2022
Delaware Medicaid Preferred Drug List (PDL)

Contents

- Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
- Be advised that any prior authorization criterion provided here is for **FEE-FOR-SERVICE** (FFS) MEMBERS **ONLY**. Prior authorization forms for FFS members can be found on the Pharmacy Corner at: https://medicaid.dhss.delaware.gov/provider/Home/PharmacyCornerLanding/tabid/2096/Default.aspx
- Prior authorizations for members enrolled with a Managed Care Organization (MCO) should be processed through the MCO following MCO criteria
    - Highmark Health Options (HHO) criteria can be reviewed at https://client.formularynavigator.com/Search.aspx?siteCode=9768635417
    - AmeriHealth Caritas criteria can be reviewed at http://www.amerihealthcaritasde.com/provider/resources/pharmacy-prior-auth.aspx

ADHD AGENTS

STIMULANTS AND RELATED AGENTS - SHORT ACTING (Clinical criteria apply for clients over age 21)

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
dexmethylphenidate IR	methylphenidate IR	amphetamine tablets	methylphenidate chewable tablets	Two preferred products required before a non-preferred product will be approved
dextroamphetamine-amphetamine IR	methylphenidate solution	dextroamphetamine solution	Evekeo ODT	Dose optimization required.
dextroamphetamine IR tablets	**Procentra**	methamphetamine	Zenzedi	

STIMULANTS AND RELATED AGENTS - LONG ACTING (Clinical criteria apply for clients over age 21)

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
armodafinil	methylphenidate LA (generic Ritalin LA)	amphetamine ER suspension	Sunosi	
atomoxetine	modafinil	Azstarys	Vyvanse chewable	
clonidine ER	Concerta	Focalin XR	Wakix	
dexmethylphenidate ER	Daytrana	methylphenidate XR (generic Aptensio XR)		
dextroamphetamine ER	Dyanavel XR	Adhansia XR		
dextroamphetamine-amphetamine ER	Quillichew ER	Adzenys XR-ODT		
guanfacine ER	Quillivant XR	Cotempla XR		
methylphenidate CD (generic Metadate CD)	Vyvanse caps	Jornay PM		
methylphenidate ER (generic Ritalin SR)		Mydayis		
methylphenidate ER 24 (generic Concerta)		Qelbree		

ANALGESICS

ANALGESICS, NARCOTIC LONG-ACTING (Clinical criteria apply to class. All agents require a prior authorization.)

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
fentanyl transdermal 12, 25, 50, 75, 100 mcg/hr	**Butrans**	buprenorphine patches	tramadol ER capsules	Two preferred products required before a non-preferred product will be approved
morphine ER tablets	Xtampza ER	fentanyl transdermal 37.5, 62.5, 87.5 mcg/hr	Arymo ER	
tramadol ER tablets		hydrocodone ER	Belbuca	
		hydromorphone ER	Hysingla ER	
		morphine ER capsules	Morphabond ER	
		oxycodone ER	Nucynta ER	
		oxymorphone ER	Oxycontin	

ANALGESICS, NARCOTIC SHORT-ACTING, NON-INJECTABLE

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
benzhydrocodone/APAP	tramadol	butorphanol nasal	oxycodone/ASA	Two preferred products required before a non-preferred product will be approved
butalbital compound/ codeine	tramadol/APAP	carisoprodol compound	oxycodone/ ibuprofen	**–Quantity limits in place:**
codeine		dihydrocodeine/APAP/ caffeine	oxymorphone	Ø oxycodone 15mg maximum of 240 units a year
codeine/APAP		Dsuvia	Nalocet	Ø oxycodone 20mg maximum of 120 units a year
hydrocodone/APAP		fentanyl	Nucynta	Ø oxycodone 30 mg maximum of 60 units a year
hydromorphone tablets		hydrocodone/ibuprofen	Oxaydo	Ø 120 short-acting units per 30 days with a total of 720 short-acting units a year
morphine tablets, solution		hydromorphone liquid, suppositories	Primlev	Ø DMMA recommends that first fill of new pain medication be limited to 15 supply
oxycodone capsules, solution, tablets		levorphanol	Prolate	
oxycodone/APAP		meperidine	Qdolo	
pentazocine/APAP		morphine concentrate, suppositories	oxycodone concentrate	

ANTIHYPERURICEMICS, ORAL

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS **Prior authorization is required**		CRITERION
allopurinol	probenecid	colchicine capsules	Gloperba	• Clinical criteria apply to colchicine with approval for treatment, not prophylaxis
colchicine tablets•	probenecid with colchicine	febuxostat		

ANTIMIGRAINE AGENTS, PROPHYLAXIS - INJECTABLE

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
Aimovig		Botox	Nurtec ODT	Product will be approved for patients with chronic migraine with inadequate response to three preferred oral agents
Ajovy		Emgality	Vyepti	

ANTIMIGRAINE AGENTS, TREATMENT

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
rizatriptan tablets, ODT	Nurtec ODT •	almotriptan	Ergomar	Two preferred products required before a non-preferred product will be approved
sumatriptan nasal spray, syringe, tablets, vial	zolmitriptan nasal spray	dihyroergotamine	Migergot	• Nurtec ODT will be approved for patients failing a trial of two preferred triptans and for patients with contraindications to triptans
		eletriptan	Onzetra	
		ergotamine/caffeine	Reyvow	
		frovatriptan	Tosymra	
		naratriptan	Treximet	
		sumatriptan cartridge, pen injector	Ubrelvy	
		sumatriptan/naproxen	Vyepti	
		zolmitriptan tablets, ODT	Zembrace	
		Cambia	Zomig	

CYTOKINE AND CAM ANTAGONISTS, ORAL/SQ

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
Enbrel	Taltz	Actemra	Rinvoq ER	Clinical criteria apply to class. All agents require a prior authorization.
Humira	Xeljanz IR	Amevive	Siliq	Xeljanz IR preferred for diagnosis of rheumatoid arthritis or ulcerative colitis only
Kineret		Arcalyst	Simponi	
Orencia		Cimzia	Simponi Aria	

Otezla		Cosentyx	Skyrizi	
		Ilaris	Stelara	
		Ilumya	Tremfya	
		Kevzara	Xeljanz XR	
		Olumiant		

NSAIDs, NASAL/ORAL/TOPICAL

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS **Prior authorization is required**		CRITERION
celecoxib		diclofenac capsules, patch	piroxicam	Two preferred products required before a non-preferred product will be approved
diclofenac drops, 1% gel, tablets		diclofenac/misoprostol	tolmetin	
ibuprofen		etodolac	Duexis	
indomethacin ER, IR		fenoprofen	Indocin	
ketorolac tablets		flurbiprofen	Licart	
meloxicam tablets		ketoprofen	Naprelan	
nabumetone		ketorolac nasal spray	Pennsaid	
naproxen IR tablets		meclofenamate	Qmiiz ODT	
sulindac		mefenamic acid	Relafen DS	
		naproxen DR, suspension	Vivlodex	
		naproxen sodium	Zipsor	
		naproxen/ esomeprazole	Zorvolex	
		oxaprozin		

OPIATE DEPENDENCE TREATMENTS

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS **Prior authorization is required**		CRITERION
buprenorphine	Sublocade	Lucemyra		
buprenorphine/naloxone	**Suboxone**	Probuphine		
naltrexone	Vivitrol	Zubsolv		

ANTIDOTES

OPIATE OVERDOSE TREATMENTS

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS		CRITERION
Kloxxado				Evzio is not covered under the Medicaid Drug Rebate Program
naloxone				
Narcan nasal spray				

ANTI-INFECTIVE AGENTS

ANTIBIOTICS, GI

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
metronidazole tablets	Firvanq	Aemcolo	vancomycin solution	●–Clinical prior authorization is required
neomycin	tinidazole	metronidazole capsules	Dificid	Patients must try and fail lactulose before Xifaxan is approved for appropriate diagnoses
vancomycin capsules		paromomycin capsules	Xifaxan 550mg●	
Xifaxan 200mg				

ANTIBIOTICS, INHALED

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
tobramycin 300mg/5mL	Bethkis	Arikayce	Kitabis Pak	
			TOBI Podhaler	
		Cayston	tobramycin 300mg/4mL	

ANTIBIOTICS, VAGINAL

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
clindamycin	Cleocin ovules	CRITERION		Two preferred products required before a non-preferred product will be approved
metronidazole	Clindesse	Solosec		
	Nuvessa	Vandazole		

ANTIFUNGALS, ORAL

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
fluconazole		Brexafemme	ketoconazole	Two preferred products required before a non-preferred product will be approved
griseofulvin suspension		clotrimazole	Noxafil	
nystatin		Cresemba	Oravig	
terbinafine		flucytosine	posaconazole	
		griseofulvin tablets	Tolsura	
		itraconazole	voriconazole	

ANTIVIRALS, ANTIRETROVIRALS

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
abacavir	Genvoya	abacavir/lamivuidine/ zidovudine	Videx	Patients on non-preferred drugs will be grandfathered
abacavir/lamivudine	Isentress	Atripla	Viracept	
atazanavir	Norvir soution	didanosine	Kaletra	
efavirenz	Odefsey	fosamprenevir	Truvada	
efavirenz-emtricitabine-tenofovir	Prezcobix	nevirapine, nevirapine ER		
emtricitabine-tenofovir disoproxil fumarate	Prezista	stavudine		
lamivudine	Retrovir injection	Aptivus		
lamivudine-zidovudine	Reyataz powder pack	Complera		
lopinavir-ritonavir	Rukobia	Fuzeon		
ritonavir	Symfi/Symfi Lo	Intelence		
tenofovir disoproxil fumarate	Tivicay	Isentress HD		
zidovudine	Triumeq	Juluca		
Biktarvy	Trogarzo	Lexiva		
Cimduo	Tybost	Norvir Powder Pack		
Delstrigo	Viread (except 300 mg tablet)	Pifeltro		
Descovy		Selzentry		
Dovato		Stribild		
Edurant		Symtuza		
Emtriva		Temixys		
Evotaz				

ANTIVIRALS, HEPATITIS C AGENTS (Clinical criteria apply to class. All agents require a prior authorization.)

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
ribavirin	Mavyret ●	ledipasvir/sofosbuvir	Peg-Intron ●	● Clinical criteria apply
sofosbuvir/velpatasvir	Epclusa Pelet Packs, 200-50mg tablets	Harvoni	Sovaldi	Pediatric strengths of Epclusa (Pelet Packs and 200-50mg tablets) and Mavyret (50-20mg) limited to 1 unit per day to ensure use for pediatrics.
		Pegasys ●	Vosevi ●	
		Epclusa 400-100mg tablets	Zepatier ●	

ANTIVIRALS, ORAL/INHALATION

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
acyclovir	valacyclovir	amantadine solution, tablets	Prevymis	Two preferred products required before a non-preferred product will be approved
amantadine capsules	valganciclovir	rimantadine	Sitavig	Liquid medications require prior authorization for clients over 10-years old
famciclovir	Relenza		Xofluza	–Quantity limits in place for oseltamivir and Relenza
oseltamivir				

CEPHALOSPORINS, ORAL

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
cefaclor IR	cefprozil	cefaclor ER tablets	cephalexin tablets	Two preferred products required before a non-preferred product will be approved
cefadroxil	cefuroxime	cefixime	Suprax	
cefdinir	cephalexin capsules, suspension	cefpodoxime		

FLUOROQUINOLONES, ORAL

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS **Prior authorization is required**		CRITERION
ciprofloxacin IR tablets		ciprofloxacin ER	ofloxacin	Two preferred products required before a non-preferred product will be
levofloxacin tablets		ciprofloxacin suspension	Baxdela	
		levofloxacin solution	Cipro	
		moxifloxacin		

LINCOSAMIDES/OXAZOLIDINONES/STREPTOGRAMINS

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS **Prior authorization is required**		CRITERION
clindamycin capsules	clindamycin solution (for client <10 yr)	linezolid •	Sivextro	• Clinical criteria apply

MACROLIDES

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS **Prior authorization is required**		CRITERION
azithromycin		clarithromycin	E.E.S. 400	
		erythromycin (all salts)	Erythrocin	

PENICILLINS, ORAL/IM

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS **Prior authorization is required**		CRITERION
amoxicillin	penicillin	amoxicillin/clavulanate 250 suspension, tablets		
amoxicillin/clavulanate (except 250 susp, tabs)	penicillin G procaine	amoxicillin/clavulanate XR		
ampicillin	Bicillin CR			
dicloxacillin	Bicillin LA			

TETRACYCLINES

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
doxycycline hyclate IR		demeclocycline	tetracycline	Two preferred products required before a non-preferred product will be approved
doxycycline monohydrate 50, 100 mg capsules		doxycycline DR	Minolira ER	
doxycycline monohydrate tablets		doxycycline monohydrate 75, 150 mg capsules	Morgidox	
minocycline capsules		doxycycline suspension	Nuzyra	
		minocycline ER	Vibramycin	
		minocycline tablets	Ximino	

URINARY ANTI-INFECTIVES

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
methenamine	nitrofurantoin mono-macrocrystals (generic Macrobid)	nitrofurantoin macrocrystals (generic Macrodantin) with the exception of 25 mg dose for peds		
nitrofurantoin macrocrystals (generic Macrodantin) 25 mg dose preferred for peds only	Monurol	nitrofurantoin suspension		

ANTINEOPLASTICS

ONCOLOGY AGENTS

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS **Prior authorization is required**		CRITERION
all drug products				

CARDIOVASCULAR AGENTS

ANGIOTENSIN MODULATORS

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
benazepril, benazepril HCTZ	losartan, losartan HCTZ	aliskerin	moexipril	Two preferred products required before a non-preferred product will be approved
enalapril, enalapril HCTZ	olmesartan, olmesartan HCTZ	candesartan, candesartan HCTZ	perindopril	Dose optimization required when applicable
fosinopril, fosinopril HCTZ	ramipril	captopril, captopril HCTZ	Tekturna HCT	
irbesartan, irbesartan HCTZ	quinapril, quinapril HCTZ	Edarbi / Edarbyclor	telmisartan, telmisartan HCTZ	
lisinopril, lisinopril HCTZ	trandolapril	Epaned	Qbrelis	
	valsartan, valsartan HCTZ	eprosartan		

ANGIOTENSIN MODULATOR/CALCIUM CHANNEL BLOCKER COMBINATIONS

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
amlodipine/benazepril	olmesartan/ amlodipine, olmesartan/ amlodipine/HCTZ	telmisartan/amlodipine		Two preferred products required before a non-preferred product will be approved
amlodipine/valsartan, amlodipine/valsartan/ HCTZ		trandolapril/verapamil		Dose optimization required when applicable

ANTIHYPERTENSIVES, SYMPATHOLYTIC

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
clonidine	methyldopa, methyldopa HCTZ			
doxazosin	prazosin			
guanfacine	terazosin			

BETA BLOCKERS

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
atenolol, atenolol/chlorthalidone	nadolol	acebutolol	Bystolic	Two preferred products required before a non-preferred product will be approved
bisoprolol, bisoprolol HCTZ	propranolol, propranolol HCTZ	betaxolol	Hemangeol	
carvedilol IR	propranolol ER	carvedilol ER	Inderal XL	
labetalol	sotalol	metoprolol HCTZ	Innopran XL	
metoprolol		pindolol	Kapspargo	
metoprolol XL		timolol	Sotylize	

CALCIUM CHANNEL BLOCKERS

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
amlodipine	nifedipine IR	diltiazem ER tablets	verapamil ER PM	Two preferred products required before a non-preferred product will be approved
diltiazem IR	nifedipine ER	isradipine	Katerzia	–Requires dose optimization when applicable
diltiazem ER capsules	verapamil IR	nimodipine^	Nymalize	^ ICD-10 code for SAH may create system-generated approval for nimodipine
felodipine	verapamil ER tablets	nisoldipine		
nicardipine	Dilt-XR	verapamil ER capsules		

DIURETICS

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
acetazolamide	indapamide	ethacrynic acid	Aldactazide	Two preferred products required before a non-preferred product will be approved
amiloride, amiloride-HCTZ	metolazone	methazolamide	Carospir	
bumetanide	spironolactone, spironolactone HCTZ	methyclothiazide	Keveyis	
chlorothiazide	torsemide	triamterene		
chlorthalidone	triamterene-HCTZ			
furosemide	Diuril			
hydrochlorothiazide				

EPINEPRINE, SELF-INJECTED

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
epinephrine auto-injector AG (labeler 49502)	Symjepi	epinephrine auto-injector (other than labeler 49502)		

HEART FAILURE DRUGS

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
Entresto		Verquvo		

LIPOTROPICS, OTHER

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
cholestyramine	fenofibric acid	colesevalam powder	Nexlizet	Two preferred products required before a non-preferred product will be approved
colesevelam tablets	gemfibrozil	ezetimibe/simvastatin	Triglide	● Clinical criteria apply
colestipol	niacin ER	Antara	Vascepa	
ezetimibe	omega-3 acid ethyl esters	Juxtapid		
fenofibrate	Praluent●	Nexletol		
	Repatha ●			

LIPOTROPICS, STATINS

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
atorvastatin	rosuvastatin	amlodipine/atorvastatin	Ezallor	Two preferred products required before a non-preferred product will be approved
lovastatin	simvastatin	fluvastatin, fluvastatin ER	Livalo	–Once daily dosing required
pravastatin		Altoprev	Zypitamag	

PAH AGENTS, ORAL & INHALED (Clinical criteria apply to class. All agents require a prior authorization.)

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
ambrisentan	**Revatio Suspension**	sildenafil suspension	Tracleer Tablets for Suspension	●–Clinical criteria apply
bosentan	Ventavis ●	Adempas	Tyvaso ●	
sildenafil tablets		Opsumit	Uptravi	
tadalafil		Orenitram ER		

VASODILATORS, CORONARY

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS **Prior authorization is required**		CRITERION
isosorbide dinitrate		nitroglycerin translingual spray	Isordil	
isosorbide mononitrate		BiDil	Nitro-Bid	
nitroglycerin patch, tablets		Dilatrate-SR	Nitromist	
ranolazine		Gonitro		

CENTRAL NERVOUS SYSTEM DRUGS

ANTIDEPRESSANTS, OTHER

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
amitriptyline	tranylcypromine	amitriptyline/ chlordiazepoxide	trazodone 300 mg	Two preferred products required before a non-preferred product will be approved
bupropion IR	trazodone 50,100,150 mg	amoxapine	trimipramine	DMAP requires prior authorization for all antidepressants for patients under six (6) years of age.
bupropion XL 150, 300 mg	venlafaxine IR	bupropion XL 450 mg	venlafaxine ER tablets	
clomipramine	venlafaxine ER caps	desipramine	Aplenzin	
desvenlafaxine ER	Marplan	imipramine pamoate	Drizalma	
doxepin		maprotiline	Emsam	
imipramine HCl		mirtazapine ODT	Fetzima	
mirtazapine tablet		nefazodone	Trintellix	
nortriptyline		protriptyline	Viibryd	
phenelzine				

ANTIDEPRESSANTS, SSRIs

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
citalopram	paroxetine IR	fluoxetine tablets	paroxetine ER	Two preferred products required before a non-preferred product will be approved
escitalopram tablet	sertraline	fluoxetine DR	Paxil	DMAP requires prior authorization for all antidepressants for patients under six (6) years of age
fluoxetine capsules, solution		fluvoxamine ER	Pexeva	Liquid medications require prior authorization for clients over 10-years old
fluvoxamine tablets		escitalopram solution		

ANTIPSYCHOTICS, ORAL/INHALATION

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
amitriptyline/ perphenazine	pimozide	aripiprazole ODT	Caplyta	PA required for all antipsychotics for patients under six (6) years of age
aripiprazole solution, tablets	quetiapine	clozapine ODT	Fanapt	*Latuda requires prior trial of one (1) preferred antipsychotic
chlorpromazine	risperidone solution, tablets	molindone	Rexulti	
clozapine	thioridazine	olanzapine ODT	Saphris	
fluphenazine	thiothixene	olanzapine / fluoxetine	Secuado	
haloperidol concentrate, solution, tablets	trifluoperazine	paliperidone ER	Versacloz	
loxapine	ziprasidone	risperidone ODT	Vraylar	
olanzapine tablets	Latuda*			
perphenazine				

ANTIPSYCHOTICS, INJECTABLE/INHALATION

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
chlorpromazine	Abilify Maintena	ziprasidone IM		PA required for all antipsychotics for patients under six (6) years of age
fluphenazine	Aristada	Adasuve		Clinical PA is required for Long-Acting Injectable Atypical Antipsychotics
fluphenazine decanoate	Invega Sustenna	Zyprexa Relprevv		
Geodon IM	Invega Trinza			
haloperidol decanoate	Perseris			
haloperidol lactate	Risperdal Consta			
olanzapine				

ANXIOLYTICS

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
buspirone	diazepam solution, tablets	alprazolam	meprobamate	Two (2) preferred products required before a non-preferred product will be approved
chlordiazepoxide	lorazepam	diazepam intensol	oxazepam	Quantity Limits of 120 units of benzodiazepines per 30 days
clorazepate		lorazepam intensol		

MOOD STABILIZERS

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
carbamazepine tablets, chewable	lithium	carbamazepine suspension		Two (2) preferred medications are required before a non-preferred medication will be approved
carbamazepine ER, XR	valproic acid	lamotrigine ER, ODT		
divalproex sodium	**Tegretol suspension**			
lamotrigine IR				

SEDATIVE HYPNOTICS

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
temazepam 15mg, 30mg		doxepin 3 mg	zolpidem ER	–Dose optimization when applicable: total quantity limit of one daily covered
zaleplon		estazolam	zolpidem sublingual	
zolpidem IR tablets		eszopiclone	Belsomra	
		flurazepam	Dayvigo	
		ramelteon	Edluar	
		temazepam 7.5, 22.5 mg	Hetlioz	
		triazolam	Zolpimist	

ENDOCRINE AND METABOLIC DRUGS

ANDROGENIC AGENTS (Clinical criteria apply to class. All agents require a prior authorization.)

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
testosterone cypionate		methyltestosterone	Jatenzo	
testosterone enanthate		testosterone gel (except preferred formulation)	Methitest	
testosterone gel pump 20.25/1.25		Androderm	Xyosted	
		Aveed		

BONE RESORPTION SUPPRESSION AND RELATED AGENTS

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS **Prior authorization is required**		CRITERION
alendronate tablets	Prolia	alendronate solution	Binosto	●–Clinical PA is required for injectable medications in this class
calcitonin-salmon nasal spray		etidronate	Evenity	
ibandronate		raloxifene	Fosamax Plus D	
		risedronate	Natpara	
		teriparatide	Tymlos	
			Xgeva	

CONTRACEPTIVES, ORAL - BIPHASIC

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS **Prior authorization is required**		CRITERION
desogestrel-ethinyl estradiol-eth estradiol		Lo Loestrin Fe		Two (2) preferred products required before a non-preferred product will be approved
				Class is grandfathered - patients on a non-preferred product can continue on that product

CONTRACEPTIVES, ORAL - COMBINATION

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
desogestrel-ethinyl estradiol	norethindrone-ethinyl estradiol-Fe tablets	drosperinone-ethinyl estradiol-levomefolate	Balcoltra	Two (2) preferred products required before a non-preferred product will be approved
drosperinone-ethinyl estradiol	norethindrone-ethinyl estradiol-Fe chewable		Taytulla	Class is grandfathered - patients on a non-preferred product can continue on that product
ethynodiol-ethinyl estradiol	norgestimate-ethinyl estradiol			
levonorgestrel-ethinyl estradiol	norgestrel-ethinyl estradiol			
norethindrone-ethinyl estradiol	Loryna			
Blisovi 24 Fe	Nymyo			
Charlotte 24 Fe	Syeda			
Junel Fe 24	Tyblume			
Larin 24 Fe	Xulane			

CONTRACEPTIVES, ORAL - EXTENDED CYCLE

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
levonorgestrel-ethinyl estradiol 0.15-0.03	**Amethia Lo**	levonorgestrel-ethinyl estradiol 90-20		Two (2) preferred products required before a non-preferred product will be approved
levonorgestrel-ethinyl estradiol-ethinyl estradiol 100-20, 150-30	**Jolessa**	levonorgestrel-ethinyl estradiol-ethinyl estradiol 0.15		
	Camrese, Camrese Lo			
	Seasonique			

CONTRACEPTIVES, ORAL - PROGESTINS

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS		CRITERION
norethindrone	Nora-BE			
	Slynd			

CONTRACEPTIVES, ORAL – TRIPHASIC

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS		CRITERION
desogestrel-ethinyl estradiol	**Leena**	norethindrone-ethinyl estradiol-iron		
levonorgestrel-ethinyl estradiol	**Tilia Fe**			
norethindrone-ethinyl estradiol				
norgestimate-ethinyl estradiol				

CONTRACEPTIVES – IUDs / IMPLANTS

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS		CRITERION
Kyleena	Nexplanon			
Liletta	Paragard			
Mirena				

CONTRACEPTIVES – VAGINAL RINGS

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS		CRITERION
Nuvaring		etonogestrel-ethinyl estradiol	Annovera	
			Eluryng	

GROWTH HORMONES (Clinical criteria apply to class. All agents require a prior authorization.)

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
Genotropin		Nutropin AQ	Serostim	Two (2) preferred products required before a non-preferred product will be approved
Norditropin		Omnitrope	Zomacton	
		Saizen	Zorbtive	

HYPOGLYCEMIA TREATMENTS

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
Baqsimi	Gvoke Hypopen	Glucagon (labeler 00548)		
Glucagen	Gvoke PFS			
Glucagon (except labeler 00548)	Zegalogue Autoinjector			
	Zegalogue Syringe			

HYPOGLYCEMICS, ALPHA-GLUCOSIDASE INHIBITORS

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
acarbose		miglitol		

HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS: AMYLIN ANALOGS (Clinical criteria apply to class. All agents require a prior authorization.)

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
			Symlin ●	

HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS: DPP-4 INHIBITORS (Clinical criteria apply to class. All agents require a prior authorization.)

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
Janumet (step-edit) ●	Jentadueto (step-edit)	alogliptin ●	Jentadueto XR	
Janumet XR (step-edit) ●	Tradjenta (step-edit)	alogliptin-metformin ●	Kombiglyze XR	
Januvia (step-edit)		alogliptin-pioglitazone ●	Onglyza	

HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS: GLP-1 RAs (Clinical criteria apply to class. All agents require a prior authorization.)

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
Ozempic		Adlyxin ●	Rybelsus●	
Trulicity ●		Bydureon	Soliqua ●	
Victoza		Byetta	Xultrophy ●	

HYPOGLYCEMICS, INSULINS

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
insulin aspart	Humalog Mix 50-50	Admelog	Humalog Mix 75/25 Kwikpen	
insulin aspart mix	Humalog Mix 75-25 vial	Afrezza	Lyumjev	
insulin lispro	Humulin R U-500	Apidra	Novolin	
insulin lispro mix	Lantus	Basaglar	Semglee	
	Levemir	Fiasp	Toujeo	
		Humulin (except U-500)	Tresiba	

HYPOGLYCEMICS, MEGLITINIDES

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
nateglinide	repaglinide			

HYPOGLYCEMICS, METFORMINS

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
glipizide-metformin	metformin IR	metformin ER (gen Fortamet, Glumetza)	Riomet	Two preferred products required before a non-preferred product will be approved
glyburide-metformin	metformin ER (gen Glucophage XR)		Riomet ER	

HYPOGLYCEMICS, SGLT2 INHIBITORS

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
Farxiga	Synjardy	Glyxambi	Steglatro	Trial of preferred medication required before non-preferred medication will be approved
Jardiance	Xigduo XR	Qtern	Synjardy XR	
Invokana		Steglujan	Trijardy XR	
Invokamet		Segluromet		

HYPOGLYCEMICS, TZDs

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
pioglitazone		pioglitazone/ glimepepiride	Avandia	
		pioglitazazone/ metformin		

GLUCOCORTICOIDS, ORAL

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
budesonide ER capsule	methylprednisolone 4mg tablets	budesonide ER tablet	Prednisone intensol, solution	Two preferred products required before a non-preferred product will be approved
dexamethasone elixir, intensol, solution, tablet	prednisolone sodium phosphate solution	cortisone	Medrol	
fludrocortisone	prednisolone solution	dexamethasone dose pack	Millipred	
hydrocortisone	prednisone dose pack, tablets	methylprednisolone 8, 16, 32 mg tablet	Ortikos	
methylprednisolone dose pack		prednisolone sodium phosphate ODT	Rayos	

PELVIC DISORDERS – ENDOMETRIOSIS, UTERINE FIBROIDS

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
Danazol	Norethindrone acetate	Lupaneta Pack		Clinical criteria apply to class. All agents require a prior authorization.
Depo-Provera	Orilissa*			*Double step through NSAIDs and/or oral contraceptives required.
Lupron Depot	Synarel			
Myfembree*	Zoladex			
Oriahnn*				

PITUITARY SUPPRESSANTS, CENTRAL PRECOCIOUS PUBERTY (CPP)

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
Lupron Depot-Ped	Synarel			
Supprelin LA	Triptodur			
Fensolvi				

PROGESTATIONAL AGENTS

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
hydroxyprogesterone caproate	progesterone capsule	Crinone		●–Clinical PA is required
medroxyprogesterone acetate tablets	progesterone IM			
medroxyprogesterone acetate IM	Depo-SubQ Provera			
norethindrone acetate tablets	Makena ●			

THYROID HORMONES

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
levothyroxine sodium tablets	NP thyroid tablets	levothyroxine sodium injection	Tirosint	
liothyronine sodium tablets	Armour thyroid	levothyroxine sodium capsules	Thyquidity	
		liothyronine sodium injection		

GASTROINTESTINAL AGENTS

ANTIEMETICS, ORAL/TRANSDERMAL

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
Diclegis		aprepitant	Akynzeo	• Clinical criteria apply
ondansetron tablets, ODT, solution	Transderm-Scop	Bonjesta •	Anzemet	
		doxylamine/pyridoxine	Emend	
		dronabinol •	Sancuso	
		granisetron	Varubi	
		scopolamine patch	Zuplenz	
		trimethobenzamide		

BILE SALTS

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
ursodiol		Chenodal	Cholbam	

CONSTIPATION – IBS – OIC, ORAL

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
Amitiza	Trulance	Motegrity		Trial of preferred medication required before non-preferred medication will be approved
Linzess		Relistor	Zelnorm	•–Clinical PA is required
Movantik		Symproic		

H. PYLORI TREATMENTS

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
Pylera		lansoprazole-amoxicillin-clarithromycin	Omeclamox Pak	
		Helidac	Talicia	

HISTAMINE II RECEPTOR BLOCKERS

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
famotidine		cimetidine		
nizatadine				

PANCREATIC ENZYMES

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
Creon		Pancreaze	Viokace	
Zenpep		Pertzye		

PHOSPHATE BINDERS

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
calcium acetate capsules	Phoslyra	calcium acetate tablets	Auryxia	PA required for all non-calcium based products
sevelamer carbonate tablet		lanthanum	Fosrenol	
		sevelamer HCl tablet	Velphoro	
		sevelamer powder pack		

PROTON PUMP INHIBITORS

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
omeprazole Rx		esomeprazole	rabeprazole	For non-preferred products, max of 60 days approval for GERD
pantoprazole tablets		lansoprazole ●	Aciphex ▲ ●	
Nexium suspension (only for age 10 and under)		omeprazole OTC	Dexilant ●	
Protonix granules (only for age 10 and under)		omeprazole/sodium bicarbonate	Prilosec packets●	
		pantoprazole granules		

ULCERATIVE COLITIS AGENTS

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
balsalazide	sulfasalazine DR	mesalamine DR 400 mg, 800 mg	Dipentum	Two (2) preferred products required before a non-preferred product will be approved
mesalamine enema kit, suppository	**Apriso**	mesalamine ER 375 mg		
mesalamine DR 1.2 gm	**Delzicol**			
sulfasalazine	Pentasa			

GENITOURINARY PRODUCTS

BLADDER RELAXANT PREPARATIONS

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS **Prior authorization is required**		CRITERION
Myrbetriq	solifenacin	darifenacin	Gelnique	
oxybutynin		tolterodine	Oxytrol	Two (2) preferred products required before a non-preferred product will be approved
oxybutynin ER		trospium	Toviaz	

BPH TREATMENTS

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS **Prior authorization is required**		CRITERION
alfuzosin	tamsulosin	dutasteride/tamsulosin	Cardura XL	Two (2) preferred products required before a non-preferred product will be approved
doxazosin	terazosin	silodosin	dutasteride	
finasteride				

HEMATOLOGICAL AGENTS

ANTICOAGULANTS, ORAL/SQ

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
enoxaparin	Eliquis	fondaparinux	Fragmin	Two (2) preferred products required before a non-preferred product will be approved
warfarin	Pradaxa		Savaysa	–Quantity limits in place on injectable formulations: 6 weeks allowed without prior authorization
	Xarelto			

HEMOPHILIA A/VWD

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
Advate	Jivi	Vonvendi		Two preferred products required before a non-preferred product will be approved
Adynovate	Koate			
Afstyla	Kogenate FS			
Alphanate	Kovaltry			
Eloctate	Humate-P			
Esperoct	Novoeight			
Hemlibra	Nuwiq			
Hemofil M	Recombinate			
	Wilate			
	Xyntha			

HEMOPHILIA B

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
Alphanine SD	Ixinity			Two preferred products required before a non-preferred product will be approved
Alprolix	Mononine	Rebinyn		
Benefix	Profilnine			
Idelvion	Rixubis			

COLONY STIMULATING FACTORS

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
Granix	Ziextenzo	Fulphila	Nyvepria	
Neupogen		Leukine	Udenyca	
Nivestym		Neulasta	Zarxio	

ERYTHROPOIESIS STIMULATING PROTEINS (Clinical criteria apply to class. All agents require a prior authorization.)

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
Epogen	Retacrit	Aranesp	Procrit	
Mircera				

HAE TREATMENTS (Clinical criteria apply to class. All agents require a prior authorization.)

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
icatibant	Kalbitor			
Berinert	Orladeyo			
Cinryze	Ruconest			
Danazol	Takhzyro			
Haegarda				

PLATELET AGGREGATION INHIBITORS

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
aspirin/dipyridamole	prasugrel	ticlopidine		Two (2) preferred products required before a non-preferred product will be approved
clopidogrel	Brilinta	Zontivity		
dipyridamole				

MEDICAL DEVICES AND SUPPLIES

BLOOD GLUCOSE METERS, TEST STRIPS

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
FreeStyle	FreeStyle Lite	All other blood glucose meters and test strips are non-preferred		
FreeStyle Freedom	FreeStyle Precision Neo (lblr 57599 only)			
FreeStyle Freedom Lite	One Touch			
FreeStyle InsuLinx	Precision Xtra (lblr 57599 only)			

CONTINUOUS GLUCOSE MONITORS (CGM)

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
DexCom	FreeStyle Libre	All other CGM devices are non-preferred		

NEUROMUSCULAR DRUGS

ANTICONVULSANTS, ORAL/RECTAL/NASAL

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
carbamazepine tablets, chewable tablets	pregabalin	carbamazepine suspension	Diacomit	Two (2) preferred products required before a non-preferred product will be approved
carbamazepine ER, XR	primidone	clonazepam ODT	Elepsia XR	Quantity limits in place: 240 adjunctive anticonvulsants per 30 days. Greater quantities require prior authorization.
clobazam	topiramate tablets, sprinkle	ethosuximide caps	Epidiolex	Brand name narrow therapeutic drugs automatically pay for seizure clients with seizure diagnosis in medical history.
clonazepam tablet	valproic acid	felbamate	Equetro	
diazepam rectal	zonisamide	lamotrigine ER, ODT	Fintepla	
divalproex sodium	Celontin	levetiracetam ER	Fycompa	
ethosuximide solution	Dilantin 30 mg capsule	oxcarbazepine suspension	Oxtellar XR	
gabapentin	Gabitril	tiagabine tablets	Spritam	
lamotrigine IR tablets, chewable tablets	Nayzilam	topiramate ER	Sympazan	
levetiracetam IR, solution	Peganone	vigabatrin	Trokendi XR	
oxcarbazepine tablets	Tegretol Suspension	Aptiom	Vimpat	
phenobarbital	Trileptal Suspension	Banzel	Xcopri	
phenytoin	Valtoco	Briviact		

ANTIPARKINSON'S AGENTS, ORAL/TRANSDERMAL

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
amantadine capsules, solution		amantadine tablets	tolcapone	Two (2) preferred products required before a non-preferred product will be approved
benztropine		bromocriptine	Gocovri	
carbidopa/levodopa IR, ER		carbidopa	Nourianz	
entacapone		carbidopa/levodopa ODT	Neupro	
pramipexole IR		carbidopa/levodopa/ entacapone	Osmolex ER	
ropinirole IR		pramipexole ER	Rytary	
selegiline		rasagaline	Xadago	
trihexyphenidyl		ropinirole ER	Zelapar	
Parlodel		selegiline capsules		

SKELETAL MUSCLE RELAXANTS

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
baclofen		carisoprodol ●	dantrolene	Two (2) preferred products required before a non-preferred product will be approved
cyclobenzaprine 5, 10 mg		carisoprodol compound w/codeine ●	metaxalone	Total quantity limit of 120 units of muscle relaxants per 30 rolling days.
methocarbamol		chlorzoxazone	orphenadrine	●–Clinical PA required:
tizanidine tablets		cyclobenzaprine 7.5 mg	tizanidine capsules	
		cyclobenzaprine ER	Norgesic Forte	

NUTRITIONAL PRODUCTS

PRENATAL VITAMINS

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
Complete Natal DHA	SE-Natal 19	All other prenatal products non-preferred		Two preferred products required before a non-preferred product will be approved
M-Natal Plus	Thrivite RX			
Niva-Plus	Trinatal Rx1			
PNV 29-1	Triveen-Duo DHA			
Prenatal Vitamin plus Low Iron	Vol-Plus			
Preplus	VP-PNV-DHA			
Pretab	Westab Plus			

PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS

ALZHEIMER'S AGENTS (Clinical criteria apply to class. All agents require a prior authorization.)

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
donepezil 5, 10 mg		donepezil ODT	memantine XR capsules	Two (2) preferred products required before a non-preferred product will be approved
memantine tablets		donepezil 23mg	rivastigmine capsules	
rivastigmine patch		galantamine	Namzaric	
		memantine solution		

MOVEMENT DISORDER

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS **Prior authorization is required**		CRITERION
tetrabenazine	Austedo			Ingrezza quantity limit - 1 capsule per day
	Ingrezza			

MULTIPLE SCLEROSIS

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS **Prior authorization is required**		CRITERION
Aubagio	glatiramer	Bafiertam	Mayzent	• Clinical PA required
Avonex	Glatopa	Extavia	Ocrevus	Preferred oral agents require a trial of a preferred injectable agent
Betaseron	Gilenya	Kesimpta	Plegridy	
dalfampridine	Rebif	Lemtrada	Tecfidera	
dimethyl fumarate	Tysabri	Mavenclad	Vumerity	
Copaxone			Zeposia	

NEUROPATHIC PAIN

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS **Prior authorization is required**		CRITERION
duloxetine 20, 30, 60 mg		duloxetine 40 mg	Horizant	
gabapentin		Drizalma	Lyrica CR	
lidocaine patch		Gralise	Savella	
pregabalin			Ztildo	

RESPIRATORY AGENTS

ANTIHISTAMINES, MINIMALLY SEDATING

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS **Prior authorization is required**		CRITERION
cetirizine solution, tablets		cetirizine capsules, chewable tablets	levocetirizine	Two (2) preferred products required before a non-preferred product will be approved
loratadine solution, tablets		cetirizine-D	loratadine chewable tablets, ODT	
		desloratadine	loratadine-D	
		fexofenadine, fexofenadine-D		

BRONCHODILATORS, BETA AGONIST

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS **Prior authorization is required**		CRITERION
albuterol nebulizer solution, syrup	Serevent	albuterol HFA, tablets	Brovana	
terbutaline	Striverdi Respimat	levalbuterol	Perforomist	Two (2) preferred products required before a non-preferred product will be approved
ProAir HFA	**Ventolin HFA**	metaproterenol	Proair Digihaler	
ProAir Respiclick				

COPD AGENTS

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS **Prior authorization is required**		CRITERION
albuterol/ipratropium nebulizer solution	Incruse Ellipta	Bevespi	Spiriva Respimat	
ipratropium nebulizer solution	Spiriva Handihaler	Breztri	Tudorza	
Atrovent HFA	Stiolto Respimat	Daliresp	Trelegy	
Anoro Ellipta		Duaklir	Yupelri	
Combivent		Lonhala		

COUGH and COLD

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
benzonatate	hydrocodone/ homatropine syrup	All other cough/cold products non-preferred		Two preferred products required before a non-preferred product will be approved
brompheniramine/ pseudoephedrine/DM syrup	promethazine DM syrup			**Quantity limits in place:**
guaifenesin liquid	promethazine/ codeine syrup			Narcotic antitussives - 240ml per 30 days and 480ml per 90 days without a comorbid diagnosis
guaifenesin DM liquid	phenylephrine tablets			Tussionex - 120ml per 84 days and 900ml per year
guaifenesin ER tablets	pseudoephedrine liquid, tablets			
guaifenesin/codeine syrup	Bromfed DM syrup			
hydrocodone/ chlorpheniramine susp	Mucinex ER tablet			

GLUCOCORTICOIDS, INHALED

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
budesonide inhalation solution 0.25, 0.5 mg^	Dulera	budesonide inhalation solution 1 mg	Asmanex HFA	^ Approval for budesonide may be generated by system for patients:
Advair Diskus, HFA	Flovent Diskus, HFA	fluticasone/salmeterol	Breo Ellipta	- Aged 6 years and older and with
Asmanex Twisthaler	Pulmicort Flexhaler	Airduo Digihaler	QVAR Redihaler	- Diagnosis on file indicating developmental delay
	Symbicort	Alvesco	Wixela Inhub	
		Armonair Digihailer		
		Arnuity Ellipta		

INTRANASAL RHINITIS AGENTS

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS **Prior authorization is required**		CRITERION
azelastine 0.1% (generic Astelin)		azelastine 0.15% (generic Astepro)	Beconase AQ	Two (2) preferred products required before a non-preferred product will be approved
budesonide		azelastine/fluticasone	Omnaris	
fluticasone Rx		flunisolide	Qnasl	
ipratropium		fluticasone OTC	Xhance	
triamcinolone		mometasone	Zetonna	
		olopatadine		

LEUKOTRIENE RECEPTOR ANTAGONISTS

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS **Prior authorization is required**		CRITERION
montelukast tablet, chewable tablets		montelukast granules ●	zileuton ER	Trial of preferred medication required before a non-preferred will be approved
		zafirlukast ●	Zyflo	●**–Clinical criteria apply.** ICD-10 code for asthma indication may create a system-generated approval

MABs-ANTI-IL, ANTI-IGE

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS **Prior authorization is required**		CRITERION
Dupixent		Nucala		Clinical criteria apply to class. All agents require a prior authorization.
Fasenra				
Xolair				

TOPICAL PRODUCTS

ACNE AGENTS, TOPICAL (Clinical criteria apply to class. All agents require a prior authorization.)

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
adapalene/benzoyl peroxide		adapalene	Amzeeq	Two (2) preferred products required before a non-preferred product will be approved
benzoyl peroxide		clindamycin foam, gel	Arazlo	Class only covered up to 20 years old; use in older patients is considered cosmetic.
clindamycin lotion, solution, swab		clindamycin/benzoyl peroxide gel 1/5% (generic Benzaclin), 1.2/2.5% (generic Acanya)	Azelex	
clindamycin/benzoyl peroxide gel 1.2/5% (generic Duac)		clindamycin/tretinoin	Clindacin ETZ/PAC	
erythromycin gel, solution		dapsone	Differin	
tretinoin cream		erythromycin swab	Epiduo Forte	
tretinoin 0.01, 0.025% gel		erythromycin/benzoyl peroxide	Fabior	
		sulfacetamide sodium	Inova	
		sodium sulfacetamide/ sulfur	Neuac	
		tretinoin 0.05% gel	Onexton	
		tretinoin microsphere	Retin-A Micro	
		Aklief	Sumadan	
		Altreno	Sumaxin	

ANTIBIOTICS, TOPICAL

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
bacitracin	mupirocin ointment	mupirocin cream	Cortisporin	Two preferred products required before a non-preferred product will be approved
bacitracin/polymyxin	neomycin/bacitracin/ polymyxin	neomycin/bacitracin/ polymyxin/pramoxine	Neo-Synalar	
gentamicin		neomycin/polymyxin/ pramoxine	Xepi	

ANTIFUNGALS, TOPICAL

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
butenafine		ciclopirox gel, shampoo, suspension	oxiconazole	Two preferred products required before a non-preferred product will be approved
ciclopirox cream, solution		clotrimazole solution	terbinafine	
clotrimazole cream		clotrimazole/ betamethasone lotion	tolnaftate	
clotrimazole/ betamethasone cream		ketoconazole foam	Alevazol	
econazole		luliconazole	Ertaczo	
ketoconazole cream, shampoo		miconazole	Exelderm	
nystatin		miconazole/zinc/ petrolatum	Jublia	
nystatin/triamcinolone ointment		naftifine	Kerydin	
		nystatin/triamcinolone cream	Oxistat	

ANTIPARASITICS, TOPICAL

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
permethrin	**Natroba**	lindane	Crotan	
piperonyl butoxide/ pyrethrins		malathion	Sklice	
		spinosad	Vanalice	

ANTIPSORIATIC AGENTS, ORAL

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
acitretin			methoxsalen	

ANTIPSORIATIC AGENTS, TOPICAL

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
calcipotriene		acitretin	Duobrii	
		calcipotriene/ betamethasone	Enstilar	
		calcitriol	Sorilux	
		methoxsalen	Taclonex	
		tazarotene	Tazorac	

ANTIVIRALS, TOPICAL

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
acyclovir ointment		acyclovir cream	Denavir	
docosanol			Xerese	

IMMUNOMODULATORS, ATOPIC DERMATITIS (Clinical criteria apply to class. All agents require a prior authorization.)

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
Dupixent	Protopic	pimecrolimus		Eucrisa will be electronically approved after trial of a preferred topical steroid or immunomodulator
Elidel	tacrolimus			– Quantity limits are in place: 400 grams per year
Eucrisa				

IMMUNOMODULATORS, TOPICAL

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
imiquimod cream pack		imiquimod cream pump	Veregen	
			Zyclara	

OPHTHALMICS, ALLERGIC CONJUNCTIVITIS

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
azelastine		epinastine	Bepreve	Two (2) preferred products required before a non-preferred product will be approved
cromolyn		Alocril	Emadine	
ketotifen		Alomide	Lastacaft	
olopatadine (all strengths)		Alrex		

OPHTHALMICS, ANTIBIOTICS

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS **Prior authorization is required**		CRITERION
bacitracin/polymyxin	ofloxacin	bacitracin	sulfacetamide	Two (2) preferred products required before a non-preferred product will be approved
ciprofloxacin	polymyxin/ trimethoprim	gatifloxacin	Azasite	
erythromycin	tobramycin	levofloxacin	Besivance	
gentamicin	Ciloxan ointment	moxifloxacin viscous (generic Moxeza)	Natacyn	
moxifloxacin (generic Vigamox)	Gentak ointment	neomycin/bacitracin/ polymyxin	Tobrex	
		neomycin/polymyxin/ gramicidin		

OPHTHALMICS, ANTIBIOTIC-STEROID COMBINATIONS

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS **Prior authorization is required**		CRITERION
neomycin/polymyxin/ dexamethasone	Tobradex ointment	neomycin /polymyxin/HC	Blephamide (all formulations)	Two (2) preferred products required before a non-preferred product will be approved
sulfacetamide/ prednisolone	**Tobradex suspension**	neomycin/bacitracin/ polymyxin/HC	Pred-G	
		tobramycin/ dexamethasone	Tobradex ST	
			Zylet	

OPHTHALMICS, ANTI-INFLAMMATORIES

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS **Prior authorization is required**		CRITERION
dexamethasone	Durezol	bromfenac	Ilevro	
diclofenac	Flarex	loteprednol	Iluvien	Two (2) preferred products required before a non-preferred product will be approved
fluorometholone	FML Forte and SOP	prednisolone/ nepafenac	Inveltys	
flurbiprofen	Lotemax	Acuvail	Lotemax SM	
ketorolac (all strengths)	Maxidex	Bromsite	Ozurdex	
prednisolone	Nevanac	Dextenza	Prolensa	
	Pred Forte	Dexycu	Retisert	
	Pred Mild	Eysuvis	Triesence	
			Yutiq	

OPHTHALMICS, GLAUCOMA AGENTS

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS **Prior authorization is required**		CRITERION
brimonidine 0.2%	Alphagan **P**	apraclonidine	Betoptic S	Two (2) preferred products required before a non-preferred product will be approved
carteolol	Combigan	betaxolol	Iopidine	
dorzolamide	Rhopressa	bitamoprost	Lumify	
dorzolamide/timolol	Rocklatan	brimonidine 0.15%	Lumigan	
latanoprost	Simbrinza	brinzolamide	Vyzulta	
levobunolol	Travatan Z	phospholine iodide	Xelpros	
pilocarpine		timolol gel	Zioptan	
timolol solution		travaprost		
		Azopt		

OPHTHALMICS, IMMUNOMODULATORS

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
Restasis		Cequa	Xiidra	
		Restasis Multidose		

OTIC ANTIBIOTICS

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
neomycin/polymyxin/ hydrocortisone	Cortisporin-TC	ciprofloxacin	Otiprio	
Ciprodex	ofloxacin	ciprofloxacin/ dexamethasone	Otovel	
Cipro HC		Coly-Mycin S		

OTIC ANTI-INFECTIVES, ANESTHETICS

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
acetic acid		acetic acid/ hydrocortisone		Two (2) preferred products required before a non-preferred product will be approved

STEROIDS, TOPICAL

PREFERRED AGENTS Preferred status implementation: 1/1/22		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
clobetasol ointment, solution, spray	Capex shampoo	alclometasone	Apexicon E	Two (2) preferred products required before a non-preferred product will be approved
fluocinonide ointment 0.05%	Derma-Smoothe-FS	amcinonide	Bryhali	
fluticasone cream, ointment	Scalpicin	betamethasone dipropionate	Cordran	
hydrocortisone		betamethasone dipropionate/propylene glycol	DermacinRx	
hydrocortisone acetate		betamethasone valerate	Dermasorb	
mometasone		clobetasol cream, foam, gel, lotion, shampoo	Ellzia Pak	
triamcinolone cream, lotion, ointment		clocortolone	Halog	

		desonide	Impoyz	
		desoximetasone	Lexette	
		diflorasone	Micort-HC	
		fluocinolone cream, oil, ointment, shampoo, solution	Pandel	
		fluocinonide (except 0.05% ointment)	Pediaderm	
		flurandrenolide	SanadermRx	
		fluticasone lotion	Silazone	
		halcinonide	Sernivo	
		halobetasol	Synalar	
		hydrocortisone butyrate	Texacort	
		hydrocortisone valerate	Tovet	
		prednicarbate	Topicort	
		triamcinolone aerosol	Ultravate	