DELAWARE HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID & MEDICAL ASSISTANCE

Delaware Medical Assistance Program

2025 Delaware Medicaid Preferred Drug List (PDL)

- 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
  - Delaware First Health criteria can be reviewed at https://www.delawarefirsthealth.com/providers/resources/clinical-payment-policies.html

The DMAP may limit the duration of time that a member may receive medication during a 12-month period or may establish a lifetime limit for particular classes of drugs or specific products.

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PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
ACNE AGENTS		
ORAL		**Review Schedule: 2nd Quarter**
AMNESTEEM (isotretinoin) CLARAVIS (isotretinoin) isotretinoin ZENATANE (isotretinoin)	ABSORICA (isotretinoin) ABSORICA LD (isotretinoin, micronized)	• Two (2) preferred products required before a non-preferred product will be approved. • Class only covered up to 20 years old; use in older patients is considered cosmetic.
TOPICAL		**Review Schedule 1st Quarter**
adapalene 0.3% gel/gel pump RX adapalene/benzoyl peroxide benzoyl peroxide clindamycin gel, lotion, solution, swab clindamycin/benzoyl peroxide gel 1.2/5% (generic DUAC) erythromycin gel, solution tretinoin cream tretinoin 0.01 %, 0.025% gel	ACANYA (clindamycin/benzoyl peroxide) adapalene 0.1% cream, 0.1% gel OTC AKLIEF (trifarotene) ALTRENO (tretinoin) ARAZLO (tazarotene) ATRALIN (tretinoin) AVAR (sulfacetamide sodium/sulfur) AVITA (tretinoin) BENZAMYCIN (erythromycin/benzoyl peroxide) BP 10-1 (sulfacetamide sodium/sulfur) BPO (benzoyl peroxide) CABTREO (clindamycin/adapalene/benzoyl peroxide) CLEOCIN T (clindamycin) CLINDACIN ETZ/PAC (clindamycin) CLINDACIN P (clindamycin) CLINDAGEL (clindamycin) clindamycin foam clindamycin/benzoyl peroxide gel 1/5% (generic BENZACLIN), 1.5/2.5% (generic ACANYA), 1.2/3.75% (generic ONEXTON) clindamycin/tretinoin dapsone DIFFERIN (adapalene) EPIDUO (adapalene/benzoyl peroxide) EPIDUO FORTE (adapalene/benzoyl peroxide) ERY/ERYGEL (erythromycin) erythromycin swab erythromycin/benzoyl peroxide EVOCLIN (clindamycin) FABIOR (tazarotene) KLARON (sulfacetamide sodium) LINTERA (benzoyl peroxide) NEUAC (benzoyl peroxide/clindamycin) ONEXTON (benzoyl peroxide/clindamycin) RETIN-A (tretinoin) cream, gel RETIN-A MICRO (tretinoin)	• Two (2) preferred products required before a non-preferred product will be approved. • Class only covered up to 20 years old; use in older patients is considered cosmetic.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
	sodium sulfacetamide/sulfur SSS (sulfacetamide sodium/sulfur) sulfacetamide sodium SUMADAN (sulfacetamide sodium/sulfur) SUMADAN XLT (sulfacetamide sodium/sulfur) SUMAXIN (sulfacetamide sodium/sulfur) tazarotene foam tretinoin 0.05% gel tretinoin microsphere TWYNEO (tretinoin/benzoyl peroxide) WINLEVI (clascoterone) ZIANA (clindamycin/tretinoin) ZMA CLEAR (sulfacetamide sodium/sulfur)	
ANALGESICS		
ANALGESICS, NARCOTIC LONG-ACTING **(Clinical criteria applies to class. All agents require a prior authorization.)**		Review Schedule: 1st Quarter
BUTRANS (buprenorphine) fentanyl transdermal 12, 25, 50, 75, 100 mcg/hr morphine ER tablets tramadol ER tablets *	BELBUCA (buprenorphine buccal film) buprenorphine patches CONZIP (tramadol) fentanyl transdermal 37.5, 62.5, 87.5 mcg/hr hydrocodone ER hydromorphone ER HYSINGLA ER (hydrocodone) morphine ER capsules MS CONTIN (morphine) oxycodone ER OXYCONTIN (oxycodone) oxymorphone ER tramadol ER capsules *	• Two (2) preferred products required before a non-preferred product will be approved. • **DMMA recommends that first fill of new pain medication be limited to 15-day supply.** • * Tramadol quantity limits – 240 units per 30 days
ANALGESICS, NARCOTIC SHORT-ACTING, NON-INJECTABLE		**Review Schedule: 2nd Quarter**
acetaminophen/codeine butalbital/ASA/caffeine/codeine #3 butalbital/acetaminophen/caffeine/codeine butalbital compound/codeine codeine ENDOCET (oxycodone/acetaminophen) hydrocodone/APAP solution, tablets hydromorphone tablets morphine concentrate, tablets, solution oxycodone capsules, solution, tablets oxycodone/APAP solution, tablets tramadol 50 mg tablets * tramadol/APAP *	ACTIQ (fentanyl) buccal butorphanol nasal spray dihydrocodeine/APAP/caffeine DILAUDID (hydromorphone) fentanyl FENTORA (fentanyl) buccal FIORICET-CODEINE (butalbital/acetaminophen/caffeine/codeine) hydrocodone/ibuprofen hydromorphone liquid, suppositories levorphanol meperidine solution, tablets morphine concentrate, suppositories NALOCET (oxycodone/acetaminophen) oxycodone concentrate	• Two (2) preferred products required before a non-preferred product will be approved. • **DMMA recommends that first fill of new pain medication be limited to 7-day supply.** • ^ PA required, to include reason tramadol 50 mg tablets, cannot be used, before product will be approved. **QUANTITY LIMITS IN PLACE:** • **Oxycodone 15 mg maximum of 240 units per year** • **Oxycodone 20 mg maximum of 120 units per year** • **Oxycodone 30 mg maximum of 60 units per year**

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
	oxycodone/ASA oxymorphone pentazocine HCl/naloxone HCl PERCOCET (oxycodone/acetaminophen) PROLATE (oxycodone/acetaminophen) ROXICODONE (oxycodone) ROXYBOND (oxycodone) SEGLENTIS (tramadol/celecoxib) tramadol 25 mg, 75 mg ^, 100 mg tablets, solution *	• **120 short-acting units per 30 days with a total of 720 short-acting units per year** • * Tramadol quantity limits – 240 units per 30 days
ANTIHYPERURICEMICS, ORAL		**Review Schedule: 2nd Quarter**
allopurinol 100 mg, 300 mg tablets colchicine tablets febuxostat probenecid probenecid with colchicine	allopurinol 200 mg tablets * colchicine capsules COLCRYS (colchicine) GLOPERBA (colchicine) LODOCO (colchicine) ** MITIGARE (colchicine) ULORIC (febuxostat)	• Two (2) preferred products required before a non-preferred product will be approved. • * PA required, to include reason allopurinol 2 x 100 mg tablets cannot be used, before product will be approved. • ** Step through preferred colchicine product required.
ANTIMIGRAINE AGENTS, PROPHYLAXIS **(Clinical criteria applies to individual agents in class.)**		**Review Schedule: 4th Quarter**
AIMOVIG (erenumab-aooe) * AJOVY (fremanezumab) * EMGALITY (galcanezumab-gnlm) 120 mg pen/syringe* NURTEC ODT (rimegepant) **	BOTOX (onabotulinumtoxinA) EMGALITY (galcanezumab) 100 mg syringe * QULIPTA (atogepant) VYEPTI (eptinezumab-jjmr)	• Two (2) preferred products required before a non-preferred product will be approved. • * Product will be approved. for patients with chronic migraine with inadequate response to two (2) preferred anti-migraine agents (acute and/or prophylaxis). • ** One (1) CGRP receptor antagonists required before product will be approved. Abbreviation: CGRP = calcitonin gene-related peptide
ANTIMIGRAINE AGENTS, TREATMENT **(Clinical criteria applies to individual agents in class.)**		**Review Schedule: 4th Quarter**
naratriptan NURTEC ODT (rimegepant) * rizatriptan ODT, tablets sumatriptan nasal spray, syringe, tablets, vial zolmitriptan ODT, tablets	almotriptan dihydroergotamine eletriptan FROVA (frovatriptan) frovatriptan IMITREX (sumatriptan) MAXALT (rizatriptan) MIGERGOT (ergotamine tartrate/caffeine) MIGRANAL (dihydroergotamine mesylate) RELPAX (eletriptan)	• Two (2) preferred products required before a non-preferred product will be approved. • Quantity limits on Triptans – 9 units per 45 days • * Nurtec ODT will be approved. for patients failing a trial of two preferred triptans and for patients with contraindications to triptans.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
	REYVOW (lasmiditan) sumatriptan cartridge, pen injector sumatriptan/naproxen SYMBRAVO (rizatriptan/meloxicam) ** TOSYMRA (sumatriptan) UBRELVY (ubrogepant) VYEPTI (eptinezumab-jjmr) ZAVZPRET (zavegepant) ZEMBRACE (sumatriptan) zolmitriptan nasal spray ZOMIG (zolmitriptan)	• ** PA required, to include reason separate ingredients cannot be used concurrently, before product will be approved
CYTOKINE AND CAM ANTAGONISTS, ORAL/SUBCUTANEOUS **(Clinical criteria applies to class. All agents require a prior authorization.)**		**Review Schedule: 4th Quarter**
AVSOLA (infliximab-axxq) ENBREL (etanercept) ENTYVIO (vedolizumab) HUMIRA (adalimumab) infliximab KINERET (anakinra) ORENCIA (abatacept) OTEZLA (apremilast) 30 mg tablet, starter pack RINVOQ (upadactinib) TALTZ (ixekizumab) TYENNE (tocilizumab) XELJANZ IR (tofacitinib) XELJANZ XR (tofacitinib) 11 mg tablet	ABRILADA (adalimumab-afzb) ACTEMRA (tocilizumab) adalimumab-aacf adalimumab-adaz adalimumab-adbm adalimumab-fkjp adalimumab-ryvk AMJEVITA (adalimumab-atto) ARCALYST (rilonacept) BIMZELX (bimekizumab-bkzx) CIMZIA (certolizumab pegol) COSENTYX (secukinumab) CYLTEZO (adalimumab-adbm) HADLIMA (adalimumab-bwwd) HULIO (adalimumab-fkjp) HYRIMOZ (adalimumab-adaz) IDACIO (adalimumab-aacf) ILARIS (canakinumab) ILUMYA (tildrakizumab-asmn) INFLECTRA (infliximab-dyyb) KEVZARA (sarilumab) LITFULO (ritlecitinib) OLUMIANT (baricitinib) OMVOH (mirikizumab-mrkz) OTEZLA (apremilast) 20 mg tablet, starter pack OTULFI (ustekinumab -aauz) PYZCHIVA (ustekinumab-ttwe) REMICADE (infliximab) RENFLEXIS (infliximab-abdb) RINVOQ LQ (upadactinib) SELARSDI (ustekinumab-aekn) SILIQ (brodalumab) SIMLANDI (adalimumab-ryvk) SIMPONI (golimumab) SIMPONI ARIA (golimumab) SKYRIZI (risankizumab-rzaa)	• Two (2) preferred products required before a non-preferred product will be approved.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
	SOTYKTU (deucravacitinib) SPEVIGO (spesolimab-sbzo) STELARA (ustekinumab) STEQEYMA (ustekinumab-stba) TOFIDENCE (tocilizumab) TREMFYA (guselkumab) ustekinumab ustekinumab-ttwe VELSIPITY (etrasimod arginine) XELJANZ (tofacitinib) solution XELJANZ XR (tofacitinib) 22 mg tablet YESINTEK (ustekinumab-kfce) YUFLYMA (adalimumab-aaty) YUSIMRY (adalimumab-aqvh) ZYMFENTRA (infliximab-dyyb)	
NSAIDs, NASAL/ORAL/TOPICAL **(Clinical criteria applies to individual agents in class.)**		**Review Schedule: 3rd Quarter**
celecoxib diclofenac sodium 1.5% solution drops, 1% gel OTC, tablets ibuprofen indomethacin capsules ketorolac tablets meloxicam tablets nabumetone naproxen IR tablets sulindac	ARTHROTEC (diclofenac sodium/misoprostol) CATAFLAM (diclofenac potassium) CELEBREX (celecoxib) DAYPRO (oxaprozin) diclofenac epolamine patch diclofenac potassium diclofenac sodium 1% gel RX, 2% solution pump diclofenac/misoprostol diflunisal DOLOBID (diflunisal) * etodolac ELYXYB (celecoxib) FELDENE (piroxicam) fenoprofen flurbiprofen ibuprofen/famotidine indomethacin suppositories, suspension INDOCIN (indomethacin) ketoprofen LOFENA (diclofenac potassium) meclofenamate mefenamic acid meloxicam capsules NALFON (fenoprofen) NAPRELAN (naproxen) naproxen DR, suspension naproxen/esomeprazole naproxen sodium oxaprozin PENNSAID (diclofenac) piroxicam RELAFEN (nabumetone)	• Two (2) preferred products required before a non-preferred product will be approved. • * Five (5) preferred products required before Dolobid will be approved.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
	RELAFEN DS (nabumetone) tolmetin VOLTAREN (diclofenac sodium) 1% GEL	
OPIATE DEPENDENCE TREATMENTS		**Review Schedule: 4th Quarter**
BRIXADI (buprenorphine) buprenorphine buprenorphine/naloxone naltrexone SUBLOCADE (buprenorphine) VIVITROL (naltrexone)	lofexidine LUCEMYRA (lofexidine) SUBOXONE films (buprenorphine/naloxone) ZUBSOLV (buprenorphine/naloxone)	• Two (2) preferred products required before a non-preferred product will be approved.
ANTIDOTES		
CHELATING AGENTS		**Review Schedule: 4th Quarter**
CHEMET (succimer) deferasirox tablets	deferasirox granules, ODT EXJADE (deferasirox) FERRIPROX (deferiprone) JADENU (deferasirox)	• Two (2) preferred products required before a non-preferred product will be approved.
OPIATE OVERDOSE TREATMENTS		**Review Schedule: 4th Quarter**
KLOXXADO (naloxone) naloxone injection naloxone nasal spray RX, OTC NARCAN nasal spray RX, OTC (naloxone)	nalmefene injection OPVEE (nalmefene) ZIMHI (naloxone hydrochloride)	• Two (2) preferred products required before a non-preferred product will be approved.
OTHER		**Review Schedule: 4th Quarter**
deferoxamine mesylate vials	DESFERAL (deferoxamine mesylate) vials deferoxamine mesylate vials (00409-2337-25 only)	• One (1) preferred product required before a non-preferred product will be approved.
ANTI-INFECTIVE AGENTS		
ANTIBIOTICS, GI **(Clinical criteria applies to individual agents in class.)**		**Review Schedule: 4th Quarter**
metronidazole 250 mg, 500 mg tablets neomycin tinidazole vancomycin capsules, solution XIFAXAN 200 mg (rifaximin)	AEMCOLO (rifamycin) DIFICID (fidaxomicin) * FIRVANQ (vancomycin) FLAGYL (metronidazole) LIKMEZ (metronidazole) metronidazole 125 mg tablets, capsules ** nitazoxanide tablets	• Two (2) preferred products required before a non-preferred product will be approved. • * Step through one (1) preferred vancomycin product required before product will be approved.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
	paromomycin capsules VANCOCIN (vancomycin) VOWST (fecal microbiota spores, live-brpk) XIFAXAN 550 mg (rifaximin)	• ** PA required, to include reason metronidazole 250 mg tablets cannot be used, before product will be approved.
ANTIBIOTICS, INHALED		**Review Schedule: 4th Quarter**
tobramycin 300 mg/5 mL (gen TOBI PODHALER)	ARIKAYCE (amikacin) BETHKIS (tobramycin) CAYSTON (aztreonam) KITABIS PAK (tobramycin) TOBI PODHALER (tobramycin) tobramycin 300 mg/4 ml tobramycin 300 mg/5 mL (gen KITABIS PAK)	• One (1) preferred product required before a non-preferred product will be approved.
ANTIBIOTICS, VAGINAL		**Review Schedule: 4th Quarter**
CLEOCIN ovules (clindamycin) clindamycin metronidazole 0.75% gel NUVESSA (metronidazole)	CLINDESSE (clindamycin) metronidazole 1.3% gel SOLOSEC (secnidazole) VANDAZOLE (metronidazole) XACIATO (clindamycin)	• Two (2) preferred products required before a non-preferred product will be approved.
ANTIFUNGALS, ORAL		**Review Schedule: 4th Quarter**
fluconazole griseofulvin suspension nystatin terbinafine	ANCOBON (flucytosine) BREXAFEMME (ibrexafungerp) clotrimazole CRESEMBA (isavuconazonium) DIFLUCAN (fluconazole) flucytosine griseofulvin tablets itraconazole ketoconazole NOXAFIL (posaconazole) suspension, PowderMix ORAVIG (miconazole) posaconazole SPORANOX (itraconazole) TOLSURA (itraconazole) VFEND (voriconazole) VIVJOA (oteseconazole) voriconazole	• Two (2) preferred products required before a non-preferred product will be approved.
ANTIVIRALS, ANTIRETROVIRALS		**Review Schedule: 4th Quarter**
abacavir abacavir/lamivudine APRETUDE (cabotegravir extended-release) atazanavir BIKTARVY (bictegravir/emtricabine/	abacavir/lamivudine/zidovudine APTIVUS (tipranavir) CIMDUO (lamivudine/tenofovir) COMBIVIR (lamivudine/zidovudine) darunavir	• Two (2) preferred products required before a non-preferred product will be approved.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
tenofovir AF) CABENUVA (cabotegravir/rilpivirine) COMPLERA (emtricitabine/relpivirine/tenofovir) DELSTRIGO (doravirine/lamivudine/tenofovir) darunavir DESCOVY (emtricitabine/tenofovir AF) DOVATO (dolutegravir/lamivudine) EDURANT (rilpivirine) efavirenz efavirenz-emtricitabine-tenofovir emtricitabine emtricitabine-tenofovir disoproxil fumarate EVOTAZ (atazanavir/cobicistat) GENVOYA (elvitegravir/cobicistat/emtricitabine/ tenofovir AF) ISENTRESS (raltegravir potassium) lamivudine lamivudine-zidovudine lopinavir-ritonavir nevirapine ODEFSEY (emtricitabine/relpivirine/tenofovir AF) PREZCOBIX (darunavir/cobicistat) RETROVIR injection (zidovudine) REYATAZ powder pack (atazanavir) ritonavir SYMTUZA (darunavir/cobicistat/emtricitabine/ tenofovir AF) tenofovir disoproxil fumarate TIVICAY (dolutegravir sodium) TIVICAY PD (dolutegravir sodium) TRIUMEQ (abacavir/lamivudine/dolutegravir) TRIUMEQ PD (abacavir/lamivudine/dolutegravir) TYBOST (cobicistat) VIREAD (except 300 mg tablets) (tenofovir disoproxil fumarate) zidovudine	efavirenz/lamivudine/tenofovir EMTRIVA (emtricitabine) EPIVIR (lamivudine) EPZICOM (abacavir/lamivudine) etravirine fosamprenavir FUZEON (enfuvirtide) INTELENCE (etravirine) ISENTRESS HD (raltegravir potassium) JULUCA (dolutegravir/rilpivirine) KALETRA (lopinavir/ritonavir) LEXIVA (fosamprenavir) maraviroc nevirapine ER NORVIR (ritonavir) 100 mg tablet, powder pack PIFELTRO (doravirine) PREZISTA (darunavir) RUKOBIA (fostemsavir) SELZENTRY (maraviroc) STRIBILD (elvitegravir/cobicistat/emtricitabine/ tenofovir) SUNLENCA (lenacapavir sodium) tablets, vial SYMFI (efavirenz/lamivudine/tenofovir) SYMFI LO (efavirenz/lamivudine/tenofovir) TRIZIVIR (abacavir/lamivudine/zidovudine) TROGARZO (ibalizumab-uiyk) TRUVADA (emtricitabine/tenofovir DF) VIRACEPT (nelfinavir mesylate) VIREAD 300 mg tablets (tenofovir disoproxil fumarate) ZIAGEN (abacavir)	
ANTIVIRALS, COVID - 19		**Review Schedule: 4th Quarter**
PAXLOVID (nirmatrelvir/ritonavir)	LAGEVRIO (molnupiravir)	• One (1) preferred product required before a non-preferred product will be approved.
ANTIVIRALS, HEPATITIS C AGENTS		**Review Schedule: 4th Quarter**
MAVYRET (glecaprevir/pibrentasvir) ribavirin sofosbuvir/velpatasvir	EPCLUSA (sofosbuvir/velpatasvir) pellet pack, tablets HARVONI (ledipasvir/sofosbuvir) ledipasvir/sofosbuvir PEGASYS (peginterferon alfa-2a) SOVALDI (sofosbuvir)	• Two (2) preferred products required before a non-preferred product will be approved. • **Limited to one treatment cycle every 365 days**

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
	VOSEVI (sofosbuvir/velpatasvir/voxilaprevir) ZEPATIER (elbasvir/grazoprevir)	
ANTIVIRALS, ORAL/INHALATION		**Review Schedule: 4th Quarter**
acyclovir amantadine capsules, solution famciclovir oseltamivir * valacyclovir valganciclovir	amantadine tablets LIVTENCITY (maribavir) PREVYMIS (letermovir) RELENZA (zanamivir) * rimantadine SITAVIG (acyclovir) TAMIFLU (oseltamivir) * VALCYTE (valganciclovir) VALTREX (valacyclovir) XOFLUZA (baloxavir marboxil)	• Two (2) preferred products required before a non-preferred product will be approved. • Liquid medications require prior authorization for members over 10-years old • *** Quantity limits in place for oseltamivir and RELENZA**
CEPHALOSPORINS, ORAL		**Review Schedule: 3rd Quarter**
cefaclor IR capsules cefdinir cefprozil cefuroxime cephalexin capsules, suspension	cefaclor ER tablet cefaclor suspension cefadroxil cefixime cefpodoxime cephalexin tablets	• Two (2) preferred products required before a non-preferred product will be approved.
FLUOROQUINOLONES, ORAL		**Review Schedule: 3rd Quarter**
ciprofloxacin IR tablets levofloxacin tablets	BAXDELA (delafloxacin) CIPRO (ciprofloxacin) ciprofloxacin ER ciprofloxacin suspension levofloxacin solution moxifloxacin ofloxacin	• Two (2) preferred products required before a non-preferred product will be approved.
LINCOSAMIDES/OXAZOLIDINONES/STREPTOGRAMINS (Clinical criteria applies to individual agents in class.)		**Review Schedule: 2nd Quarter**
clindamycin capsules clindamycin solution (for member < 10 years old)	CLEOCIN (clindamycin) linezolid * SIVEXTRO (tedizolid) * ZYVOX (linezolid) *	• One (1) preferred product required before a non-preferred product will be approved. • Liquid medications require prior authorization for members over 10 years old. • * Clinical criteria applies

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
MACROLIDES		**Review Schedule: 4th Quarter**
azithromycin clarithromycin tablets erythromycin suspension	clarithromycin suspension clarithromycin ER E.E.S. 400 ERY-TAB (erythromycin) ERYPED (erythromycin ethylsuccinate) ERYTHROCIN (erythromycin stearate) erythromycin (all other salts/formulations) ZITHROMAX (azithromycin)	• Two (2) preferred products required before a non-preferred product will be approved.
PENICILLINS, ORAL/IM		**Review Schedule: 3rd Quarter**
amoxicillin amoxicillin/clavulanate (except 250 mg suspension, tablets) ampicillin BICILLIN C-R BICILLIN L-A dicloxacillin penicillin penicillin G procaine	amoxicillin/clavulanate 250 mg suspension, tablets amoxicillin/clavulanate XR AUGMENTIN (amoxicillin/potassium clavulanate) AUGMENTIN ES (amoxicillin/potassium clavulanate)	• Two (2) preferred products required before a non-preferred product will be approved.
TETRACYCLINES		**Review Schedule: 4th Quarter**
doxycycline hyclate 20, 100 mg tablets doxycycline hyclate capsule doxycycline monohydrate 50, 100 mg capsules doxycycline monohydrate tablets minocycline capsules	demeclocycline DORYX (doxycycline hyclate) doxycycline DR doxycycline hyclate 50, 75, 150 mg tablets doxycycline monohydrate 75, 150 mg capsules doxycycline suspension minocycline ER minocycline tablets MINOLIRA ER (minocycline) NUZYRA (omadacycline) SOLODYN (minocycline) TARGADOX (doxycycline hyclate) tetracycline XIMINO (minocycline)	• Two (2) preferred products required before a non-preferred product will be approved.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
URINARY ANTI-INFECTIVES		**Review Schedule: 1st Quarter**
methenamine hippurate methenamine mandelate nitrofurantoin macrocrystals (generic MACRODANTIN) nitrofurantoin monohydrate-macrocrystals (generic MACROBID)	fosfomycin tromethamine MACROBID (nitrofurantoin monohydrate-macrocrystals) nitrofurantoin suspension	• Two (2) preferred products required before a non-preferred product will be approved.
ANTINEOPLASTICS		
ONCOLOGY AGENTS **(Clinical criteria apply to individual agents in class.)**		**Review Schedule: 3rd Quarter**
all other drug products	AFINITOR (everolimus) AFINITOR DISPERZ (everolimus) ALKERAN (melphalan) CASODEX (bicalutamide) CYTOXAN (cyclophosphamide) DANZITEN (nilotinib) * dasatinib EULEXIN (flutamide) FARESTON (toremifene) GILOTRIF (afatinib) GLEEVEC (imatinib) GLEOSTINE (lomustine) HYDREA (hydroxyurea) INLYTA (axitinib) IRESSA (gefitinib) MESNEX (mesna) NEXAVAR (sorafenib) NOLVADEX (tamoxifen) PURINETHOL (mercaptopurine) REVLIMID (lenalidomide) SUTENT (sunitinib) TARGRETIN (bexarotene) TEMODAR (temozolomide) THALOMID (thalidomide) TYKERB (lapatinib) VOTRIENT (pazopanib) XELODA (capecitabine)	• Effective January 1, 2025, any member starting a new prescription for an oral oncology medication with an AB-rated generic must attempt a 30-day supply of the generic before brand name medications will be considered, unless the brand name medication is on the Brand over Generic (BoG) list. This change does NOT impact those currently on oral oncology medications. • For brand-name medications not on the BoG list to be considered, providers must submit a prior authorization form with documentation of medical trial of the generic and outcome electronically via the DMAP Provider Portal. • Please refer to the Delaware Pharmacy Corner website for the BoG list. https://medicaid.dhss.delaware.gov/provider/Home/PharmacyCornerLanding/tabid/2096/Default.aspx • * PA required, to include reason Tasigna cannot be used, before product will be approved.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
	ZORTRESS (everolimus) ZYTIGA (abiraterone acetate)	
CARDIOVASCULAR AGENTS		
ANGIOTENSIN MODULATORS		**Review Schedule: 1st Quarter**
benazepril benazepril/HCTZ enalapril enalapril/HCTZ fosinopril irbesartan irbesartan/HCTZ lisinopril lisinopril/HCTZ losartan losartan/HCTZ olmesartan olmesartan/HCTZ quinapril quinapril/HCTZ ramipril trandolapril valsartan valsartan/HCTZ	ACCUPRIL (quinapril) ACCURETIC (quinapril/HCTZ) aliskerin ALTACE (ramipril) ATACAND (candesartan) ATACAND HCT (candesartan/HCTZ) AVALIDE (irbesartan/HCTZ) AVAPRO (irbesartan) BENICAR (olmesartan) BENICAR HCT (olmesartan/HCTZ) candesartan candesartan/HCTZ captopril captopril/HCTZ COZAAR (losartan) DIOVAN (valsartan) DIOVAN HCT (valsartan/HCTZ) EDARBI (azilsartan) EDARBYCLOR (azilsartan/chlorthalidone) EPANED (enalapril) eprosartan fosinopril/HCTZ HYZAAR (losartan/HCTZ) LOTENSIN (benazepril) LOTENSIN HCT (benazepril/HCTZ) MICARDIS (telmisartan) MICARDIS HCT (telmisartan/HCTZ) moexipril perindopril QBRELIS (lisinopril) TEKTURNA (aliskiren) telmisartan telmisartan/HCTZ VASERETIC (enalapril/HCTZ) VASOTEC (enalapril) ZESTORETIC (lisinopril/HCTZ) ZESTRIL (lisinopril)	• Two (2) preferred products required before a non-preferred product will be approved. • Dose optimization required when applicable.
ANGIOTENSIN MODULATOR/CALCIUM CHANNEL BLOCKER COMBINATIONS		**Review Schedule: 1st Quarter**
amlodipine/benazepril amlodipine/valsartan amlodipine/valsartan/ HCTZ	AZOR (amlodipine/olmesartan) EXFORGE (amlodipine/valsartan) EXFORGE HCT (amlodipine/valsartan/HCTZ)	• Two (2) preferred products required before a non-preferred product will be approved.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
olmesartan/amlodipine olmesartan/amlodipine/HCTZ	LOTREL (amlodipine/benazepril) telmisartan/amlodipine trandolapril/verapamil TRIBENZOR (olmesartan/amlodipine/HCTZ)	• Dose optimization required when applicable.
ANTIHYPERTENSIVES, SYMPATHOLYTIC		**Review Schedule: 1st Schedule**
clonidine patches, IR tablets doxazosin guanfacine methyldopa prazosin terazosin	CARDURA (doxazosin) clonidine ER (generic NEXICLON XR) MINIPRESS (prazosin) NEXICLON XR (clonidine) TEZRULY (terazosin) *	• Two (2) preferred products required before a non-preferred product will be approved. • * PA required, to include reason terazosin capsules cannot be used, before product will be approved.
BETA BLOCKERS		**Review Schedule: 2nd Quarter**
atenolol atenolol/chlorthalidone bisoprolol bisoprolol/HCTZ carvedilol IR labetalol 100 mg, 200 mg, 300 mg tablets metoprolol metoprolol ER nadolol nebivolol propranolol propranolol ER SORINE (sotalol) sotalol	acebutolol BETAPACE (sotalol) betaxolol BYSTOLIC (nebivolol) carvedilol ER CORGARD (nadolol) HEMANGEOL (propranolol) INDERAL LA (propranolol) INDERAL XL (propranolol) INNOPRAN XL (propranolol) KAPSPARGO (metoprolol) labetalol 400 mg tablets * LOPRESSOR (metoprolol) LOPRESSOR HCT (metoprolol/HCTZ) metoprolol/HCTZ pindolol SOTYLIZE (sotalol) TENORETIC (atenolol/chlorthalidone) TENORMIN (atenolol) timolol TOPROL XL (metoprolol ER) ZIAC (bisoprolol/HCTZ)	• Two (2) preferred products required before a non-preferred product will be approved. • * PA required, to include reason labetalol 2 x 200 mg tablets cannot be used, before product will be approved.
CALCIUM CHANNEL BLOCKERS		**Review Schedule: 3rd Quarter**
amlodipine CARTIA XT (diltiazem ER) DILT-XR (diltiazem ER) diltiazem ER capsules diltiazem IR felodipine nifedipine ER nifedipine IR nimodipine *	CARDIZEM (diltiazem) CARDIZEM CD (diltiazem ER) CARDIZEM LA (diltiazem ER) diltiazem ER tablets isradipine KATERZIA (amlodipine) levamlodipine maleate MATZIM LA (diltiazem ER) nicardipine	• Two (2) preferred products required before a non-preferred product will be approved. • Dose optimization required when applicable. • *** ICD-10 code for SAH may create system-generated approval for nimodipine.**

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
TAZTIA XT (diltiazem ER) TIADYLT ER (diltiazem ER) verapamil ER tablets, capsules verapamil IR	nisoldipine NORLIQVA (amlodipine) NORVASC (amlodipine) NYMALIZE (nimodipine) PROCARDIA (nifedipine) PROCARDIA XL (nifedipine ER) SULAR (nisoldipine) TIAZAC (diltiazem) verapamil ER PM verapamil SR pellet VERELAN PM (verapamil)	
DIURETICS		**Review Schedule: 1st Quarter**
acetazolamide tablets acetazolamide ER capsules amiloride amiloride/HCTZ bumetanide chlorothiazide chlorthalidone DIURIL (chlorothiazide) suspension furosemide hydrochlorothiazide (HCTZ) indapamide metolazone spironolactone spironolactone/HCTZ torsemide triamterene/HCTZ	ALDACTAZIDE (spironolactone/HCTZ) ALDACTONE (spironolactone) CAROSPIR (spironolactone) dichlorphenamide EDECRIN (ethacrynic acid) ethacrynic acid INZIRQO (HCTZ) * KERENDIA (finerenone) KEVEYIS (dichlorphenamide) LASIX (furosemide) MAXZIDE (triamterene/HCTZ) methazolamide THALITONE (chlorthalidone) triamterene	• Two (2) preferred products required before a non-preferred product will be approved. • * Step through Diuril suspension required.
EPINEPHRINE, SELF-INJECTED		**Review Schedule: 4th Quarter**
epinephrine auto-injector AG (Mylan Specialty – labeler 49502)	AUVI-Q (epinephrine) EPI-PEN (epinephrine) epinephrine auto-injector (other than Mylan Specialty – labeler 49502) NEFFY (epinephrine)	• One (1) preferred product required before a non-preferred product will be approved.
HEART FAILURE DRUGS		**Review Schedule: 4th Quarter**
ENTRESTO (valsartan/sacubitril) TABLET	INPEFA (sotagliflozin) VERQUVO (vericiguat) ENTRESTO (valsartan/sacubitril) SPRINKLE valsartan/sacubitril	• One (1) preferred product required before a non-preferred product will be approved.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
LIPOTROPICS, OTHER (Clinical criteria applies to individual agents in class.)		**Review Schedule: 4th Quarter**
cholestyramine cholestyramine light colesevelam tablets colestipol ezetimibe fenofibrate (gen LOFIBRA) fenofibrate (gen TRICOR) gemfibrozil niacin ER omega-3 acid ethyl esters PRALUENT (alirocumab) * PREVALITE (cholestyramine) POWDER, POWDER PACK REPATHA (evolocumab) *	ANTARA (fenofibrate) colesevalam powder COLESTID (colestipol) EVKEEZA (evinacumab-dgnb) ezetimibe/simvastatin fenofibrate (gen FENOGLIDE) fenofibrate (gen LIPOFEN) fenofibrate, micronized (gen ANTARA) fenofibric acid (gen FIBRICOR) fenofibric acid (gen TRILIPIX) FENOGLIDE (fenofibrate) icosapent ethyl JUXTAPID (lomitapide) LEQVIO (inclisiran) LIPOFEN (fenofibrate) LOPID (gemfibrozil) NEXLETOL (bempedoic acid) NEXLIZET (bempedoic acid/ezetimibe) TRICOR (fenofibrate) TRILIPIX (fenofibric acid) TRYNGOLZA (olesarzen) VYTORIN (ezetimibe/simvastatin) WELCHOL (colesevelam) ZETIA (ezetimibe)	• Two (2) preferred products required before a non-preferred product will be approved. • *** Clinical criteria applies**
LIPOTROPICS, STATINS		**Review Schedule: 2nd Quarter**
atorvastatin lovastatin pravastatin rosuvastatin simvastatin	ALTOPREV (lovastatin) amlodipine/atorvastatin ATORVALIQ (atorvastatin) suspension CADUET (amlodipine/atorvastatin) CRESTOR (rosuvastatin) EZALLOR (rosuvastatin) FLOLIPID (simvastatin) fluvastatin fluvastatin ER LESCOL XL (fluvastatin) LIPITOR (atorvastatin) LIVALO (pitavastatin) ZOCOR (simvastatin) ZYPITAMAG (pitavastatin)	• Two (2) preferred products required before a non-preferred product will be approved. • Once daily dosing required.
PAH AGENTS, ORAL & INHALED **(Clinical criteria applies to class. All agents require a prior authorization.)**		**Review Schedule: 4th Quarter**
ambrisentan bosentan sildenafil 20 mg tablets	ADCIRCA (tadalafil) ADEMPAS (riociguat) ALYQ (tadalafil)	• Two (2) preferred products required before a non-preferred product will be approved.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
sildenafil 10mg/ml suspension * tadalafil 20 mg tablets (generic ADCIRCA) VENTAVIS (iloprost)	LETAIRIS (ambrisentan) OPSUMIT (macitentan) OPSYNVI (macitentan/tadalafil) ORENITRAM ER (treprostinil) REVATIO (sildenafil) TADLIQ (tadalafil) suspension TRACLEER tablets for suspension (bosentan) treprostinil TYVASO DPI (treprostinil) UPTRAVI (selexipag) WINREVAIR (sotatercept)	• * PA required, to include reason sildenafil tablets cannot be used, if member is > 10-years old.
VASODILATORS, CORONARY		**Review Schedule: 1st Quarter**
isosorbide dinitrate isosorbide mononitrate isosorbide mononitrate ER nitroglycerin patches, tablets ranolazine ER	ASPRUZYO (ranolazine) BIDIL (isosorbide dinitrate/hydralazine) ISORDIL (isosorbide dinitrate tablet) isosorbide dinitrate/hydralazine NITRO-BID (nitroglycerin) ointment NITRO-DUR (nitroglycerin) patches nitroglycerin translingual spray NITROLINGUAL (nitroglycerin) spray NITROMIST (nitroglycerin) NITROSTAT (nitroglycerin) tablets	• Two (2) preferred products required before a non-preferred product will be approved.
CENTRAL NERVOUS SYSTEM DRUGS		
ANTIDEPRESSANTS, OTHER **(Clinical criteria applies to individual agent in class.)**		**Review Schedule: 4th Quarter**
amitriptyline bupropion IR bupropion SR bupropion XL 150, 300 mg clomipramine desvenlafaxine ER (gen PRISTIQ) doxepin duloxetine 20 mg, 30 mg, 60 mg imipramine HCl MARPLAN (isocarboxazid) mirtazapine tablet nortriptyline phenelzine SPRAVATO (esketamine) * tranylcypromine trazodone 50, 100, 150 mg venlafaxine ER capsules venlafaxine IR	amitriptyline/chlordiazepoxide amoxapine ANAFRANIL (clomipramine) APLENZIN (bupropion hbr) AUVELITY (dextromethorphan HBr/bupropion) bupropion XL 450 mg CYMBALTA (duloxetine) desipramine desvenlafaxine ER 50 mg, 100 mg (unbranded) DRIZALMA (duloxetine) duloxetine 40 mg EFFEXOR XR (venlafaxine ER) CAPSULES EMSAM (selegiline) FETZIMA (levomilnacipran) FORFIVO XL (bupropion) imipramine pamoate mirtazapine ODT NARDIL (phenelzine) nefazodone NORPRAMIN (desipramine)	• Two (2) preferred products required before a non-preferred product will be approved. • DMAP requires prior authorization for all antidepressants for patients under six (6) years of age. • *** Clinical criteria applies**

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
	PAMELOR (nortriptyline) PRISTIQ (desvenlafaxine) protriptyline RALDESY (trazodone) REMERON (mirtazapine) REMERON SOLUTAB (mirtazapine) trazodone 300 mg trimipramine TRINTELLIX (vortioxetine) venlafaxine HCL ER tablets venlafaxine besylate ER VIIBRYD (vilazodone HCl) vilazodone WELLBUTRIN SR (bupropion) WELLBUTRIN XL (bupropion) ZURZUVAE (zuranolone)	
ANTIDEPRESSANTS, SSRIs		**Review Schedule: 4th Quarter**
citalopram solution, tablets escitalopram tablets fluoxetine capsules, solution fluvoxamine tablets paroxetine IR tablets sertraline concentrate, tablets	CELEXA (citalopram) citalopram capsules escitalopram solution fluoxetine tablets fluoxetine DR fluvoxamine ER LEXAPRO (escitalopram) paroxetine CR, ER paroxetine capsules, suspension PAXIL (paroxetine) PEXEVA (paroxetine) PROZAC (fluoxetine) sertraline capsules ZOLOFT (sertraline)	• Two (2) preferred products required before a non-preferred product will be approved. • DMAP requires prior authorization for all antidepressants for patients under six (6) years of age. • Liquid medications require prior authorization for members over 10-years old.
ANTIPSYCHOTICS, ORAL/INHALATION **(Clinical criteria applies to individual agents in class.)**		**Review Schedule: 4th Quarter**
amitriptyline/perphenazine aripiprazole solution, tablets clozapine haloperidol concentrate, solution, tablets loxapine lurasidone olanzapine tablets paliperidone ER perphenazine pimozide quetiapine risperidone solution, tablets thioridazine	ABILIFY (aripiprazole) TABLETS ABILIFY MYCITE (aripiprazole) TABLETS aripiprazole ODT asenapine sublingual tablets CAPLYTA (lumateperone) chlorpromazine clozapine ODT CLOZARIL (clozapine) TABLETS COBENFY (xanomeline/trospium) ** FANAPT (iloperidone) fluphenazine GEODON (ziprasidone) CAPSULES INVEGA (paliperidone) TABLETS	• Two (2) preferred products required before a non-preferred product will be approved. • * Two (2) preferred products, one (1) of which must be aripiprazole solution, required before product will be approved. • ** Three (3) preferred products, one (1) of which must be Vraylar (cariprazine), required and member must not be taking other antipsychotics before product will be approved. • PA required for all antipsychotics for patients under eighteen (18) years of age.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
thiothixene trifluoperazine VRAYLAR (cariprazine) ziprasidone	LATUDA (lurasidone) LYBALVI (olanzapine/samidorphan) TABLETS molindone NUPLAZID (pimavanserin tartrate) OPIPZA (aripiprazole) * olanzapine ODT olanzapine/fluoxetine REXULTI (brexpiprazole) RISPERDAL (risperidone) TABLETS risperidone ODT SAPHRIS (asenapine) SECUADO (asenapine) SEROQUEL (quetiapine) TABLETS SEROQUEL XR (quetiapine) TABLETS VERSACLOZ (clozapine) ZYPREXA (olanzapine) TABLETS	
ANTIPSYCHOTICS, INJECTABLE/INHALATION		**Review Schedule: 4th Quarter**
ABILIFY ASIMTUFII (aripiprazole) ABILIFY MAINTENA (aripiprazole) ARISTADA (aripiprazole) chlorpromazine fluphenazine fluphenazine decanoate haloperidol decanoate haloperidol lactate INVEGA HAFYERA (paliperidone) INVEGA SUSTENNA (paliperidone) INVEGA TRINZA (paliperidone) olanzapine RISPERDAL CONSTA (risperidone) ziprasidone mesylate IM	ADASUVE (loxapine) ERZOFRI (paliperidone) GEODON IM (ziprasidone) HALDOL (haloperidol decanoate) PERSERIS (risperidone) risperidone ER vials RYKINDO (risperidone microspheres) UZEDY (risperidone)	• Two (2) preferred products required before a non-preferred product will be approved. • PA required for all antipsychotics for patients under eighteen (18) years of age.
ANXIOLYTICS		**Review Schedule: 2nd Quarter**
buspirone chlordiazepoxide clorazepate diazepam solution, tablets hydroxyzine pamoate hydroxyzine HCl solution, tablets lorazepam tablets	alprazolam ER/XR, IR, intensol, ODT ATIVAN (lorazepam) diazepam intensol LIBRIUM (chlordiazepoxide) lorazepam intensol LOREEV XR (lorazepam) meprobamate oxazepam VALIUM (diazepam) VISTARIL (hydroxyzine pamoate) XANAX (alprazolam) XANAX XR (alprazolam)	• Two (2) preferred products required before a non-preferred product will be approved. • **Quantity Limits of 120 units of benzodiazepines per 30 days**

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
MOOD STABILIZERS		**Review Schedule: 4th Quarter**
carbamazepine 100 mg chewable tablets, tablets carbamazepine ER, XR carbamazepine suspension divalproex sodium lamotrigine IR lithium IR lithium ER SUBVENITE (lamotrigine) valproic acid	carbamazepine 200 mg chewable tablets * DEPAKOTE (divalproex) DEPAKOTE ER (divalproex) LAMICTAL (lamotrigine) LAMICTAL ODT (lamotrigine) LAMICTAL XR (lamotrigine) lamotrigine ER, ODT LITHOBID (lithium) TEGRETOL (carbamazepine) suspension, tablets TEGRETOL-XR (carbamazepine) tablets TERIL (carbamazepine) suspension	• Two (2) preferred products required before a non-preferred product will be approved. • * PA required, to include reason carbamazepine 2 x 100 mg chewable tablets cannot be used, before product will be approved.
SEDATIVE HYPNOTICS		**Review Schedule: 2nd Quarter**
temazepam 15mg, 30mg zaleplon zolpidem IR tablets	AMBIEN (zolpidem) AMBIEN CR (zolpidem) BELSOMRA (suvorexant) DAYVIGO (lemborexant) doxepin 3mg, 6 mg EDLUAR (zolpidem) estazolam eszopiclone flurazepam HALCION (triazolam) HETLIOZ (tasimelteon) capsules, suspension IGALMI (dexmedetomidine HCl) LUNESTA (eszopiclone) QUVIVIQ (daridorexant HCl) ramelteon RESTORIL (temazepam) ROZEREM (ramelteon) SILENOR (doxepin) SONATA (zaleplon) tasimelteon temazepam 7.5mg, 22.5mg triazolam zolpidem ER zolpidem IR capsules	• Two (2) preferred products required before a non-preferred product will be approved. • Dose optimization required when applicable. • Quantity limits – 30 units per 30 days
DIABETIC SUPPLY LIST		
Please refer to the Delaware Pharmacy Corner website for covered Diabetic Supply products. https://medicaid.dhss.delaware.gov/provider/Home/PharmacyCornerLanding/tabid/2096/Default.aspx		

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
ENDOCRINE AND METABOLIC DRUGS		
ANDROGENIC AGENTS **(Clinical criteria applies to class. All agents require a prior authorization.)**		**Review Schedule: 4th Quarter**
DEPO-TESTOSTERONE (testosterone cypionate) testosterone cypionate testosterone enanthate testosterone gel pump 20.25/1.25	AMZIRO (testosterone cyprionate) ANDROID 25 (methyltestosterone) ANDROGEL (testosterone) AVEED (testosterone undecanoate) JATENZO (testosterone undecanoate) KYZATREX (testosterone undecanoate) METHITEST (methyltestosterone) methyltestosterone NATESTO (testosterone) TESTIM (testosterone) testosterone gel (except preferred formulation) TLANDO (testosterone undecanoate) UNDECATREX (testosterone undecanoate) VOGELXO (testosterone) XYOSTED (testosterone enanthate)	• Two (2) preferred products required before a non-preferred product will be approved.
BONE RESORPTION SUPPRESSION AND RELATED AGENTS **(Clinical criteria applies to individual agents in class)**		**Review Schedule: 4th Quarter**
alendronate tablets calcitonin-salmon nasal spray FORTEO (teriparatide) * ibandronate PROLIA (denosumab) * raloxifene XGEVA (denosumab) *	ACTONEL (risedronate) alendronate solution ATELVIA (risedronate) BINOSTO (alendronate) BONSITY (teriparatide) * EVENITY (romosozumab-aqqg) * EVISTA (raloxifene) FOSAMAX (alendronate) FOSAMAX PLUS D (alendronate/vitamin D) NATPARA * risedronate teriparatide * TYMLOS (abaloparatide) * YORVIPATH (palopegteriparatide) *	• Two (2) preferred products required before a non-preferred product will be approved. • *** Clinical PA is required for injectable medications in this class**
CONTRACEPTIVES, **ORAL – BIPHASIC**		**Review Schedule: 1st Quarter**
desogestrel-ethinyl estradiol-eth estradiol	LO LOESTRIN FE (norethindrone-ethinyl estradiol-FE)	• One (1) preferred product required before a non-preferred product will be approved.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
CONTRACEPTIVES, ORAL - COMBINATION		**Review Schedule: 1st Quarter**
desogestrel-ethinyl estradiol drosperinone-ethinyl estradiol ENSKYCE (desogestrel-ethinyl estradiol) ethynodiol-ethinyl estradiol ICLEVIA (levonorgestrel-ethinyl estradiol) levonorgestrel-ethinyl estradiol norethindrone-ethinyl estradiol norethindrone-ethinyl estradiol-FE tablets, capsule, chewables norgestimate-ethinyl estradiol norgestrel-ethinyl estradiol OCELLA (drosperinone-ethinyl estradiol) SETLAKIN (levonorgestrel-ethinyl estradiol) TRI-NYMYO (norgestimate-ethinyl estradiol) TYBLUME (levonorgestrel-ethinyl estradiol) chewable VOLNEA (desogestrel-ethinyl estradiol/ethinyl estradiol) WYMZYA FE (norethindrone-ethinyl estradiol-FE) chewable	BALCOLTRA (levonorgestrel-ethinyl estradiol-FE) BEYAZ (drosperinone-ethinyl estradiol-levomefolate) drosperinone-ethinyl estradiol-levomefolate FEMLYV (norethindrone-ethinyl estradiol) GEMMILY (norethindrone-ethinyl estradiol-FE) GENERESS FE (norethindrone-ethinyl estradiol-FE) chewable KAITLIB FE (norethindrone-ethinyl estradiol) chewable LAYOLIS FE (norethindrone-ethinyl estradiol-FE) chewable levonorgestrel-ethinyl estradiol 90-20 levonorgestrel-ethinyl estradiol-FE (gen BALCOLTRA) LOESTRIN (norethindrone-ethinyl estradiol) LOESTRIN-FE (norethindrone-ethinyl estradiol-FE) MERZEE (norethindrone-ethinyl estradiol-FE) MINASTRIN (norethindrone-ethinyl estradiol) MINZOYA (levonorgestrel-ethinyl estradiol-FE) NEXTSTELLIS (drospirenone-estetrol) SAFYRAL (drosperinone-ethinyl estradiol-levomefolate) TAYSOFY (norethindrone-ethinyl estradiol-FE) TAYTULLA (norethindrone-ethinyl estradiol) YASMIN (drosperinone-ethinyl estradiol) YAZ (drosperinone-ethinyl estradiol)	• Two (2) preferred products required before a non-preferred product will be approved.
CONTRACEPTIVES, ORAL - EXTENDED CYCLE		**Review Schedule: 1st Quarter**
AMETHIA LO (levonorgestrel-ethinyl estradiol) CAMRESE (levonorgestrel-ethinyl estradiol) CAMRESE LO (levonorgestrel-ethinyl estradiol-ethinyl estradiol) JOLESSA (levonorgestrel-ethinyl estradiol) levonorgestrel-ethinyl estradiol 0.15-0.03, 0.1-0.02 levonorgestrel-ethinyl estradiol-ethinyl estradiol 150-30, 100-20	levonorgestrel-ethinyl estradiol-ethinyl estradiol 0.15 LOSEASONIQUE (levonorgestrel-ethinyl estradiol) SEASONIQUE (levonorgestrel-ethinyl estradiol)	• Two (2) preferred products required before a non-preferred product will be approved.
CONTRACEPTIVES, ORAL - PROGESTINS		**Review Schedule: 1st Quarter**
EMZAHH (norethindrone) LYLEQ (norethindrone) NORA-BE (norethindrone) norethindrone SLYND (drospirenone)		

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
CONTRACEPTIVES, ORAL – TRIPHASIC		**Review Schedule: 1st Quarter**
ALYACEN (norethindrone-ethinyl estradiol) ARANELLE (norethindrone-ethinyl estradiol) CAZIANT (desogestrel-ethinyl estradiol) DASETTA (norethindrone-ethinyl estradiol) ENPRESSE (levonorgestrel-ethinyl estradiol) FINZALA (norethindrone-ethinyl estradiol-iron) LEENA (norethindrone-ethinyl estradiol) LEVONEST (levonorgestrel-ethinyl estradiol) levonorgestrel-ethinyl estradiol NORTREL (norethindrone-ethinyl estradiol) NYLIA (norethindrone-ethinyl estradiol) norethindrone-ethinyl estradiol-iron norgestimate-ethinyl estradiol TILIA FE (norethindrone-ethinyl estradiol-iron) TRI-ESTARYLLA (norgestimate-ethinyl estradiol) TRI-LINYAH (norgestimate-ethinyl estradiol) TRI-MILI (norgestimate-ethinyl estradiol) TRY-NYMYO (norgestimate-ethinyl estradiol) TRI-SPRINTEC (norgestimate-ethinyl estradiol) TRI-VYLIBRA (norgestimate-ethinyl estradiol) TRIVORA (levonorgestrel-ethinyl estradiol) VELIVET (desogestrel-ethinyl estradiol)	TRI-LEGEST (norethindrone-ethinyl estradiol-iron)	• Two (2) preferred products required before a non-preferred product will be approved.
CONTRACEPTIVES – IUDs / IMPLANTS		**Review Schedule: 1st Quarter**
KYLEENA (levonorgestrel) LILETTA (levonorgestrel) MIRENA (levonorgestrel) NEXPLANON (etonogestrel) PARAGARD		
CONTRACEPTIVES – PATCHES		**Review Schedule: 1st Quarter**
ethinyl estradiol-norelgestromin	TWIRLA (levonorgestrel-ethinyl estradiol) XULANE (ethinyl estradiol-norelgestromin) ZAFEMY (ethinyl estradiol-norelgestromin)	• One (1) preferred product required before a non-preferred product will be approved.
CONTRACEPTIVES – VAGINAL RINGS		**Review Schedule: 1st Quarter**
NUVARING (etonogestrel-ethinyl estradiol)	ANNOVERA (ethinyl estradiol-segesterone) ELURYNG (etonogestrel-ethinyl estradiol) ENILLORING (etonogestrel-ethinyl estradiol) etonogestrel-ethinyl estradiol HALOETTE (etonogestrel-ethinyl estradiol)	• One (1) preferred product required before a non-preferred product will be approved.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
GROWTH HORMONES **(Clinical criteria applies to class. All agents require a prior authorization.)**		**Review Schedule: 4th Quarter**
GENOTROPIN (somatropin) NORDITROPIN (somatropin) SKYTROFA (lonapegsomatropin-tcgd) *	NGENLA (somatrogon-ghla) NUTROPIN AQ (somatropin) OMNITROPE (somatropin) SAIZEN (somatropin) SEROSTIM (somatropin) SOGROYA (somapacitan-beco) ZOMACTON (somatropin) ZORBTIVE (somatropin)	• Two (2) preferred products required before a non-preferred product will be approved. • * Step through 6-month trial of SAGH required. Abbreviation: SAGH – short-acting growth hormone
HYPOGLYCEMIA TREATMENTS		**Review Schedule: 4th Quarter**
BAQSIMI (glucagon) (Amphastar – labeler code 000548) glucagon ZEGALOGUE autoinjector (dasiglucagon) ZEGALOGUE syringe (dasiglucagon)	BAQSIMI (glucagon) (Lilly – labeler code 00002) GVOKE HYPOPEN (glucagon) GVOKE PFS (glucagon) GVOKE kit (glucagon)	• Two (2) preferred products required before a non-preferred product will be approved.
HYPOGLYCEMICS, ALPHA-GLUCOSIDASE INHIBITORS		**Review Schedule: 1st Quarter**
acarbose	GLYSET (migitol) miglitol	• One (1) preferred product required before a non-preferred product will be approved.
HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS: AMYLIN ANALOGS **(Clinical criteria applies to class. All agents require a prior authorization.)**		**Review Schedule: 4th Quarter**
	SYMLIN (pramlintide)	
HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS: DPP-4 INHIBITORS **(Clinical criteria applies to class. All agents require a prior authorization.)**		**Review Schedule: 4th Quarter**
JANUMET (sitagliptin phos/metformin) JANUMET XR (sitagliptin phos/metformin) JANUVIA (sitagliptin phos) JENTADUETO (linagliptin/metformin) TRADJENTA (linagliptin)	alogliptin alogliptin-metformin alogliptin-pioglitazone JENTADUETO XR (linagliptin/metformin) KOMBIGLYZE XR (saxagliptin/metformin) NESINA (alogliptin) OSENI (alogliptin/pioglitazone) saxagliptin saxagliptin/metformin sitagliptin (gen ZITUVIO) sitagliptin/metformin (gen ZITUVIMET)	• Two (2) preferred products required before a non-preferred product will be approved.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
	ZITUVIO (sitagliptin) ZITUVIMET (sitagliptin/metformin) ZITUVIMET XR (sitagliptin/metformin)	
HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS: GLP-1 RAs **(Clinical criteria applies to class. All agents require a prior authorization.)**		**Review Schedule: 4th Quarter**
OZEMPIC (semaglutide) TRULICITY (dulaglutide) VICTOZA (liraglutide)	BYDUREON BCISE (exenatide) BYETTA (exenatide) exenatide liraglutide MOUNJARO (tirzepatide) RYBELSUS (semaglutide) * SOLIQUA (insulin glargine/lixisenatide) XULTOPHY (insulin degludec/liraglutide)	• Two (2) preferred products required before a non-preferred product will be approved. • * PA required for R2 formulation, to include reason R1 formulation cannot be used, before product will be approved
HYPOGLYCEMICS, INSULINS		**Review Schedule: 4th Quarter**
HUMALOG MIX 50-50 (insulin lispro/lispro protamine) HUMALOG MIX 75-25 (insulin lispro/lispro protamine) vial HUMULIN R U-500 (insulin) HUMULIN R vial HUMULIN 70-30 vial insulin aspart insulin aspart mix insulin lispro insulin lispro mix LANTUS (insulin glargine) NOVOLIN N (insulin isophane) NOVOLIN R (insulin) TOUJEO SOLOSTAR (insulin glargine) TOUJEO SOLOSTAR MAX (insulin glargine)	ADMELOG (insulin lispro) AFREZZA (insulin) APIDRA (insulin glulisine) BASAGLAR (insulin glargine) BASAGLAR TEMPO (insulin glargine) FIASP (insulin aspart) HUMALOG U-100 (insulin lispro) HUMALOG U-200 (insulin lispro) HUMALOG JUNIOR (insulin lispro) HUMALOG MIX 75-25 (insulin lispro/lispro protamine) pen HUMULIN N HUMULIN 70/30 pen insulin degludec insulin glargine SOLOSTAR (gen TOUJEO) Insulin glargine SOLOSTAR MAX (gen TOUJEO) insulin glargine-YFGN insulin glargine LYUMJEV (insulin lispro) NOVOLIN N (insulin isophane) vial NOVOLIN R (insulin) vial NOVOLIN 70/30 NOVOLOG (insulin aspart) NOVOLOG MIX 70/30 REZVOGLAR KWIKPEN (insulin glargine-aglr) SEMGLEE (insulin glargine) TRESIBA (insulin degludec)	• Two (2) preferred products required before a non-preferred product will be approved.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
HYPOGLYCEMICS, MEGLITINIDES		**Review Schedule: 1st Quarter**
nateglinide repaglinide		
HYPOGLYCEMICS, METFORMINS		**Review Schedule: 4th Quarter**
glipizide-metformin glyburide-metformin metformin IR 500 mg, 850 mg, 1000 mg metformin ER (generic GLUCOPHAGE XR)	GLUMETZA (metformin ER) metformin ER (generic FORTAMET, GLUMETZA) metformin IR solution metformin IR 625 mg RIOMET (metformin IR solution)	• Two (2) preferred products required before a non-preferred product will be approved.
HYPOGLYCEMICS, SGLT2 INHIBITORS		**Review Schedule: 4th Quarter**
FARXIGA (dapagliflozin) INVOKAMET (canagliflozin/metformin) INVOKAMET XR (canagliflozin/metformin) INVOKANA (canagliflozin) JARDIANCE (empagliflozin) SYNJARDY (empagliflozin/metformin) XIGDUO XR (dapagliflozin/metformin)	dapagliflozin dapagliflozin/metformin GLYXAMBI (empagliflozin/linagliptin) QTERN (dapagliflozin/saxagliptin) SEGLUROMET (ertugliflozin/metformin) STEGLATRO (ertugliflozin) STEGLUJAN (ertugliflozin/sitagliptin) SYNJARDY XR (empagliflozin/metformin) TRIJARDY XR (empagliflozin/linagliptin/metformin)	• Two (2) preferred products required before a non-preferred product will be approved.
HYPOGLYCEMICS, TZDs		**Review Schedule: 1st Quarter**
pioglitazone	ACTOPLUS MET (pioglitazone/metformin) ACTOS (pioglitazone) DUETACT (pioglitazone/glimepiride) pioglitazone/glimepiride pioglitazone/metformin	• One (1) preferred product required before a non-preferred product will be approved.
HYPERPARATHYROIDS		
cinacalcet tablets	paricalcitol capsules SENISPAR (cinacalcet) RAYALDEE (calcifediol) ZEMPLAR (paricalcitol) capsules, vials	• One (1) preferred product required before a non-preferred product will be approved.
GLUCOCORTICOIDS, ORAL		**Review Schedule: 4th Quarter**
budesonide ER capsules dexamethasone elixir, intensol, solution, tablets fludrocortisone hydrocortisone methylprednisolone dose pack	AGAMREE (vamorolone) ALKINDI SPRINKLES (hydrocortisone) granules budesonide ER tablet CORTEF (hydrocortisone) cortisone	• Two (2) preferred products required before a non-preferred product will be approved.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
methylprednisolone 4mg tablets prednisolone solution prednisolone sodium phosphate solution prednisone dose pack, tablets	deflazacort dexamethasone dose pack EMFLAZA (deflazacort) tablets, suspension EOHILIA (budesonide) HEMADY (dexamethasone) MEDROL (methylprednisolone) methylprednisolone 8, 16, 32 mg tablet prednisolone tablets prednisolone sodium phosphate ODT prednisone intensol, solution RAYOS (prednisone) TARPEYO (budesonide)	
NON-ALCOHOLIC STEATOHEPATITIS (NASH) TREATMENT AGENTS (Clinical criteria applies to class.)		**Review Schedule: 2nd Quarter**
	REZDIFFRA (resmetriom)	
PELVIC DISORDERS – ENDOMETRIOSIS, UTERINE FIBROIDS		**Review Schedule: 4th Quarter**
danazol DEPO-SUBQ PROVERA 104 (medroxyprogesterone) LUPRON DEPOT (leuprolide) MYFEMBREE (relugolix-estradiol-norethindrone acetate) norethindrone acetate ORILISSA (elagolix) SYNAREL (nafarelin)	ORIAHNN (elagolix-estradiol-norethindrone)	• Two (2) preferred products required before a non-preferred product will be approved.
PITUITARY SUPPRESSANTS, CENTRAL PRECOCIOUS PUBERTY (CPP)		**Review Schedule: 4th Quarter**
FENSOLVI (leuprolide acetate) leuprolide acetate 22.5 mg vial LUPRON DEPOT–PED (leuprolide) SUPPRELIN LA (histrelin) SYNAREL (nafarelin)	TRIPTODUR (triptorelin)	• Two (2) preferred products required before a non-preferred product will be approved.
POTASSIUM REMOVING AGENTS		**Review Schedule: 4th Quarter**
LOKELMA (sodium zirconium cyclosilicate)	VELTASSA (patiromer calcium sorbitex)	• One (1) preferred product required before a non-preferred product will be approved.
PROGESTATIONAL AGENTS		**Review Schedule: 2nd Quarter**

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
DEPO-PROVERA (medroxyprogesterone) medroxyprogesterone acetate tablets medroxyprogesterone acetate IM norethindrone acetate tablets progesterone capsule progesterone IM	CRINONE (progesterone) PROMETRIUM (progesterone) PROVERA (medroxyprogesterone)	• Two (2) preferred products required before a non-preferred product will be approved.
THYROID HORMONES		**Review Schedule: 4th Quarter**
ARMOUR THYROID (thyroid desiccated) ERMEZA (levothyroxine sodium) EUTHYROX (levothyroxine sodium) LEVO-T (levothyroxine sodium) levothyroxine sodium tablets liothyronine sodium tablets NP THYROID (thyroid desiccated)	ADTHYZA (thyroid desiccated) CYTOMEL (liothyronine sodium) levothyroxine sodium injection levothyroxine sodium capsules LEVOXYL (levothyroxine sodium) liothyronine sodium injection SYNTHROID (levothyroxine sodium) THYQUIDITY (levothyroxine sodium) UNITHROID (levothyroxine sodium)	• Two (2) preferred products required before a non-preferred product will be approved.
UREA CYCLE DISORDER AGENTS		**Review Schedule: 4th Quarter**
carglumic acid (Eton – labeler code 71863) PHEBURANE (sodium phenylbutyrate) sodium phenylbutyrate powder, tabs	BUPHENYL powder, tabs (sodium phenylbutyrate) CARBAGLU (carglumic acid) carglumic acid (Burel – labeler code 35573) OLPRUVA (sodium phenylbutyrate) RAVICTI (sodium phenylbutyrate)	• Two (2) preferred products required before a non-preferred product will be approved.
VASOMOTOR SYMPTOMS		**Review Schedule: 4th Quarter**
	VEOZAH (fezolinetant)	
GASTROINTESTINAL AGENTS		
ANTIEMETICS, ORAL/TRANSDERMAL **(Clinical criteria applies to individual agents in class.)**		**Review Schedule: 4th Quarter**
DICLEGIS (doxylamine/pyridoxine) ondansetron tablets, ODT (4mg, 8 mg), solution scopolamine patch	AKYNZEO (netupitant/palonosetron) ANZEMET (dolasetron) aprepitant BONJESTA (doxylamine/pyridoxine) * doxylamine/pyridoxine dronabinol * EMEND (aprepitant) capsules, suspension granisetron MARINOL (dronabinol) * ondansetron ODT 16 mg SANCUSO (granisetron) TRANSDERM-SCOP (scopolamine)	• Two (2) preferred products required before a non-preferred product will be approved. • *** Clinical criteria applies**

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
	trimethobenzamide VARUBI (rolapitant)	
BILE SALTS		**Review Schedule: 4th Quarter**
ursodiol capsules, tablets	CHENODAL (chenodiol) CHOLBAM (cholic acid) IQIRVO (elafibranor) LIVDELZI (seladelpar) LIVMARLY (maralixibat) OCALIVA (obeticholic acid) RELTONE (ursodiol) URSO FORTE (ursodiol)	• Two (2) preferred products required before a non-preferred product will be approved.
BOWEL PREP		**Review Schedule: 4th Quarter**
CLENPIQ GAVILYTE-C GAVILYTE-G GOLYTELY MOVIPREP NULYTELY PEG 3350 PEG 3350-ELECTROLYTE PEG 3350-Sod Sul-NACL-KCL- ASB-C PLENVU SODIUM SULF-POTASSIUM SULF-MAG SULF SUPREP	SUFLAVE SUTAB	• Two (2) preferred products required before a non-preferred product will be approved.
CONSTIPATION – IBS, ORAL		**Review Schedule: 4th Quarter**
LINZESS (linaclotide) lubiprostone MOVANTIK (naloxegol) TRULANCE (plecanatide)	AMITIZA (lubiprostone) ISBRELA (tenapanor) MOTEGRITY (prucalopride) prucalopride RELISTOR (methylnaltrexone) SYMPROIC (naldemedine)	• Two (2) preferred products required before a non-preferred product will be approved.
DIARRHEA – IBS, ORAL		**Review Schedule: 4th Quarter**
	alosetron LOTRONEX (alosetron) MYTESI (crofelemer) VIBERZI (eluxadoline)	
H. PYLORI TREATMENTS		**Review Schedule: 4th Quarter**
PYLERA (bismuth subcitrate potassium-metronidazole-tetracycline)	bismuth-metronidazole- tetracycline lansoprazole-amoxicillin-clarithromycin	• One (1) preferred product required before a non-preferred product will be approved.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
	OMECLAMOX PAK (omeprazole-clarithromycin-amoxicillin) TALICIA (omeprazole magnesium-amoxicillin-rifabutin) VOQUEZNA DUAL PAK (vonoprazan-amoxicillin) VOQUEZNA TRIPLE PAK (vonoprazan-amoxicillin-clarithromycin)	
HISTAMINE II RECEPTOR BLOCKERS		**Review Schedule: 1st Quarter**
famotidine nizatidine	cimetidine	• Two (2) preferred products required before a non-preferred product will be approved.
HYPERPHOSPHATEMIA AGENTS, OTHER		**Review Schedule: 1st Quarter**
	XPHOZAH (tenapanor)	• Two (2) preferred phosphate binder products required before a non-preferred product will be approved. • PA required for all non-calcium-based products.
HYPERPHOSPHATEMIA AGENTS, PHOSPHATE BINDERS		**Review Schedule: 1st Quarter**
calcium acetate capsules sevelamer carbonate tablet	AURYXIA (ferric citrate) calcium acetate tablets ferric citrate FOSRENOL (lanthanum carbonate) lanthanum RENAGEL (sevelamer HCl) RENVELA (sevelamer carbonate) sevelamer HCl tablet sevelamer powder VELPHORO (sucroferric oxyhydroxide)	• Two (2) preferred products required before a non-preferred product will be approved. • PA required for all non-calcium based products.
PANCREATIC ENZYMES		**Review Schedule: 4thQuarter**
CREON (pancrelipase) ZENPEP (pancrelipase)	PERTZYE (pancrelipase) VIOKACE (pancrelipase)	• Two (2) preferred products required before a non-preferred product will be approved.
PROTON PUMP INHIBITORS		**Review Schedule: 1st Quarter**
omeprazole RX pantoprazole tablets PROTONIX (pantoprazole) granules	DEXILANT (dexlansoprazole) dexlansoprazole esomeprazole KONVOMEP (omeprazole/sodium bicarbonate) lansoprazole NEXIUM (esomeprazole) omeprazole OTC omeprazole/sodium bicarbonate	• Two (2) preferred products required before a non-preferred product will be approved. • Quantity limits apply to class. • Liquid medications require prior authorization for members over 10 years old.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
	pantoprazole granules PREVACID (lansoprazole) PRILOSEC (omeprazole) packets PROTONIX (pantoprazole) tablets rabeprazole VOQUENZA (vonoprazan) ZEGRID (omeprazole/sodium bicarbonate)	
ULCERATIVE COLITIS AGENTS		**Review Schedule: 3rd Quarter**
APRISO (mesalamine) balsalazide DELZICOL (mesalamine) mesalamine enema, suppository mesalamine DR 1.2 gm PENTASA (mesalamine) sulfasalazine sulfasalazine DR	AZULFIDINE (sulfasalazine) budesonide foam CANASA (mesalamine) COLAZAL (balsalazide) DIPENTUM (olsalazine) LIALDA (mesalamine) mesalamine DR 400 mg, 800 mg, 1.2 g mesalamine enema kit mesalamine ER 375 mg, 500 mg ROWSA (mesalamine) SFROWSA (mesalamine) UCERIS (budesonide)	• Two (2) preferred products required before a non-preferred product will be approved.
GENE THERAPY		
CENTRAL NERVOUS SYSTEM: SPINAL MUSCULAR ATROPHY **(Clinical criteria applies to class. All agents require a prior authorization.)**		
ZOLGENSMA (onasemnogene abeparvovec)		
GENITOURINARY PRODUCTS		
BLADDER RELAXANT PREPARATIONS		**Review Schedule: 4th Quarter**
MYRBETRIQ (mirabegron) tablets oxybutynin 5 mg oxybutynin ER oxybutynin syrup solifenacin	darifenacin DETROL (tolterodine) DETROL LA (tolterodine) fesoterodine GEMTESA (vibegron) mirabegron tablets MYRBETRIQ (mirabegron) suspension oxybutynin 2.5 mg OXYTROL (oxybutynin) tolterodine TOVIAZ (fesoterodine) trospium VESICARE (solifenacin) tablets VESICARE LS (solifenacin) suspension	• Two (2) preferred products required before a non-preferred product will be approved.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
BPH TREATMENTS		**Review Schedule: 2nd Quarter**
alfuzosin doxazosin finasteride 5 mg tamsulosin terazosin	CARDURA (doxazosin) CARDURA XL (doxazosin) dutasteride dutasteride/tamsulosin finasteride/tadalafil PROSCAR (finasteride) RAPAFLO (silodosin) silodosin tadalafil 5 mg *	• Two (2) preferred products required before a non-preferred product will be approved. • * For BPH diagnosis only
HEMATOLOGICAL AGENTS		
ANTICOAGULANTS, ORAL/SQ		**Review Schedule: 4th Quarter**
ELIQUIS (apixaban) enoxaparin JANTOVEN (warfarin) PRADAXA (dabigatran) capsules warfarin XARELTO (rivaroxaban) tablets	ARIXTRA (fondaparinux) dabigatran etexilate fondaparinux FRAGMIN (dalteparin) LOVENOX (enoxaparin) PRADAXA (dabigatran) pellets rivaroxaban SAVAYSA (edoxaban) XARELTO (rivaroxaban) suspension	• Two (2) preferred products required before a non-preferred product will be approved. • Quantity limits in place on injectable formulations: 6 weeks allowed without prior authorization.
HEMOPHILIA A/VWD		**Review Schedule: 4th Quarter**
AFSTYLA (antihemophilic factor – recombinant) ALPHANATE (antihemophilic factor/von Willebrand factor complex- human) FEIBA (anti-inhibitor coagulant complex) HEMLIBRA (emicizumab-kxwh) HEMOFIL M (antihemophilic factor – human) HUMATE-P (antihemophilic factor/von Willebrand factor complex- human) JIVI (antihemophilic factor – recombinant) KOATE (antihemophilic factor – recombinant) KOVALTRY (antihemophilic factor – recombinant) NOVOSEVEN (coagulation factor VIIa – recombinant) NOVOEIGHT (antihemophilic factor – recombinant) NUWIQ (antihemophilic factor – recombinant) OBIZUR (antihemophilic factor – recombinant) WILATE (von Willebrand factor/coagulation factor VIII complex – human) XYNTHA (antihemophilic factor – recombinant)	ADVATE (antihemophilic factor – recombinant) ADYNOVATE (antihemophilic factor – recombinant) ALHEMO (concizumab-mtci) * ALTUVIIIO (antihemophilic factor – recombinant) ELOCTATE (antihemophilic factor – recombinant) ESPEROCT (antihemophilic factor – recombinant) HYMPAVZI (marstacimab-hncq) * KOGENATE FS (antihemophilic factor – recombinant) QFITLIA (fitusiran) * RECOMBINATE (antihemophilic factor – recombinant) SEVENFACT (coagulation factor VIIa – recombinant) VONVENDI (von Willebrand factor – recombinant)	• Two (2) preferred products required before a non-preferred product will be approved. • * Approval criteria dependent on diagnosis (Dx) o Dx hemophilia B – use of preferred product not required prior to approval. o Dx hemophilia A – use of or contraindication to Hemlibra required before non-preferred product will be approved.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
XYNTHA SOLOFUSE (antihemophilic factor – recombinant)		
HEMOPHILIA B		**Review Schedule: 4th Quarter**
ALPHANINE SD (coagulation factor IX – human) ALPROLIX (coagulation factor IX – recombinant) BENEFIX (coagulation factor IX – recombinant) IXINITY (coagulation factor IX – recombinant) REBINYN (coagulation factor IX – recombinant) PROFILNINE (factor IX complex) RIXUBIS (coagulation factor IX – recombinant)	IDELVION (coagulation factor IX – recombinant)	• Two (2) preferred products required before a non-preferred product will be approved.
COLONY STIMULATING FACTORS		**Review Schedule: 4th Quarter**
FULPHILA (pegfilgrastim-jmdb) NEUPOGEN (filgrastim) NYVEPRIA (pegfilgrastim-apgf)	FYLNETRA (pegfilgrastim-pbbk) GRANIX (tbo-filgrastim) LEUKINE (sargramostim) NEULASTA (pegfilgrastim) NIVESTYM (figrastim-aafi) vial, syringe RELEUKO (filgrastim-ayow) ROLVEDON (eflapegrastim-xnst) STIMUFEND (pegfilgrastim-fpgk) UDENYCA (pegfilgrastim-cbqv) ZARXIO (filgrastim-sndz) ZIEXTENZO (pegfilgrastim-bmez)	• Two (2) preferred products required before a non-preferred product will be approved.
ERYTHROPOIESIS STIMULATING PROTEINS **(Clinical criteria applies to class. All agents require a prior authorization.)**		**Review Schedule: 4th Quarter**
MIRCERA (methoxy polyethylene glycol-epoetin beta) RETACRIT (epoetin alfa-epbx) (Pfizer – labeler code 00069)	ARANESP (darbepoetin alfa) EPOGEN (epoetin alfa) PROCRIT (epoetin alfa) RETACRIT (epoetin alfa-epbx) (Vifor – labeler code 59353)	• Two (2) preferred products required before a non-preferred product will be approved.
HAE TREATMENTS **(Clinical criteria applies to class. All agents require a prior authorization.)**		**Review Schedule: 4th Quarter**
BERINERT (human C1 inhibitor) CINRYZE (human C1 inhibitor) danazol HAEGARDA (human C1 inhibitor) icatibant KALBITOR (escallantide) ORLADEYO (berotralstat) RUCONEST (recombinant C1 esterase inhibitor) SAJAZIR (icatibant) TAKHZYRO (lanadelumab-flyo)	FIRAZYR (icatibant)	• Two (2) preferred products required before a non-preferred product will be approved.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
PLATELET AGGREGATION INHIBITORS		**Review Schedule: 4th Quarter**
aspirin/dipyridamole BRILINTA (ticagrelor) clopidogrel dipyridamole prasugrel	aspirin/omeprazole EFFIENT (prasugrel) PLAVIX (clopidogrel) ticagrelor ticlopidine YOSPRALA (aspirin/omeprazole) ZONTIVITY (vorapaxar)	• Two (2) preferred products required before a non-preferred product will be approved.
SICKLE CELL ANEMIA AGENTS		**Review Schedule: 4th Quarter**
DROXIA (hydroxyurea) hydroxyurea	ADAKVEO (crizanlizumab-tmca) vials ENDARI (glutamine) HYDREA (hydroxyurea) SIKLOS (hydroxyurea)	• Two (2) preferred products required before a non-preferred product will be approved.
THROMBOPOIETICS		**Review Schedule: 2nd Quarter**
NPLATE (romiplostim) PROMACTA (eltrombopag olamine) tablets	ALVAIZ (eltrombopag) DOPTELET (avatrombopag maleate) MULPLETA (lusutrombopag) PROMACTA (eltrombopag maleate) powder packs TAVALISSE (fostanatiniv disodium)	• Two (2) preferred products required before a non-preferred product will be approved.
IMMUNE GLOBULINS		
IMMUNE GLOBULINS		**Review Schedule: 4th Quarter**
BIVIGAM GAMMAGARD GAMMAGARD S-D GAMUNEX-C OCTAGAM PRIVIGEN XEMBIFY	ALYGLO ASCENIV CUTAQUIG CUVITRU GAMASTAN GAMMAKED GAMMAPLEX HIZENTRA HYQVIA PANZYGA	• Two (2) preferred products required before a non-preferred product will be approved.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
MEDICAL DEVICES AND SUPPLIES		
BLOOD GLUCOSE METERS, TEST STRIPS		
Please refer to the Delaware Pharmacy Corner website for covered Diabetic Supply products. https://medicaid.dhss.delaware.gov/provider/Home/PharmacyCornerLanding/tabid/2096/Default.aspx	All other blood glucose meters and test strips are non-preferred	Two (2) preferred products required before a non-preferred product will be approved.
CONTINUOUS GLUCOSE MONITORS (CGMs)		
Please refer to the Delaware Pharmacy Corner website for covered Diabetic Supply products. https://medicaid.dhss.delaware.gov/provider/Home/PharmacyCornerLanding/tabid/2096/Default.aspx	All other CGM devices are non-preferred	• Two (2) preferred products required before a non-preferred product will be approved.
INSULIN PUMPS (Clinical criteria applies to class. All preferred agents require prior authorization. All non-preferred insulin pumps are not covered under pharmacy)		
Please refer to the Delaware Pharmacy Corner website for covered Diabetic Supply products. https://medicaid.dhss.delaware.gov/provider/Home/PharmacyCornerLanding/tabid/2096/Default.aspx	All other insulin pumps are non-preferred.	• All other insulin pumps are not payable under the pharmacy benefit. These claims need to be billed under the Durable Medical Equipment benefit.
RESPIRATORY DEVICES		
ACE AEROSOL CLOUD ENHANCER SPACER EASIVENT EASIVENT SPACER OPTICHAMBER OPTICHAMBER DIAMOND	AEROCHAMBER PLUS FLOW-VU FLEXICHAMBER MASK FLEXICHAMBER SPACER SPACE CHAMBER COMPACT SPACE CHAMBER	• Two (2) preferred products required before a non-preferred product will be approved.
NEUROMUSCULAR DRUGS		
ANTICONVULSANTS, ORAL/RECTAL/NASAL		**Review Schedule: 4th Quarter**
BRIVIACT (brivaracetam) carbamazepine 100 mg chewable tablets, tablets carbamazepine ER, XR carbamazepine suspension clobazam clonazepam tablets diazepam rectal DILANTIN (phenytoin) 30 mg capsules divalproex sodium	APTIOM (eslicarbazepine acetate) BANZEL (rufinamide) carbamazepine 200 mg chewable tablets CARBATROL (carbamazepine) CELONTIN (methsuxamide) clonazepam ODT DEPAKOTE (divalproex sodium) tablet, sprinkles DEPAKOTE ER (divalproex sodium) DIACOMIT (stiripentol)	• Two (2) preferred products required before a non-preferred product will be approved. • Quantity limits in place: 240 adjunctive anticonvulsants per 30 days. Greater quantities require prior authorization. • * PA required, to include reason topiramate 2 x 25 mg capsules cannot be used, before product will be approved.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
EPITOL (carbamazepine) ethosuximide solution gabapentin lacosamide solution, tablets lamotrigine IR tablets, chewable tablets levetiracetam IR tablets, solution NAYZILAM (midazolam) oxcarbazepine tablets, suspension phenobarbital phenytoin pregabalin primidone SUBVENITE (lamotrigine) topiramate tablets valproic acid VALTOCO (diazepam) zonisamide	DIASTAT (diazepam) rectal DIASTAT ACUDIAL (diazepam) rectal DILANTIN (phenytoin) 100 mg capsules, chewable tablets, suspension EPIDIOLEX (cannabidiol) EPRONTIA (topiramate) EQUETRO (carbamazepine) ethosuximide capsules felbamate FELBATOL (felbamate) FINTEPLA (fenfluramine) FYCOMPA (perampanel) GABITRIL (tiagabine) KEPPRA (levetiracetam) KEPPRA XR (levetiracetam) KLONOPIN (clonazepam) LAMICTAL (lamotrigine) LAMICTAL XR (lamotrigine) lamotrigine ER, ODT levetiracetam ER, tablets for oral suspension LIBERVANT (diazepam) LYRICA (pregabalin) LYRICA CR (pregabalin) methsuxamide MOTPOLY XR (lacosamide) MYSOLINE (primidone) NEURONTIN (gabapentin) ONFI (clobazam) oxcarbazapine ER OXTELLAR XR (oxcarbazapine) PHENYTEK (phenytoin) QUDEXY XR (topiramate) rufinamide SABRIL (vigabatrin) SPRITAM (levetiracetam) SYMPAZAN (clobazam) TEGRETOL (carbamazepine) suspension, tablets TEGRETOL XR (carbamazepine) tiagabine tablets TOPAMAX (topiramate) topiramate ER topiramate sprinkle capsules * TRILEPTAL (oxcarbazepine) suspension, tablets TROKENDI XR (topiramate) vigabatrin VIGADRONE (vigabatrin) VIGAFYDE (vigabatrin) ** VIMPAT (lacosamide) XCOPRI (cenobamate) ZARONTIN (ethosuximide) ZONISADE (zonisamide)	• ** Step through vigabatrin powder packets required.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
	ZTALMY (ganaxolone)	
ANTIPARKINSON'S AGENTS, ORAL/TRANSDERMAL		**Review Schedule: 1st Quarter**
amantadine capsules, solution benztropine bromocriptine carbidopa/levodopa IR, ER entacapone pramipexole IR ropinirole IR selegiline capsules, tablets trihexyphenidyl	amantadine tablets AZILECT (rasagiline) carbidopa carbidopa/levodopa ODT carbidopa/levodopa/entacapone COMTAN (entacapone) CREXONT ER (carbidopa/levodopa) DHIVY (carbidopa/levodopa) DUOPA (carbidopa/levodopa) GOCOVRI (amantadine) INBRIJA (levodopa) LODOSYN (carbidopa) NEUPRO (rotigotine) NOURIANZ (istradefylline) ONAPGO (apomorphine) ONGENTYS (opicapone) OSMOLEX ER (amantadine) pramipexole ER rasagiline ropinirole ER RYTARY (carbidopa/levodopa) SINEMET 10-100 (carbidopa/levodopa) STALEVO (carbidopa/levodopa/entacapone) TASMAR (tolcapone) tolcapone VYALEV (foscarbidopa/foslevodopa) XADAGO (safinamide) ZELAPAR (selegiline)	• Two (2) preferred products required before a non-preferred product will be approved.
SKELETAL MUSCLE RELAXANTS **(Clinical criteria applies to individual agents in class.)**		**Review Schedule: 3rd Quarter**
baclofen 5 mg, 10 mg, 20 mg tablets ** cyclobenzaprine 5 mg, 10 mg tablets methocarbamol tizanidine tablets	AMRIX (cyclobenzaprine) baclofen 15 mg tablets, solution, suspension ** carisoprodol *** carisoprodol compound with codeine * chlorzoxazone cyclobenzaprine 7.5 mg tablets cyclobenzaprine ER DANTRIUM (dantrolene) dantrolene FEXMID (cyclobenzaprine) FLEQSUVY (baclofen) LYVISPAH (baclofen) metaxalone ^	• Two (2) preferred products required before a non-preferred product will be approved. • Total quantity limit of 120 units of muscle relaxants per 30 rolling days. • * Clinical PA required • ** Baclofen – no quantity limits • ***Carisoprodol quantity limit – 84 units per 90 days

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
	orphenadrine orphenadrine, aspirin, caffeine SOMA (carisoprodol) *** TANLOR (methocarbamol) tizanidine capsules ZANAFLEX (tizanidine)	• ^ PA required for 640 mg, to include reason 400 mg or 800 mg tablets cannot be used, before product will be approved.
NUTRITIONAL PRODUCTS		
PRENATAL VITAMINS		**Review Schedule: 1st Quarter**
COMPLETE NATAL DHA M-NATAL PLUS NIVA-PLUS PNV 29-1 PRENATAL PLUS PRENATAL VITAMIN plus LOW IRON PREPLUS PRETAB THRIVITE RX TRINATAL RX 1 TRIVEEN-DUO DHA VIRT-C DHA VOL-PLUS VP-PNV-DHA WESNATAL DHA COMPLETE WESTAB PLUS	All other prenatal products non-preferred	• Two (2) preferred products required before a non-preferred product will be approved.
OBESITY TREATMENT AGENTS **(Clinical criteria applies to class. All agents require a prior authorization.)**		**Review Schedule: 4th Quarter**
CONTRAVE ER (naltrexone/bupropion ER) tablets phentermine capsules, tablets WEGOVY (semaglutide) pen injectors ZEPBOUND (tirzepatide)	ADIPEX-P (phentermine) capsules, tablets benzphetamine HCl tablets diethylpropion HCl tablets diethylpropion HCl ER tablets LOMAIRA (phentermine) tablet orlistat phendimetrazine tartrate tablets phendimetrazine tartrate ER capsules SAXENDA (liraglutide) pen injectors XENICAL (orlistat) capsules	• Two (2) preferred products required before a non-preferred product will be approved.
OVER THE COUNTER DRUGS		
		Review Schedule: 3rd Quarter
Please refer to the Delaware Pharmacy Corner website for covered OTC products.		

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
https://medicaid.dhss.delaware.gov/provider/Home/PharmacyCornerLanding/tabid/2096/Default.aspx		
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS		
ALZHEIMER'S AGENTS		**Review Schedule: 3rd Quarter**
donepezil 5 mg, 10 mg tablets memantine tablets rivastigmine patch	ADLARITY (donepezil) ARICEPT (donepezil) donepezil ODT donepezil 23 mg EXELON (rivastigmine) patches galantamine memantine capsules, solution memantine/donepezil ER NAMENDA (memantine) NAMENDA XR (memantine) NAMZARIC (memantine/donepezil) RAZADYNE ER (galantamine) rivastigmine capsules	• Two (2) preferred products required before a non-preferred product will be approved.
MOVEMENT DISORDER		**Review Schedule: 4th Quarter**
AUSTEDO (deutetrabenazine) INGREZZA (valbenazine) * tetrabenazine	AUSTEDO XR (deutetrabenazine) INGREZZA SPRINKLE (valbenazine) XENAZINE (tetrabenazine)	• Two (2) preferred products required before a non-preferred product will be approved. • * Ingrezza quantity limit – 1 capsule per day
MULTIPLE SCLEROSIS **(Clinical criteria applies to individual agents in class.)**		**Review Schedule: 4th Quarter**
AVONEX (interferon beta-1a) * dalfampridine dimethyl fumarate fingolimod glatiramer GLATOPA (glatiramer acetate) KESIMPTA (ofatumumab) REBIF (interferon beta-1a) * REBIF REBIDOSE (interferon beta-1a) * teriflunomide TYSABRI (natalizumab) *	AMPYRA (dalfampridine) AUBAGIO (teriflunomide) BAFIERTAM (monomethyl fumarate) BETASERON (interferon beta-1b) * BRIUMVI (ublituximab-xiiy) COPAXONE (glatiramer acetate) EXTAVIA (interferon beta-1b) GILENYA (fingolimod) LEMTRADA (alemtuzumab) MAVENCLAD (cladribine) MAYZENT (siponimod) OCREVUS (ocrelizumab) OCREVUS ZUNOVO (ocrelizumab) PLEGRIDY (peginterferon beta-1a) PONVORY (ponesimod) TASCENSO ODT (fingolimod) TECFIDERA (dimethyl fumarate) VUMERITY (diroximel fumarate) ZEPOSIA (ozanimod)	• Two (2) preferred products required before a non-preferred product will be approved. • * Clinical criteria applies

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
NEUROPATHIC PAIN		**Review Schedule: 1st Quarter**
gabapentin lidocaine patch 4%, 5% lidocaine/prilocaine cream pregabalin	GRALISE (gabapentin) HORIZANT (gabapentin enacarbil) LIDODERM (lidocaine) patches LYRICA CR (pregabalin) NEURONTIN (gabapentin) pregabalin ER QUTENZA KIT (capsaicin/skin cleanser) SAVELLA (milnacipran HCl) ZTLIDO (lidocaine)	• Two (2) preferred products required before a non-preferred product will be approved.
RESPIRATORY AGENTS		
ANTIHISTAMINES, MINIMALLY SEDATING		**Review Schedule: 3rd Quarter**
cetirizine solution, tablets loratadine solution, tablets	cetirizine capsules, chewable tablets cetirizine-D CLARINEX (desloratadine) CLARINEX-D (desloratadine/pseudoephedrine) desloratadine fexofenadine fexofenadine-D levocetirizine loratadine chewable tablets, ODT loratadine-D	• Two (2) preferred products required before a non-preferred product will be approved.
BRONCHODILATORS, BETA AGONIST		**Review Schedule: 4th Quarter**
albuterol HFA (gen ProAir HFA, PROVENTIL HFA) albuterol nebulizer solution, syrup SEREVENT (salmeterol) STRIVERDI RESPIMAT (olodaterol) terbutaline VENTOLIN HFA (albuterol sulfate)	albuterol HFA (gen VENTOLIN HFA) albuterol tablets arformoterol vials BROVANA (arformoterol tartrate) formoterol vials levalbuterol HFA, vials PERFOROMIST (formoterol fumarate) PROAIR RESPICLICK (albuterol sulfate) XOPENEX HFA (levalbuterol)	• Two (2) preferred products required before a non-preferred product will be approved.
COPD AGENTS		**Review Schedule: 4th Quarter**
albuterol/ipratropium nebulizer solution ANORO ELLIPTA (umeclidinium/vilanterol) ATROVENT HFA (ipratropium bromide) COMBIVENT (ipratropium bromide/albuterol) INCRUSE ELLIPTA (umeclidinium) ipratropium nebulizer solution SPIRIVA HANDIHALER (tiotropium bromide) SPIRIVA RESPIMAT (tiotropium bromide)	BEVESPI (glycopyrrolate/formoterol fumarate) BREZTRI (budesonide, glycopyrrolate, formoterol fumarate) DALIRESP (roflumilast) DUAKLIR (aclidinium/formoterol) OHTUVAYRE (ensifentrine) * roflumilast tablets tiotropium bromide inhaler	• Two (2) preferred products required before a non-preferred product will be approved. • * Step through 3-month trial LABA + LAMA dual therapy, with or without ICS, required.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
STIOLTO RESPIMAT (tiotropium bromide/olodaterol)	TRELEGY (fluticasone furoate, umeclidinium, vilanterol) TUDORZA (aclidinium bromide) umeclidinium/vilanterol YUPELRI (revefenacin)	Abbreviations: LABA – long-acting beta$_2$ agonist LAMA – long-acting muscarinic antagonist ICS – inhaled corticosteroid
COUGH AND COLD		**Review Schedule: 3rd Quarter**
benzonatate BROMFED DM (brompheniramine/ dextromethorphan/pseudoephedrine) syrup brompheniramine/pseudoephedrine/DM syrup guaifenesin liquid guaifenesin DM liquid guaifenesin ER tablets guaifenesin/codeine syrup hydrocodone/homatropine syrup promethazine DM syrup promethazine/codeine syrup phenylephrine tablets pseudoephedrine liquid, tablets	All other cough and cold products are non-preferred	• Two (2) preferred products required before a non-preferred product will be approved. • Quantity limits in place: o Narcotic antitussives – 240ml per 30 days and 480ml per 90 days without a comorbid diagnosis o Tussionex – 120ml per 84 days and 480ml per year • Additional preferred OTC Cough and Cold agents may be found on the OTC List on the pharmacist corner
GLUCOCORTICOIDS, INHALED		**Review Schedule: 4th Quarter**
ADVAIR DISKUS, HFA (fluticasone propionate/salmeterol) ARNUITY ELLIPTA (fluticasone furoate) ASMANEX HFA (mometasone furoate) ASMANEX TWISTHALER (mometasone furoate) budesonide inhalation solution 0.25 mg, 0.5 mg * DULERA (mometasone furoate/formoterol fumarate) fluticasone proprionate HFA * PULMICORT FLEXHALER (budesonide) QVAR REDIHALER (beclomethasone dipropionate) SYMBICORT (budesonide/formoterol fumarate dihydrate)	AIRDUO RESPICLICK (fluticasone propionate/salmeterol) AIRSUPRA (albuterol sulfate/budesonide) ALVESCO (ciclesonide) BREO ELLIPTA (fluticasone furoate/vilanterol) BREYNA (budesonide/formoterol fumarate) budesonide inhalation solution 1 mg budesonide/formoterol fumarate dihydrate fluticasone/salmeterol diskus, HFA fluticasone/vilanterol PULMICORT (budesonide) inhalation solution WIXELA INHUB (fluticasone propionate/salmeterol)	• Two (2) preferred products required before a non-preferred product will be approved. • * Approval for budesonide may be generated by system for patients: o Aged 6 years and older AND with o Diagnosis on file indicating developmental delay • * Prior authorization required for ≥ 18 years of age.
INTRANASAL RHINITIS AGENTS		**Review Schedule: 1st Quarter**
azelastine 0.1% fluticasone RX ipratropium	azelastine 0.15% azelastine/fluticasone BECONASE AQ (beclomethasone dipropionate) budesonide OTC DYMISTA (azelastine/fluticasone) FLONASE SENSIMIST OTC (fluticasone) flunisolide fluticasone OTC mometasone	• Two (2) preferred products required before a non-preferred product will be approved.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
	NASACORT OTC (triamcinolone) NASONEX OTC (mometasone) olopatadine OMNARIS (ciclesonide) QNASL (beclomethasone dipropionate) RYALTRIS (olopatadine HCl/mometasone) SINUVA (mometasone) triamcinolone XHANCE (fluticasone propionate) ZETONNA (ciclesonide)	
LEUKOTRIENE RECEPTOR ANTAGONISTS		**Review Schedule: 4th Quarter**
montelukast tablets, chewable tablets	ACCOLATE (zafirlukast) montelukast granules SINGULAIR (montelukast) zafirlukast zileuton ER ZYFLO (zileuton)	• One (1) preferred product required before a non-preferred will be approved.
MABs-ANTI-IL, ANTI-IGE **(Clinical criteria applies to class. All agents require a prior authorization.)**		**Review Schedule: 4th Quarter**
DUPIXENT (dupilumab) FASENRA (benralizumab) NUCALA (mepolizumab) TEZSPIRE (tezepelumab-ekko) XOLAIR (omalizumab)	CINQAIR (reslizumab)	• Two (2) preferred products required before a non-preferred product will be approved.
STIMULANTS AND RELATED AGENTS		
NARCOLEPTIC AGENTS		**Review Schedule: 4th Quarter**
armodafinil modafinil	NUVIGIL (armodafinil) PROVIGIL (modafinil) sodium oxybate SUNOSI (solriamfetol) WAKIX (pitolisant) XYREM (sodium oxybate) XYWAV (sodium oxybate)	• Two (2) preferred products required before a non-preferred product will be approved.
STIMULANTS AND RELATED AGENTS - SHORT ACTING **(Clinical criteria applies for members over age 21.)**		**Review Schedule: 4th Quarter**
dexmethylphenidate IR dextroamphetamine/amphetamine IR dextroamphetamine IR tablets methylphenidate IR methylphenidate solution	ADDERALL (amphetamine/dextroamphetamine) amphetamine tablets dextroamphetamine solution EVEKEO ODT, TABLETS (amphetamine) FOCALIN (dexmethylphenidate)	• Two (2) preferred products required before a non-preferred product will be approved. • Dose optimization required

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
PROCENTRA (dextroamphetamine)	methamphetamine METHYLIN (methylphenidate) solution methylphenidate chewable tablets RITALIN (methylphenidate) ZENZEDI (dextroamphetamine)	
STIMULANTS AND RELATED AGENTS - LONG ACTING **(Clinical criteria applies for members over age 21.)**		**Review Schedule: 4th Quarter**
atomoxetine clonidine ER 0.1 mg tablet DAYTRANA (methylphenidate) patches dexmethylphenidate ER dextroamphetamine ER dextroamphetamine-amphetamine ER DYANAVEL XR (amphetamine/dextroamphetamine SR) suspension guanfacine ER methylphenidate CD (generic METADATE CD) methylphenidate ER (generic RITALIN SR) methylphenidate ER 24 (generic CONCERTA) methylphenidate LA (generic RITALIN LA) QUILLICHEW ER (methylphenidate IR/ER, 30:70%) QUILLIVANT XR (methylphenidate IR/ER, 20:80%) VYVANSE (lisdexamfetamine) capsules	ADDERALL XR (amphetamine/ dextroamphetamine SR 24 HR, IR/ER, 50:50%) ADZENYS XR ODT (amphetamine SR 24 HR, IR/ER, 50:50%) amphetamine ER suspension APTENSIO XR (methylphenidate) AZSTARYS (serdexmethylphenidate/ dexmethylphenidate) CONCERTA (methylphenidate SA OSM IR/ER, 22:78%) COTEMPLA XR (methylphenidate IR/ER 25:75%) DYANAVEL XR (amphetamine/dextroamphetamine SR) tablets FOCALIN XR (dexmethylphenidate SR 24 HR) INTUNIV (guanfacine ER) JORNAY PM (methylphenidate ER) lisdexamfetamine methylphenidate XR (generic Aptensio XR) methylphenidate (transdermal) patch TD24 MYDAYIS (mixed amphetamine salts) ONYDA XR (clonidine hydrochloride) QELBREE (viloxazine hydrochloride) RELEXXII ER 24 (methylphenidate ER OSM IR/ER, 22:78% RITALIN LA (methylphenidate) STRATTERA (atomoxetine) VYVANSE (lisdexamfetamine) chewable tablets XELSTRYM (dextroamphetamine) patches	• Two (2) preferred products required before a non-preferred product will be approved.
SMOKING CESSATION		
SMOKING CESSATION PRODUCTS		**Review Schedule: 1st Quarter**
bupropion SR nicotine lozenge, gum, patch varenicline	CHANTIX (varenicline) NICOTROL NS	• Please refer to the Delaware OTC Rebate List on the DMAP Provider Pharmacy Portal. • Two (2) preferred products required before a non-preferred product will be approved.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
TOPICAL PRODUCTS		
ANTIBIOTICS, TOPICAL		**Review Schedule: 1st Quarter**
bacitracin bacitracin/polymyxin gentamicin mupirocin ointment neomycin/bacitracin/polymyxin	CENTANY (mupirocin) mupirocin cream neomycin/bacitracin/polymyxin/pramoxine neomycin/polymyxin/pramoxine NEO-SYNALAR (fluocinolone/neomycin) XEPI (ozenoxacin)	• Two (2) preferred products required before a non-preferred product will be approved.
ANTIFUNGALS, TOPICAL		**Review Schedule: 4th Quarter**
butenafine ciclopirox cream, solution clotrimazole cream clotrimazole/betamethasone cream, lotion econazole ketoconazole cream, shampoo miconazole nitrate solution w/ applicator nystatin nystatin/triamcinolone ointment	ALEVAZOL (clotrimazole) CICLODAN (ciclopirox) ciclopirox gel, shampoo, suspension clotrimazole solution ERTACZO (sertaconazole) EXELDERM (sulconazole) JUBLIA (efinaconazole) ketoconazole foam KETODAN (ketoconazole) LOPROX (ciclopirox) luliconazole LUZU (luliconazole) miconazole miconazole/zinc/petrolatum NAFTIN (naftifine) naftifine nystatin/triamcinolone cream oxiconazole OXISTAT (oxiconazole) terbinafine tolnaftate VOTRIZA-AL (clotrimazole) lotion VUSION (miconazole/zinc/petrolatum)	• Two (2) preferred products required before a non-preferred product will be approved.
ANTIPARASITICS, TOPICAL		**Review Schedule: 4th Quarter**
NATROBA (spinosad) permethrin piperonyl butoxide/pyrethrins	CROTAN (crotamiton) ivermectin lotion malathion OVIDE (malathion) lotion SKLICE (ivermectin) spinosad VANALICE (pyrethrins/piperonyl butoxide)	• Two (2) preferred products required before a non-preferred product will be approved.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
ANTIPSORIATIC AGENTS, ORAL		**Review Schedule: 3rd Quarter**
acitretin	methoxsalen	• One (1) preferred product required before a non-preferred product will be approved.
ANTIPSORIATIC AGENTS, TOPICAL		**Review Schedule: 3rd Quarter**
calcipotriene cream, ointment, solution	calcipotriene foam calcipotriene/betamethasone calcitriol DUOBRII (halobetasol propionate/tazarotene) ENSTILAR (calcipotriene/betamethasone) SORILUX (calcipotriene) tazarotene cream, gel TAZORAC (tazarotene) VECTICAL (calcitriol) VTAMA (tapinarof) ZORYVE 0.3% (roflumilast)	• One (1) preferred product required before a non-preferred product will be approved.
ANTIVIRALS, TOPICAL		**Review Schedule: 4th Quarter**
acyclovir ointment docosanol	acyclovir cream DENAVIR (penciclovir) penciclovir cream XERESE (acyclovir/hydrocortisone) ZOVIRAX (acyclovir)	• Two (2) preferred products required before a non-preferred product will be approved.
IMMUNOMODULATORS, ATOPIC DERMATITIS **(Clinical criteria applies to class. All agents require a prior authorization.)**		**Review Schedule: 4th Quarter**
ADBRY (tralokinumab-ldrm) EUCRISA (crisaborole) * pimecrolimus tacrolimus	CIBINQO (abrocitinib) EBGLYSS (lebrikizumab-lbkz) ELIDEL (pimecrolimus) NEMLUVIO (nemolizumab-ilto) OPZELURA (ruxolitinib) ZORYVE 0.15% (roflumilast)	• Quantity limits are in place: 400 grams per year • * Eucrisa will be electronically approved after trial of a preferred topical steroid or immunomodulator
IMMUNOMODULATORS, TOPICAL		**Review Schedule: 3rd Quarter**
imiquimod 3.75% cream imiquimod 5% cream packet	imiquimod cream pump VEREGEN (sinecatechins) ZYCLARA (imiquimod)	• Two (2) preferred products required before a non-preferred product will be approved.
OPHTHALMICS, ALLERGIC CONJUNCTIVITIS		**Review Schedule: 3rd Quarter**
ALAWAY (ketotifen) azelastine cromolyn	ALOMIDE (lodoxamide) ALREX (loteprednol) bepotastine	• Two (2) preferred products required before a non-preferred product will be approved.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
ketotifen olopatadine 0.1%, 0.2% OTC olopatadine 0.2% RX	BEPREVE (bepotastine) epinastine LASTACAFT OTC (alcaftadine) olopatadine 0.1% RX PATADAY (olopatadine) ZADITOR (ketotifen) ZERVIATE (cetirizine)	
OPHTHALMICS, ANTIBIOTICS		**Review Schedule: 3rd Quarter**
bacitracin/polymyxin CILOXAN (ciprofloxacin) ointment ciprofloxacin erythromycin gentamicin moxifloxacin (generic VIGAMOX) ofloxacin POLYCIN (bacitracin/polymyxin) polymyxin/trimethoprim tobramycin	AZASITE (azithromycin) bacitracin bacitracin/polymyxin BESIVANCE (besifloxacin) gatifloxacin levofloxacin moxifloxacin viscous (generic MOXEZA) NATACYN (natamycin) neomycin/bacitracin/polymyxin neomycin/polymyxin/gramicidin OCUFLOX (ofloxacin) POLYTRIM (polymyxin/trimethoprim) sulfacetamide TOBREX (tobramycin) VIGAMOX (moxifloxacin) XDEMVY (lotilaner) ZYMAXID (gatifloxacin)	• Two (2) preferred products required before a non-preferred product will be approved.
OPHTHALMICS, ANTIBIOTIC-STEROID COMBINATION		**Review Schedule: 3rd Quarter**
neomycin/polymyxin/dexamethasone sulfacetamide/prednisolone TOBRADEX (tobramycin/dexamethasone) ointment	MAXITROL (neomycin/polymyxin/dexamethasone) neomycin/bacitracin/polymyxin/HC neomycin/polymyxin/HC NEO-POLYCIN HC (neomycin/bacitracin/polymyxin/HC) TOBRADEX ST (tobramycin/dexamethasone) tobramycin/dexamethasone ZYLET (loteprednol/tobramycin)	• Two (2) preferred products required before a non-preferred product will be approved.
OPHTHALMICS, ANTI-INFLAMMATORIES		**Review Schedule: 3rd Quarter**
dexamethasone diclofenac DUREZOL (difluprednate) FLAREX (fluorometholone) fluorometholone flurbiprofen FML FORTE (fluorometholone) ketorolac (all strengths) LOTEMAX (loteprednol)	ACULAR (ketorolac) ACULAR LS (ketorolac) ACUVAIL (ketorolac) bromfenac BROMSITE (bromfenac) clobetasol DEXTENZA (dexamethasone) difluprednate EYSUVIS (loteprednol etabonate)	• Two (2) preferred products required before a non-preferred product will be approved.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
MAXIDEX (dexamethasone) NEVANAC (nepafenac) PRED FORTE (prednisolone) PRED MILD (prednisolone) prednisolone	FML LIQUFILM (fluorometholone) ILEVRO (nepafenac) ILUVIEN (fluocinolone acetate) INVELTYS (loteprednol etabonate) LOTEMAX SM (loteprednol etabonate) loteprednol OZURDEX (dexamethasone) PROLENSA (bromfenac) RETISERT (fluocinolone acetonide) TRIESENCE (triamcinolone acetonide) XIPERE (triamcinolone acetonide) YUTIQ (fluocinolone acetonide)	
OPHTHALMICS, GLAUCOMA AGENTS		**Review Schedule: 3rd Quarter**
ALPHAGAN P (brimonidine) brimonidine 0.2% carteolol COMBIGAN (brimonidine/timolol) dorzolamide dorzolamide/timolol drops ISTALOL (timolol maleate) latanoprost levobunolol pilocarpine SIMBRINZA (brinzolamide/brimonidine) timolol maleate solution travoprost	apraclonidine AZOPT (brinzolamide) betaxolol BETIMOL (timolol hemihydrate) BETOPTIC (betaxolol) BETOPTIC S (betaxolol) brimatoprost brimonidine/timolol brimonidine 0.1%, 0.15% brinzolamide COSOPT (dorzolomide/timolol) COSOPT PF (dorzolomide/timolol) dorzolamide/timolol droperette iDOSE (travoprost) iopidine IYUZEH (latanoprost/PF) LUMIFY (brimonidine tartrate) LUMIGAN (bimatoprost) phospholine iodine RHOPRESSA (netarsudil) ROCKLATAN (netarsudil/latanoprost) tafluprost droperette timolol hemihydrate timolol maleate gel timolol maleate drop daily timolol maleate droperette TIMOPTIC (timolol) TIMOPTIC XE (timolol) TRAVATAN Z (travoprost) VYZULTA (latanoprostene bunod) XALATAN (latanoprost) XELPROS (latanoprost) ZIOPTAN (tafluprost)	• Two (2) preferred products required before a non-preferred product will be approved.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
OPHTHALMICS, IMMUNOMODULATORS		**Review Schedule: 4th Quarter**
RESTASIS (cyclosporine) vials	CEQUA (cyclosporine) cyclosporine droperettes MIEBO (perfluorohexyloctane) RESTASIS MULTIDOSE (cyclosporine) TYRVAYA (varenicline) VERKAZIA (cyclosporine) VEVYE (cyclosporine) XIIDRA (lifitegrast)	• One (1) preferred product required before a non-preferred product will be approved.
OTIC ANTIBIOTICS		**Review Schedule: 3rd Quarter**
CIPRO HC (ciprofloxacin/hydrocortisone) CORTISPORIN-TC (neomycin/colistin/hydrocortisone/thonzonium) neomycin/polymyxin/hydrocortisone ofloxacin	ciprofloxacin ciprofloxacin/dexamethasone ciprofloxacin/fluocinolone OTOVEL (ciprofloxacin/fluocinolone acetate)	• Two (2) preferred products required before a non-preferred product will be approved.
OTIC ANTI-INFECTIVES, ANESTHETICS		**Review Schedule: 1st Quarter**
acetic acid	acetic acid/hydrocortisone	• One (1) preferred product required before a non-preferred product will be approved.
ROSACEA AGENTS, TOPICAL		**Review Schedule: 1st Quarter**
azelaic acid (generic FINACEA) metronidazole 0.75% cream, 0.75% gel metronidazole 1% gel pump	brimonidine EPSOLAY (benzoyl peroxide) FINACEA (azelaic acid) ivermectin cream METROCREAM (metronidazole) METROGEL (metronidazole) metronidazole 0.75% lotion metronidazole 0.1% gel MIRVASO (brimonidine) NORITATE (metronidazole) RHOFADE (oxymetazoline) ROSADAN (metronidazole) SOOLANTRA (ivermectin)	• Two (2) preferred products required before a non-preferred product will be approved.
STEROIDS, TOPICAL		**Review Schedule: 3rd Quarter**
clobetasol ointment, solution fluocinolone topical solution, oil fluocinonide ointment 0.05% fluticasone cream, ointment hydrocortisone (except 2.5% solution) hydrocortisone acetate mometasone SCALPICIN (hydrocortisone)		alclometasone amcinonide APEXICON E (diflorasone diacetate) betamethasone dipropionate betamethasone dipropionate/propylene glycol betamethasone valerate BRYHALI (halobetasol propionate) clobetasol cream, foam, gel, lotion, shampoo, spray

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
triamcinolone cream, lotion, 0.025%, 0.1%, 0.5% ointment		clocortolone CLOBEX (clobetasol) CLODAN (clobetasol) CORDRAN (fludroxycortide) DERMACINRX DERMA-SMOOTHE FS (fluocinolone) DERMASORB (triamcinolone) desonide DESOWEN (desonide) desoximetasone diflorasone fluocinolone cream, ointment fluocinonide (except 0.05% ointment) flurandrenolide fluticasone lotion halcinonide halobetasol hydrocortisone 2.5% solution hydrocortisone butyrate hydrocortisone valerate LEXETTE (halobetasol propionate) MICORT-HC (hydrocortisone acetate) OLUX-E (clobetasol) PANDEL (hydrocortisone probutate) prednicarbate SERNIVO (betamethasone dipropionate) SYNALAR (fluocinolone) TEXACORT (hydrocortisone) TOPICORT (desoximetasone) TOVET (clobetasol) triamcinolone 0.05% ointment, aerosol ULTRAVATE (halobetasol)