DELAWARE HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID & MEDICAL ASSISTANCE

Delaware Medical Assistance Program

2024 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.

PREFERRED AGENTS Preferred status implementation: 1/1/24	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
ADHD AGENTS		
STIMULANTS AND RELATED AGENTS - SHORT ACTING (Clinical criteria apply for clients over age 21)		
dexmethylphenidate IR dextroamphetamine/amphetamine IR dextroamphetamine IR tablets methylphenidate IR methylphenidate solution PROCENTRA (dextroamphetamine)	ADDERALL (amphetamine/dextroamphetamine) amphetamine tablets dextroamphetamine solution EVEKEO ODT, TABLETS (amphetamine) FOCALIN (dexmethylphenidate) methamphetamine METHYLIN (methylphenidate) solution methylphenidate chewable tablets RITALIN (methylphenidate) ZENZEDI (dextroamphetamine)	• Two (2) preferred products required before a non-preferred product will be approved • Dose optimization required
STIMULANTS AND RELATED AGENTS - LONG ACTING (Clinical criteria apply for clients over age 21)		
armodafinil atomoxetine clonidine ER CONCERTA (methylphenidate SA OSM IR/ER, 22:78%) 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) modafinil 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%) APTENSIO XR (methylphenidate) AZSTARYS (serdexmethylphenidate/ dexmethylphenidate) COTEMPLA XR (methylphenidate IR/ER 25:75%) DEXEDRINE CR (dextroamphetamine 24 HR SR) DYANAVEL XR (amphetamine/dextroamphetamine SR) tablets FOCALIN XR (dexmethylphenidate SR 24 HR) INTUNIV (guanfacine ER) JORNAY PM (methylphenidate ER) lisdexamfetamine METADATE CD (methylphenidate) methylphenidate XR (generic Aptensio XR) methylphenidate (transdermal) patch TD24 MYDAYIS (mixed amphetamine salts) NUVIGIL (armodafinil) PROVIGIL (modafinil) QELBREE (viloxazine hydrochloride) RELEXXII ER 24 (methylphenidate ER OSM IR/ER, 22:78% RITALIN LA (methylphenidate) STRATTERA (atomoxetine) SUNOSI (solriamfetol HCl) VYVANSE (lisdexamfetamine) chewable tablets WAKIX (pitolisant) XELSTRYM (dextroamphetamine) patches	• Two (2) preferred products required before a non-preferred product will be approved

PREFERRED AGENTS Preferred status implementation: 1/1/24	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
ANALGESICS		
ANALGESICS, NARCOTIC LONG-ACTING (Clinical criteria apply to class. All agents require a prior authorization.)		
BUTRANS (buprenorphine) fentanyl transdermal 12, 25, 50, 75, 100 mcg/hr morphine ER tablets tramadol ER tablets * XTAMPZA ER (oxycodone)	BELBUCA (buprenorphine buccal film) buprenorphine patches CONZIP (tramadol) fentanyl transdermal 37.5, 62.5, 87.5 mcg/hr hydrocodone ER hydromorphone ER HYSLINGA ER (hydrocodone) morphine ER capsules MS CONTIN (morphine) NUCYNTA ER (tapentadol) 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		
acetaminophen/codeine ASCOMP-CODEINE (codeine/butalbital/ASA/caffeine) benzhydrocodone/APAP butalbital compound/codeine codeine ENDOCET (oxycodone/acetaminophen) FIORICET-CODEINE (butalbital/acetaminophen/caffeine/codeine) hydrocodone/APAP solution, tablets hydromorphone tablets morphine tablets, solution oxycodone capsules, solution, tablets oxycodone/APAP solution, tablets tramadol tramadol/APAP	ACTIQ (fentanyl) buccal butorphanol nasal spray dihydrocodeine/APAP/caffeine DILAUDID (hydromorphone) DSUVIA (sufentanil) fentanyl FENTORA (fentanyl) buccal hydrocodone/ibuprofen hydromorphone liquid, suppositories levorphanol meperidine solution, tablets morphine concentrate, suppositories NALOCET (oxycodone/acetaminophen) NUCYNTA (tapentadol) oxycodone concentrate oxycodone/ASA oxymorphone pentazocine HCl/naloxone HCl PERCOCET (oxycodone/acetaminophen) PROLATE (oxycodone/acetaminophen) QDOLO (tramadol) ROXICODONE (oxycodone) ROXYBOND (oxycodone) SEGLENTIS (tramadol/celecoxib) tramadol HCL solution	• 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** **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** • **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

PREFERRED AGENTS Preferred status implementation: 1/1/24	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
ANTIHYPERURICEMICS, ORAL (Clinical criteria apply to individual agents in class)		
allopurinol colchicine tablets * febuxostat probenecid probenecid with colchicine	colchicine capsules COLCRYS (cochicine) GLOPERBA (colchicine) MITIGARE (colchicine) ULORIC (febuxostat) ZYLOPRIM (allopurinol)	• Two (2) preferred products required before a non-preferred product will be approved • * **Clinical criteria apply to colchicine with approval for treatment, not prophylaxis**
ANTIMIGRAINE AGENTS, PROPHYLAXIS		
AIMOVIG (erenumab) AJOVY (fremanezumab) EMGALITY (galcanezumab)	BOTOX (onabotulinumtoxinA) NURTEC ODT (rimegepant) QULIPTA (atogepant) VYEPTI (eptinezumab-jjmr)	• Product will be approved for patients with chronic migraine with inadequate response to three (3) preferred anti-migraine agents (acute and/or prophylaxis)
ANTIMIGRAINE AGENTS, TREATMENT (Clinical criteria apply to individual agents in class.)		
naratriptan NURTEC ODT * (rimegepant) rizatriptan ODT, tablets sumatriptan nasal spray, syringe, tablets, vial zolmitriptan ODT, tablets	almotriptan CAMBIA (diclofenac potassium) dihydroergotamine eletriptan ERGOMAR (ergotamine tartrate) ergotamine/caffeine FROVA (frovatriptan) frovatriptan IMITREX (sumatriptan) MAXALT (rizatriptan) MIGERGOT (ergotamine tartrate/caffeine) ONZETRA (sumatriptan) RELPAX (eletriptan) REYVOW (lasmiditan) sumatriptan cartridge, pen injector sumatriptan/naproxen TOSYMRA (sumatriptan) TREXIMET (sumatriptan/naproxen) TRUDHESA (dihydroergotamine mesylate) UBRELVY (ubrogepant) VYEPTI (eptinezumab-jjmr) ZEMBRACE (sumatriptan) zolmitriptan nasal spray ZOMIG (zolmitriptan)	• 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**
CYTOKINE AND CAM ANTAGONISTS, ORAL/SUBCUTANEOUS (Clinical criteria apply to class. All agents require a prior authorization.)		
ENBREL (etanercept) HUMIRA (adalimumab) KINERET (anakinra)	ACTEMRA (tocilizumab) AMEVIVE (alefacept) AMJEVITA (adalimumab-atto)	• Two (2) preferred products required before a non-preferred product will be approved

PREFERRED AGENTS Preferred status implementation: 1/1/24	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
ORENCIA (abatacept) OTEZLA (apremilast) TALTZ (ixekizumab) XELJANZ IR (tofacitinib)	ARCALYST (rilonacept) 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) KEVZARA (sarilumab) OLUMIANT (baricitinib) RINVOQ ER (upadactinib) SILIQ (brodalumab) SIMPONI (golimumab) SIMPONI ARIA (golimumab) SKYRIZI (risankizumab-rzaa) SOTYKTU (deucravacitinib) SPEVIGO (spesolimab-sbzo) STELARA (ustekinumab) TREMFYA (guselkumab) XELJANZ (tofacitinib) solution XELJANZ XR (tofacitinib) YUFLYMA (adalimumab-aaty) YUSIMRY (adalimumab-aqvh)	
NSAIDs, NASAL/ORAL/TOPICAL		
celecoxib diclofenac sodium drops, 1% gel, tablets ibuprofen indomethacin ER indomethacin IR ketorolac tablets meloxicam tablets nabumetone naproxen IR tablets sulindac	ARTHROTEC (diclofenac sodium/misoprostol) CAMBIA (diclofenac potassium) CELEBREX (celecoxib) DAYPRO (oxaprozin) diclofenac epolamine patch diclofenac potassium diclofenac sodium solution diclofenac/misoprostol DUEXIS (famotidine/ibuprofen) etodolac etodolac ER ELYXYB (celecoxib) FELDENE (piroxicam) fenoprofen FLECTOR (diclofenac epolamine) patches fluriprofen ibuprofen/famotidine INDOCIN (indomethacin) ketoprofen ketorolac nasal spray LICART (diclofenac epolamine) LOFENA (diclofenac potassium)	• Two (2) preferred products required before a non-preferred product will be approved

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	meclofenamate mefenamic acid meloxicam capsules NALFON (fenoprofen) NAPRELAN (naproxen) naproxen DR, suspension naproxen/esomeprazole naproxen sodium oxaprozin PENNSAID (diclofenac) piroxicam QMIIZ ODT (meloxicam) RELAFEN DS (nabumetone) SPRIX (ketorolac) NASAL SPRAY tolmetin VOLTAREN (diclofenac sodium) 1% GEL VENNGEL ONE (diclofenac sodium) VIMOVO (naproxen/esomeprazole) VIVLODEX (meloxicam) ZIPSOR (diclofenac potassium) ZORVOLEX (diclofenac)	
OPIATE DEPENDENCE TREATMENTS		
BRIXADI (buprenorphine) buprenorphine buprenorphine/naloxone naltrexone SUBLOCADE (buprenorphine) VIVITROL (naltrexone)	LUCEMYRA (lofexidine) PROBUPHINE (buprenorphine) SUBOXONE films (buprenorphine/naloxone) ZUBSOLV (buprenorphine/naloxone)	
ANTIDOTES		
OPIATE OVERDOSE TREATMENTS		
KLOXXADO (naloxone) naloxone injection naloxone nasal spray RX, OTC NARCAN nasal spray (naloxone)	ZIMHI (naloxone hydrochloride)	
ANTI-INFECTIVE AGENTS		
ANTIBIOTICS, GI		
FIRVANQ (vancomycin) metronidazole tablets neomycin	AEMCOLO (rifamycin) DIFICID (fidaxomicin) FLAGYL (metronidazole)	• Two (2) preferred products required before a non-preferred product will be approved

PREFERRED AGENTS Preferred status implementation: 1/1/24	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
tinidazole vancomycin capsules XIFAXAN 200 mg (rifaximin)	metronidazole capsules paromomycin capsules VANCOCIN (vancomycin) vancomycin solution VOWST (fecal microbiota spores, live-brpk) XIFAXAN 550 mg (rifaximin)	
ANTIBIOTICS, INHALED		
tobramycin 300 mg/5 ml	ARIKAYCE (amikacin) BETHKIS (tobramycin) CAYSTON (aztreonam) KITABIS PAK (tobramycin) TOBI PODHALER (tobramycin) tobramycin 300 mg/4 ml	
ANTIBIOTICS, VAGINAL		
CLEOCIN ovules (clindamycin) clindamycin CLINDESSE (clindamycin) metronidazole NUVESSA (metronidazole)	SOLOSEC (secnidazole) VANDAZOLE (metronidazole) XACIATO (clindamycin)	• Two (2) preferred products required before a non-preferred product will be approved
ANTIFUNGALS, ORAL		
fluconazole griseofulvin suspension nystatin terbinafine	ANCOBON (flucytosine) BREXAFEMME (ibrexafungerp) clotrimazole CRESEMBA (isavuconazonium) DIFLUCAN (fluconazole) flucytosine griseofulvin tablets itraconazole NOXAFIL (posaconazole) suspension, PowderMix ORAVIG (miconazole) ketoconazole 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		
abacavir	abacavir/lamivudine/zidovudine APTIVUS (tipranavir)	

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abacavir/lamivudine APRETUDE (cabotegravir extended-release) atazanavir BIKTARVY (bictegravir/emtricabine/ tenofovir AF) CABENUVA 600-900/3 (cabotegravir/rilpivirine) CABENUVA 400-600/2 (cabotegravir/rilpivirine) COMPLERA (emtricitabine/relpivirine/tenofovir) DELSTRIGO (doravirine/lamivudine/tenofovir) DESCOVY (emtricitabine/tenofovir AF) DOVATO (dolutegravir/lamivudine) EDURANT (rilpivirine) efavirenz efavirenz-emtricitabine-tenofovir emtricitabine-tenofovir disoproxil fumarate EMTRIVA (emtricitabine) EVOTAZ (atazanavir/cobicistat) GENVOYA (elvitegravir/cobicistat/emtricitabine/ tenofovir AF) ISENTRESS (raltegravir potassium) lamivudine lamivudine-zidovudine lopinavir-ritonavir nevirapine NORVIR solution (ritonavir) ODEFSEY (emtricitabine/relpivirine/tenofovir AF) PREZCOBIX (darunavir/cobicistat) PREZISTA (darunavir ethanolate) RETROVIR injection (zidovudine) REYATAZ powder pack (atazanavir) ritonavir tenofovir disoproxil fumarate TIVICAY (dolutegravir sodium) TIVICAY PD (dolutegravir sodium) TRIUMEQ (abacavir/lamivudine/dolutegravir) TYBOST (cobicistat) VIREAD (except 300 mg tablets) (tenofovir disoproxil fumarate) zidovudine	ATRIPLA (efavirenz/emtricitabine/tenofovir) CIMDUO (lamivudine/tenofovir) COMBIVIR (lamivudine/zidovudine) darunavir efavirenz/lamivudine/tenofovir 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 powder pack (ritonavir) PIFELTRO (doravirine) RUKOBIA (fostemsavir) SELZENTRY (maraviroc) STRIBILD (elvitegravir/cobicistat/emtricitabine/ tenofovir) SUNLENCA (lenacapavir sodium) tablets, vial SYMFI (efavirenz/lamivudine/tenofovir) SYMFI LO (efavirenz/lamivudine/tenofovir) SYMTUZA (darunavir/cobicistat/emtricitabine/ tenofovir AF) TRIUMEQ PD (abacavir/lamivudine/dolutegravir) TRIZIVIR (abacavir/lamivudine/zidovudine) TROGARZO (ibalizumab-uiyk) TRUVADA (emtricitabine/tenofovir DF) VIRACEPT (nelfinavir mesylate) VIREAD 300 mg tablets (tenofovir disoproxil fumarate) ZIAGEN (abacavir)	• Two (2) preferred products required before a non-preferred product will be approved
ANTIVIRALS, COVID - 19		
PAXLOVID (nirmatrelvir – ritonavir)	LAGEVRIO (molnupiravir)	
ANTIVIRALS, HEPATITIS C AGENTS		
MAVYRET (glecaprevir/pibrentasvir) ribavirin	EPCLUSA (sofosbuvir/velpatasvir) pelet pack, tablets	• Two (2) preferred products required before a non-preferred product will be approved

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sofosbuvir/velpatasvir	HARVONI (ledipasvir/sofosbuvir) ledipasvir/sofosbuvir PEGASYS (peginterferon alfa-2a) PEG-INTRON (peginterferon alfa-2b) SOVALDI (sofosbuvir) VOSEVI (sofosbuvir/velpatasvir/voxilaprevir) ZEPATIER (elbasvir/grazoprevir)	**Limited to one treatment cycle every 365 days**
ANTIVIRALS, ORAL/INHALATION		
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 clients over 10-years old • *** Quantity limits in place for oseltamivir and RELENZA**
CEPHALOSPORINS, ORAL		
cefaclor IR capsules cefdinir cefprozil cefuroxime cephalexin capsules, suspension	cefaclor ER tablet cefaclor suspension cefadroxil cefixime cefpodoxime cephalexin tablets SUPRAX (cefixime)	• Two (2) preferred products required before a non-preferred product will be approved
FLUOROQUINOLONES, ORAL		
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 apply to individual agents in class)		
clindamycin capsules clindamycin solution (for client < 10 years old)	CLEOCIN (clindamycin) linezolid * SIVEXTRO (tedizolid) ZYVOX* (linezolid)	• Liquid medications require prior authorization for clients over 10 years old • * Clinical criteria apply

PREFERRED AGENTS Preferred status implementation: 1/1/24	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
MACROLIDES		
azithromycin erythromycin suspension	clarithromycin E.E.S. 400 ERY-TAB (erythromycin) ERYPED (erythromycin ethylsuccinate) ERYTHROCIN (erythromycin stearate) erythromycin (all other salts/formulations) ZITHROMAX (azithromycin)	
PENICILLINS, ORAL/IM		
amoxicillin amoxicillin/clavulanate (except 250 mg suspension, tabs) 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)	• Two (2) preferred products required before a non-preferred product will be approved
TETRACYCLINES		
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) MORGIDOX (doxycycline) NUZYRA (omadacycline) SOLODYN (minocycline) TARGADOX (doxycycline hyclate) tetracycline VIBRAMYCIN (doxycycline) XIMINO (minocycline)	• Two (2) preferred products required before a non-preferred product will be approved
URINARY ANTI-INFECTIVES		
methenamine hippurate methenamine mandelate MONUROL (fosfomycin tromethamine) nitrofurantoin macrocrystals (generic	fosfomycin tromethamine HIPREX (methenamine hippurate) MACROBID (nitrofurantoin mono-macrocrystals) MACRODANTIN (nitrofurantoin microcrystal)	• Two (2) preferred products required before a non-preferred product will be approved

PREFERRED AGENTS Preferred status implementation: 1/1/24	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
MACRODANTIN) 25 mg dose preferred for pediatrics only nitrofurantoin mono-macrocrystals (generic MACROBID)	nitrofurantoin macrocrystals (generic MACRODANTIN) except for 25 mg dose for pediatrics nitrofurantoin suspension	
ANTINEOPLASTICS		
ONCOLOGY AGENTS		
all other drug products	AFINITOR (everolimus) AFINITOR DISPERZ (everolimus) ALKERAN (melphalan) CASODEX (bicalutamide) CYTOXAN (cyclophosphamide) EULEXIN (flutamide) EVISTA (raloxifene) GILOTRIF (afatinib) GLEEVEC (imatinib) GLEOSTINE (lomustine) HYDREA (hydroxyurea) INLYTA (axitinib) IRESSA (gefitinib) MESNEX (mesna) MYLERAN (busulfan) NEXAVAR (sorafenib) NOLVADEX (tamoxifen) PURINETHOL (mercaptopurine) REVLIMID (lenalidomide) SUTENT (sunitinib) TARCEVA (erlotinib) TEMODAR (temozolomide) THALOMID (thalidomide) TYKERB (lapatinib) XELODA (capecitabine) ZORTRESS (everolimus) ZYTIGA (abiraterone acetate)	• Effective January 1, 2024, 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. This change does NOT impact those currently on oral oncology medications. • For brand-name medication to be considered, providers must submit a prior authorization form with documentation of medical trial and outcome electronically via the DMAP Provider Portal.
CARDIOVASCULAR AGENTS		
ANGIOTENSIN MODULATORS		
benazepril benazepril/HCTZ enalapril enalapril/HCTZ fosinopril	ACCUPRIL (quinapril) ACCURETIC (quinapril/HCTZ) aliskerin ALTACE (ramipril) ATACAND (candesartan)	• Two (2) preferred products required before a non-preferred product will be approved • Dose optimization required when applicable

PREFERRED AGENTS Preferred status implementation: 1/1/24	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
irbesartan irbesartan/HCTZ lisinopril lisinopril/HCTZ losartan losartan/HCTZ olmesartan olmesartan/HCTZ ramipril quinapril quinapril/HCTZ trandolapril valsartan valsartan/HCTZ	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) 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)	
ANGIOTENSIN MODULATOR/CALCIUM CHANNEL BLOCKER COMBINATIONS		
amlodipine/benazepril amlodipine/valsartan amlodipine/valsartan/ HCTZ olmesartan/amlodipine olmesartan/amlodipine/HCTZ	AZOR (amlodipine/olmesartan) EXFORGE (amlodipine/valsartan) EXFORGE HCT (amlodipine/valsartan/HCTZ) LOTREL (amlodipine/benazepril) telmisartan/amlodipine trandolapril/verapamil TRIBENZOR (olmesartan/amlodipine/HCTZ)	• Two (2) preferred products required before a non-preferred product will be approved • Dose optimization required when applicable
ANTIHYPERTENSIVES, SYMPATHOLYTIC		
clonidine patches, tablets clonidine ER doxazosin guanfacine	CARDURA (doxazosin) MINIPRESS (prazosin)	

PREFERRED AGENTS Preferred status implementation: 1/1/24	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
methyldopa prazosin terazosin		
BETA BLOCKERS		
atenolol atenolol/chlorthalidone bisoprolol bisoprolol/HCTZ carvedilol IR labetalol metoprolol metoprolol ER nebivolol nadolol propranolol propranolol ER SORINE (sotalol) sotalol	acebutolol BETAPACE (sotalol) betaxolol BYSTOLIC (nebivolol) carvedilol ER COREG (carvedilol) COREG CR (carvedilol) CORGARD (nadolol) HEMANGEOL (propranolol) INDERAL LA (propranolol) INDERAL XL (propranolol) INNOPRAN XL (propranolol) KAPSPARGO (metoprolol) 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
CALCIUM CHANNEL BLOCKERS		
amlodipine CARTIA XT (diltiazem ER) DILT-XR (diltiazem ER) diltiazem ER capsules diltiazem IR felodipine nifedipine ER nifedipine IR nimodipine * TAZTIA XT (diltiazem ER) TIADYLT ER (diltiazem ER) verapamil ER tablets, capsules verapamil IR	CARDIZEM (diltiazem) CARDIZEM CD (diltiazem ER) CARDIZEM LA (diltiazem ER) diltiazem ER tablets isradipine KATERZIA (amlodipine) levamlodipine maleate MATZIM LA (diltiazem ER) nicardipine nisoldipine NORLIQVA (amlodipine) NORVASC (amlodipine) NYMALIZE (nimodipine) PROCARDIA (nifedipine) PROCARDIA XL (nifedipine ER) SULAR (nisoldipine)	• 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 Preferred status implementation: 1/1/24	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
	TIAZAC (diltiazem) verapamil ER PM verapamil SR pellet VERELAN (verapamil) VERELAN PM (verapamil)	
DIURETICS		
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 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
EPINEPHRINE, SELF-INJECTED		
epinephrine auto-injector AG (labeler 49502) SYMJEPI (epinephrine)	AUVI-Q (epinephrine) EPI-PEN (epinephrine) epinephrine auto-injector (other than labeler 49502)	
HEART FAILURE DRUGS		
ENTRESTO (valsartan/sacubitril)	INPEFA (sotagliflozin) VERQUVO (vericiguat)	
LIPOTROPICS, OTHER (Clinical criteria apply to individual agents in class)		
cholestyramine cholestyramine light colesevelam tablets colestipol ezetimibe fenofibrate fenofibric acid gemfibrozil niacin ER omega-3 acid ethyl esters	ANTARA (fenofibrate) COLESTID (colestipol) colesevalam powder ezetimibe/simvastatin FENOGLIDE (fenofibrate) icosapent ethyl JUXTAPID (lomitapide) LEQVIO (inclisiran) LIPOFEN (fenofibrate) LOPID (gemfibrozil)	• Two (2) preferred products required before a non-preferred product will be approved • *** Clinical criteria apply**

PREFERRED AGENTS Preferred status implementation: 1/1/24	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
PRALUENT * (alirocumab) PREVALITE (cholestyramine) POWDER REPATHA * (evolocumab)	LOVAZA (omega-3 acid ethyl esters) NEXLETOL (bempedoic acid) NEXLIZET (bempedoic acid/ezetimibe) PREVALITE (cholestyramine) POWDER PACK TRICOR (fenofibrate) TRIGLIDE (fenofibrate) TRILIPIX (fenofibric acid) VASCEPA (icosapent ethyl) VYTORIN (ezetimibe/simvastatin) WELCHOL (colesevelam) ZETIA (ezetimibe)	
LIPOTROPICS, STATINS		
atorvastatin lovastatin pravastatin rosuvastatin simvastatin	ALTOPREV (lovastatin) amlodipine/atorvastatin ATORVALIQ (atorvastatin) suspension CADUET (amlodipine/atorvastatin) CRESTOR (rosuvastatin) EZALLOR (rosuvastatin) 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 apply to class. All agents require a prior authorization.)		
ambrisentan bosentan sildenafil 20mg tablets tadalafil VENTAVIS (iloprost)	ADCIRCA (tadlafil) ADEMPAS (riociguat) ALYQ (tadalafil) LETAIRIS (ambrisentan) OPSUMIT (macitentan) ORENITRAM ER (treprostinil) REVATIO suspension (sildenafil) sildenafil 10mg/ml suspension TADLIQ (tadalafil) suspension TRACLEER tablets for suspension (bosentan) TYVASO starter kit (treprostinil) TYVASO DPI (treprostinil) UPTRAVI (selexipag)	• Two (2) preferred products required before a non-preferred product will be approved
VASODILATORS, CORONARY		
isosorbide dinitrate isosorbide mononitrate	ASPRUZYO (ranolazine) BIDIL (isosorbide dinitrate/hydralazine)	• Two (2) preferred products required before a non-preferred product will be approved

PREFERRED AGENTS Preferred status implementation: 1/1/24	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
isosorbide mononitrate ER nitroglycerin patches, tablets ranolazine ER	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	
CENTRAL NERVOUS SYSTEM DRUGS		
ANTIDEPRESSANTS, OTHER		
amitriptyline bupropion IR bupropion SR bupropion XL 150, 300 mg clomipramine desvenlafaxine ER doxepin imipramine HCl MARPLAN (isocarboxazid) mirtazapine tablet nortriptyline phenelzine 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 desipramine DRIZALMA (duloxetine) EFFEXOR XR (venlafaxine ER) CAPSULES EMSAM (selegiline) FETZIMA (levomilnacipran) FORFIVO XL (bupropion) imipramine pamoate mirtazapine ODT NARDIL (phenelzine) nefazodone NORPRAMIN (desipramine) PAMELOR (nortriptyline) PRISTIQ (desvenlafaxine) protriptyline 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)	• 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.
ANTIDEPRESSANTS, SSRIs		
citalopram solution, tablets	CELEXA (citalopram)	

PREFERRED AGENTS Preferred status implementation: 1/1/24	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
escitalopram tablets fluoxetine capsules, solution fluvoxamine tablets paroxetine IR tablets sertraline concentrate, tablets	citalopram capsules escitalopram solution fluoxetine tablets fluoxetine DR fluvoxamine ER sympatjLEXAPRO (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 clients over 10-years old
ANTIPSYCHOTICS, ORAL/INHALATION		
amitriptyline/perphenazine aripiprazole tablets clozapine haloperidol concentrate, solution, tablets loxapine lurasidone olanzapine tablets paliperidone ER perphenazine pimozide quetiapine risperidone solution, tablets thioridazine thiothixene trifluoperazine VRAYLAR (cariprazine) ziprasidone	ABILIFY (aripiprazole) TABLETS ABILIFY MYCITE (aripiprazole) TABLETS aripiprazole ODT, solution asenapine sublingual tablets CAPLYTA (lumateperone) chlorpromazine CLOZARIL (clozapine) TABLETS clozapine ODT FANAPT (iloperidone) fluphenazine GEODON (ziprasidone) CAPSULES INVEGA (paliperidone) TABLETS LATUDA (lurasidone) LYBALVI (olanzapine/samidorphan) TABLETS molindone NUPLAZID (pimavanserin tartrate) olanzapine ODT olanzapine/fluoxetine REXULTI (brexpiprazole) RISPERDAL (risperidone) TABLETS risperidone ODT SAPHRIS (asenapine) SECUADO (asenapine) SEROQUEL (quetiapine) TABLETS SEROQUEL XR (quetiapine) TABLETS SYMBYAX (olanzapine/fluoxetine) VERSACLOZ (clozapine) ZYPREXA (olanzapine) TABLETS ZYPREXA ZYDIS (olanzapine) ODT TABLETS	• 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
ANTIPSYCHOTICS, INJECTABLE/INHALATION (Clinical criteria apply to individual agents in class)		

PREFERRED AGENTS Preferred status implementation: 1/1/24	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
ABILIFY ASIMTUFII (aripiprazole) ABILIFY MAINTENA * (aripiprazole) ARISTADA * (aripiprazole) chlorpromazine fluphenazine fluphenazine decanoate haloperidol decanoate haloperidol lactate INVEGA SUSTENNA * (paliperidone) INVEGA TRINZA * (paliperidone) olanzapine PERSERIS * (risperidone) RISPERDAL CONSTA * (risperidone) ziprasidone mesylate IM	ADASUVE (loxapine) GEODON IM (ziprasidone) HALDOL (haloperidol decanoate) INVEGA HAFEYRA (paliperidone) UZEDY (risperidone) ZYPREXA (olanzapine) ZYPREXA RELPREVV (olanzapine)	• 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 • *** Clinical PA is required for Long-Acting Injectable Atypical Antipsychotics**
ANXIOLYTICS		
buspirone chlordiazepoxide clorazepate diazepam solution, tablets lorazepam tablets	alprazolam ER/XR, IR, intensol, ODT ATIVAN (lorazepam) diazepam intensol lorazepam intensol LIBRIUM (chlordiazepoxide) LOREEV XR (lorazepam) meprobamate oxazepam TRANXENE (clorazepate) VALIUM (diazepam) 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**
MOOD STABILIZERS		
carbamazepine tablets, chewable carbamazepine ER, XR carbamazepine suspension divalproex sodium lamotrigine IR lithium SUBVENITE (lamotrigine) valproic acid	DEPAKOTE (divalproex) DEPAKOTE ER (divalproex) EPITOL (carbamazepine) tablets, chewable tablets 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
SEDATIVE HYPNOTICS		
temazepam 15mg, 30mg	AMBIEN (zolpidem)	

PREFERRED AGENTS Preferred status implementation: 1/1/24	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
zaleplon zolpidem IR tablets	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: total quantity limit of one daily covered • 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		
ENDOCRINE AND METABOLIC DRUGS		
ANDROGENIC AGENTS (Clinical criteria apply to class. All agents require a prior authorization.)		
DEPO-TESTOSTERONE (testosterone cypionate) testosterone cypionate testosterone enanthate testosterone gel pump 20.25/1.25	ANDRODERM (testosterone) ANDROID 25 (methyltestosterone) ANDROGEL (testosterone) AVEED (testosterone undecanoate) FORTESTA (testosterone) JATENZO (testosterone undecanoate) KYZATREX (testosterone undecanoate) METHITEST (methyltestosterone) methyltestosterone NATESTO (testosterone) TESTIM (testosterone)	• Two (2) preferred products required before a non-preferred product will be approved

PREFERRED AGENTS Preferred status implementation: 1/1/24	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
	testosterone gel (except preferred formulation) TLANDO (testosterone undecanoate) VOGELXO (testosterone) XYOSTED (testosterone enanthate)	
BONE RESORPTION SUPPRESSION AND RELATED AGENTS (Clinical criteria apply to individual agents in class)		
alendronate tablets calcitonin-salmon nasal spray ibandronate PROLIA * (denosumab)	ACTONEL (risedronate) alendronate solution ATELVIA (risedronate) BINOSTO (alendronate) BONSITY (teriparatide) * EVENITY * (romosozumab-aqqg) EVISTA (raloxifene) FORTEO (teriparatide) * FOSAMAX (alendronate) FOSAMAX PLUS D (alendronate/vitamin D) NATPARA * raloxifene risedronate teriparatide * TYMLOS * (abaloparatide) XGEVA * (denosumab)	• 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		
desogestrel-ethinyl estradiol-eth estradiol	LO LOESTRIN FE (norethindrone-ethinyl estradiol-Fe)	
CONTRACEPTIVES, ORAL - COMBINATION		
desogestrel-ethinyl estradiol drosperinone-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)	BALCOLTRA (levonorgestrel-ethinyl estradiol) BEYAZ (drosperinone-ethinyl estradiol-levomefolate) drosperinone-ethinyl estradiol-levomefolate 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 LOESTRIN (norethindrone-ethinyl estradiol) LOESTRIN-FE (norethindrone-ethinyl estradiol-Fe) MERZEE (norethindrone-ethinyl estradiol-Fe)	• Two (2) preferred products required before a non-preferred product will be approved

PREFERRED AGENTS Preferred status implementation: 1/1/24	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
TYBLUME (levonorgestrel-ethinyl estradiol) chewable VOLNEA (desogestrel-ethinyl estradiol/ethinyl estradiol) WYMZYA FE (norethindrone-ethinyl estradiol-Fe) chewable	MINASTRIN (norethindrone-ethinyl estradiol) 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)	
CONTRACEPTIVES, ORAL - EXTENDED CYCLE		
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 MICROGESTIN-FE (norethindrone-ethinyl estradiol-Fe)	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		
LYLEQ (norethindrone) NORA-BE (norethindrone) norethindrone SLYND (drospirenone)		
CONTRACEPTIVES, ORAL – TRIPHASIC		
desogestrel-ethinyl estradiol FINZALA (norethindrone-ethinyl estradiol-iron) LEENA (norethindrone-ethinyl estradiol) levonorgestrel-ethinyl estradiol 6-5-10 norethindrone-ethinyl estradiol norgestimate-ethinyl estradiol TILIA FE (norethindrone-ethinyl estradiol-Fe)	norethindrone-ethinyl estradiol-iron	• Two (2) preferred products required before a non-preferred product will be approved
CONTRACEPTIVES – IUDs / IMPLANTS		
KYLEENA (levonorgestrel) LILETTA (levonorgestrel) MIRENA (levonorgestrel)		

PREFERRED AGENTS Preferred status implementation: 1/1/24	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
NEXPLANON (etonogestrel) PARAGARD		
CONTRACEPTIVES – PATCHES		
XULANE (ethinyl estradiol-norelgestromin)	TWIRLA (levonorgestrel-ethinyl estradiol) ZAFEMY (ethinyl estradiol-norelgestromin)	
CONTRACEPTIVES – VAGINAL RINGS		
NUVARING (etonogestrel-ethinyl estradiol)	ANNOVERA (ethinyl estradiol-segesterone) ELURYNG (etonogestrel-ethinyl estradiol) etonogestrel-ethinyl estradiol HALOETTE (etonogestrel-ethinyl estradiol)	
GROWTH HORMONES (Clinical criteria apply to class. All agents require a prior authorization.)		
GENOTROPIN (somatropin) NORDITROPIN (somatropin) NUTROPIN AQ (somatropin)	OMNITROPE (somatropin) SAIZEN (somatropin) SEROSTIM (somatropin) SKYTROFA (lonapegsomatropin-tcgd) SOGROYA (somapacitan-beco) ZOMACTON (somatropin) ZORBTIVE (somatropin)	
HYPOGLYCEMIA TREATMENTS		
BAQSIMI (glucagon) GLUCAGEN (glucagon) glucagon (except labeler 00548, 63323) ZEGALOGUE autoinjector (dasiglucagon) ZEGALOGUE syringe (dasiglucagon)	glucagon (labeler 00548, 63323) 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		
acarbose	GLYSET (migitol) miglitol	
HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS: AMYLIN ANALOGS (Clinical criteria apply to class. All agents require a prior authorization.)		
	SYMLIN (pramlintide)	
HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS: DPP-4 INHIBITORS (Clinical criteria apply to class. All agents require a prior authorization.)		
JANUMET (sitagliptin/metformin) JANUMET XR (sitagliptin/metformin) JANUVIA (sitagliptin) JENTADUETO (linagliptin/metformin)	alogliptin alogliptin-metformin alogliptin-pioglitazone JENTADUETO XR (linagliptin/metformin)	

PREFERRED AGENTS Preferred status implementation: 1/1/24	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
TRADJENTA (linagliptin)	KAZANO (alogliptin) KOMBIGLYZE XR (saxagliptin/metformin) NESINA (alogliptin) ONGLYZA (saxagliptin)	
HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS: GLP-1 RAs (Clinical criteria apply to class. All agents require a prior authorization.)		
OZEMPIC (semaglutide) TRULICITY (dulaglutide) VICTOZA (liraglutide)	BYDUREON BCISE (exenatide) BYETTA (exenatide) RYBELSUS (semaglutide) SOLIQUA (insulin glargine/lixisenatide) XULTOPHY (insulin degludec/liraglutide)	• Two (2) preferred products required before a non-preferred product will be approved
HYPOGLYCEMICS, INSULINS		
APIDRA (insulin glulisine) pens, vials HUMALOG MIX 50-50 (insulin lispro/lispro protamine) vial, pens HUMALOG MIX 75-25 (insulin lispro/lispro protamine) vial HUMULIN R U-500 (insulin) vial, pen HUMULIN R vials HUMULIN 70-30 vial insulin aspart pen, cartridge, vial insulin aspart mix pen, vial insulin glargine (labeler 00955 only) insulin lispro pen, vial insulin lispro mix pen LANTUS (insulin glargine) pen, vial LEVEMIR (insulin detemir) pen, vial NOVOLIN N FLEXPEN NOVOLIN R FLEXPEN TOUJEO SOLOSTAR (insulin glargine) pen TOUJEO SOLOSATR MAX (insulin glargine) pen	ADMELOG (insulin lispro) vials, pens AFREZZA (insulin) cartridges BASAGLAR (insulin glargine) pens BASAGLAR TEMPO (insulin glargine) pens FIASP (insulin aspart) HUMALOG (insulin lispro) cartridges, vials HUMALOG JUNIOR (insulin lispro) pens HUMALOG MIX 75-25 (insulin lispro/lispro protamine) pen HUMALOG U-100 (insulin lispro) HUMALOG U-200 (insulin lispro) HUMULIN (except U-500, 70-30, R vial) (insulin) vial, pen insulin degludec insulin glargine solostar pen insulin glargine-YFGN pen, vial insulin glargine vial LYUMJEV (insulin lispro) pens, vials NOVOLIN (except N and R FLEXPEN) (insulin) pens, vials NOVOLIN MIX pens, vials NOVOLOG (insulin aspart) cartridges, pens, vials NOVOLOG MIX pens, vials REZVOGLAR KWIKPEN (insulin glargine-aglr) SEMGLEE (insulin glargine) pens, vials TRESIBA (insulin degludec) pens, vials	• Two (2) preferred products required before a non-preferred product will be approved
HYPOGLYCEMICS, MEGLITINIDES		
nateglinide repaglinide		

PREFERRED AGENTS Preferred status implementation: 1/1/24	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
HYPOGLYCEMICS, METFORMINS		
glipizide-metformin glyburide-metformin metformin IR metformin ER (generic GLUCOPHAGE XR)	FORTAMET (metformin ER) GLUMETZA (metformin ER) metformin ER (generic FORTAMET, GLUMETZA) metformin IR solution	• Two (2) preferred products required before a non-preferred product will be approved
HYPOGLYCEMICS, SGLT2 INHIBITORS		
FARXIGA (dapagliflozin) INVOKANA (canagliflozin) INVOKAMET (canagliflozin/metformin) INVOKAMET XR (canagliflozin/metformin) JARDIANCE (empagliflozin) SYNJARDY (empagliflozin/metformin) XIGDUO XR (dapagliflozin/metformin)	GLYXAMBI (empagliflozin/linagliptin) QTERN (dapagliflozin/saxagliptin) SEGLUROMET (ertugliflozin/metformin) STEGLUJAN (ertugliflozin/sitagliptin) STEGLATRO (ertugliflozin) SYNJARDY XR (empagliflozin/metformin) TRIJARDY XR (empagliflozin/linagliptin/metformin)	• Two (2) preferred products required before a non-preferred product will be approved
HYPOGLYCEMICS, TZDs		
pioglitazone	ACTOPLUS MET (pioglitazone/metformin) ACTOS (pioglitazone) DUETACT (pioglitazone/glimepiride) pioglitazone/glimepiride pioglitazone/metformin	
GLUCOCORTICOIDS, ORAL		
budesonide ER capsules dexamethasone elixir, intensol, solution, tablets fludrocortisone hydrocortisone methylprednisolone dose pack methylprednisolone 4mg tablets prednisolone solution prednisolone sodium phosphate solution prednisone dose pack, tablets	ALKINDI SPRINKLES (hydrocortisone) granules budesonide ER tablet CORTEF (hydrocortisone) cortisone dexamethasone dose pack EMFLAZA (deflazacort) tablets, suspension HEMADY (dexamethasone) MEDROL (methylprednisolone) methylprednisolone 8, 16, 32 mg tablet prednisolone tablets prednisolone sodium phosphate ODT prednisone intensol, solution RAYOS (prednisone) TARPEYO (budesonide)	• Two (2) preferred products required before a non-preferred product will be approved
PELVIC DISORDERS – ENDOMETRIOSIS, UTERINE FIBROIDS		
danazol DEPO-PROVERA (medroxyprogesterone) LUPRON DEPOT (leuprolide)	ORIAHNN * (elagolix-estradiol-norethindrone)	• Two (2) preferred products required before a non-preferred product will be approved

PREFERRED AGENTS Preferred status implementation: 1/1/24	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
MYFEMBREE * (relugolix-estradiol-norethindrone acetate) norethindrone acetate ORILISSA (elagolix) SYNAREL (nafarelin)		• *** Double step through NSAIDs and/or oral contraceptives required.**
PITUITARY SUPPRESSANTS, CENTRAL PRECOCIOUS PUBERTY (CPP)		
FENSOLVI (leuprolide acetate) leuprolide acetate 22.5 mg vial LUPRON DEPOT–PED (leuprolide) SUPPRELIN LA (histrelin) SYNAREL (nafarelin) TRIPTODUR (triptorelin)		
POTASSIUM REMOVING AGENTS		
LOKELMA (sodium zirconium cyclosilicate)	VELTASSA (patiromer calcium sorbitex)	
PROGESTATIONAL AGENTS (Clinical criteria apply to individual agents in class)		
DEPO-SUBQ PROVERA (medroxyprogesterone) medroxyprogesterone acetate tablets medroxyprogesterone acetate IM norethindrone acetate tablets progesterone capsule progesterone IM	CRINONE (progesterone) PROMETRIUM (progesterone)	• Two (2) preferred products required before a non-preferred product will be approved
THYROID HORMONES		
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) TIROSINT (levothyroxine) capsules, solution UNITHROID (levothyroxine sodium)	• Two (2) preferred products required before a non-preferred product will be approved
GASTROINTESTINAL AGENTS		
ANTIEMETICS, ORAL/TRANSDERMAL (Clinical criteria apply to individual agents in class)		

PREFERRED AGENTS Preferred status implementation: 1/1/24	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
DICLEGIS (doxylamine/pyridoxine) ondansetron tablets, ODT, solution TRANSDERM-SCOP (scopolamine)	AKYNZEO (netupitant/palonosetron) ANZEMET (dolasetron) aprepitant BONJESTA * (doxylamine/pyridoxine) doxylamine/pyridoxine dronabinol * EMEND (aprepitant) capsules, suspension granisetron MARINOL (dronabinol) * SANCUSO (granisetron) scopolamine patch trimethobenzamide VARUBI (rolapitant)	• Two (2) preferred products required before a non-preferred product will be approved • *** Clinical criteria apply**
BILE SALTS		
ursodiol capsules, tablets	CHENODAL (chenodiol) CHOLBAM (cholic acid) RELTONE (ursodiol) URSO (ursodiol) URSO FORTE (ursodiol)	
BOWEL PREP		
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	SUTAB	• Two (2) preferred products required before a non-preferred product will be approved
CONSTIPATION – IBS – OIC, ORAL		
AMITIZA (lubiprostone) LINZESS (linaclotide) MOVANTIK (naloxegol) TRULANCE (plecanatide)	lubiprostone MOTEGRITY (prucalopride) RELISTOR (methylnaltrexone) SYMPROIC (naldemedine)	• Two (2) preferred products required before a non-preferred product will be approved

PREFERRED AGENTS Preferred status implementation: 1/1/24	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
H. PYLORI TREATMENTS		
PYLERA (bismuth subcitrate potassium-metronidazole-tetracycline)	bismuth-metronidazole- tetracycline lansoprazole-amoxicillin-clarithromycin OMECLAMOX PAK (omeprazole-clarithromycin-amoxicillin) TALICIA (omeprazole magnesium-amoxicillin-rifabutin)	
HISTAMINE II RECEPTOR BLOCKERS		
famotidine nizatidine	cimetidine	• Two (2) preferred products required before a non-preferred product will be approved
PANCREATIC ENZYMES		
CREON (pancrelipase) ZENPEP (pancrelipase)	PANCREAZE (pancrelipase) PERTZYE (pancrelipase) VIOKACE (pancrelipase)	• Two (2) preferred products required before a non-preferred product will be approved
PHOSPHATE BINDERS		
calcium acetate capsules sevelamer carbonate tablet	AURYXIA (ferric citrate) calcium acetate tablets FOSRENOL (lanthanum carbonate) lanthanum RENAGEL (sevelamer HCl) RENVELA (sevelamer carbonate) sevelamer HCl tablet sevelamer powder VELPHORO (sucroferric oxyhydroxide)	• PA required for all non-calcium based products • Two (2) preferred products required before a non-preferred product will be approved
PROTON PUMP INHIBITORS		
omeprazole RX pantoprazole tablets PROTONIX (pantoprazole) granules	ACIPHEX (rabeprazole) DEXILANT (dexlansoprazole) dexlansoprazole esomeprazole KONVOMEP (omeprazole/sodium bicarbonate) lansoprazole NEXIUM (esomeprazole) capsules, suspension omeprazole OTC omeprazole/sodium bicarbonate pantoprazole granules PREVACID (lansoprazole) PRILOSEC (omeprazole) packets PROTONIX (pantoprazole) tablets	• Quantity limits apply to class • Two (2) preferred products required before a non-preferred product will be approved • Liquid medications require prior authorization for clients over 10 years old

PREFERRED AGENTS Preferred status implementation: 1/1/24	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
	rabeprazole ZEGRID (omeprazole/sodium bicarbonate)	
ULCERATIVE COLITIS AGENTS		
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 mesalamine enema kit mesalamine ER 375 mg ROWSA (mesalamine) SFROWSA (mesalamine) UCERIS (budesonide)	• Two (2) preferred products required before a non-preferred product will be approved
GENITOURINARY PRODUCTS		
BLADDER RELAXANT PREPARATIONS		
MYRBETRIQ (mirabegron) tablets oxybutynin 5 mg oxybutynin ER oxybutynin syrup solifenacin	darifenacin DETROL (tolterodine) DETROL LA (tolterodine) fesoterodine GEMTESA (vibegron) oxybutynin 2.5 mg OXYTROL (oxybutynin) MYRBETRIQ (mirabegron) suspension tolterodine TOVIAZ (fesoterodine) trospium VESICARE (solifenacin) tablets VESICARE LS (solifenacin) suspension	• Two (2) preferred products required before a non-preferred product will be approved
BPH TREATMENTS		
alfuzosin doxazosin finasteride 5 mg tamsulosin terazosin	AVODART (dutasteride) CARDURA (doxazosin) CARDURA XL (doxazosin) dutasteride dutasteride/tamsulosin ENTADFI (finasteride/tadalafil) FLOMAX (tamsulosin) JALYN (dutasteride/tamsulosin)	• Two (2) preferred products required before a non-preferred product will be approved

PREFERRED AGENTS Preferred status implementation: 1/1/24	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
	PROSCAR (finasteride) RAPAFLO (silodosin) silodosin	
HEMATOLOGICAL AGENTS		
ANTICOAGULANTS, ORAL/SQ		
ELIQUIS (apixaban) enoxaparin JANTOVEN (warfarin) PRADAXA (dabigatran) capsules warfarin XARELTO (rivaroxaban) tablets	ARIXTRA (fondaparinux) dabigatran etexilate fondaparinux FRAGMIN (dalteparin) LOVENOX (enoxaparin) PRADAXA (dabigatran) pellets 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		
AFSTYLA ALPHANATE HEMLIBRA (emicizumab-kxwh) HEMOFIL M HUMATE-P JIVI KOATE KOVALTRY HUMATE-P NOVOEIGHT NUWIQ WILATE XYNTHA XYNTHA SOLOFUSE	ADVATE ADYNOVATE ALTUVIIIO ELOCTATE ESPEROCT KOGENATE FS RECOMBINATE VONVENDI	• Two (2) preferred products required before a non-preferred product will be approved
HEMOPHILIA B		
ALPHANINE SD ALPROLIX BENEFIX IXINITY PROFILNINE RIXUBIS	IDELVION REBINYN	• Two (2) preferred products required before a non-preferred product will be approved
COLONY STIMULATING FACTORS		
GRANIX (tbo-filgrastim) NEUPOGEN (filgrastim)	FULPHILA (pegfilgrastim-jmdb) FYLNETRA	

PREFERRED AGENTS Preferred status implementation: 1/1/24	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
NYVEPRIA (pegfilgrastim-apgf) RELEUKO ZIEXTENZO (pegfilgrastim-bmez)	LEUKINE (sargramostim) NEULASTA (pegfilgrastim) NIVESTYM (figrastim-aafi) vial, syringe ROLVEDON STIMUFEND UDENYCA (pegfilgrastim-cbqv) ZARXIO (filgrastim-sndz)	• Two (2) preferred products required before a non-preferred product will be approved
ERYTHROPOIESIS STIMULATING PROTEINS (Clinical criteria apply to class. All agents require a prior authorization.)		
EPOGEN (epoetin alpha) MIRCERA (methoxypolyethylene glycolepoetin beta) RETACRIT (epoetin alpha-epbx)	ARANESP (darbepoetin alfa) PROCRIT (epoetin alpha)	• Two (2) preferred products required before a non-preferred product will be approved
HAE TREATMENTS (Clinical criteria apply to class. All agents require a prior authorization.)		
BERINERT (human C1 inhibitor) CINRYZE (human C1 inhibitor) danazol FIRAZYR (icatibant) HAEGARDA (human C1 inhibitor) icatibant KALBITOR (escallantide) ORLADEYO (berotralstat) RUCONEST (recombinant C1 esterase inhibitor) SAJAZIR (icatibant) TAKHZYRO (lanadelumab-flyo)		
PLATELET AGGREGATION INHIBITORS		
aspirin/dipyridamole BRILINTA (ticagrelor) clopidogrel dipyridamole prasugrel	EFFIENT (prasugrel) PLAVIX (clopidogrel) ticlopidine ZONTIVITY (vorapaxar)	• Two (2) preferred products required before a non-preferred product will be approved
SICKLE CELL ANEMIA AGENTS		
DROXIA (hydroxyurea) hydroxyurea	ADAKVEO (crizanlizumab-tmca) vials ENDARI (glutamine) OXBRYTA (voxelotor) SIKLOS (hydroxyurea)	

PREFERRED AGENTS Preferred status implementation: 1/1/24	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
MEDICAL DEVICES AND SUPPLIES		
BLOOD GLUCOSE METERS, TEST STRIPS		
FREESTYLE FREESTYLE FREEDOM FREESTYLE FREEDOM LITE FREESTYLE INSULINX FREESTYLE LITE FREESTYLE PRECISION NEO (labeler 57599 only) PRECISION XTRA (labeler 57599 only)	All other blood glucose meters and test strips are non-preferred	• Two (2) preferred products required before a non-preferred product will be approved • Please refer to the Pharmacy Diabetic Supply list on the pharmacist corner webpage for details on glucose meters and test strips
CONTINUOUS GLUCOSE MONITORS (CGMs)		
DEXCOM FREESTYLE LIBRE	All other CGM devices are non-preferred	• Two (2) preferred products required before a non-preferred product will be approved • Please refer to the Pharmacy Diabetic Supply list on the pharmacist corner webpage for details on CGM's
INSULIN PUMPS (Clinical criteria apply to class. All preferred agents require prior authorization. All non-preferred insulin pumps are not covered under pharmacy)		
OMNIPOD CLASSIC OMNIPOD DASH OMNIPOD 5	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. • Please refer to the Pharmacy Diabetic Supply list on the pharmacist corner webpage for details on insulin pumps
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	
NEUROMUSCULAR DRUGS		
ANTICONVULSANTS, ORAL/RECTAL/NASAL		
BRIVIACT (brivaracetam) carbamazepine tablets, chewable tablets, suspension carbamazepine ER, XR CELONTIN (methsuxamide) clobazam clonazepam tablets diazepan rectal DILANTIN (phenytoin) 30 mg capsules	APTIOM (eslicarbazepine acetate) BANZEL (rufinamide) CARBATROL (carbamazepine) clonazepam ODT DEPAKOTE (divalproex sodium) DIACOMIT (stiripentol) DIASTAT (diazepam) rectal DIASTAT ACUDIAL (diazepam) rectal DILANTIN (phenytoin) chewable tablets, suspension	• 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. • Brand name narrow therapeutic drugs automatically pay for seizure clients with seizure diagnosis in medical history.

PREFERRED AGENTS Preferred status implementation: 1/1/24	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
divalproex sodium 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) tiagabine tablets TRILEPTAL (oxcarbazepine) suspension valproic acid VALTOCO (diazepam) zonisamide	EPIDIOLEX (cannabidiol) EPRONTIA (topiramate) EQUETRO (carbamazepine) ethosuximide capsules EQUETRO (carbamazepine) felbamate FELBATOL (felbamate) FINTEPLA (fenfluramine) FYCOMPA (perampanel) GABITRIL (tiagabine) KEPPRA (levetiracetam) KEPPRA XR (levetiracetam) KLONOPIN (clonazepam) LAMICTAL (lamotrigine) lamotrigine ER, ODT levetiracetam ER LYRICA (pregabalin) methsuxamide MYSOLINE (primidone) NEURONTIN (gabapentin) ONFI (clobazam) OXTELLAR XR (oxcarbazapine) PHENYTEK (phenytoin) QUDEXY XR (topiramate) rufinamide SABRIL (vigabatrin) SPRITAM (levetiracetam) SYMPAZAN (clobazam) TEGRETOL (carbamazepine) suspension, tablets TEGRETOL XR (carbamazepine) TOPAMAX (topiramate) topiramate ER TRILEPTAL (oxcarbazepine) tablets TROKENDI XR (topiramate) vigabatrin VIGADRONE (vigabatrin) VIMPAT (lacosamide) XCOPRI (cenobamate) ZARONTIN (ethosuximide) ZONISADE (zonisamide) ZTALMY (ganaxolone)	
ANTIPARKINSON'S AGENTS, ORAL/TRANSDERMAL		
amantadine capsules, solution bromocriptine benztropine carbidopa/levodopa IR, ER	amantadine tablets AZILECT (rasagiline) carbidopa carbidopa/levodopa ODT	• Two (2) preferred products required before a non-preferred product will be approved

PREFERRED AGENTS Preferred status implementation: 1/1/24	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
entacapone pramipexole IR ropinirole IR selegiline capsules, tablets trihexyphenidyl	carbidopa/levodopa/entacapone COMTAN (entacapone) DHIVY (carbidopa/levodopa) DUOPA (carbidopa/levodopa) GOCOVRI (amantadine) INBRIJA (levodopa) LODOSYN (carbidopa) MIRAPEX ER (pramipexole) NOURIANZ (istradefylline) NEUPRO (rotigotine) OSMOLEX ER (amantadine) PARLODEL (bromocriptine) pramipexole ER rasagiline ropinirole ER RYTARY (carbidopa/levodopa) SINEMET 10-100 (carbidopa/levodopa) STALEVO (carbidopa/levodopa/entacapone) TASMAR (tolcapone) tolcapone XADAGO (safinamide) ZELAPAR (selegiline)	
SKELETAL MUSCLE RELAXANTS (Clinical criteria apply to INDIVIDUAL agents in class.)		
baclofen ** cyclobenzaprine 5 mg, 10 mg methocarbamol tizanidine tablets	AMRIX (cyclobenzaprine) baclofen solution, suspension ** carisoprodol * carisoprodol compound with codeine * chlorzoxazone cyclobenzaprine 7.5 mg cyclobenzaprine ER DANTRIUM (dantrolene) dantrolene FEXMID (cyclobenzaprine) FLEQSUVY (baclofen) LYVISPAH (baclofen) metaxalone orphenadrine orphenadrine, aspirin, caffeine SOMA (carisoprodol) tizanidine capsules ZANAFLEX (tizanidine)	• 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 • * Carisoprodol quantity limit – 84 units per 90 days • ** Baclofen – no quantity limits

PREFERRED AGENTS Preferred status implementation: 1/1/24	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
NUTRITIONAL PRODUCTS		
PRENATAL VITAMINS		
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 apply to class. All agents require a prior authorization.)		
CONTRAVE ER (naltrexone/bupropion ER) tablets phentermine capsules, tablets SAXENDA (liraglutide) pen injectors WEGOVY (semaglutide) pen injectors	ADIPEX-P (phentermine) capsules, tablets amphetamine sulfate tablets benzphetamine HCl tablets diethylpropion HCl tablets diethylpropion HCl ER tablets EVEKEO (amphetamine) tablets, ODT LOMAIRA (phentermine) tablet orlistat phendimetrazine tartrate tablets phendimetrazine tartrate ER capsules XENICAL (orlistat) capsules	• Two (2) preferred products required before a non-preferred product will be approved
OVER THE COUNTER DRUGS		
Please refer to the Delaware Pharmacy Corner website for covered OTC products. https://medicaid.dhss.delaware.gov/provider/Home/PharmacyCornerLanding/tabid/2096/Default.aspx		
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS		
ALZHEIMER'S AGENTS		
donepezil 5 mg, 10 mg tablets	ADLARITY (donepezil)	

PREFERRED AGENTS Preferred status implementation: 1/1/24	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
memantine tablets rivastigmine patch	ARICEPT (donepzzil) donepezil ODT donepezil 23 mg EXELON (rivastigmine) patches galantamine memantine capsules, solution NAMENDA (memantine) NAMENDA XR (memantine) NAMZARIC (memantine HCl/donepezil HCl) RAZADYNE ER (galantamine) rivastigmine capsules	• Two (2) preferred products required before a non-preferred product will be approved
MOVEMENT DISORDER		
AUSTEDO (deutetrabenazine) AUSTEDO XR (deutetrabenazine) INGREZZA * (valbenazine) tetrabenazine	XENAZINE (tetrabenazine)	• * Ingrezza quantity limit – 1 capsule per day
MULTIPLE SCLEROSIS		
AVONEX (interferon beta-1a)[PA] BETASERON (interferon beta-1b)[PA] dalfampridine dimethyl fumarate fingolimod glatiramer GLATOPA (glatiramer acetate) KESIMPTA (ofatumumab)[PA] REBIF (interferon beta-1a)[PA] REBIF REBIDOSE (interferon beta-1a)[PA] teriflunomide TYSABRI (natalizumab)[PA]	AMPYRA (dalfampridine) AUBAGIO (teriflunomide) BAFIERTAM (monomethyl fumarate) BRIUMVI (ublituximad-xiiy) COPAXONE (glatiramer acetate) EXTAVIA (interferon beta-1b) GILENYA (fingolimod) LEMTRADA (alemtuzumab) MAVENCLAD (cladribine) MAYZENT (siponimod) OCREVUS (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
NEUROPATHIC PAIN		
duloxetine 20 mg, 30 mg, 60 mg gabapentin lidocaine patch 4%, 5% pregabalin	CYMBALTA (duloxetine) duloxetine 40 mg GRALISE (gabapentin) HORIZANT (gabapentin enacarbil) LIDODERM (lidocaine) patches LYRICA CR (pregabalin) NEURONTIN (gabapentin)	• Two (2) preferred products required before a non-preferred product will be approved

PREFERRED AGENTS Preferred status implementation: 1/1/24	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
	pregabalin ER QUTENZA KIT (capsaicin/skin cleanser) SAVELLA (milnacipran HCl) ZTILDO (lidocaine)	
RESPIRATORY AGENTS		
ANTIHISTAMINES, MINIMALLY SEDATING		
cetirizine solution, tablets loratadine solution, tablets	cetirizine capsules, chewable tablets cetirizine-D 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		
albuterol HFA nebulizer solution, syrup levalbuterol HFA PROAIR RESPICLICK (albuterol sulfate) PROVENTIL HFA (albuterol sulfate) SEREVENT (salmeterol) STRIVERDI RESPIMAT (olodaterol) terbutaline XOPENEX (levalbuterol) VENTOLIN HFA (albuterol sulfate)	albuterol tablets arformoterol vials BROVANA (arformoterol tartrate) formoterol vials levalbuterol vials metaproterenol PERFOROMIST (formoterol fumarate) PROAIR DIGIHALER (albuterol sulfate)	• Two (2) preferred products required before a non-preferred product will be approved
COPD AGENTS		
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) STIOLTO RESPIMAT (tiotropium bromide/olodaterol)	BEVESPI (glycopyrrolate/formoterol fumarate) BREZTRI (budesonide, glycopyrrolate, formoterol fumate) DALIRESP (roflumilast) DUAKLIR (aclidinium/formoterol) LONHALA (glycopyrrolate) roflumilast tablets TUDORZA (aclidinium bromide) TRELEGY (fluticasone furoate, umeclidinium, vilanterol) YUPELRI (revefenacin)	• Two (2) preferred products required before a non-preferred product will be approved

PREFERRED AGENTS Preferred status implementation: 1/1/24	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
COUGH AND COLD		
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 MUCINEX ER (guaifenesin) tablet 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: ○ Narcotic antitussives – 240ml per 30 days and 480ml per 90 days without a comorbid diagnosis ○ Tussionex – 120ml per 84 days and 900ml per year • Additional preferred OTC Cough and Cold agents may be found on the OTC List on the pharmacist corner
GLUCOCORTICOIDS, INHALED		
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) FLOVENT DISKUS, HFA (fluticasone propionate) PULMICORT FLEXHALER (budesonide) QVAR REDIHALER (beclomethasone dipropionate) SYMBICORT (budesonide/formoterol fumarate dihydrate)	AIRDUO DIGIHALER (fluticasone propionate/salmeterol) AIRDUO RESPICLICK (fluticasone propionate/salmeterol) ALVESCO (ciclesonide) ARMONAIR DIGIHALER (fluticasone propionate) BREO ELLIPTA (fluticasone furoate/vilanterol) BREYNA (budesonide/formoterol fumarate) budesonide inhalation solution 1 mg budesonide/formoterol fumarate dihydrate HFA fluticasone/salmeterol diskus, HFA fluticasone proprionate 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: ○ Aged 6 years and older AND with ○ Diagnosis on file indicating developmental delay
INTRANASAL RHINITIS AGENTS		
azelastine 0.1% budesonide fluticasone RX ipratropium triamcinolone	azelastine 0.15% azelastine/fluticasone BECONASE AQ (beclomethasone dipropionate) DYMISTA (azelastine/fluticasone) flunisolide fluticasone OTC mometasone olopatadine OMNARIS (ciclesonide) QNASL (beclomethasone dipropionate) RYALTRIS (olopatadine HCl/mometasone)	• Two (2) preferred products required before a non-preferred product will be approved

PREFERRED AGENTS Preferred status implementation: 1/1/24	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
	SINUVA (mometasone) XHANCE (fluticasone propionate) ZETONNA (ciclesonide)	
LEUKOTIENE RECEPTOR ANTAGONISTS		
montelukast tablets, chewable tablets	ACCOLATE (zafirlukast) montelukast granules SINGULAIR (montelukast) zafirlukast zileuton ER ZYFLO (zileuton)	• Trial of preferred medication required before a non-preferred will be approved
MABs-ANTI-IL, ANTI-IGE (Clinical criteria apply to class. All agents require a prior authorization)		
DUPIXENT (dupilumab) pens, syringes FASENRA (benralizumab) auto-injectors, syringes NUCALA (mepolizumab) auto-injectors, 40 mg/0.4 ml syringes TEZSPIRE (tezepelumab-ekko) pens XOLAIR (omalizumab) vials	NUCALA (mepolizumab) 100 mg/1 ml syringes, vials TEZSPIRE (tezepelumab-ekko) syringes XOLAIR (omalizumab) syringes	• Two (2) preferred products required before a non-preferred product will be approved
TOPICAL PRODUCTS		
ACNE AGENTS, TOPICAL		
adapalene/benzoyl peroxide benzoyl peroxide clindamycin 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) ACZONE (dapsome) adapalene AKLIEF (trifarotene) ALTRENO (tretinoin) AMZEEQ (minocycline) ARAZLO (tazarotene) ATRALIN (tretinoin) AVAR (sulfacetamide sodium/sulfur) AVITA (tretinoin) AZELEX (azelaic acid) BENZAMYCIN (erythromycin/benzoyl peroxide) BP 10-1 (sulfacetamide sodium/sulfur) BPO (benzoyl peroxide) CLEOCIN T (clindamycin) CLINDACIN ETZ/PAC (clindamycin) CLINDACIN P (clindamycin) CLINDAGEL (clindamycin) clindamycin foam, gel	• 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 Preferred status implementation: 1/1/24	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
	clindamycin/benzoyl peroxide gel 1/5% (generic BENZACLIN), 1.5/2.5% (generic ACANYA) clindamycin/tretinoin dapsone DIFFERIN (adapalene) EPIDUO (adapalene/benzoyl peroxide) EPIDUO FORTE (adapalene/benzoyl peroxide) EPSOLAY (benzoyl peroxide) ERY/ERYGEL (erythromycin) erythromycin swab erythromycin/benzoyle peroxide FABIOR (tazarotene) INOVA (benzoyl peroxide) KLARON (sulfacetamide sodium) NEUAC (benzoyl peroxide/clindamycin) ONEXTON (benzoyl peroxide/clindamycin) RETIN-A (tretinoin) cream, gel RETIN-A MICRO (tretinoin) sodium sulfacetamide/sulfur SSS (sulfacetamide sodium/sulfur) sulfacetamide sodium SUMADAN (sulfacetamide sodium/sulfur) SUMADAN XLT (sulfacetamide sodium/sulfur) SUMAXIN (sulfacetamide sodium/sulfur) tazarotene foam, gel tretinoin 0.05% gel tretinoin microsphere WINLEVI (clascoterone) ZIANA (clindamycin/tretinoin) ZMA CLEAR (sulfacetamide sodium/sulfur)	
ANTIBIOTICS, TOPICAL		
bacitracin bacitracin/polymyxin gentamicin mupirocin ointment neomycin/bacitracin/polymyxin	CORTISPORIN (neomycin/polymyxin/hydrocortisone acetate) 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		
butenafine ciclopirox cream, solution clotrimazole cream clotrimazole/betamethasone cream, lotion econazole	ALEVAZOL (clotrimazole) CICLODAN (ciclopirox) ciclopirox gel, shampoo, suspension clotrimazole solution ERTACZO (sertaconazole)	• Two (2) preferred products required before a non-preferred product will be approved

PREFERRED AGENTS Preferred status implementation: 1/1/24	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
ketoconazole cream, shampoo miconazole nitrate solution w/ applicator nystatin nystatin/triamcinolone ointment	EXELDERM (sulconazole) JUBLIA (efinaconazole) KERYDIN (tavaborole) ketoconazole foam KETODAN (ketoconazole) LOPROX (ciclopirox) luliconazole LUZU (luliconazole) MENTAX (butenafine) miconazole miconazole/zinc/petrolatum NAFTIN (naftifine) naftifine nystatin/triamcinolone cream oxiconazole OXISTAT (oxiconazole) terbinafine tolnaftate VOTRIZA-AL (clotrimazole) lotion VUSION (miconazole/zinc/petrolatum)	
ANTIPARASITICS, TOPICAL		
NATROBA (spinosad) permethrin piperonyl butoxide/pyrethrins	CROTAN (crotamiton) lindane malathion SKLICE (ivermectin) spinosad VANALICE (pyrethrins/piponyl butoxide)	• Two (2) preferred products required before a non-preferred product will be approved
ANTIPSORIATIC AGENTS, ORAL		
acitretin	methoxsalen	
ANTIPSORIATIC AGENTS, TOPICAL		
calcipotriene	calcipotriene/betamethasone calcitriol DUOBRII (halobetasol propionate/tazarotene) ENSTILAR (calcipotriene/betamethasone) SORILUX (calcipotriol) TACLONEX (betamethasone/calcipotriene) TAZORAC (tazarotene) tazarotene VTAMA (tapinarof) ZORYVE (roflumilast)	

PREFERRED AGENTS Preferred status implementation: 1/1/24	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
ANTIVIRALS, TOPICAL		
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 apply to class. All agents require a prior authorization.)		
ADBRY (tralokinumab-ldrm) DUPIXENT (dupilumab) ELIDEL (pimecrolimus) PROTOPIC (tacrolimus) tacrolimus	CIBINQO (abrocitinib) EUCRISA (crisaborole) OPZELURA (ruxolitinib) pimecrolimus RINVOQ ER (upadactinib)	• 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		
imiquimod cream pack	imiquimod cream pump VEREGEN (sinecatechins) ZYCLARA (imiquimod)	
OPHTHALMICS, ALLERGIC CONJUNCTIVITIS		
azelastine cromolyn ketotifen olopatadine (all strengths)	ALAWAY (ketotifen) ALOCRIL (nedocromil) ALOMIDE (lodoxamide) ALREX (loteprednol) BEPREVE (bepotastine) epinastine LASTACAFT (alcaftadine) PATADAY (olopatadine) ZADITOR (ketotifen)	• Two (2) preferred products required before a non-preferred product will be approved
OPHTHALMICS, ANTIBIOTICS		
bacitracin/polymyxin CILOXAN (ciprofloxacin) ointment ciprofloxacin erythromycin gentamicin moxifloxacin (generic VIGAMOX) ofloxacin POLYCIN (bacitracin/polymyxin) polymyxin/trimethoprim tobramycin	AZASITE (azithromycin) bacitracin BESIVANCE (besifloxacin) BLEPH-10 (sulfacetamide) gatifloxacin levofloxacin moxifloxacin viscous (generic MOXEZA) NATACYN (natamycin) neomycin/bacitracin/polymyxin neomycin/polymyxin/gramicidin OCUFLOX (ofloxacin) POLYTRIM (polymyxin/trimethoprim)	• Two (2) preferred products required before a non-preferred product will be approved

PREFERRED AGENTS Preferred status implementation: 1/1/24	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
	sulfacetamide TOBREX (tobramycin) VIGAMOX (moxifloxacin) ZYMAXID (gatifloxacin)	
OPHTHALMICS, ANTIBIOTIC-STEROID COMBINATION		
neomycin/polymyxin/dexamethasone sulfacetamide/prednisolone TOBRADEX (tobramycin/dexamethasone) ointment, suspension	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		
dexamethasone diclofenac DUREZOL (difluprednate) FLAREX (fluorometholone) fluorometholone flurbiprofen FML FORTE (fluorometholone) ketorolac (all strengths) LOTEMAX (loteprednol) MAXIDEX (dexamethasone) NEVANAC (nepafenac) PRED FORTE (prednisolone) PRED MILD (prednisolone) prednisolone	ACULAR (ketorolac) ACULAR LS (ketorolac) ACUVAIL (ketorolac) bromfenac BROMSITE (bromfenac) DEXTENZA (dexamethasone) DEXYCU (dexamethasone) difluprednate EYSUVIS (loteprednol etabonate) FML (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)	• Two (2) preferred products required before a non-preferred product will be approved
OPHTHALMICS, GLAUCOMA AGENTS		
ALPHAGAN P (brimonidine) brimonidine 0.2% carteolol COMBIGAN (brimonidine/timolol) dorzolamide dorzolamide/timolol drops	apraclonidine AZOPT (brinzolamide) betaxolol BETOPTIC (betaxolol) BETOPTIC S (betaxolol) brimatoprost	• Two (2) preferred products required before a non-preferred product will be approved

PREFERRED AGENTS Preferred status implementation: 1/1/24	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
latanoprost levobunolol pilocarpine SIMBRINZA (brinzolamide/brimonidine) timolol solution travoprost	brimonidine/timolol brimonidine 0.15% brinzolamide COSOPT (dorzolomide/timolol) COSOPT PF (dorzolomide/timolol) dorzolamide/timolol droperette lopidine LUMIFY (brimonidine tartrate) LUMIGAN (bimatoprost) phospholine iodine RHOPRESSA (netarsudil) ROCKLATAN (netarsudil/latanoprost) tafluprost droperette timolol gel timolol drop daily timolol droperette TIMOPTIC (timolol) TIMOPTIC XE (timolol) TRAVATAN Z (travoprost) VUITY (pilocarpine) VYZULTA (latanoprostene bunod) XALATAN (latanoprost) XELPROS (latanoprost) ZIOPTAN (tafluprost)	
OPHTHALMICS, IMMUNOMODULATORS		
RESTASIS (cyclosporine)	CEQUA (cyclosporine) cyclosporine droperettes MIEBO (perfluorohexyloctane) RESTASIS MULTIDOSE (cyclosporine) VERKAZIA (cyclosporine) XIIDRA (lifitegrast)	
OTIC ANTIBIOTICS		
CIPRODEX (ciprofloxacin/dexamethasone) CIPRO HC (ciprofloxacin/hydrocortisone) CORTISPORIN-TC (neomycin/colistin/hydrocortisone/thonzonium) neomycin/polymyxin/hydrocortisone ofloxacin	ciprofloxacin ciprofloxacin/dexamethasone ciprofloxacin/fluocinolone COLY-MYCIN S (colistin sulfate/ neomycin/ hydrocortisone) OTOVEL (ciprofloxacin/fluocinolone acetate)	• Two (2) preferred products required before a non-preferred product will be approved
OTIC ANTI-INFECTIVES, ANESTHETICS		
acetic acid	acetic acid/hydrocortisone	

PREFERRED AGENTS Preferred status implementation: 1/1/24	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
STEROIDS, TOPICAL		
CAPEX (flupcinolone) shampoo clobetasol ointment, solution fluocinolone topical solution, oil fluocinonide ointmemt 0.05% fluticasone cream, ointment hydrocortisone hydrocortisone acetate mometasone SCALPICIN (hydrocortisone) triamcinolone cream, lotion, ointment	alclometasone amcinonide APEXICON E (diflorasone diacetate) betamethasone dipropionate betamethasone dipropionate/propylene glycol betamethasone valerate BRYHALI (halobetasol propionate) clobetasol cream, foam, gel, lotion, shampoo, spray clocortolone CLODAN (clobetasol) CORDRAN (fludroxycortide) DERMACINRX DERMA-SMOOTHE FS (fluocinolone) DERMASORB (triamcinolone) desonide desoximetasone diflorasone ELLZIA PAK (triamcinolone/dimethicone) fluocinolone cream, ointment, shampoo fluocinonide (except 0.05% ointment) flurandrenolide fluticasone lotion halcinonide halobetasol HALOG (halocinonide) hydrocortisone butyrate hydrocortisone valerate IMPOYZ (clobetasol propionate) LEXETTE (halobetasol propionate) MICORT-HC (hydrocortisone acetate) OLUX-E (clobetasol) PANDEL (hydrocortisone probutate) PEDIADERM (triamcinolone/emollient) prednicarbate SANADERMRX (triamcinolone/dimethicone/silicone) SILAZONE (triamcinolone acetonide/silicones) SERNIVO (betamethasone dipropionate) SYNALAR (fluocinolone) TEXACORT (hydrocortisone) TOPICORT (desoximetasone) TOVET (clobetasol) triamcinolone aerosol ULTRAVATE (halobetasol)	• Two (2) preferred products required before a non-preferred product will be approved