SUSPENSION (phenytoin) PEGANONE (ethotoin) phenytoin capsules, chewable tablets, suspension	PHENYTEK (phenytoin)	
SUCCINIMIDES		
CELONTIN (methsuximide) ethosuximide capsules ethosuximide syrup	ZARONTIN CAPSULES (ethosuximide) ZARONTIN SYRUP (ethosuximide)	
ANTIDEPRESSANTS, OTHER		
CLASS PA CRITERIA: See below for individual subclass criteria.		
MONOAMINE OXIDASE INHIBITORS (MAOIs)[AP]		
	MARPLAN (isocarboxazid) NARDIL (phenelzine) phenelzine tranylcypromine	Patients stabilized on MAOI agents will be grandfathered.
SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIs)[AP]		
desvenlafaxine succinate ER (generic PRISTIQ) duloxetine capsules venlafaxine ER capsules venlafaxine ER tablets venlafaxine IR tablets	CYMBALTA (duloxetine) desvenlafaxine fumarate ER EFFEXOR XR (venlafaxine) FETZIMA (levomilnacipran) PRISTIQ (desvenlafaxine)	Non-preferred agents require separate 30-day trials of a preferred agent in this subclass **AND** a Selective Serotonin Reuptake Inhibitor (SSRI) before they will be approved, unless one of the exceptions on the PA form is present.
SECOND GENERATION NON-SSRI, OTHER[AP]		
bupropion IR bupropion SR bupropion XL mirtazapine trazodone	AUVELITY (dextromethorphan HBr/bupropion)* EMSAM (selegiline) FORFIVO XL (bupropion) nefazodone RALDESY SOLUTION (trazodone)** REMERON (mirtazapine) TRINTELLIX (vortioxetine) VIIBRYD (vilazodone HCl)	Non-preferred agents require separate 30-day trials of a preferred agent in this subclass **AND** an SSRI before they will be approved, unless one of the exceptions on the PA form is present. *Auvelity may be approved after the following has been met:

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	vilazodone WELLBUTRIN SR	1. The diagnosis is Major Depressive Disorder (MDD); AND 2. Documentation is provided giving medical reasoning beyond convenience as to why the clinical need cannot be met with using a combination of the preferred individual components; AND 3. A trial of 60 days resulting in an inadequate clinical response, with two distinct classes used to treat MDD, with one of the trials being bupropion. **Raldesy may only be authorized for those who are unable to ingest solid dosage forms of trazodone due to documented oral-motor difficulties or dysphagia.
SELECTED TRICYCLIC ANTIDEPRESSANTS (TCAs)		
imipramine HCl	imipramine pamoate	Non-preferred agents require a twelve-week trial of imipramine HCl before they will be approved, unless one of the exceptions on the PA form is present.
ANTIDEPRESSANTS, SSRIs[AP]		
CLASS PA CRITERIA: Non-preferred agents require 30-day trials of at least two preferred agents before they will be approved, unless one of the exceptions on the PA form is present. Upon hospital discharge, patients admitted with a primary mental health diagnosis who have been stabilized on a non-preferred SSRI will receive an authorization to continue that drug.		
citalopram escitalopram tablets fluoxetine capsules, solution fluvoxamine paroxetine sertraline	CELEXA (citalopram) citalopram capsules escitalopram solution fluoxetine tablets fluoxetine DR capsules fluvoxamine ER LEXAPRO (escitalopram) paroxetine 7.5 mg capsules paroxetine ER paroxetine suspension PAXIL (paroxetine) PAXIL CR (paroxetine) PEXEVA (paroxetine) PROZAC (fluoxetine) SARAFEM (fluoxetine) sertraline capsules ZOLOFT (sertraline)	
ANTIEMETICS[AP]		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
CLASS PA CRITERIA: See below for subclass criteria.		
5HT3 RECEPTOR BLOCKERS		
granisetron tablets ondansetron ODT, solution, tablets	ondansetron vials SANCUSO (granisetron) SUSTOL (granisetron) ZOFRAN (ondansetron) ZUPLENZ (ondansetron)	Non-preferred agents require a three-day trial of a preferred agent before they will be approved, unless one of the exceptions on the PA form is present.
CANNABINOIDS		
	dronabinol* MARINOL (dronabinol)*	*Dronabinol will only be authorized for: 1. The treatment of anorexia associated with weight loss in patients with AIDS or cancer and unresponsive to megestrol; OR 2. The prophylaxis of chemotherapy induced nausea and vomiting unresponsive to three-day trials of ondansetron or promethazine for
SUBSTANCE P ANTAGONISTS		
aprepitant EMEND 125 mg CAPSULES (aprepitant) EMEND SUSPENSION (aprepitant)	EMEND 80 mg CAPSULES (aprepitant) EMEND TRIPACK (aprepitant) VARUBI (rolapitant)	Non-preferred agents require a three-day trial of a preferred agent before they will be approved, unless one of the exceptions on the PA form is present.
COMBINATIONS		
DICLEGIS (doxylamine/pyridoxine) doxylamine/pyridoxine (generic DICLEGIS)	AKYNZEO (netupitant/palonosetron) BONJESTA (doxylamine/pyridoxine)	Non-preferred agents may only be approved after a trial and failure of a preferred agent, unless one of the exceptions on the PA form is present.
ANTIFUNGALS, ORAL		
CLASS PA CRITERIA: Non-preferred agents will only be authorized if one of the exceptions on the PA form is present		
clotrimazole fluconazole* griseofulvin*** nystatin terbinafine[CL/PA]	CRESEMBA (isavuconazonium)[CL/PA]** BREXAFEMME (ibrexafungerp) DIFLUCAN (fluconazole) flucytosine itraconazole ketoconazole**** MYCELEX (clotrimazole) NOXAFIL (posaconazole) ORAVIG (miconazole) posaconazole tablets SPORANOX (itraconazole) TOLSURA (itraconazole) VFEND (voriconazole) VIVJOA (oteseconazole) voriconazole suspension voriconazole tablets	*Fluconazole requires PA when limits are exceeded. **Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. ***PA is not required for griseofulvin suspension for children up to 18 years of age for the treatment of tinea capitis. ****Ketoconazole will be authorized if the following criteria are met: 1. Diagnosis of one of the following fungal infections: blastomycosis, coccidioidomycosis, histoplasmosis,

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
		chromomycosis, or paracoccidioidomycosis; AND 2. Documented failure or intolerance of all other diagnosis-appropriate antifungal therapies, i.e., itraconazole, fluconazole, flucytosine, etc.; AND 3. Baseline assessment of the liver status including alanine aminotransferase (ALT), aspartate aminotransferase (AST), total bilirubin, alkaline phosphatase, prothrombin time, and international normalized ratio (INR) before starting treatment; AND 4. Weekly monitoring of serum ALT for the duration of treatment (if ALT values increase to a level above the upper limit of normal or 30% above baseline, or if the patient develops symptoms of abnormal liver function, treatment should be interrupted, and a full set of liver tests be obtained. Liver tests should be repeated to ensure normalization of values.); AND 5. Assessment of all concomitant medications for potential adverse drug interactions with ketoconazole. **Ketoconazole will not be authorized for treatment for fungal infections of the skin and nails.**
ANTIFUNGALS, TOPICAL[AP]		
CLASS PA CRITERIA: Non-preferred agents require 14-day trials of two preferred agents before they will be approved, unless one of the exceptions on the PA form is present. If a non-preferred shampoo is requested, a 14-day trial of one preferred product (i.e., ketoconazole shampoo) is required.		
ANTIFUNGALS		
econazole ketoconazole cream, shampoo miconazole (OTC) nystatin	CICLODAN (ciclopirox) ciclopirox EXTINA (ketoconazole) GYNAZOLE 1 CREAM (butoconazole) KERYDIN (tavaborole) ketoconazole foam KETODAN (ketoconazole) luliconazole cream miconazole/petrolatum/zinc oxide naftifine cream NAFTIN GEL (naftifine) oxiconazole cream	Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. *Oxistat cream will be authorized for children up to 13 years of age for tinea corporis, tinea cruris, tinea pedis, and tinea (pityriasis) versicolor.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	OXISTAT (oxiconazole)* sulconazole nitrate cream, solution tavaborole 5% topical solution VUSION (miconazole/petrolatum/zinc oxide)	
ANTIFUNGAL/STEROID COMBINATIONS		
clotrimazole/betamethasone cream	clotrimazole/betamethasone lotion nystatin/triamcinolone	
ANTIHEMOPHILIA FACTOR AGENTS[CL/PA]		
CLASS PA CRITERIA: All agents will require prior authorization, and non-preferred agents require medical reasoning explaining why the need cannot be met using a preferred product. All currently established regimens shall be grandfathered with documentation of adherence to therapy.		
FACTOR VIII		
AFSTYLA ALPHANATE HEMOFIL M HUMATE-P JIVI KOATE KOGENATE FS KOVALTRY NOVOEIGHT NUWIQ WILATE XYNTHA XYNTHA SOLOFUSE	ADVATE ADYNOVATE ALTUVIIIO ELOCTATE ESPEROCT RECOMBINATE VONVENDI	
BYPASSING AGENTS		
	FEIBA NOVOSEVEN SEVENFACT	
FACTOR IX		
ALPHANINE SD ALPROLIX BENEFIX IXINITY MONONINE PROFILNINE RIXUBIS	IDELVION REBINYN	
NON-FACTOR REPLACEMENT		
HEMLIBRA (emicizumab-kxwh)	ALHEMO (concizumab-mtci)* HYMPAVZI (marstacimab-hncq)** QFITLIA (fitusiran)*	*Alhemo and Qfitlia may be approvable for routine prophylaxis to prevent or reduce the frequency of bleeding episodes in adults and pediatric patients greater than or equal to (≥) 12 years of age with hemophilia B (congenital factor IX deficiency) with or without factor IX inhibitors.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
		**Hympavzi may be approvable for routine prophylaxis to prevent or reduce the frequency of bleeding episodes in adults and pediatric patients greater than or equal to (≥) 12 years of age with hemophilia B (congenital factor IX deficiency) without factor IX inhibitors.
ANTIHYPERTENSIVES, SYMPATHOLYTICS		
CLASS PA CRITERIA: Non-preferred agents require 30-day trials of each preferred unique chemical entity in the corresponding formulation before they will be approved, unless one of the exceptions on the PA form is present.		
clonidine patches clonidine tablets		
ANTIHYPERURICEMICS		
CLASS PA CRITERIA: Non-preferred agents require a 30-day trial of one of the preferred agents for the prevention of gouty arthritis attacks (colchicine/probenecid, probenecid, or allopurinol) before they will be approved, unless one of the exceptions on the PA form is present.		
ANTIMITOTICS		
colchicine tablets	colchicine capsules COLCRYS TABLETS (colchicine) MITIGARE (colchicine) GLOPERBA (colchicine)*	In the case of acute gouty attacks, 10-day supply (20 units) of the preferred agent(s) in this subclass will be authorized for 90 days. *Gloperba may only be authorized for those who are unable to ingest solid dosage forms due to documented oral-motor difficulties or dysphagia.
ANTIMITOTIC-URICOSURIC COMBINATION		
colchicine/probenecid		
URICOSURIC		
probenecid		
XANTHINE OXIDASE INHIBITORS		
allopurinol febuxostat tablets	ULORIC (febuxostat) ZYLOPRIM (allopurinol)	
ANTIMIGRAINE AGENTS, PROPHYLAXIS[CL/PA]		
CLASS PA CRITERIA: All agents require prior authorization. Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. Non-preferred agents require a 90-day trial of all preferred agents		
AIMOVIG (erenumab) AJOVY (fremanezumab) EMGALITY AUTOINJECTOR, 120 mg SYRINGE (galcanezumab)	EMGALITY 300 mg SYRINGE (galcanezumab)* NURTEC ODT (rimegepant)** QULIPTA (atogepant)	*Emgality 300 mg/3 mL requires review by the Medical Director and is available only on appeal. **Nurtec ODT for a diagnosis of **Migraine Prophylaxis**: Maximum Quantity limit of 16 tablets per 32 days.
ANTIMIGRAINE AGENTS, ACUTE[AP]		
CLASS PA CRITERIA: Non-preferred agents require three-day trials of each preferred unique chemical entity as well as a three-day trial using the same route of administration as the requested agent (if available), before they will be approved, unless one of the exceptions on the PA form is present.		
TRIPTANS		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
naratriptan rizatriptan ODT rizatriptan tablets sumatriptan injection pens, vials sumatriptan nasal spray sumatriptan tablets zolmitriptan ODT zolmitriptan tablets	almotriptan AMERGE (naratriptan) eletriptan FROVA (frovatriptan) frovatriptan MAXALT (rizatriptan) MAXALT MLT (rizatriptan) ONZETRA XSAIL (sumatriptan)* RELPAX (eletriptan) TOSYMRA NASAL SPRAY (sumatriptan)* ZEMBRACE SYMTOUCH (sumatriptan) zolmitriptan nasal spray ZOMIG (zolmitriptan) ZOMIG ZMT (zolmitriptan)	***In addition to the Class Criteria:** Onzetra Xsail and Tosymra require three-day trials of each preferred injectable, nasal and oral forms of sumatriptan.
TRIPTAN COMBINATIONS		
	sumatriptan/naproxen sodium SYMBRAVO (meloxicam/rizatriptan)* TREXIMET (sumatriptan/naproxen sodium)	*Symbravo may be approved after the following has been met: 1. Symbravo is being used in adult patients for acute treatment of migraine with or without aura; AND 2. A trial resulting in an inadequate clinical response with sumatriptan/naproxen sodium; AND 3. A trial resulting in an inadequate clinical response with a preferred oral CGRP for migraine treatment; AND 4. Documentation is provided giving medical reasoning beyond convenience as to why the clinical need cannot be met with using a combination of the preferred individual components.
OTHER		
NURTEC ODT (rimegepant)* UBRELVY (ubrogepant)*	CAMBIA (diclofenac) D.H.E 45 AMPULE (dihydroergotamine)** dihydroergotamine injection, nasal spray** ELYXYB (celecoxib) MIGERGOT RECTAL SUPPOSITORY (ergotamine/caffeine)** REYVOW (lasmiditan)*** TRUDHESA NASAL SPRAY (dihydroergotamine) ZAVZPRET NASAL SPRAY (zavegepant)****	*Nurtec ODT and Ubrelvy For a diagnosis of **Migraine Treatment**: requires three-day trials of two preferred chemically distinct triptans before it may be approved, unless one of the exceptions on the PA form is present. Maximum Quantity: Nurtec- limit of eight tablets per 30 days. Ubrelvy- limit of ten tablets per 30 days. **All non-preferred Ergot Alkaloid agents require three-day trials of two preferred triptans as well as a three-day trial of a preferred triptan using the same route of administration as the

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
		requested agent (if available), before they will be approved, unless one of the exceptions on the PA form is present. **NOTE: Ergot derivatives should not be used with or within 24 hours of triptans.** ****Additional Ergot Alkaloid criteria:** **Rectal suppository:** Migergot rectal suppository may only be authorized after a trial and failure of a preferred triptan nasal spray. **Injection:** Dihydroergotamine injection and D.H.E 45 ampule may only be approved for cluster headaches. ***Reyvow requires a three-day trial of two preferred chemically distinct triptans as well as a three-day trial of Nurtec ODT and Ubrelvy before it may be approved, unless one of the exceptions on the PA form is present. ****Zavzpret may be authorized after a trial and failure of a preferred CGRP agent used for acute treatment **AND** trial and failure of two chemically distinct preferred triptans, including sumatriptan nasal spray (unless contraindicated).
ANTIPARASITICS, TOPICAL[AP]		
CLASS PA CRITERIA: Non-preferred agents require trials of each preferred agent (which are age and weight appropriate) before they will be approved, unless one of the exceptions on the PA form is present.		
NATROBA (spinosad) permethrin 5% cream pyrethrins-piperonyl butoxide (OTC) spinosad (NDC 52246-0570-04)	ELIMITE CREAM (permethrin) EURAX (crotamiton) ivermectin 0.5% lotion LICE EGG REMOVER (benzalkonium chloride) (OTC) lindane malathion OVIDE (malathion) PRURADIK (crotamiton) SKLICE (ivermectin) spinosad (all other NDCs) VANALICE (piperonyl/pyrethrum)	
ANTIPARKINSON'S AGENTS		
CLASS PA CRITERIA: Patients starting therapy on drugs in this class must show a documented allergy to all preferred agents in the corresponding subclass before a non-preferred agent will be authorized.		
ANTICHOLINERGICS		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
benztropine trihexyphenidyl		
CATECHOL-O-METHYLTRANSFERASE (COMT) INHIBITORS		
entacapone	COMTAN (entacapone) ONGENTYS (opicapone) tolcapone	COMT Inhibitor agents will only be approved as add-on therapy to a levodopa-containing regimen for treatment of documented motor complications.
DOPAMINE AGONISTS		
APOKYN PEN (apomorphine) bromocriptine pramipexole ropinirole	apomorphine cartridge KYNMOBI FILMS (apomorphine) MIRAPEX ER (pramipexole)* NEUPRO (rotigotine) pramipexole ER ropinirole ER	*Mirapex ER will be authorized for a diagnosis of Parkinsonism without a trial of preferred agents.
OTHER ANTIPARKINSON'S AGENTS		
amantadine[AP]* carbidopa/levodopa carbidopa/levodopa/entacapone selegiline	AZILECT (rasagiline) carbidopa CREXONT (carbidopa/levodopa) GOCOVRI ER (amantadine) INBRIJA (levodopa) carbidopa/levodopa ODT NOURIANZ (istradefylline) OSMOLEX ER (amantadine) PARLODEL (bromocriptine) rasagiline RYTARY (carbidopa/levodopa) SINEMET (carbidopa/levodopa) STALEVO (carbidopa/levodopa/entacapone) XADAGO (safinamide) ZELAPAR (selegiline)	*Amantadine will not be authorized for the treatment or prophylaxis of influenza.
ANTIPSORIATICS, TOPICAL		
CLASS PA CRITERIA: Non-preferred agents require a 30-day trial of a preferred agent. Documentation describing the reason for failure of the preferred agent must be provided. The required trial may be overridden when documented evidence is provided that the use of these preferred agent(s) would be medically contraindicated.		
calcipotriene solution ENSTILAR (calcipotriene/betamethasone) TACLONEX SUSPENSION (calcipotriene/betamethasone)	calcipotriene cream calcipotriene/betamethasone ointment, suspension calcitriol SORILUX (calcipotriene) tazarotene cream VTAMA (tapinarof) ZORYVE 0.3% CREAM*, FOAM** (roflumilast)	*Zoryve 0.3% cream or foam for ***plaque psoriasis***: Requires a 30-day trial of either Taclonex suspension, Enstilar, OR calcipotriene solution. Zoryve 0.3% foam for ***seborrheic dermatitis***: 1. Requires a concurrent trial with an antifungal shampoo (e.g., ketoconazole) AND a high potency corticosteroid (foam, lotion, shampoo or spray) for four weeks.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
		2. For seborrheic dermatitis NOT affecting the scalp: a. A concurrent trial with a topical antifungal (e.g., ketoconazole cream) AND a high potency corticosteroid for two weeks; AND b. A concurrent trial with a topical antifungal (e.g., ketoconazole cream) AND tacrolimus for four weeks.
ANTIPSYCHOTICS, ATYPICAL AND COMBINATION		
CLASS PA CRITERIA: All antipsychotic agents require prior authorization for children up to 18 years of age. All prior authorization requests for antipsychotics for children 6 years of age and younger will be reviewed by Medicaid's consultant psychiatrist. Non-preferred agents require 30-day trials of two preferred Atypical Antipsychotics approved or medically accepted for the member's diagnosis or indication, including the generic formulation of the requested agent (if available), before they will be approved unless one of the exceptions on the PA form is present. When determining requests for non-preferred products, any trial utilizing a preferred agent whose dose or duration was limited due to adverse effects or clear lack of efficacy will be considered complete only if the agent was being taken within the FDA-approved therapeutic range.* Patients shall be grandfathered onto their existing therapy, provided the requested agent is being used according to the manufacturer label. Continuation of therapy for an off-label indication or non-standard dosage may be granted a 30-day prior authorization while the medical director reviews the request. *According to manufacturer dosing recommendations.		
SINGLE INGREDIENT		
ABILIFY ASIMTUFII (aripiprazole)CL/PA ABILIFY MAINTENA (aripiprazole)CL/PA aripiprazole tablets ARISTADA (aripiprazole)CL/PA ARISTADA INITIO (aripiprazole)CL/PA asenapine sublingual tablets clozapine INVEGA HAFYERA (paliperidone)CL/PA* INVEGA SUSTENNA (paliperidone)CL/PA INVEGA TRINZA (paliperidone)CL/PA** lurasidone olanzapine olanzapine ODT paliperidone ER PERSERIS (risperidone)CL/PA quetiapineAP for the 25 mg Tablet Only*** quetiapine ER RYKINDO (risperidone) risperidone ODT, solution, tablets UZEDY (risperidone) VRAYLAR (cariprazine)******	ABILIFY TABLETS (aripiprazole) ABILIFY MYCITE (aripiprazole) ADASUVE (loxapine) aripiprazole ODT, solution CAPLYTA (lumateperone) clozapine ODT CLOZARIL (clozapine) COBENFY (xanomeline/trospium) ERZOFRI (paliperidone) FANAPT (iloperidone) GEODON (ziprasidone) GEODON IM (ziprasidone) INVEGA ER (paliperidone) LATUDA (lurasidone) LYBALVI (olanzapine/samidorphan)**** NUPLAZID (pimavanserin)***** olanzapine IMCL/PA olanzapine/fluoxetine OPIPZA FILMS (aripiprazole) REXULTI (brexpiprazole) RISPERDAL (risperidone)	**The following criteria exceptions apply to the specified products:** ***Invega Hafyera may only be authorized after four-month treatment with Invega Sustenna or at least one three-month cycle with Invega Trinza.** ****Invega Trinza will be authorized after four- month treatment with Invega Sustenna.** *****Quetiapine 25 mg will be authorized:** **1. For a diagnosis of schizophrenia; OR** **2. For a diagnosis of bipolar disorder; OR** **3. When prescribed concurrently with other** strengths of Seroquel in order to achieve therapeutic treatment levels. **Quetiapine 25 mg will not be authorized for**

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ziprasidone	RISPERDAL CONSTA (risperidone)[CL/PA] SAPHRIS (asenapine) SECUADO (asenapine) SEROQUEL (quetiapine) SEROQUEL XR (quetiapine) VERSACLOZ (clozapine) ZYPREXA (olanzapine) ZYPREXA IM (olanzapine)[CL/PA] ZYPREXA RELPREVV (olanzapine)	experienced clinically significant weight gain (documentation must be provided) which necessitated disruption of treatment. Patient must also have had an intolerance, inadequate treatment response or contraindication to two preferred antipsychotics, which have a lower potential of weight gain. ***Prior to initiating Lybalvi, there should be at least a seven-day opioid-free interval from the last use of short-acting opioids, and at least a 14-day opioid free interval from the last use of long-acting opioids to avoid precipitation of opioid withdrawal.*** *****Nuplazid may only be authorized for the treatment of Parkinson Disease Induced Psychosis after documented treatment failure with quetiapine. ******Vraylar may be authorized for the indication of major depressive disorder, as adjunct therapy, only after two separate trials and failures of two preferred antidepressants, each optimized up to a maximally tolerated therapeutic dose, for a minimum of 60 days. For all other indications, a trial and failure of one preferred antipsychotic optimized up to a maximally tolerated therapeutic dose, for a minimum of 60 days is required
ANTIRETROVIRALS[AP]		
CLASS PA CRITERIA: Non-preferred drugs require medical reasoning beyond convenience or enhanced compliance as to why the clinical need cannot be met with a preferred agent or combination of preferred agents. **NOTE**: Regimens consisting of preferred agents will result in no more than one additional unit per day over equivalent regimens composed of non-preferred agents. Patients already on a non-preferred regimen shall be grandfathered.		
SINGLE TABLET REGIMENS		
BIKTARVY (bictegravir/emtricitabine/tenofovir alafenamide) COMPLERA (emtricitabine/rilpivirine/tenofovir disoproxil fumarate) DELSTRIGO (doravirine/lamivudine/tenofovir disoproxil fumarate) DOVATO (dolutegravir/lamivudine) efavirenz/emtricitabine/tenofovir disoproxil fumarate GENVOYA (elvitegravir/cobicistat/emtricitabine/tenofovir alafenamide) ODEFSEY (emtricitabine/rilpivirine/tenofovir alafenamide)	ATRIPLA (efavirenz/emtricitabine/tenofovir disoproxil fumarate) efavirenz/lamivudine/tenofovir disoproxil fumarate JULUCA (dolutegravir/rilpivirine) STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir disoproxil fumarate)* SYMFI (efavirenz/lamivudine/tenofovir disoproxil fumarate) SYMFI LO (efavirenz/lamivudine/tenofovir disoproxil fumarate) SYMTUZA (darunavir/cobicistat/emtricitabine/tenofovir alafenamide)	*Stribild requires medical reasoning beyond convenience or enhanced compliance as to why the medical need cannot be met with the preferred agent Genvoya.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
TRIUMEQ (abacavir/dolutegravir/lamivudine)	TRIUMEQ PD (abacavir/dolutegravir/lamivudine)	
INTEGRASE STRAND TRANSFER INHIBITORS		
ISENTRESS (raltegravir potassium) TIVICAY (dolutegravir sodium) TIVICAY PD (dolutegravir sodium)	ISENTRESS HD (raltegravir potassium)	
NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTI)		
abacavir sulfate tablets EMTRIVA (emtricitabine) EPIVIR SOLUTION (lamivudine) lamivudine tenofovir disoproxil fumarate VIREAD ORAL POWDER (tenofovir disoproxil fumarate) ZIAGEN SOLUTION (abacavir sulfate) zidovudine	abacavir sulfate solution didanosine DR capsules emtricitabine capsules EPIVIR TABLETS (lamivudine) RETROVIR (zidovudine) stavudine VIDEX EC (didanosine) VIDEX SOLUTION (didanosine) VIREAD TABLETS (tenofovir disoproxil fumarate) ZIAGEN TABLETS (abacavir sulfate)	
NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITOR (NNRTI)		
efavirenz	EDURANT (rilpivirine) EDURANT PED (rilpivirine) etravirine INTELENCE (etravirine) nevirapine nevirapine ER PIFELTRO (doravirine) SUSTIVA (efavirenz) VIRAMUNE SUSPENSION (nevirapine) VIRAMUNE ER 24H (nevirapine)	
PHARMACOENHANCER – CYTOCHROME P450 INHIBITOR		
TYBOST (cobicistat)		
PROTEASE INHIBITORS (PEPTIDIC)		
atazanavir EVOTAZ (atazanavir/cobicistat) REYATAZ POWDER PACK (atazanavir) ritonavir tablets	fosamprenavir LEXIVA (fosamprenavir) NORVIR (ritonavir)* REYATAZ CAPSULES (atazanavir) VIRACEPT (nelfinavir mesylate)	*Norvir powder pack may be authorized for those who are unable to ingest solid dosage forms due to documented oral-motor difficulties or dysphagia.
PROTEASE INHIBITORS (NON-PEPTIDIC)		
darunavir PREZCOBIX (darunavir/cobicistat)	APTIVUS (tipranavir) PREZISTA (darunavir)	
ENTRY INHIBITORS – CCR5 CO-RECEPTOR ANTAGONISTS		
	maraviroc SELZENTRY (maraviroc)	
ENTRY INHIBITORS – FUSION INHIBITORS		
	FUZEON (enfuvirtide)*	*Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.
COMBINATION PRODUCTS – NRTIs		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
abacavir/lamivudine lamivudine/zidovudine	abacavir/lamivudine/zidovudine CIMDUO (lamivudine/tenofovir disoproxil fumarate) COMBIVIR (lamivudine/zidovudine) EPZICOM (abacavir/lamivudine) TEMIXYS (lamivudine/tenofovir disoproxil fumarate) TRIZIVIR (abacavir/lamivudine/zidovudine)	
COMBINATION PRODUCTS – NUCLEOSIDE & NUCLEOTIDE ANALOG RTIs		
DESCOVY (emtricitabine/tenofovir alafenamide) emtricitabine/tenofovir alafenamide	TRUVADA (emtricitabine/tenofovir alafenamide)	
COMBINATION PRODUCTS – PROTEASE INHIBITORS		
lopinavir/ritonavir	KALETRA (lopinavir/ritonavir)	
PRODUCTS FOR PRE-EXPOSURE PROPHYLAXIS (PrEP)		
APRETUDE (cabotegravir) DESCOVY (emtricitabine/tenofovir alafenamide) emtricitabine/tenofovir alafenamide YEZTUGO TABLETS, VIAL (lenacapavir)	TRUVADA (emtricitabine/tenofovir alafenamide)	
ANTIVIRALS, ORAL		
CLASS PA CRITERIA: Non-preferred agents require five-day trials of each preferred agent in the same subclass before they will be approved, unless one of the exceptions on the PA form is present.		
ANTI-HERPES		
acyclovir valacyclovir	famciclovir SITAVIG (acyclovir) VALTREX (valacyclovir)	
ANTI-INFLUENZA		
Oseltamivir PAXLOVID (nirmatrelvir/ritonavir)*	FLUMADINE (rimantadine) RELENZA (zanamivir) rimantadine TAMIFLU (oseltamivir) XOFLUZA (baloxavir)	**In addition to the Class Criteria:** The anti-influenza agents will be authorized only for a diagnosis of influenza. *Paxlovid may be authorized for the treatment of mild to moderate COVID-19 in adults who are at high risk for progression to severe COVID-19, including hospitalization or death.
ANTIVIRALS, TOPICAL[AP]		
CLASS PA CRITERIA: Non-preferred agents require a five-day trial of the preferred agent before they will be approved, unless one of the exceptions on the PA form is present.		
acyclovir ointment DENAVIR (penciclovir)	acyclovir cream docosanol cream penciclovir cream	
BETA BLOCKERS[AP]		
CLASS PA CRITERIA: Non-preferred agents require 14-day trials of three chemically distinct preferred agents, including the generic formulation of the requested non-preferred agent before they will be approved, unless one of the exceptions on the PA form is present.		
BETA BLOCKERS		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
acebutolol atenolol betaxolol bisoprolol HEMANGEOL (propranolol)* metoprolol metoprolol ER nadolol nebivolol pindolol propranolol propranolol ER SORINE (sotalol) sotalol timolol	BETAPACE (sotalol) BYSTOLIC (nebivolol) CORGARD (nadolol) INDERAL LA (propranolol) INDERAL XL (propranolol) INNOPRAN XL (propranolol) KAPSPARGO SPRINKLE (metoprolol) LOPRESSOR SOLUTION, TABLETS (metoprolol) TENORMIN (atenolol) TOPROL XL (metoprolol)	*Hemangeol will be authorized for the treatment of proliferating infantile hemangioma requiring systemic therapy.
BETA BLOCKER/DIURETIC COMBINATION DRUGS		
atenolol/chlorthalidone bisoprolol/HCTZ metoprolol/HCTZ propranolol/HCTZ	nadolol/bendroflumethiazide TENORETIC (atenolol/chlorthalidone) ZIAC (bisoprolol/HCTZ)	
BETA- AND ALPHA-BLOCKERS		
carvedilol labetalol	carvedilol ER capsules COREG (carvedilol) COREG CR (carvedilol)	
BLADDER RELAXANT PREPARATIONS[AP]		
CLASS PA CRITERIA: Non-preferred agents require 30-day trials of each chemically distinct preferred agent before they will be approved, unless one of the exceptions on the PA form is present		
DETROL LA (tolterodine) fesoterodine ER GELNIQUE (oxybutynin) MYRBETRIQ TABLETS (mirabegron) oxybutynin ER oxybutynin IR OXYTROL (oxybutynin) solifenacin	darifenacin ER tablets DETROL (tolterodine) DITROPAN XL (oxybutynin) ENABLEX (darifenacin) flavoxate GEMTESA (vibegron) mirabegron ER MYRBETRIQ SUSPENSION (mirabegron) tolterodine tolterodine ER TOVIAZ (fesoterodine) trospium trospium ER VESICARE (solifenacin) VESICARE LS (solifenacin)	
BONE RESORPTION SUPPRESSION AND RELATED AGENTS		
CLASS PA CRITERIA: See below for class criteria.		
BISPHOSPHONATES		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
alendronate tablets ibandronate	ACTONEL (risedronate) alendronate solution ATELVIA (risedronate) BINOSTO (alendronate) BONIVA (ibandronate) FOSAMAX TABLETS (alendronate) FOSAMAX PLUS D (alendronate/vitamin D) risedronate	Non-preferred agents require six-month trials of **each** preferred Bisphosphonate agent before they will be approved, unless one of the exceptions on the PA form is present.
OTHER BONE RESORPTION SUPPRESSION AND RELATED AGENTS		
	BONSITY (teriparatide) calcitonin EVISTA (raloxifene)* FORTEO (teriparatide) MIACALCIN (calcitonin) raloxifene* teriparatide TYMLOS (abaloparatide)	Non-preferred agents require a six-month trial of a preferred Bisphosphonate agent before they will be approved, unless one of the exceptions on the PA form is present. *Raloxifene will be authorized for postmenopausal women with osteoporosis who are at high risk for invasive breast cancer.
BPH TREATMENTS		
CLASS PA CRITERIA: See below for individual subclass criteria.		
5-ALPHA-REDUCTASE (5AR) INHIBITORS AND PDE-5 AGENTS		
finasteride	AVODART (dutasteride) CIALIS 5 mg (tadalafil) dutasteride ENTADFI CAPSULES (finasteride/tadalafil)* PROSCAR (finasteride) tadalafil	Non-preferred 5AR agents require a 30-day trial of finasteride before they will be approved, unless one of the exceptions on the PA form is present. Non-preferred PDE-5 agents require 30-day trials of finasteride **AND** a preferred alpha blocker before they will be approved, unless one of the exceptions on the PA form is present. *Documentation of medical reasoning beyond convenience must be provided as to why the clinical need cannot be met with finasteride used in combination with tadalafil.
ALPHA BLOCKERS		
alfuzosin doxazosin tamsulosin terazosin	CARDURA (doxazosin) CARDURA XL (doxazosin) FLOMAX (tamsulosin) RAPAFLO (silodosin) silodosin TEZRULY SOLUTION (terazosin)*	Non-preferred alpha blockers require 30-day trials of at least two preferred agents in this subclass, including the generic formulation of the requested non-preferred agent before they will be approved, unless one of the exceptions on the PA form is present. *Tezruly may only be authorized for those who are unable to ingest solid dosage forms of

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
		terazosin due to documented oral-motor difficulties or dysphagia.
5AR INHIBITORS/ALPHA BLOCKER COMBINATIONS		
	dutasteride/tamsulosin JALYN (dutasteride/tamsulosin)	**Substitute for Class Criteria:** Concurrent 30-day trials of dutasteride and tamsulosin are required before the non-preferred agent will be authorized.
BRONCHODILATORS, BETA AGONIST[AP]		
CLASS PA CRITERIA: Non-preferred agents require 30-day trials of each chemically distinct preferred agent in their corresponding subclass, unless one of the exceptions on the PA form is present.		
INHALATION SOLUTION		
albuterol	arformoterol BROVANA (arformoterol) formoterol levalbuterol metaproterenol PERFOROMIST (formoterol) XOPENEX (levalbuterol)*	*Xopenex Inhalation Solution will be authorized for 12 months for a diagnosis of asthma or COPD for patients on concurrent asthma controller therapy (either oral or inhaled) with documentation of failure on a trial of albuterol or documented intolerance of albuterol, or for concurrent diagnosis of heart disease.
INHALERS, LONG-ACTING		
SEREVENT (salmeterol)	STRIVERDI RESPIMAT (olodaterol)	
INHALERS, SHORT-ACTING		
albuterol HFA AIRSUPRA (albuterol/budesonide)* PROAIR HFA (albuterol) PROAIR RESPICLICK (albuterol) PROVENTIL HFA (albuterol) VENTOLIN HFA (albuterol)	PROAIR DIGIHALER (albuterol) XOPENEX HFA (levalbuterol)	*Airsupra may be approved for patients ≥ 18 years of age AND the patient has had a documented side effect, allergy, treatment failure, or a contraindication to Symbicort and Dulera being used as needed for asthma exacerbations. Additionally, medical reasoning beyond convenience, as to why the need cannot be met with the combination of preferred single agents (albuterol and budesonide), is required.
ORAL		
albuterol syrup	albuterol ER albuterol IR metaproterenol terbutaline	
CALCIUM CHANNEL BLOCKERS[AP]		
CLASS PA CRITERIA: Non-preferred agents require 14-day trials of each preferred agent within the corresponding subclass before they will be approved, unless one of the exceptions on the PA form is present.		
LONG-ACTING		
Amlodipine diltiazem CD diltiazem ER felodipine ER nifedipine ER	CALAN SR (verapamil) DILT-XR diltiazem LA KATERZIA SUSPENSION (amlodipine)* levamlodipine maleate	*Katerzia and Norliqva may be authorized for children who are six to 10 years of age who are unable to ingest solid dosage forms.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
verapamil ER	MATZIM LA (diltiazem) nisoldipine NORLIQVA (amlodipine)* NORVASC (amlodipine) PROCARDIA XL (nifedipine) SULAR (nisoldipine) verapamil ER PM VERELAN/VERELAN PM (verapamil)	Therapy may be authorized for older patients with clinical documentation indicating oral-motor difficulties or dysphagia. In addition, Norliqva may only be authorized for patients who have a documented allergy or are unable to tolerate Katerzia.
SHORT-ACTING		
diltiazem verapamil	isradipine nicardipine nifedipine nimodipine NYMALIZE SOLUTION (nimodipine) PROCARDIA (nifedipine)	
CEPHALOSPORINS AND RELATED ANTIBIOTICS		
CLASS PA CRITERIA: Non-preferred agents require a five-day trial of a preferred agent within the corresponding subclass before they will be approved, unless one of the exceptions on the PA form is present.		
BETA LACTAMS AND BETA LACTAM/BETA-LACTAMASE INHIBITOR COMBINATIONS		
amoxicillin/clavulanate IR	amoxicillin/clavulanate ER AUGMENTIN (amoxicillin/clavulanate)	
CEPHALOSPORINS		
cefaclor capsules cefadroxil tablets cefdinir cefuroxime tablets cephalexin capsules, suspension	cefaclor suspension cefaclor ER tablets cefadroxil capsules cefadroxil suspension cefixime cefpodoxime cefprozil cefuroxime suspension cephalexin tablets KEFLEX (cephalexin) SUPRAX (cefixime)	
COPD AGENTS		
CLASS PA CRITERIA: Non-preferred agents require a 60-day trial of one preferred agent from the corresponding subclass before they will be approved, unless one of the exceptions on the PA form is present.		
ANTICHOLINERGIC[AP]		
ATROVENT HFA (ipratropium) INCRUSE ELLIPTA (umeclidinium) ipratropium nebulizer solution SPIRIVA HANDIHALER (tiotropium) SPIRIVA RESPIMAT (tiotropium)	TUDORZA (aclidinium) YUPELRI SOLUTION (revefenacin)	
ANTICHOLINERGIC-BETA AGONIST COMBINATIONS[AP]		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
albuterol/ipratropium nebulizer solution ANORO ELLIPTA (umeclidinium/vilanterol) COMBIVENT RESPIMAT (albuterol/ipratropium) STIOLTO RESPIMAT (tiotropium/olodaterol)	BEVESPI (glycopyrrolate/formoterol) DUAKLIR PRESSAIR (aclidinium/formoterol)* umeclidinium/vilanterol	***In addition to the Class Criteria:** Duaklir Pressair requires 60-day trials of each long-acting preferred agent, as well as a 60-day trial of Stiolto Respimat.
ANTICHOLINERGIC-BETA AGONIST-GLUCOCORTICOID COMBINATIONS		
	BREZTRI AEROSPHERE (budesonide/ glycopyrrolate/formoterol)* TRELEGY ELLIPTA (fluticasone/umeclidinium/ vilanterol)**	*Breztri may be authorized for patients currently established on the individual components for at least 30 days. **Trelegy Ellipta may be authorized for patients currently established on the individual components for at least 30 days.
PHOSPHODIESTERASE INHIBITORS		
roflumilast	DALIRESP (roflumilast) OHTUVAYRE (ensifentrine)*	*Ohtuvayre may be authorized when used for maintenance treatment in patients with moderate-to-severe COPD **AND** the patient has had a documented side effect, allergy, treatment failure, or a contraindication to maximally tolerated dual therapy with at least one inhaled long-acting muscarinic antagonist (LAMA) **AND** at least one inhaled long-acting beta-agonist (LABA) **OR** maximally tolerated triple therapy with at least one inhaled LAMA + LABA **AND** at least one inhaled corticosteroid (when blood eosinophils greater than or equal to (>) 300 cells/microL).
CROHNS DISEASE, ORAL STEROIDS		
Please see the following PDL classes for PDL status of additional agents used for induction and remission: Cytokine and CAM Antagonists, Immunosuppressives, and Ulcerative Colitis Agents – Oral.		
budesonide ER capsules (generic ENTOCORT EC)	ENTOCORT EC (budesonide)* ORTIKOS (budesonide)*	*Entocort EC and Ortikos may only be authorized if the patient has a documented allergy, or intolerance, to generic budesonide 3 mg 24-hour capsules.
CYTOKINE & CAM ANTAGONISTS[CL/PA]		
CLASS PA CRITERIA: Non-preferred agents require 90-day trials of all preferred agents which are indicated for the diagnosis, unless one of the exceptions on the PA form is present. ***Patients stabilized for at least six months on their existing non-preferred regimen shall be grandfathered (provided the current therapy is for a labeled indication AND a more cost-effective biosimilar product is not available). In cases where a biosimilar exists but is also non-preferred, the PA vendor shall advise the provider which product is the most cost-effective agent. All off-label requests require review by the Medical Director.*** **Full PA criteria may be found on the** PA Criteria **page by clicking the hyperlink.**		
ANTI-TNFs		
adalimumab-fkjp AVSOLA (infliximab-axxq) ENBREL (etanercept) HADLIMA (adalimumab-bwwd) HUMIRA (adalimumab)	ABRILADA (adalimumab-afzb) adalimumab-aacf adalimumab-aaty adalimumab-adbm adalimumab-adaz	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
infliximab SIMLANDI (adalimumab-ryvk) SIMPONI SUBCUTANEOUS (golimumab)	AMJEVITA (adalimumab-atto) CIMZIA (certolizumab pegol) CYLTEZO (adalimumab-adbm) HULIO (adalimumab-fkjp) HYRIMOZ (adalimumab-adaz) IDACIO (adalimumab-aacf) INFLECTRA (infliximab-dyyb) REMICADE (infliximab) RENFLEXIS (infliximab-abda) YUFLYMA (adalimumab-aaty) YUSIMRY (adalimumab-aqvh) ZYMFENTRA (infliximab-dyyb)	
OTHERS		
KINERET (anakinra) ORENCIA CLICKJECT, VIALS (abatacept) OTEZLA (apremilast) PYZCHIVA (ustekinumab-ttwe)*** TALTZ (ixekizumab)* TYENNE (tocilizumab-aazg) XELJANZ (tofacitinib)	ACTEMRA ACTPEN (tocilizumab) ACTEMRA SUBCUTANEOUS (tocilizumab) BIMZELX (bimekizumab-bkzx) COSENTYX (secukinumab) ENTYVIO (vedolizumab) ILARIS (canakinumab) ILUMYA (tildrakizumab) IMULDOSA (ustekinumab-srlf) KEVZARA (sarilumab) OLUMIANT (baricitinib) OMVOH (mirikizumab-mrkz) ORENCIA SYRINGE (abatacept) OTEZLA XR (apremilast) OTULFI (ustekinumab-aauz) RINVOQ ER (upadacitinib)** SELARSDI (ustekinumab-aekn) SKYRIZI (risankizumab-rzaa) SOTYKTU (deucravacitinib) STELARA SUBCUTANEOUS (ustekinumab) STEQEYMA (ustekinumab-stba) TOFIDENCE (tocilizumab-bavi) TREMFYA (guselkumab) VELSIPITY (etrasimod) WEZLANA (ustekinumab-auub) XELJANZ XR (tofacitinib) YESINTEK (ustekinumab-kfce)	*Taltz will be authorized for treatment of plaque psoriasis, psoriatic arthritis, and ankylosing spondylitis only after inadequate response to a 90-day trial of one preferred Anti-TNF agent. **Full PA criteria for Rinvoq ER may be found on the PA Criteria page by clicking the hyperlink. ***In addition to the Class Criteria, Pyzchiva may be authorized for a diagnosis of an FDA approved indication after a 90-day trial of one preferred Anti-TNF agent.
DIABETES AGENTS, BIGUANIDES		
CLASS PA CRITERIA: Non-preferred agents require a 90-day trial of a preferred agent of similar duration before they will be approved, unless one of the exceptions on the PA form is present.		
metformin metformin ER (generic GLUCOPHAGE XR)	FORTAMET (metformin ER) GLUCOPHAGE XR (metformin ER) GLUMETZA (metformin ER)*	*Glumetza will be approved only after a 30-day trial of Fortamet.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	metformin solution (generic RIOMET) metformin ER (generic GLUMETZA and FORTAMET) RIOMET (metformin)	
DIABETES AGENTS, DPP-4 INHIBITORS		
CLASS PA CRITERIA: Non-preferred agents are available only on appeal. **NOTE:** DPP-4 inhibitors will NOT be approved in combination with a GLP-1 agonist.		
JANUMET (sitagliptin/metformin) JANUMET XR (sitagliptin/metformin) JANUVIA (sitagliptin) JENTADUETO (linagliptin/metformin) TRADJENTA (linagliptin)	alogliptin alogliptin/metformin alogliptin/pioglitazone BRYNOVIN SOLUTION (sitagliptin) JENTADUETO XR (linagliptin/metformin) KAZANO (alogliptin/metformin) KOMBIGLYZE XR (saxagliptin/metformin) NESINA (alogliptin) ONGLYZA (saxagliptin) OSENI (alogliptin/pioglitazone) sitagliptin sitagliptin/metformin ZITUVIMET (sitagliptin/metformin) ZITUVIMET XR (sitagliptin/metformin) ZITUVIO (sitagliptin)	
DIABETES AGENTS, GLP-1 AGONISTS[CL/PA]		
Preferred agents may be authorized with a diagnosis of Diabetes Mellitus Type II. **CLASS PA CRITERIA: Non-preferred agents will only be approved (in six-month intervals) if ALL of the following criteria have been met:** **1. Diagnosis of Diabetes Mellitus Type II.** **2. Current A1C must be submitted. Agents in this class will not be approved for patients with a starting A1C of less than (<) 7%.** **3. Documentation demonstrating 90 days of compliance on all current diabetic therapies is provided.** **4. Documentation demonstrating treatment failure with all unique preferred agents in the same class.** Re-authorizations will require documentation of continued compliance on all diabetic therapies and A1C levels must reach goal (either an A1C of less than or equal to (≤) 8% or demonstrated continued improvement). **NOTE: GLP-1 agents will NOT be approved in combination with a DPP-4 inhibitor.**		
OZEMPIC (semaglutide) TRULICITY (dulaglutide) VICTOZA (liraglutide)	BYDUREON BCISE (exenatide) BYETTA (exenatide) liraglutide MOUNJARO (tirzepatide) RYBELSUS (semaglutide)	
DIABETES AGENTS, INSULIN AND RELATED		
CLASS PA CRITERIA: Non-preferred agents require a 90-day trial of a pharmacokinetically similar agent before they will be approved, unless one of the exceptions on the PA form is present.		
APIDRA (insulin glulisine) HUMALOG (insulin lispro) HUMALOG U-100 KWIKPEN (insulin lispro)	ADMELOG (insulin lispro) AFREZZA (insulin)[CL/PA] BASAGLAR (insulin glargine)	*Non-preferred insulin combination products require that the patient must already be established on the individual agents at doses not

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
HUMALOG JR KWIKPEN (insulin lispro) HUMALOG MIX PENS, VIALS (insulin lispro/lispro protamine) HUMULIN 70/30 (insulin) HUMULIN R U-500 KWIKPEN (insulin) HUMULIN R U-500 VIALS (insulin) insulin aspart flexpen, penfill, vials insulin aspart/aspart protamine pens, vials insulin lispro U-100 kwikpen, vials LANTUS (insulin glargine) NOVOLOG (insulin aspart) NOVOLOG MIX (insulin aspart/aspart protamine) NOVOLIN N (insulin) SEMGLEE (insulin glargine) TOUJEO MAX SOLOSTAR (insulin glargine) TOUJEO SOLOSTAR (insulin glargine)	FIASP (insulin aspart) HUMALOG U-200 KWIKPEN (insulin lispro) HUMULIN PENS (insulin) HUMULIN N VIALS (insulin) HUMULIN R VIALS (insulin) insulin glargine insulin lispro junior kwikpen insulin lispro/lispro protamine mix LYUMJEV (insulin lispro) MERILOG (insulin aspart-szjj) NOVOLIN (insulin) REZVOGLAR (insulin glargine-aglr) SOLIQUA (insulin glargine/lixisenatide)* TRESIBA (insulin degludec)** TRESIBA FLEXTOUCH (insulin degludec)** XULTOPHY (insulin degludec/liraglutide)*	exceeding the maximum dose achievable with the combination product and require medical reasoning beyond convenience or enhanced compliance as to why the clinical need cannot be met with a combination of preferred single-ingredient agents. **Patients stabilized on Tresiba may be grandfathered at the request of the prescriber if the prescriber considers the preferred products to be clinically inappropriate. **Tresiba U-100 may be approved only for: Patients who have demonstrated at least a six-month history of compliance on a preferred long-acting insulin and who continue to have regular incidents of hypoglycemia. **Tresiba U-200 may be approved only for: Patients who require once daily doses of at least 60 units of long-acting insulin and have demonstrated at least a six-month history of compliance on a preferred long-acting insulin and who continue to have regular incidents of hypoglycemia.
DIABETES AGENTS, MEGLITINIDES		
CLASS PA CRITERIA: Non-preferred agents are available only on appeal.		
MEGLITINIDES		
nateglinide repaglinide	PRANDIN (repaglinide) STARLIX (nateglinide)	
MEGLITINIDE COMBINATIONS		
	repaglinide/metformin	
DIABETES AGENTS, MISCELLANEOUS		
CLASS PA CRITERIA: Welchol will be authorized for add-on therapy for Diabetes Mellitus Type II when there is a previous history of a 30-day trial of an oral diabetic agent.		
colesevelam	SYMLIN (pramlintide)* WELCHOL (colesevelam)[AP]	*Symlin will be authorized with a history of bolus insulin utilization in the past 90 days with no gaps in insulin therapy greater than (>) 30 days.
DIABETES AGENTS, SGLT2 INHIBITORS		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
CLASS PA CRITERIA: Non-preferred agents will only be approved (in six-month intervals) if ALL of the following criteria have been met: **1. Current A1C must be submitted. Agents in this class will not be approved for patients with a starting A1C of less than (<) 7%.** **2. Documentation demonstrating 90 days of compliance on all current diabetic therapies is provided.** **3. Documentation demonstrating treatment failure with all unique preferred agents in the same class.** Re-authorizations will require documentation of continued compliance on all diabetic therapies and A1C levels must reach goal (either an A1C of less than or equal to (≤) 8% or demonstrated continued improvement). **For all other FDA approved indications:** A 30-day trial and failure of each preferred SGLT2 is required.		
SGLT2 INHIBITORS		
FARXIGA (dapagliflozin) JARDIANCE (empagliflozin)	dapagliflozin INVOKANA (canagliflozin) STEGLATRO (ertugliflozin)	
SGLT2 COMBINATIONS		
GLYXAMBI (empagliflozin/linagliptin) SYNJARDY (empagliflozin/metformin) SYNJARDY XR (empagliflozin/metformin) TRIJARDY XR (empagliflozin/linagliptin/metformin) XIGDUO XR (dapagliflozin/metformin)	dapagliflozin/metformin INVOKAMET (canagliflozin/metformin) INVOKAMET XR (canagliflozin/metformin) QTERN (dapagliflozin/saxagliptin) SEGLUROMET (ertugliflozin/metformin) STEGLUJAN (ertugliflozin/sitagliptin)	
DIABETES AGENTS, TZD		
CLASS PA CRITERIA: Non-preferred agents are available only on appeal.		
THIAZOLIDINEDIONES		
pioglitazone	ACTOS (pioglitazone) AVANDIA (rosiglitazone)	
TZD COMBINATIONS		
	ACTOPLUS MET (pioglitazone/metformin)* DUETACT (pioglitazone/glimepiride)* pioglitazone/glimepiride pioglitazone/metformin	*Patients are required to use the components of Actoplus Met and Duetact separately. Exceptions will be handled on a case-by-case basis.
DRY EYE PRODUCTS		
CLASS PA CRITERIA: Non-preferred agents require a 60-day trial of the preferred agent(s).		
RESTASIS (cyclosporine) XIIDRA (lifitegrast)	CEQUA (cyclosporine) cyclosporine dropperette MIEBO RESTASIS MULTIDOSE (cyclosporine)* TRYPTYR (acoltremon) TYRVAYA (varenicline) VEVYE (cyclosporine)	*Restasis Multidose is approvable only on appeal and requires medical reasoning as to why the clinical need cannot be met with the preferred product (Restasis).
DUCHENNE MUSCULAR DYSTROPHY (DMD), CORTICOSTEROIDS		
CLASS PA CRITERIA: Non-preferred agents are available only on appeal.		
AGAMREE (vamorolone)* EMFLAZA TABLETS (deflazacort)*	deflazacort* EMFLAZA SUSPENSION (deflazacort) JAYTHARI (deflazacort)*	*Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
EPINEPHRINE, SELF-ADMINISTERED		
CLASS PA CRITERIA: A non-preferred agent may be authorized with documentation showing the patient's inability to follow the instructions, or the patient's failure to understand the training for the preferred agent(s).		
epinephrine (labeler 49502 only) EPIPEN (epinephrine) EPIPEN JR (epinephrine)	AUVI-Q (epinephrine) epinephrine (all labelers except 49502) NEFFY NASAL SPRAY (epinephrine) SYMJEPI (epinephrine)	
ERYTHROPOIESIS STIMULATING PROTEINS[CL/PA]		
CLASS PA CRITERIA: Non-preferred agents require a 30-day trial of a preferred agent before they will be approved, unless one of the exceptions on the PA form is present.		
EPOGEN (rHuEPO) RETACRIT (epoetin alpha)	ARANESP (darbepoetin) MIRCERA (methoxy PEG-epoetin) PROCRIT (rHuEPO)	Erythropoiesis agents will be authorized if the following criteria are met: 1. Hemoglobin or hematocrit less than (<) 10/30 respectively. For renewal, hemoglobin or hematocrit levels greater than (>) 12/36 will require dosage reduction or discontinuation. Exceptions will be considered on an individual basis after medical documentation is reviewed (laboratory values must be dated within six weeks of request); AND 2. Transferrin saturation greater than or equal to (>) 20%, ferritin levels greater than or equal to (>) 100 mg/ml, or on concurrent therapeutic iron therapy (laboratory values must be dated within three weeks of request). For re-authorization, transferrin saturation or ferritin levels are not required if the patient has been responsive to the erythropoietin agent; AND 3. For HIV-infected patients, endogenous serum erythropoietin level must be less than or equal to (≤) 500 mU/ml to initiate therapy; AND 4. No evidence of untreated GI bleeding, hemolysis, or Vitamin B-12, iron or folate deficiency.
FLUOROQUINOLONES, ORAL[AP]		
CLASS PA CRITERIA: Non-preferred agents require a five-day trial of a preferred agent before they will be approved, unless one of the exceptions on the PA form is present.		
CIPRO SUSPENSION (ciprofloxacin) ciprofloxacin levofloxacin tablets	BAXDELA (delafloxacin) CIPRO TABLETS (ciprofloxacin) ciprofloxacin suspension	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	levofloxacin solution moxifloxacin ofloxacin	
GLUCOCORTICOIDS, INHALED[AP]		
CLASS PA CRITERIA: Non-preferred agents require 30-day trials of each chemically unique preferred agent before they will be approved, unless one of the exceptions on the PA form is present.		
GLUCOCORTICOIDS		
ARNUITY ELLIPTA (fluticasone) ASMANEX TWISTHALER (mometasone) budesonide 0.5 mg/2 ml and 0.25 mg/2 ml nebulizer solution PULMICORT FLEXHALER (budesonide)	ALVESCO (ciclesonide) ARMONAIR DIGIHALER (fluticasone) ASMANEX HFA (mometasone)* budesonide 1 mg/2 ml nebulizer solution fluticasone HFA* PULMICORT NEBULIZER SOLUTION (budesonide) QVAR REDIHALER (beclomethasone)	*Fluticasone HFA and Asmanex HFA are approved for children less than or equal to (≤) 10 years of age.
GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS		
ADVAIR DISKUS (fluticasone/salmeterol) ADVAIR HFA (fluticasone/salmeterol) DULERA (mometasone/formoterol) SYMBICORT (budesonide/formoterol)	AIRDUO DIGIHALER (fluticasone/salmeterol) AIRDUO RESPICLICK (fluticasone/salmeterol) BREO ELLIPTA (fluticasone/vilanterol) budesonide/formoterol fluticasone/salmeterol fluticasone/vilanterol WIXELA (fluticasone/salmeterol)	
GROWTH HORMONES AND ACHONDROPLASIA AGENTS[CL/PA]		
CLASS PA CRITERIA: Non-preferred agents require three-month trials of each preferred agent before they will be approved, unless one of the exceptions on the PA form is present.		
GENOTROPIN (somatropin) NORDITROPIN (somatropin)	HUMATROPE (somatropin) INCRELEX (mecasermin) NGENLA (somatrogon-ghla) NUTROPIN AQ (somatropin) OMNITROPE (somatropin) SAIZEN (somatropin) SEROSTIM (somatropin) SKYTROFA (lonapegsomatropin) SOGROYA (somapacitan-beco) VOXZOGO (vosoritide)* ZOMACTON (somatropin) ZORBTIVE (somatropin)	Patients already on a non-preferred agent will receive authorization to continue therapy on that agent for the duration of the existing PA. *Full PA criteria for Voxzogo may be found on the PA Criteria page by clicking the hyperlink.
***H. PYLORI* TREATMENT**		
CLASS PA CRITERIA: Non-preferred agents require a trial of the combination of individual preferred components of the requested non-preferred agent and must be used at the recommended dosages, frequencies, and duration of the non-preferred agent before they will be approved, unless one of the exceptions on the PA form is present.		
Please use individual components: 1. preferred PPI (omeprazole or pantoprazole)	HELIDAC (bismuth/metronidazole/tetracycline) lansoprazole/amoxicillin/clarithromycin	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
2. amoxicillin 3. tetracycline capsules 4. metronidazole 5. clarithromycin 6. bismuth PYLERA (bismuth/metronidazole/tetracycline)	OMECLAMOX-PAK (omeprazole/amoxicillin/ clarithromycin) TALICIA (omeprazole/amoxicillin/rifabutin) tetracycline tablets VOQUEZNA DUAL PAK (vonoprazan/amoxicillin) VOQUEZNA TRIPLE PAK (vonoprazan/amoxicillin/ clarithromycin)	
HEART FAILURE TREATMENTS		
This is not an all-inclusive list of agents available for the treatment of heart failure. Please see the following classes for PDL status of additional agents: Beta Blockers and SGLT2 agents.		
sacubitril/valsartan	ENTRESTO (sacubitril/valsartan)* ENTRESTO SPRINKLE CAPSULES (sacubitril/ valsartan)** INPEFA (sotagliflozin)*** KERENDIA (finerenone) VERQUVO (vericiguat)****	*Entresto may be authorized only for patients greater than or equal to (≥) 1 year of age diagnosed with chronic heart failure **Entresto sprinkle capsules may be authorized for children who are 1 to 9 years of age who are unable to ingest solid dosage forms. Therapy may be authorized for older patients with clinical documentation indicating oral-motor difficulties or dysphagia. ***Inpefa may be authorized for an FDA approved indication **AND** clinical reasoning must be provided as to why the medical need cannot be met with a preferred SGLT2 agent. ****Full PA criteria for Verquvo may be found on the PA Criteria page by clicking the hyperlink.
HEPATITIS B TREATMENTS		
CLASS PA CRITERIA: Non-preferred agents require 90-day trials of each preferred agent before they will be approved, unless one of the exceptions on the PA form is present.		
BARACLUDE SOLUTION (entecavir)* entecavir lamivudine HBV	adefovir BARACLUDE TABLETS (entecavir) EPIVIR HBV (lamivudine) HEPSERA (adefovir) VEMLIDY (tenofovir alafenamide)	*Baraclude solution may be authorized only for those who are unable to ingest solid dosage forms due to documented oral-motor difficulties or dysphagia.
HEPATITIS C TREATMENTS		
CLASS PA CRITERIA: Requests for non-preferred regimens require medical reasoning why a preferred regimen cannot be used.		
MAVYRET (pibrentasvir/glecaprevir) ribavirin sofosbuvir/velpatasvir (labeler 72626)	EPCLUSA (sofosbuvir/velpatasvir) HARVONI (ledipasvir/sofosbuvir) ledipasvir/sofosbuvir PEGASYS (pegylated interferon) PEG-INTRON (pegylated interferon) RIBASPHERE 400 mg and 600 mg (ribavirin) RIBASPHERE RIBAPAK (ribavirin)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	SOVALDI (sofosbuvir) VIEKIRA XR (dasabuvir/ombitasvir/paritaprevir/ritonavir)* VOSEVI (sofosbuvir/velpatasvir/voxilaprevir) ZEPATIER (elbasvir/grazoprevir)	
HYPERPARATHYROID AGENTS[AP]		
CLASS PA CRITERIA: Non-preferred agents require 30-day trials of each preferred agent before they will be approved, unless one of the exceptions on the PA form is present.		
cinacalcet paricalcitol capsules	doxercalciferol HECTOROL (doxercalciferol) paricalcitol injection RAYALDEE (calcifediol) SENSIPAR (cinacalcet) ZEMPLAR (paricalcitol)	
HYPERPHOSPHATEMIA AGENTS[AP]		
CLASS PA CRITERIA: Non-preferred agents require a 30-day trial of at least two preferred agents, one of which must be sevelamer carbonate, unless one of the exceptions on the PA form is present.		
calcium acetate capsules CALPHRON (calcium acetate) MAGNEBIND RX (calcium carbonate/folic acid/magnesium carbonate) sevelamer carbonate	AURYXIA (ferric citrate) calcium acetate tablets FOSRENOL (lanthanum) lanthanum chewable tablets RENAGEL (sevelamer) RENVELA (sevelamer carbonate) sevelamer carbonate powder packets sevelamer HCl VELPHORO (sucroferric oxyhydroxide) XPHOZAH (tenapanor)*	*One additional 30-day trial of a non-preferred phosphate binder (such as ferric citrate, lanthanum, or Velphoro) is required prior to Xphozah approval.
HYPOGLYCEMIA TREATMENTS		
CLASS PA CRITERIA: Non-preferred agents require clinical reasoning beyond convenience why the preferred glucagon products cannot be used.		
BAQSIMI SPRAY (glucagon) glucagon vial glucagon emergency kit GVOKE (glucagon) ZEGALOGUE (dasiglucagon)	GLUCAGEN HYPOKIT (glucagon)	
HYPOPARATHYROID AGENTS		
	YORVIPATH (palopegteriparatide)*	*Yorvipath may be authorized for adult patients diagnosed with hypoparathyroidism who have documentation supporting the inability to achieve disease control with conventional therapies such as prescribed calcium supplements and prescribed active forms of vitamin D.
IMMUNOMODULATORS, ATOPIC DERMATITIS		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
CLASS PA CRITERIA: Non-preferred agents require a 30-day trial of a medium to high potency topical corticosteroid **AND all** preferred agents in this class, unless one of the exceptions on the PA form is present. Requirement for topical corticosteroids may be excluded with involvement of sensitive areas such as the face and skin folds.		
SYSTEMIC TREATMENTS		
ADBRY (tralokinumab)* DUPIXENT (dupilumab)* EBGLYSS (lebrikizumab)*	CIBINQO (abrocitinib)* NEMLUVIO (nemolizumab-ilto)*	*Full PA criteria may be found on the PA Criteria page by clicking the hyperlink
TOPICAL TREATMENTS		
OPZELURA CREAM (ruxolitinib)* tacrolimus ointment	ANZUPGO (delgocitinib) EUCRISA (crisaborole)[AP]** pimecrolimus cream VTAMA (tapinarof) ZORYVE 0.15% CREAM (roflumilast)***	*Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. **Eucrisa requires a 30-day trial of tacrolimus **OR** a medium to high potency corticosteroid unless contraindicated. ***Zoryve 0.15% cream for Atopic Dermatitis requires 30-day trials each of a medium to high potency topical corticosteroid AND tacrolimus ointment.
IMMUNOMODULATORS, GENITAL WARTS & ACTINIC KERATOSIS AGENTS		
CLASS PA CRITERIA: Non-preferred agents require 30-day trials of each preferred agent before they will be approved, unless one of the exceptions on the PA form is present.		
CONDYLOX GEL (podofilox) fluorouracil 5% cream imiquimod cream	ALDARA (imiquimod) diclofenac 3% gel fluorouracil 0.5% cream imiquimod pump podofilox VEREGEN (sinecatechins)	
IMMUNOSUPPRESSIVES, ORAL		
CLASS PA CRITERIA: Non-preferred agents require a 14-day trial of a preferred agent before they will be approved, unless one of the exceptions on the PA form is present		
azathioprine cyclosporine cyclosporine, modified mycophenolate mofetil sirolimus tacrolimus capsules	ASTAGRAF XL (tacrolimus) CELLCEPT (mycophenolate mofetil) ENVARSUS XR (tacrolimus) everolimus tablets IMURAN (azathioprine) LUPKYNIS (voclosporin)* mycophenolic acid mycophenolic mofetil suspension MYFORTIC (mycophenolic acid) MYHIBBIN (mycophenolate mofetil suspension)*** NEORAL (cyclosporine, modified) PROGRAF (tacrolimus) RAPAMUNE (sirolimus) REZUROCK (belumosudil)**	*Lupkynis requires a 90-day trial of Benlysta prior to approval. Full PA criteria for Lupkynis may be found on the PA Criteria page by clicking the hyperlink. **Rezurock may be authorized after a trial of two systemic treatments for chronic graft-versus-host disease. Examples of systemic therapy may include methylprednisolone, Imbruvica (ibrutinib capsules and tablets), cyclosporine, tacrolimus, sirolimus, imatinib and mycophenolate mofetil. ***Myhibbin may be authorized for those who are unable to ingest solid dosage forms due to

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	SANDIMMUNE (cyclosporine) ZORTRESS (everolimus)	documented oral-motor difficulties or dysphagia AND documentation is provided as to why the clinical need cannot be met with mycophenolate suspension.
INTRANASAL RHINITIS AGENTS[AP]		
CLASS PA CRITERIA: See below for individual subclass criteria.		
ANTICHOLINERGICS		
ipratropium	ATROVENT (ipratropium)	Non-preferred agents require 30-day trials of one preferred nasal anti-cholinergic agent, **AND** one preferred antihistamine, **AND** one preferred intranasal corticosteroid agent before they will be approved, unless one of the exceptions on the PA form is present.
ANTIHISTAMINES		
azelastine olopatadine	PATANASE (olopatadine)	
COMBINATIONS		
	azelastine/fluticasone DYMISTA (azelastine/fluticasone)* RYALTRIS (olopatadine HCl/mometasone)**	*Dymista requires a concurrent 30-day trial of each preferred component before it will be approved, unless one of the exceptions on the PA form is present. **Ryaltris requires a 30-day trial of each individual component before it may be approved.
CORTICOSTEROIDS		
fluticasone propionate OMNARIS (ciclesonide) QNASL HFA (beclomethasone)	BECONASE AQ (beclomethasone) flunisolide mometasone NASONEX (mometasone)	Non-preferred agents require 30-day trials of each preferred agent in this subclass before they will be approved, unless one of the exceptions on the PA form is present.
IRRITABLE BOWEL SYNDROME/SHORT BOWEL SYNDROME/SELECTED GI AGENTS		
CLASS PA CRITERIA: All agents are approvable only for patients 18 years of age and older. **See below for additional subclass criteria**		
CONSTIPATION		
LINZESS 145 mcg and 290 mcg (linaclotide) lubiprostone capsules MOVANTIK (naloxegol)	AMITIZA (lubiprostone) IBSRELA (tenapanor) LINZESS 72 mcg (linaclotide) MOTEGRITY (prucalopride) prucalopride SYMPROIC (naldemedine)	No agent shall be approved to treat opioid induced constipation (OIC) without evidence of at least 90 days of opioid use preceding the request. Continuation of coverage shall be granted with evidence of continuous and concurrent opioid use. **Agents may be authorized only for their FDA-approved labeled indication. The following agent-specific criteria shall also apply, unless one of the exceptions on the PA form is present:**

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
		Ibsrela requires 30-day trials of each preferred agent for IBS-C, however for males, a trial of lubiprostone is not required. **Linzess 72 mcg** may only be approved for a diagnosis of chronic idiopathic constipation (CIC) AND for those who cannot tolerate the 145 mcg dose. Linzess may also be approvable for a diagnosis of functional constipation for pediatric patients 6 to 17 years of age. **Motegrity** requires a 30-day trial of both lubiprostone and Linzess. **Symproic** is indicated for OIC and require 30-day trials of both Movantik and lubiprostone.
DIARRHEA		
	alosetron LOTRONEX (alosetron) MYTESI (crofelemer) VIBERZI (eluxadoline)	Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.
LAXATIVES AND CATHARTICS		
CLASS PA CRITERIA: Non-preferred agents require trials of each preferred agent before they will be approved, unless one of the exceptions on the PA form is present.		
CLENPIQ (sodium picosulfate/magnesium oxide/ citric acid) COLYTE GOLYTELY NULYTELY peg 3350 sodium sulfate/potassium sulfate/magnesium sulfate (generic SUPREP)	peg 3350/sodium sulfate/sodium chloride/potassium chloride/sodium ascorbate/ascorbic acid (generic MOVIPREP) SUFLAVE (peg 3350/sodium sulfate/potassium chloride/magnesium sulfate/sodium chloride) SUPREP SUTAB (sodium sulfate/magnesium sulfate/potassium chloride)	
LEUKOTRIENE MODIFIERS		
CLASS PA CRITERIA: Non-preferred agents require 30-day trials of each preferred agent before they will be approved, unless one of the exceptions on the PA form is present.		
montelukast zafirlukast	ACCOLATE (zafirlukast) SINGULAIR (montelukast) zileuton ZYFLO (zileuton)	
LIPOTROPICS, OTHER (Non-statins)		
CLASS PA CRITERIA: Non-preferred agents require a 12-week trial of a preferred agent before they will be approved, unless one of the exceptions on the PA form is present.		
APOC-III-DIRECTED ASO		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	TRYNGOLZA (olezarsen)*	*Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.
BEMPEDOIC ACIDS		
	NEXLIZET (bempedoic acid/ezetimibe) NEXLETOL (bempedoic acid)	* Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.
BILE ACID SEQUESTRANTS[AP]		
cholestyramine colesevelam colestipol tablets	COLESTID (colestipol) colestipol granules QUESTRAN (cholestyramine) WELCHOL (colesevelam)*	*Welchol will be authorized for add-on therapy for Diabetes Mellitus Type II when there is a previous history of a 30-day trial of an oral agent (metformin, sulfonylurea, or thiazolidinedione [TZD]). See Diabetes Agents, Miscellaneous.
CHOLESTEROL ABSORPTION INHIBITORS		
ezetimibe	ZETIA (ezetimibe)	
FATTY ACIDS		
omega-3 acid ethyl esters	icosapent ethyl capsules* LOVAZA (omega-3-acid ethyl esters)	*Icosapent ethyl capsules may be approved if the following criteria are met (A or B): A. The patient has a triglyceride level of at least 500 mg/dL and has previously completed at least a 12-week trial on omega-3 acid ethyl esters; OR B. The patient has an initial triglyceride level of at least 150 mg/dL; AND The patient has either established cardiovascular disease or diabetes; **AND** The patient will be concurrently receiving a statin.
FIBRIC ACID DERIVATIVES[AP]		
fenofibrate 54 mg and 160 mg fenofibrate micronized 67 mg, 134 mg and 200 mg fenofibrate nanocrystallized 48 mg and 145 mg gemfibrozil	ANTARA (fenofibrate) fenofibrate 40 mg tablets fenofibrate 150 mg capsules fenofibrate 43 mg, 50 mg, 120 mg and 130 mg fenofibrate micronized 30 mg and 90 mg fenofibric acid FENOGLIDE (fenofibrate) FIBRICOR (fenofibric acid) LIPOFEN (fenofibrate) LOPID (gemfibrozil) TRICOR (fenofibrate nanocrystallized) TRILIPIX (fenofibric	
MTP INHIBITORS		
	JUXTAPID (lomitapide)*	*Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.
PCSK-9 INHIBITORS		
PRALUENT (alirocumab)* REPATHA (evolocumab)*	LEQVIO (inclisiran)*	*Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
LIPOTROPICS, STATINS[AP]		
CLASS PA CRITERIA: See below for individual subclass criteria.		
STATINS		
atorvastatin lovastatin pravastatin rosuvastatin simvastatin**	ALTOPREV (lovastatin) ATORVALIQ (atorvastatin)*** CRESTOR (rosuvastatin) EZALLOR SPRINKLE (rosuvastatin)* fluvastatin fluvastatin ER LESCOL XL (fluvastatin) LIPITOR (atorvastatin) LIVALO (pitavastatin) PRAVACHOL (pravastatin) ZOCOR (simvastatin)** ZYPITAMAG (pitavastatin)	Non-preferred agents require 12-week trials of two preferred agents, including the generic formulation of the requested non-preferred agent, before they will be approved, unless one of the exceptions on the PA form is present. *Ezallor sprinkle will only be authorized for those who are unable to ingest solid dosage forms due to documented oral-motor difficulties or dysphagia. **Zocor/simvastatin 80 mg tablets will require a clinical PA. ***Atorvaliq may be authorized for children who are 6 to 10 years of age who are unable to ingest solid dosage forms. Atorvaliq may be authorized for older patients with clinical documentation indicating oral-motor difficulties or dysphagia.
STATIN COMBINATIONS		
	amlodipine/atorvastatin CADUET (amlodipine/atorvastatin) ezetimibe/simvastatin* VYTORIN (ezetimibe/simvastatin)*	Non-preferred agents require 30-day concurrent trials of the corresponding preferred single agents before they will be approved, unless one of the exceptions on the PA form is present. *Vytorin will be authorized only after an insufficient response to a 12-week trial of the maximum tolerable dose of atorvastatin or rosuvastatin, unless one of the exceptions on the PA form is present. Vytorin 80/10 mg tablets will require a clinical PA.
MABS, ANTI-IL/IgE		
CLASS PA CRITERIA: Non-preferred agents require 90-day trials of all preferred agents which are indicated for the diagnosis. **Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.**		
DUPIXENT (dupilumab) FASENRA (benralizumab) NUCALA AUTOINJECTOR, SYRINGE (mepolizumab) XOLAIR VIAL (omalizumab)	NUCALA VIAL (mepolizumab) TEZSPIRE (tezepelumab-ekko) XOLAIR SYRINGE (omalizumab)	
MACROLIDES		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
CLASS PA CRITERIA: Non-preferred agents require a five-day trial of each preferred agent before they will be approved, unless one of the exceptions on the PA form is present.		
MACROLIDES		
azithromycin packet, suspension, tablets clarithromycin tablets	clarithromycin suspension clarithromycin ER E.E.S. (erythromycin ethylsuccinate) ERY-TAB (erythromycin) ERYPED (erythromycin ethylsuccinate) ERYTHROCIN (erythromycin stearate) erythromycin tablets erythromycin DR capsules, tablets erythromycin estolate ZITHROMAX (azithromycin)	
MAJOR ADVERSE CARDIOVASCULAR EVENT (MACE) REDUCTION AGENTS, GLP-1 AGONISTS		
CLASS PA CRITERIA: Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.		
WEGOVY		
METABOLIC DYSFUNCTION-ASSOCIATED STEATOHEPATITIS (MASH)		
CLASS PA CRITERIA: *Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.		
WEGOVY*	REZDIFFRA (resmetirom)*	
MULTIPLE SCLEROSIS AGENTS		
CLASS PA CRITERIA: Non-preferred agents require 90-day trials of two chemically unique preferred agents (in the same subclass) before they will be approved, unless one of the exceptions on the PA form is present.		
INTERFERONS[AP]		
AVONEX (interferon beta-1a) AVONEX PEN (interferon beta-1a) BETASERON (interferon beta-1b) REBIF (interferon beta-1a) REBIF REBIDOSE (interferon beta-1a)	EXTAVIA KIT (interferon beta-1b) EXTAVIA VIAL (interferon beta-1b) PLEGRIDY (peginterferon beta-1a)	
NON-INTERFERONS		
COPAXONE 20 mg (glatiramer) dalfampridine ER dimethyl fumarate fingolimod KESIMPTA INJECTION (ofatumumab) teriflunomide	AMPYRA (dalfampridine) AUBAGIO (teriflunomide) BAFIERTAM CAPSULES (monomethyl fumarate) COPAXONE 40 mg (glatiramer)* GILENYA (fingolimod) glatiramer GLATOPA (glatiramer) MAVENCLAD (cladribine) MAYZENT (siponimod)** PONVORY (ponesimod) TASCENSO ODT (fingolimod lauryl sulfate) TECFIDERA (dimethyl fumarate) VUMERITY (diroximel fumarate) ZEPOSIA (ozanimod)	*Copaxone 40 mg will only be authorized for documented injection site issues. **Mayzent may be authorized with no additional requirement beyond the diagnosis for patients with documented secondary progressive MS.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
NEUROPATHIC PAIN		
CLASS PA CRITERIA: Non-preferred agents require a 30-day trial of a preferred agent in the corresponding dosage form (oral or topical) before they will be approved, unless one of the exceptions on the PA form is present.		
capsaicin (OTC) duloxetine gabapentin lidocaine 5% patches LYRICA CAPSULES, SOLUTION (pregabalin) pregabalin capsules	CYMBALTA (duloxetine) DRIZALMA SPRINKLE (duloxetine)* gabapentin ER (generic GRALISE) GRALISE (gabapentin)** HORIZANT (gabapentin)*** lidocaine 4% patches LIDODERM (lidocaine) LYRICA CR (pregabalin)**** NEURONTIN (gabapentin) pregabalin solution pregabalin ER tablets (generic LYRICA CR) SAVELLA (milnacipran)***** ZTLIDO PATCHES (lidocaine)	*Drizalma sprinkle will only be authorized for those who are unable to ingest solid dosage forms due to documented oral-motor difficulties or dysphagia. **Gralise will be authorized only if the following criteria are met: 1. Diagnosis of postherpetic neuralgia; AND 2. Trial of a TCA for at least 30 days; AND 3. Ninety-day trial of gabapentin immediate release formulation (positive response without adequate duration); AND 4. The request is for once daily dosing with 1800 mg maximum daily dosage. ***Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. ****Lyrica CR requires medical reasoning beyond convenience as to why the need cannot be met using preferred pregabalin capsules. *****Savella will be authorized for a diagnosis of fibromyalgia only after a 90-day trial of one preferred agent.
NSAIDS[AP]		
CLASS PA CRITERIA: See below for subclass PA criteria.		
NON-SELECTIVE		
diclofenac IR diclofenac SR flurbiprofen ibuprofen capsules, chewable tablets, suspension, tablets (Rx, OTC) indomethacin ketoprofen ketorolac meloxicam tablets nabumetone naproxen sodium capsules, tablets naproxen sodium DS tablets piroxicam	DAYPRO (oxaprozin) diclofenac potassium capsules, tablets diflunisal EC-naproxen DR tablets etodolac IR etodolac SR famotidine/ibuprofen FELDENE (piroxicam) fenoprofen INDOCIN SUPPOSITORIES (indomethacin) INDOCIN SUSPENSION (indomethacin) indomethacin ER ketoprofen ER	Non-preferred agents require 30-day trials of each preferred agent before they will be approved, unless one of the exceptions on the PA form is present.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
sulindac	ketorolac spray LOFENA (diclofenac) meclofenamate mefenamic acid meloxicam suspension meloxicam submicronized capsules (generic VIVLODEX) MOBIC TABLETS (meloxicam) NALFON (fenoprofen) NAPRELAN (naproxen) naproxen suspension naproxen CR oxaprozin RELAFEN DS (nabumetone) SPRIX (ketorolac) TIVORBEX (indomethacin) tolmetin VIVLODEX (meloxicam) VOLTAREN (diclofenac) ZIPSOR (diclofenac potassium) ZORVOLEX (diclofenac)	
NSAID/GI PROTECTANT COMBINATIONS		
	ARTHROTEC (diclofenac/misoprostol) diclofenac/misoprostol ibuprofen/famotidine naproxen/esomeprazole VIMOVO (naproxen/esomeprazole)	Non-preferred agents are only available on appeal and require medical reasoning beyond convenience as to why the need cannot be met with the combination of preferred single agents.
COX-II SELECTIVE		
celecoxib	CELEBREX (celecoxib)	
TOPICAL		
diclofenac gel (Rx)*	diclofenac patches diclofenac solution LICART PATCHES (diclofenac) PENNSAID (diclofenac)	Non-preferred agents require a 30-day trial of the preferred topical agent and 30-day trials of each preferred oral NSAID before they will be approved, unless one of the exceptions on the PA form is present. *Diclofenac gel will be limited to 100 grams per month.
OBSTRUCTIVE SLEEP APNEA AGENTS		
CLASS PA CRITERIA:		
ZEPBOUND (tirzepatide)*		*Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.
OPHTHALMIC ANTIBIOTICS[AP]		
CLASS PA CRITERIA: Non-preferred agents require three-day trials of each preferred agent before they will be approved, unless one of the excerptions on the PA form is present.		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
bacitracin/polymyxin ointment ciprofloxacin* erythromycin gentamicin moxifloxacin* neomycin/bacitracin/polymyxin ofloxacin* polymyxin/trimethoprim tobramycin TOBREX OINTMENT (tobramycin)	AZASITE (azithromycin) bacitracin BESIVANCE (besifloxacin)* BLEPH-10 (sulfacetamide) CILOXAN (ciprofloxacin)* gatifloxacin* neomycin/polymyxin/gramicidin OCUFLOX (ofloxacin)* POLYTRIM (polymyxin/trimethoprim) sulfacetamide drops sulfacetamide ointment TOBREX (tobramycin) VIGAMOX (moxifloxacin)* XDEMVY (lotilaner)** ZYMAXID (gatifloxacin)*	*Prior authorization of any fluoroquinolone agent requires three-day trials of all other preferred agents unless definitive laboratory cultures exist indicating the need to use a fluoroquinolone. Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. **Xdemvy may be authorized for the treatment of demodex blepharitis without further restrictions.
OPHTHALMIC ANTIBIOTIC/STEROID COMBINATIONS[AP]		
CLASS PA CRITERIA: Non-preferred agents require three-day trials of each preferred agent before they will be approved, unless one of the exceptions on the PA form is present.		
MAXITROL OINTMENT, SUSPENSION (neomycin/polymyxin/dexamethasone) neomycin/bacitracin/polymyxin/hydrocortisone neomycin/polymyxin/dexamethasone PRED-G SUSPENSION (prednisolone/gentamicin) sulfacetamide/prednisolone TOBRADEX OINTMENT (tobramycin/dexamethasone) TOBRADEX SUSPENSION (tobramycin/dexamethasone) TOBRADEX ST (tobramycin/dexamethasone) tobramycin/dexamethasone suspension ZYLET (loteprednol/tobramycin)	neomycin/polymyxin/hydrocortisone PRED-G OINTMENT (prednisolone/gentamicin)	
OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS[AP]		
CLASS PA CRITERIA: Non-preferred agents require 30-day trials of three preferred chemically unique agents before they will be approved, unless one of the exceptions on the PA form is present.		
ALAWAY (ketotifen) ALREX (loteprednol) azelastine BEPREVE (bepotastine) cromolyn EYSUVIS (loteprednol) ketotifen ZADITOR (ketotifen) (OTC)	ALOCRIL (nedocromil) ALOMIDE (lodoxamide) bepotastine epinastine loteprednol LUMIFY (brimonidine) olopatadine 0.1% olopatadine 0.2% PATADAY ONCE and TWICE DAILY (olopatadine) ZERVIATE (cetirizine)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
OPHTHALMICS, ANTI-INFLAMMATORIES		
CLASS PA CRITERIA: Non-preferred agents require five-day trials of at least two preferred agents before they will be approved, unless one of the exceptions on the PA form is present. Trials must include at least one agent with the same mechanism of action as the requested non-preferred agent.		
dexamethasone diclofenac DUREZOL (difluprednate) FLAREX (fluorometholone) FML (fluorometholone) FML FORTE (fluorometholone) FML S.O.P. (fluorometholone) ketorolac LOTEMAX GEL, OINTMENT, SUSPENSION (loteprednol) MAXIDEX (dexamethasone) NEVANAC (nepafenac) PRED FORTE (prednisolone) PRED MILD (prednisolone) prednisolone acetate prednisolone sodium phosphate	ACULAR (ketorolac) ACULAR LS (ketorolac) ACUVAIL (ketorolac tromethamine) bromfenac BROMSITE (bromfenac) difluprednate fluorometholone flurbiprofen ILEVRO (nepafenac) INVELTYS (loteprednol) LOTEMAX SM (loteprednol etabonate) loteprednol drops, gel OMNIPRED (prednisolone) OZURDEX (dexamethasone) PROLENSA (bromfenac) RETISERT (fluocinolone) TRIESENCE (triamcinolone)	
OPHTHALMICS, GLAUCOMA AGENTS		
CLASS PA CRITERIA: Non-preferred agents will only be authorized if there is an allergy to all preferred agents in the corresponding subclass.		
COMBINATION AGENTS		
COMBIGAN (brimonidine/timolol) dorzolamide/timolol SIMBRINZA (brinzolamide/brimonidine)	brimonidine-timolol COSOPT PF (dorzolamide/timolol)	
BETA BLOCKERS		
BETOPTIC S (betaxolol) carteolol levobunolol timolol drops	betaxolol ISTALOL (timolol) timolol gel TIMOPTIC (timolol)	
CARBONIC ANHYDRASE INHIBITORS		
AZOPT (brinzolamide) dorzolamide	brinzolamide TRUSOPT (dorzolamide)	
PARASYMPATHOMIMETICS		
pilocarpine		
PROSTAGLANDIN ANALOGS		
latanoprost TRAVATAN-Z (travoprost)	bimatoprost IYUZEH (latanoprost) LUMIGAN (bimatoprost) tafluprost travoprost VYZULTA (latanoprostene)* XALATAN (latanoprost)	*Vyzulta prior authorization requires failure on a three-month trial of at least one preferred prostaglandin eye drop used in combination with an agent from another subclass.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	XELPROS (latanoprost) ZIOPTAN (tafluprost)	
	RHO-KINASE INHIBITORS	
RHOPRESSA (netarsudil) ROCKLATAN (netarsudil/latanoprost)		
	SYMPATHOMIMETICS	
ALPHAGAN P SOLUTION (brimonidine) brimonidine 0.2%	apraclonidine brimonidine 0.15% IOPIDINE (apraclonidine)	
OPIATE DEPENDENCE TREATMENTS		
CLASS PA CRITERIA: Bunavail and Zubsolv may only be approved with a documented intolerance or allergy to Suboxone films AND buprenorphine/naloxone tablets. *West Virginia Medicaid's buprenorphine coverage policy may be viewed by clicking on the following hyperlink: Buprenorphine Coverage Policy and Related Forms		
BRIXADI (buprenorphine)CL/PA buprenorphine/naloxone tablets KLOXXADO NASAL SPRAY (naloxone) naloxone cartridge, syringe, vials naloxone nasal spray (OTC) NARCAN NASAL SPRAY (naloxone) REXTOVY NASAL SPRAY (naloxone) SUBLOCADE (buprenorphine solution)CL/PA SUBOXONE FILMS (buprenorphine/naloxone) VIVITROL (naltrexone)	BUNAVAIL FILMS (buprenorphine/naloxone) buprenorphine tablets buprenorphine/naloxone films lofexidine LUCEMYRA (lofexidine)* naloxone nasal spray (Rx) OPVEE NASAL SPRAY (nalmefene) ZIMHI (naloxone hydrochloride) ZUBSOLV (buprenorphine/naloxone)	*Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.
ORAL AND TOPICAL CONTRACEPTIVES		
CLASS PA CRITERIA: Non-preferred agents require a trial with three preferred contraceptive products including a trial with a preferred product with the same route of administration as the requested non-preferred agent before they will be approved, unless one of the exceptions on the PA form is present.		
ALTAVERA AMETHYST APRI AUBRA EQ AUROVELA AVIANE AYUNA AZURETTE BALZIVA BEYAZ BLISOVI FE CAMILA CAMRESE 3 MONTH CHATEAL EQ CYRED EQ DEBLITANE DOLISHALE	ALYACEN AMETHIA 3 MONTH ARANELLE ASHLYNA 3 MONTH AUROVELA 24 FE AUROVELA FE BALCOLTRA BLISOVI 24 FE BRIELLYN CAMRESE LO 3 MONTH CHARLOTTE 24 FE CHEWABLE TABLETS CRYSELLE DASETTA DAYSEE 3 MONTH drospirenone-ethinyl estradiol-levomefolate ECONTRA ONE-STEP ELINEST	*Phexxi may be approvable when it is prescribed for the prevention of pregnancy; **AND** reasoning is provided as to why the clinical need cannot be met with a preferred agent. Phexxi will not be approved for use by patients who are also using hormonal contraceptive vaginal rings.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
drospirenone-ethinyl estradiol ENSKYCE ERRIN ESTARYLLA FALMINA HAILEY FE HEATHER INCASSIA ISIBLOOM JENCYCLA JOLESSA 3 MONTH JULEBER JUNEL FE KARIVA KURVELO LARIN FE LESSINA LEVONEST levonorgestrel levonorgestrel-ethinyl estradiol levonorgestrel-ethinyl estradiol 3 month (generic LOSEASONIQUE) levonorgestrel-ethinyl estradiol-ferrous bisglycinate LO LOESTRIN FE LORYNA LUTERA LYLEQ MARLISSA MIBELAS 24 FE MICROGESTIN FE MILI MONO-LINYAH MY CHOICE MY WAY NATAZIA NEW DAY NIKKI NORA-BE norethindrone norethindrone-ethinyl estradiol norethindrone-ethinyl estradiol-iron tablets norgestimate-ethinyl estradiol NYLIA OCELLA PORTIA SHAROBEL	ELLA ENPRESSE ethynodiol-ethinyl estradiol FINZALA GEMMILY HAILEY HAILEY 24 FE ICLEVIA 3 MONTH INTROVALE 3 MONTH JAIMIESS 3 MONTH JASMIEL JOYEAUX JUNEL JUNEL FE 24 KAITLIB FE KALLIGA KELNOR 1-35 KELNOR 1-50 LARIN LARIN 24 FE LAYOLIS FE CHEWABLE TABLETS LEENA levonorgestrel-ethinyl estradiol 3 month (generic JOLESSA) LOESTRIN LOESTRIN FE LOJAIMIESS 3 MONTH LOW-OGESTREL LO-ZUMANDIMINE MICROGESTIN MINZOYA NECON NEXTSTELLIS norethindrone-ethinyl estradiol-iron capsules norethindrone-ethinyl estradiol-iron chewable tablets NORTREL OPILL (norgestrel) (OTC) OPTION 2 PHEXXI VAGINAL GEL* PHILITH PIMTREA QUARTETTE RECLIPSEN RIVELSA 3 MONTH SAFYRAL SETLAKIN 3 MONTH	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
SIMLIYA SPRINTEC SRONYX TARINA FE 1-20 EQ TAYTULLA TRI-ESTARYLLA TRI-LINYAH TRI-LO-ESTARYLLA TRI-LO-MARZIA TRI-LO-MILI TRI-LO-SPRINTEC TRI-MILI TRI-SPRINTEC TRI-VYLIBRA TRI-VYLIBRA LO TWIRLA PATCHES VIENVA VIORELE VOLNEA VYLIBRA YASMIN-28 YAZ ZAFEMY PATCHES ZOVIA 1-35 ZUMANDIMINE	SIMPESSE 3 MONTH SLYND SYEDA TARINA 24 FE TILIA FE TRI-LEGEST FE TURQOZ TYBLUME CHEWABLE TABLETS VELIVET VESTURA VYFEMLA WERA WYMZYA FE CHEWABLE TABLETS XULANE PATCHES	
OTIC ANTIBIOTICS[AP]		
CLASS PA CRITERIA: Non-preferred agents require five-day trials of each preferred agent before they will be approved, unless one of the exceptions on the PA form is present.		
CIPRO HC (ciprofloxacin/hydrocortisone) ciprofloxacin/dexamethasone CORTISPORIN-TC (colistin/hydrocortisone/neomycin) neomycin/polymyxin/HC solution, suspension ofloxacin	ciprofloxacin ciprofloxacin/fluocinolone OTOVEL (ciprofloxacin/fluocinolone)	
PULMONARY ARTERY HYPERTENSION (PAH) AGENTS[CL/PA]		
CLASS PA CRITERIA: Non-preferred agents require a 30-day trial of a preferred agent before they will be approved, unless one of the exceptions on the PA form is present.		
ACTIVIN SIGNALING INHIBITOR		
	WINREVAIR (sotatercept-csrk)*	*Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.
COMBINATIONS		
	OPSYNVI (macitentan/tadalafil)*	*Opsynvi requires review by the Medical Director and is available only on appeal.
ENDOTHELIN RECEPTOR ANTAGONISTS		
bosentan	ambrisentan	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
LETAIRIS (ambrisentan)	OPSUMIT (macitentan) TRACLEER SUSPENSION (bosentan)	
GUANYLATE CYCLASE INHIBITORS		
	ADEMPAS (riociguat)*	*Adempas requires a 30-day trial of a preferred agent from any other PAH Class before it may be approved, unless one of the exceptions on the PA form is present.
PAH AGENTS – PDE5s		
sildenafil tablets	ADCIRCA (tadalafil) LIQREV (sildenafil)* REVATIO IV (sildenafil) REVATIO TABLETS (sildenafil) sildenafil suspension (generic REVATIO)** TADLIQ SUSPENSION (tadalafil)***	*Liqrev may be authorized for those who are unable to ingest solid dosage forms due to documented oral-motor difficulties or dysphagia **AND** documentation is provided as to why the clinical need cannot be met with sildenafil suspension. **Sildenafil suspension may be authorized for those who are unable to ingest solid dosage forms due to documented oral-motor difficulties or dysphagia. ***Tadliq may be authorized for those who are unable to ingest solid dosage forms due to documented oral-motor difficulties or dysphagia **AND** after a 30-day trial of sildenafil suspension resulting in an inadequate treatment response.
PAH AGENTS – PROSTACYCLINS		
epoprostenol (generic FLOLAN) epoprostenol (generic VELETRI)	FLOLAN (epoprostenol) ORENITRAM ER (treprostinil) REMODULIN (treprostinil sodium) treprostinil (generic REMODULIN) TYVASO (treprostinil) TYVASO DPI (treprostinil) UPTRAVI (selexipag) VELETRI (epoprostenol) YUTREPIA (treprostinil)	
PANCREATIC ENZYMES[AP]		
CLASS PA CRITERIA: Non-preferred agents require a 30-day trial of a preferred agent before they will be approved, unless one of the exceptions on the PA form is present. For members with cystic fibrosis, a trial of a preferred agent will not be required.		
CREON PERTZYE ZENPEP	VIOKACE	
PITUITARY SUPPRESSIVE AGENTS, LHRH[CL/PA]		
CLASS PA CRITERIA: Unless otherwise noted, non-preferred agents are available only on appeal.		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
FENSOLVI SYRINGE (leuprolide acetate) LUPANETA (leuprolide) LUPRON DEPOT KIT (leuprolide) LUPRON DEPOT-PED KIT (leuprolide) MYFEMBREE (relugolix/estradiol/norethindrone)* ORILISSA (elagolix)* SYNAREL (nafarelin) TRELSTAR (triptorelin) TRIPTODUR (triptorelin)	leuprolide ORIAHNN (elagolix/estradiol/norethindrone)* SUPPRELIN LA KIT (histrelin)	*Full PA criteria for Myfembree, Orilissa and Oriahnn may be found on the PA Criteria page by clicking the hyperlink. In addition, Orilissa and Oriahnn may only be approved if there is a documented side effect, allergy, or treatment failure with Myfembree. Use of GnRH receptor antagonists will be limited to 24 months.
PLATELET AGGREGATION INHIBITORS		
CLASS PA CRITERIA: Non-preferred agents require a 30-day trial of a preferred agent before they will be approved, unless one of the exceptions on the PA form is present.		
BRILINTA (ticagrelor) clopidogrel dipyridamole prasugrel ticagrelor 90 mg tablets (generic BRILINTA 90 mg)	clopidogrel kit dipyridamole/aspirin EFFIENT (prasugrel) PLAVIX (clopidogrel) ticagrelor 60 mg tablets (generic BRILINTA 60 mg) ZONTIVITY (vorapaxar)	
POTASSIUM REMOVING AGENTS		
CLASS PA CRITERIA: Non-preferred agents require a 30-day trial of a preferred agent before they will be approved, unless one of the exceptions on the PA form is present.		
LOKELMA (sodium zirconium cyclosilicate) VELTASSA (patiromer calcium sorbitex)	KIONEX (sodium polystyrene sulfonate) SPS (sodium polystyrene sulfonate)	
PROGESTINS FOR CACHEXIA		
CLASS PA CRITERIA: Non-preferred agents require a 30-day trial of a preferred agent before they will be approved, unless one of the exceptions on the PA form is present.		
megestrol		
PROTON PUMP INHIBITORS (PPI)[AP]		
CLASS PA CRITERIA: Non-preferred agents require 60-day trials of both omeprazole (Rx) and pantoprazole at the maximum recommended dose, inclusive of a concurrent 30-day trial at the maximum dose of an H_2 antagonist before they will be approved, unless one of the exceptions on the PA form is present.		
omeprazole (Rx) pantoprazole tablets PROTONIX GRANULES (pantoprazole)*	ACIPHEX (rabeprazole) ACIPHEX SPRINKLE (rabeprazole) DEXILANT (dexlansoprazole) dexlansoprazole DR capsules esomeprazole magnesium KONVOMEP (omeprazole/sodium bicarbonate) lansoprazole (Rx) NEXIUM (esomeprazole) NEXIUM PACKETS (esomeprazole) omeprazole/sodium bicarbonate (Rx) pantoprazole granule packets PREVACID CAPSULES (lansoprazole) PREVACID SOLUTABS (lansoprazole)* PRILOSEC (omeprazole) (Rx)	*Prior authorization is required for members 9 years of age or older for these agents. **Voquezna is NOT a PPI but will remain on the PDL in this class due to similar indications.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	PROTONIX DR TABLETS (pantoprazole) rabeprazole VOQUEZNA (vonoprazan)** ZEGERID (omeprazole/sodium bicarbonate) (Rx)	
SEDATIVE HYPNOTICS[AP]		
CLASS PA CRITERIA: Non-preferred agents require 30-day trials of all preferred agents in **BOTH subclasses** before they will be approved, unless one of the exceptions on the PA form is present. All agents except melatonin will be limited to 15 tablets in a 30-day period. **NOTE**: WV Medicaid covers melatonin up to a maximum dose of 9 mg/day without a PA. Melatonin labeler code 51645 is preferred. Please refer to the posted Covered OTC Products for a complete list of payable NDCs.		
BENZODIAZEPINES		
temazepam 15 mg and 30 mg	estazolam flurazepam HALCION (triazolam) RESTORIL (temazepam) temazepam 7.5 mg and 22.5 mg triazolam	
OTHER		
BELSOMRA (suvorexant)** melatonin ROZEREM (ramelteon) zolpidem 5 mg and 10 mg	AMBIEN (zolpidem) AMBIEN CR (zolpidem) DAYVIGO (lemborexant) doxepin 3 mg and 6 mg EDLUAR (zolpidem) eszopiclone HETLIOZ (tasimelteon)[CL]* LUNESTA (eszopiclone) QUVIVIQ (daridorexant) ramelteon SILENOR (doxepin) tasimelteon zaleplon zolpidem ER 6.25 mg and 12.5 mg	For treatment naïve female patients, zolpidem and zolpidem ER maximum dosages will be limited to 5 mg and 6.25 mg respectively per day. *Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. **Belsomra may be approved after a trial of zolpidem or temazepam, unless one of the exceptions on the PA form is present.
SKELETAL MUSCLE RELAXANTS[AP]		
CLASS PA CRITERIA: See below for individual subclass criteria.		
ACUTE MUSCULOSKELETAL RELAXANT AGENTS		
chlorzoxazone (generic PARAFON FORTE) cyclobenzaprine IR 5 mg and 10 mg methocarbamol	AMRIX (cyclobenzaprine) carisoprodol* carisoprodol/ASA* carisoprodol/ASA/codeine* chlorzoxazone (generic LORZONE) cyclobenzaprine ER cyclobenzaprine IR 7.5 mg FEXMID (cyclobenzaprine) LORZONE (chlorzoxazone) metaxalone orphenadrine	Non-preferred agents require 30-day trials of each preferred agent before they will be approved, unless one of the exceptions on the PA form is present, with the exception of carisoprodol. *Carisoprodol requires 30-day trials of each of the preferred acute musculoskeletal relaxants and metaxalone before it will be approved.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	orphenadrine ER ROBAXIN (methocarbamol) SKELAXIN (metaxalone) SOMA (carisoprodol) TANLOR (methocarbamol)	
MUSCULOSKELETAL RELAXANT AGENTS USED FOR SPASTICITY		
baclofen tizanidine tablets	baclofen solution, suspension* DANTRIUM (dantrolene) dantrolene FLEQSUVY SUSPENSION (baclofen)* LYVISPAH GRANULE PACKETS (baclofen)* tizanidine capsules ZANAFLEX (tizanidine)	Non-preferred agents require 30-day trials of each preferred agent before they will be approved, unless one of the exceptions on the PA form is present. *Oral baclofen solution/suspension, Fleqsuvy suspension and Lyvispah granules may only be authorized for those who are unable to ingest solid dosage forms due to documented oral-motor difficulties or dysphagia.
STEROIDS, TOPICAL		
CLASS PA CRITERIA: Non-preferred agents require five-day trials of one form of **EACH** preferred unique active ingredient in the corresponding potency group before they will be approved, unless one of the exceptions on the PA form is present.		
VERY HIGH & HIGH POTENCY		
betamethasone dipropionate cream betamethasone valerate cream, lotion, ointment clobetasol emollient clobetasol propionate cream, gel, ointment, shampoo, solution fluocinonide gel triamcinolone acetonide cream, lotion, ointment	amcinonide APEXICON E (diflorasone diacetate) betamethasone dipropionate gel, lotion, ointment clobetasol lotion clobetasol propionate foam, spray CLODAN KIT (clobetasol propionate) CLODAN SHAMPOO (clobetasol propionate) desoximetasone cream, gel, ointment, spray diflorasone diacetate DIPROLENE (betamethasone dipropionate/propylene glycol) fluocinonide cream, emollient, ointment, solution halcinonide cream halobetasol propionate IMPEKLO LOTION (clobetasol propionate) KENALOG (triamcinolone acetonide) LEXETTE FOAM (halobetasol) OLUX (clobetasol propionate) OLUX-E (clobetasol propionate emulsion) PSORCON (diflorasone diacetate) TEMOVATE (clobetasol propionate) TOPICORT CREAM, GEL, OINTMENT, SPRAY (desoximetasone) TOVET FOAM (clobetasol) ULTRAVATE (halobetasol propionate)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	ULTRAVATE PAC cream	
	MEDIUM POTENCY	
fluticasone propionate cream, ointment mometasone furoate triamcinolone acetonide 0.025% cream triamcinolone acetonide 0.1% cream	BESER LOTION (fluticasone) betamethasone valerate foam clocortolone cream CORDRAN (flurandrenolide) CUTIVATE (fluticasone propionate) fluocinolone acetonide cream, ointment, solution flurandrenolide cream, lotion, ointment fluticasone propionate lotion hydrocortisone butyrate cream, ointment, solution hydrocortisone valerate LUXIQ (betamethasone valerate) PANDEL (hydrocortisone probutate) prednicarbate	
	LOW POTENCY	
fluocinolone oil hydrocortisone cream (Rx, OTC) hydrocortisone lotion hydrocortisone ointment (Rx, OTC) hydrocortisone solution (OTC) hydrocortisone acetate (Rx, OTC) hydrocortisone/aloe cream (OTC) hydrocortisone/ aloe ointment (OTC)	alclometasone dipropionate AQUA GLYCOLIC HC (hydrocortisone) DERMA-SMOOTHE FS (fluocinolone acetonide) DESONATE (desonide) desonide cream, lotion, ointment hydrocortisone/aloe gel hydrocortisone/mineral oil/petrolatum hydrocortisone acetate/urea SCALPICIN (hydrocortisone) (OTC) SYNALAR (fluocinolone) TEXACORT (hydrocortisone)	
STIMULANTS AND RELATED AGENTS		
CLASS PA CRITERIA: A prior authorization is required for adults 18 years of age or older. Non-preferred agents require a 30-day trial of at least one preferred agent in the same subclass and with a similar duration of effect and mechanism of action, unless one of the exceptions on the PA form is present. **NOTE**: Children under 18 years of age may continue their existing therapy at the discretion of the prescriber.		
	AMPHETAMINES	
ADDERALL XR (amphetamine salt combination) amphetamine salt combination ER amphetamine salt combination IR dextroamphetamine ER dextroamphetamine IR DYANAVEL XR SUSPENSION (amphetamine) PROCENTRA SOLUTION (dextroamphetamine)	ADDERALL (amphetamine salt combination) ADZENYS ER SUSPENSION (amphetamine) ADZENYS XR ODT (amphetamine) amphetamine tablets DESOXYN (methamphetamine) DEXEDRINE ER (dextroamphetamine) dextroamphetamine solution DYANAVEL XR TABLETS (amphetamine) EVEKEO (amphetamine) EVEKEO ODT (amphetamine) lisdexamfetamine capsules, chewable tablets methamphetamine MYDAYIS (dextroamphetamine/amphetamine salt)*	**In addition to the Class Criteria**: 30-day trials of at least three antidepressants are required before amphetamines will be authorized for depression. *Mydayis requires a 30-day trial of at least one long-acting preferred agent in this subclass and a trial of Adderall XR.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	VYVANSE CAPSULES (lisdexamfetamine) VYVANSE CHEWABLE TABLETS (lisdexamfetamine) XELSTRYM PATCHES (dextroamphetamine) ZENZEDI (dextroamphetamine)	
NON-AMPHETAMINE		
atomoxetine* clonidine ER clonidine IR CONCERTA (methylphenidate) dexmethylphenidate IR dexmethylphenidate XR guanfacine ER guanfacine IR methylphenidate solution methylphenidate CD capsules methylphenidate ER tablets (generic RITALIN SR) methylphenidate ER 24 tablets (generic CONCERTA) methylphenidate ER CD capsules methylphenidate IR QUILLICHEW ER (methylphenidate) QUILLIVANT XR (methylphenidate) RITALIN LA (methylphenidate)	ADHANSIA XR (methylphenidate) APTENSIO XR (methylphenidate) AZSTARYS (dexmethylphenidate/ serdexmethylphenidate) COTEMPLA XR ODT (methylphenidate) DAYTRANA (methylphenidate) FOCALIN IR (dexmethylphenidate) FOCALIN XR (dexmethylphenidate) INTUNIV (guanfacine ER) JORNAY PM (methylphenidate) METHYLIN SOLUTION (methylphenidate) methylphenidate chewable tablets methylphenidate ER capsules methylphenidate ER 72 mg tablets methylphenidate ER LA capsules methylphenidate LA capsules methylphenidate patches ONYDA XR (clonidine) QELBREE (viloxazine)** RELEXXII (methylphenidate ER) RITALIN (methylphenidate) STRATTERA (atomoxetine)*	*Strattera is limited to a maximum of 100 mg per day. **Qelbree may be authorized after a 30-day trial and failure of either two preferred ADHD agents OR atomoxetine.
NARCOLEPTIC AGENTS		
armodafinil* modafinil*	NUVIGIL (armodafinil)* PROVIGIL (modafinil)* sodium oxybate* SUNOSI (solriamfetol)** WAKIX (pitolisant)*** XYREM (sodium oxybate)* XYWAV (calcium/magnesium/potassium/sodium oxybate)*	*Full PA criteria for Narcoleptic Agents and Xyrem and Xywav may be found on the PA Criteria page by clicking the hyperlink. **Sunosi is approvable only with documentation of treatment failure after 30-day trials of both armodafinil and modafinil. ***Wakix is approvable only with documentation of treatment failure after 30-day trials of armodafinil, modafinil and Sunosi.
TETRACYCLINES		
CLASS PA CRITERIA: Non-preferred agents require 10-day trials of each preferred agent before they will be approved, unless one of the exceptions on the PA form is present.		
doxycycline hyclate capsules doxycycline hyclate 100 mg tablets	demeclocycline** DORYX (doxycycline hyclate) doxycycline hyclate 50 mg, 75 mg and 150 mg tablets	*Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
doxycycline monohydrate 50 mg and 100 mg capsules minocycline capsules tetracycline capsules	doxycycline hyclate DR 50 mg tablets doxycycline hyclate DR 75 mg, 100 mg, 150 mg and 200 mg tablets doxycycline monohydrate 40 mg, 75 mg and 150 mg capsules doxycycline monohydrate suspension doxycycline monohydrate tablets MINOCIN (minocycline) minocycline tablets minocycline ER capsules MINOLIRA ER (minocycline) MORGIDOX KIT (doxycycline) NUZYRA (omadacycline)* tetracycline tablets VIBRAMYCIN CAPSULES, SUSPENSION, SYRUP (doxycycline) XIMINO (minocycline)	**Demeclocycline will be authorized for conditions caused by susceptible strains of organisms designated in the product information supplied by the manufacturer. A culture and sensitivity (C&S) report must accompany this request. Demeclocycline will also be authorized for Syndrome of Inappropriate Antidiuretic Hormone (SIADH).
ULCERATIVE COLITIS AGENTS[AP]		
CLASS PA CRITERIA: Non-preferred agents require 30-day trials of each preferred dosage form or chemical entity before the corresponding non-preferred agent of that dosage form or chemical entity will be approved, unless one of the exceptions on the PA form is present.		
ORAL		
balsalazide PENTASA 250 mg (mesalamine) PENTASA 500 mg (mesalamine) sulfasalazine	AZULFIDINE (sulfasalazine) budesonide ER tablets DIPENTUM (olsalazine) LIALDA (mesalamine) mesalamine ZEPOSIA (ozanimod)	
RECTAL		
mesalamine	mesalamine kit ROWASA (mesalamine) SF ROWASA (mesalamine)	
VAGINAL RING CONTRACEPTIVES		
CLASS PA CRITERIA: Non-preferred drugs require medical reasoning beyond convenience or enhanced compliance as to why the clinical need cannot be met with a preferred agent.		
ELURYNG (etonogestrel/ethinyl estradiol) ENILLORING (etonogestrel/ethinyl estradiol) etonogestrel/ethinyl estradiol vaginal ring HALOETTE (etonogestrel/ethinyl estradiol) NUVARING (etonogestrel/ethinyl estradiol)	ANNOVERA (segesterone/ethinyl estradiol)	
VASODILATORS, CORONARY		
CLASS PA CRITERIA: Non-preferred agents require 30-day trials of each preferred dosage form before they will be approved, unless one of the exceptions on the PA form is present.		
SUBLINGUAL NITROGLYCERIN		
nitroglycerin spray (generic NITROLINGUAL)	GONITRO SPRAY POWDER (nitroglycerin)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
nitroglycerin sublingual NITROSTAT SUBLINGUAL (nitroglycerin)	nitroglycerin spray (generic NITROMIST) NITROLINGUAL SPRAY (nitroglycerin) NITROMIST (nitroglycerin)	
TOPICAL NITROGLYCERIN		
MINITRAN PATCHES (nitroglycerin) NITRO-BID OINTMENT nitroglycerin patches	NITRO-DUR PATCHES (nitroglycerin)	
VMAT INHIBITORS		
CLASS PA CRITERIA: All agents require prior authorization. Full PA criteria for VMAT inhibitors may be found on the PA Criteria page by clicking the hyperlink.		
AUSTEDO TABLETS (deutetrabenazine) AUSTEDO XR (deutetrabenazine) INGREZZA CAPSULES (valbenazine) INGREZZA SPRINKLE CAPSULES (valbenazine) tetrabenazine tablets	XENAZINE TABLETS	
MISCELLANEOUS COVERED AGENTS		
This category contains covered agents which either did not easily fit into a single PDL category or had criteria that was too lengthy to cite within the PDL itself. Full criteria for the agents listed below may be found by following this hyperlink: (https://bms.wv.gov/prior-authorization-criteria). Please note that some agents may be available only by billing the appropriate HCPCS code noted in the criteria.		
Abecma Adbry Afinitor Agamree Albenza and Emverm Alyftrek Amondys 45 Antifungal Agents Atypical Antipsychotic Agents for Children up to 18 years of age Belbuca Benlysta Botox Breyanzi Cabenuva Camzyos Carbaglu Carvykti Casgevy CGRP Receptor Antagonists (antimigraine agents, prophylaxis) Cibinqo Continuous Glucose Monitors Corlanor Cresemba Cuvposa Cytokine & CAM Antagonists Diclegis Dificid		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Dojolvi Droxidopa Duavee Dupixent Ebglyss Elevidys Emflaza Enspryng Esbriet Evrysdi ExJade Exondys 51 Fasenra Ferriprox Fintepla Fuzeon Gattex Growth Hormone for Adults Growth Hormone for Children Hereditary Angioedema Agents (prophylaxis) Hereditary Angioedema Agents (treatment) Hetlioz Horizant HP Acthar HyQvia Increlex Juxtapid Kalydeco Kerendia Ketoconazole Korlym Kuvan Kymriah Kynamro Leqvio Lucemyra Lutathera Lupkynis Luxturna Lyfgenia Mozobil Myalept Myfembree Mytesi Narcoleptic Agents Natpara		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Nexletol and Nexlizet Non-Sedating Antihistamines Nucala Nuzyra OFEV Omnipod Opzelura Oralair Oriahnn Orilissa Orkambi Osphena Oxlumo Palynziq PCSK9 Inhibitor Rectiv Rezdiffra Riluzole Rinvoq Sirturo Spinraza Spravato Suboxone Policy Symdeko Synagis Testosterone Tezspire Thalomid Trikafta Tryvio V-Go Veozah Verquvo Viberzi and Lotronex Vowst Voxzogo Vyondys 53 Wegovy Winrevair Xanax XR Xhance Xolair Xyrem and Xywav Yescarta Zepbound Zolgensma		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Zulresso Zurampic Zurzuvae Zynteglo Zyvox		