DELAWARE HEALTH AND SOCIAL SERVICES
DIVISION OF MEDICAID & MEDICAL ASSISTANCE
Delaware Medical Assistance Program

2026 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
- For brand-name medications not on the Brand over Generic (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.
  - A brand-name agent highlighted in yellow on the PDL is preferred over its generic. Please note that some brand name agents may not be listed on the PDL.
  - Please refer to the Delaware Pharmacy Corner website for a complete listing of BoG agents at https://medicaid.dhss.delaware.gov/provider/Home/PharmacyCornerLanding/tabid/2096/Default.aspx
- For all requests for a non-solid dosage form, for a member 10 years of age or older, providers must submit a prior authorization form with documentation of a trial and failure of solid dosage form(s) or a medical reason to why the solid dosage form is contraindicated.

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 ISOTRETINOIN PRODUCTS		**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	adapalene 0.1% cream, 0.1% gel OTC AKLIEF (trifarotene) AVAR (sulfacetamide sodium/sulfur) BP 10-1 (sulfacetamide sodium/sulfur) BPO (benzoyl peroxide) CLEOCIN T (clindamycin) CLINDACIN ETZ/PAC (clindamycin) CLINDACIN P (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 (erythromycin) erythromycin swab erythromycin/benzoyl peroxide EVOCLIN (clindamycin) FABIOR (tazarotene) LINTERA (benzoyl peroxide) NEUAC (benzoyl peroxide/clindamycin) 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)	• 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
	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 tablet tramadol ER tablet *	BELBUCA (buprenorphine buccal film) buprenorphine patch CONZIP (tramadol) fentanyl transdermal 37.5, 62.5, 87.5 mcg/hr hydrocodone ER hydromorphone ER HYSINGLA ER (hydrocodone) morphine ER capsule MS CONTIN (morphine) oxycodone ER OXYCONTIN (oxycodone) oxymorphone ER tapentadol ER tramadol ER capsule *	• Two (2) preferred products required before a non-preferred product will be approved. Additional requirements are as follows: • **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, tablet hydromorphone tablet morphine concentrate, tablet, solution oxycodone capsule, solution, tablet oxycodone/APAP tablet tramadol 50 mg tablet * tramadol/APAP *	butorphanol nasal spray dihydrocodeine/APAP/caffeine DILAUDID (hydromorphone) hydrocodone/ibuprofen hydromorphone liquid, suppository levorphanol meperidine solution, tablet morphine suppository NALOCET (oxycodone/acetaminophen) oxycodone concentrate oxycodone/ASA oxymorphone pentazocine HCl/naloxone HCl PERCOCET (oxycodone/acetaminophen) PROLATE (oxycodone/acetaminophen) ROXICODONE (oxycodone) ROXYBOND (oxycodone) tapentadol tramadol 25 mg, 75 mg ^, 100 mg tablet, solution * XYVONA (levorphanol)	• Two (2) preferred products required before a non-preferred product will be approved. Additional requirements are as follows: • **DMMA recommends that first fill of new pain medication be limited to 7-day supply.** • ^ PA required, to include reason tramadol 50 mg tablet, cannot be used, before product will be approved. **QUANTITY LIMITS IN PLACE:** • 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	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
ANALGESICS, NON-NARCOTIC SHORT-ACTING		**Review Schedule: 2nd Quarter**
JOURNAVX (suzetrigine)		
ANTIHYPERURICEMICS, ORAL		**Review Schedule: 2nd Quarter**
allopurinol 100 mg, 300 mg tablet colchicine tablet febuxostat probenecid probenecid with colchicine	allopurinol 200 mg tablet * colchicine capsule COLCRYS (colchicine) GLOPERBA (colchicine) LODOCO (colchicine) ** MITIGARE (colchicine) ULORIC (febuxostat)	• Two (2) preferred products required before a non-preferred product will be approved. Additional requirements are as follows: • * 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* QULIPTA (atogepant) **	BOTOX (onabotulinumtoxinA) EMGALITY (galcanezumab) 100 mg syringe * NURTEC ODT (rimegepant) *** VYEPTI (eptinezumab-jjmr)	• Two (2) preferred products required before a non-preferred product will be approved. Additional requirements are as follows: • * 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) injectable CGRP receptor antagonist required before product will be approved. • *** Two (2) preferred products, one of which must be Qulipta, required before a 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 rizatriptan ODT, tablet sumatriptan nasal spray, auto-injector pen, tablet, vial UBRELVY (ubrogepant) * zolmitriptan ODT, tablet	almotriptan BREKIYA (dihydroergotamine) dihydroergotamine eletriptan ERGOMAR (ergotamine tartrate)	• Two (2) preferred products required before a non-preferred product will be approved. Additional requirements are as follows:

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
	FROVA (frovatriptan) frovatriptan IMITREX (sumatriptan) MAXALT (rizatriptan) MIGERGOT (ergotamine tartrate/caffeine) MIGRANAL (dihydroergotamine mesylate) NURTEC ODT (rimegepant) ** RELPAX (eletriptan) REYVOW (lasmiditan) RIZAFILM (rizatriptan) µ sumatriptan/naproxen SYMBRAVO (rizatriptan/meloxicam) *** TOSYMRA (sumatriptan) ZAVZPRET (zavegepant) zolmitriptan nasal spray ZOMIG (zolmitriptan)	• Quantity limits on Triptans and CGRP antagonists – 9 units per 45 days • * Ubrelvy will be approved. for patients failing a trial of two preferred triptans or for patients with contraindications to triptans. • ** Two (2) preferred products, one of which must be Ubrelvy, required before a product will be approved. • *** PA required, to include reason separate ingredients cannot be used concurrently, before product will be approved • µ PA required to include a clinical rationale to why preferred rizatriptan ODT cannot be used
CYTOKINE AND CAM ANTAGONISTS, ORAL/SUBCUTANEOUS **(Clinical criteria applies to class. All agents require a prior authorization.)**		**Review Schedule: 4th Quarter**
adalimumab-adaz AVSOLA (infliximab-axxq) ENBREL (etanercept) ENTYVIO (vedolizumab) HADLIMA (adalimumab-bwwd) HUMIRA (adalimumab) infliximab KINERET (anakinra) ORENCIA (abatacept) OTEZLA (apremilast) 30 mg tablet, starter pack PYZCHIVA (ustekinumab-ttwe) RINVOQ (upadactinib) TALTZ (ixekizumab) TYENNE (tocilizumab) tofacitinib IR tablets tofacitinib XR 11mg tablets	ABRILADA (adalimumab-afzb) ACTEMRA (tocilizumab) adalimumab-aacf adalimumab-adbm adalimumab-fkjp adalimumab-ryvk AMJEVITA (adalimumab-atto) ARCALYST (rilonacept) AVTOZMA (tocilizumab-anoh) BIMZELX (bimekizumab-bkzx) CIMZIA (certolizumab pegol) COSENTYX (secukinumab) CYLTEZO (adalimumab-adbm) HULIO (adalimumab-fkjp) HYRIMOZ (adalimumab-adaz) ICOTYDE (icotrokinra) ILARIS (canakinumab) ILUMYA (tildrakizumab-asmn) IMULDOSA (ustekinumab-srlf) INFLECTRA (infliximab-dyyb) KEVZARA (sarilumab) LEQSELVI (deuruxolitinib) LITFULO (ritlecitinib) OLUMIANT (baricitinib) OMVOH (mirikizumab-mrkz) OTEZLA (apremilast) 20 mg tablet, starter pack OTEZLA XR (apremilast) OTULFI (ustekinumab -aauz) REMICADE (infliximab) RENFLEXIS (infliximab-abdb)	• Two (2) preferred products required before a non-preferred product will be approved. Additional requirements are as follows: • *Would require use of two (2) of the preferred XR 11mg tablets prior to approval

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
	RINVOQ LQ (upadactinib) SELARSDI (ustekinumab-aekn) SIMLANDI (adalimumab-ryvk) SIMPONI (golimumab) SIMPONI ARIA (golimumab) SKYRIZI (risankizumab-rzaa) SOTYKTU (deucravacitinib) SPEVIGO (spesolimab-sbzo) STARJEMZA (ustekinumab-hmny) STELARA (ustekinumab) STEQEYMA (ustekinumab-stba) tofacitinib solution tofacitinib XR 22mg Tablet* TOFIDENCE (tocilizumab) TREMFYA (guselkumab) ustekinumab ustekinumab-aauz ustekinumab-aekn ustekinumab-ttwe VELSIPITY (etrasimod arginine) XELJANZ IR (tofacitinib) XELJANZ (tofacitinib) solution XELJANZ XR (tofacitinib) 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, tablet ibuprofen (except 300 mg tablet) indomethacin capsule (except 200mg) ketorolac tablet ** meloxicam tablet nabumetone naproxen IR tablet sulindac	ARTHROTEC (diclofenac sodium/misoprostol) CATAFLAM (diclofenac potassium) CELEBREX (celecoxib) diclofenac epolamine patch diclofenac potassium diclofenac sodium 1% gel RX, 2% solution pump diclofenac/misoprostol diflunisal DOLOBID (diflunisal) * etodolac ELYXYB (celecoxib) fenoprofen flurbiprofen ibuprofen 300 mg tablet ibuprofen/famotidine indomethacin 200mg capsule indomethacin suppository, suspension INDOCIN (indomethacin) ketoprofen ketoprofen ER	• Two (2) preferred products required before a non-preferred product will be approved. Additional requirements are as follows: • * Dolobid will require five (5) preferred products in total before approval. • ** PA required, to include reason 2 x 500 mg nabumetone tablets cannot be used, before product will be approved. • *** Quantity limits on ketorolac – 20 units per 30 days • ^ PA required, to include reason meloxicam tablet cannot be used, before product will be approved.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
	ketorolac vial *** LOFENA (diclofenac potassium) LURBIRO (flurbiprofen) meclofenamate mefenamic acid meloxicam capsule NALFON (fenoprofen) NAPRELAN (naproxen) naproxen DR, suspension naproxen/esomeprazole naproxen sodium ORUDIS (ketoprofen) oxaprozin PENNSAID (diclofenac) piroxicam RELAFEN (nabumetone) RELAFEN DS (nabumetone) ** tolmetin VOLTAREN (diclofenac sodium) 1% GEL VYSCOXA (celecoxib) ZYBIC (meloxicam) ^	
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**
deferasirox granules *, tablet	deferasirox ODT deferiprone EXJADE (deferasirox) FERRIPROX (deferiprone) JADENU (deferasirox)	• One (1) preferred product required before a non-preferred product will be approved. Additional requirements are as follows: • * Requires prior authorization for members ≥ 10-years old
OPIATE OVERDOSE TREATMENTS		**Review Schedule: 4th Quarter**
KLOXXADO (naloxone) naloxone injection naloxone nasal spray RX, OTC NARCAN nasal spray OTC (naloxone)	nalmefene injection NARCAN nasal spray RX (naloxone) OPVEE (nalmefene) REZENOPY (naloxone) REXTOVY (naloxone)	• Two (2) preferred products required before a non-preferred product will be approved.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
	ZIMHI (naloxone hydrochloride) ZURNAI (nalmefene)	
ANTI-INFECTIVE AGENTS		
ANTIBIOTICS, GI		**Review Schedule: 4th Quarter**
metronidazole 250 mg, 500 mg tablet neomycin tinidazole vancomycin capsule, solution	DIFICID (fidaxomicin) * fidaxomicin * FIRVANQ (vancomycin) LIKMEZ (metronidazole) metronidazole capsule **, 125 mg tablet nitazoxanide tablet VANCOCIN (vancomycin) VOWST (fecal microbiota spores, live-brpk)	• Two (2) preferred products required before a non-preferred product will be approved. Additional requirements are as follows: • * Step through one (1) preferred vancomycin product required before product will be approved. • ** PA required, to include reason metronidazole 250 mg tablet 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**
clotrimazole fluconazole griseofulvin suspension nystatin terbinafine	CRESEMBA (isavuconazonium) DIFLUCAN (fluconazole) flucytosine griseofulvin tablet itraconazole ketoconazole NOXAFIL (posaconazole) suspension, PowderMix ORAVIG (miconazole) posaconazole	• Two (2) preferred products required before a non-preferred product will be approved.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
	SPORANOX (itraconazole) TOLSURA (itraconazole) VFEND (voriconazole) VIVJOA (oteseconazole) voriconazole	
ANTIVIRALS, ANTIRETROVIRALS		**Review Schedule: 4th Quarter**
abacavir abacavir/lamivudine APRETUDE (cabotegravir extended-release) atazanavir BIKTARVY (bictegravir/emtricabine/ tenofovir AF) CABENUVA (cabotegravir/rilpivirine) COMPLERA (emtricitabine/rilpivirine/tenofovir) DELSTRIGO (doravirine/lamivudine/tenofovir) darunavir DESCOVY (emtricitabine/tenofovir AF) DOVATO (dolutegravir/lamivudine) EDURANT tablet for suspension (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/rilpivirine/tenofovir AF) PIFELTRO (doravirine) PREZCOBIX (darunavir/cobicistat) RETROVIR injection (zidovudine) REYATAZ powder pack (atazanavir) rilpivirine tablet 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) YEZTUGO (lenacapavir) zidovudine	abacavir/lamivudine/zidovudine APTIVUS (tipranavir) BIXLENVO (bictegravir/lenacapavir) β BIXLENVO/SUNLENCA (bictegravir/lenacapavir) β CIMDUO (lamivudine/tenofovir) darunavir EDURANT tablet (rilpivirine) efavirenz/lamivudine/tenofovir emtricitabine/rilpivirine/tenofovir EMTRIVA (emtricitabine) EPIVIR (lamivudine) EPZICOM (abacavir/lamivudine) etravirine fosamprenavir FUZEON (enfuvirtide) IDVYNSO (doravirine/islatravir) INTELENCE (etravirine) ISENTRESS HD (raltegravir potassium) JULUCA (dolutegravir/rilpivirine) KALETRA (lopinavir/ritonavir) maraviroc nevirapine ER NORVIR (ritonavir) PREZCOBIX PED (darunavir/cobicistat) * PREZISTA (darunavir) RUKOBIA (fostemsavir) SELZENTRY (maraviroc) STRIBILD (elvitegravir/cobicistat/emtricitabine/ tenofovir) SUNLENCA (lenacapavir) SYMFI (efavirenz/lamivudine/tenofovir) TROGARZO (ibalizumab-uiyk) TRUVADA (emtricitabine/tenofovir DF) VIRACEPT (nelfinavir mesylate) VIREAD (tenofovir disoproxil fumarate) ZIAGEN (abacavir)	• Two (2) preferred products required before a non-preferred product will be approved. Additional requirements are as follows: • * Requires prior authorization for members ≥ 10-years old • β Medical rationale to why the patient cannot use a preferred one tablet regime OR medical reason why patient is unable to remain ON the current one tablet preferred regime is required prior to approval

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
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 B AGENTS		**Review Schedule: 4th Quarter**
VEMLIDY (tenofovir alafenamide)		
ANTIVIRALS, HEPATITIS C AGENTS		**Review Schedule: 4th Quarter**
MAVYRET (glecaprevir/pibrentasvir) ribavirin sofosbuvir/velpatasvir	EPCLUSA (sofosbuvir/velpatasvir) pellet pack, tablet HARVONI (ledipasvir/sofosbuvir) ledipasvir/sofosbuvir PEGASYS (peginterferon alfa-2a) SOVALDI (sofosbuvir) VOSEVI (sofosbuvir/velpatasvir/voxilaprevir) ZEPATIER (elbasvir/grazoprevir)	• Two (2) preferred products required before a non-preferred product will be approved. • **Limited to one treatment cycle every 365 days**
ANTIVIRALS, ORAL/INHALATION/INJECTION		**Review Schedule: 4th Quarter**
acyclovir amantadine capsule, solution famciclovir oseltamivir * PREVYMIS (letermovir) vial valacyclovir valganciclovir	amantadine tablet LIVTENCITY (maribavir) PREVYMIS (letermovir) tablet, pellet RELENZA (zanamivir) * rimantadine SITAVIG (acyclovir) TAMIFLU (oseltamivir) * VALCYTE (valganciclovir) solution VALTREX (valacyclovir) XOFLUZA (baloxavir marboxil)	• Two (2) preferred products required before a non-preferred product will be approved. Additional requirements are as follows: • Liquid medications require prior authorization for members ≥ 10-years old • *** Quantity limits in place for oseltamivir and RELENZA**
CEPHALOSPORINS, ORAL		**Review Schedule: 3rd Quarter**
cefaclor IR capsule cefadroxil capsule cefdinir cefpodoxime tablets cefprozil cefuroxime cephalexin 250 mg, 500 mg capsule, suspension	cefaclor ER tablet cefaclor suspension cefadroxil suspension, tablet cefixime cefpodoxime suspension cephalexin 750 mg capsule, tablet	• Two (2) preferred products required before a non-preferred product will be approved.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
FLUOROQUINOLONES, ORAL		**Review Schedule: 3rd Quarter**
ciprofloxacin IR tablet levofloxacin tablet	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 capsule clindamycin solution	CLEOCIN (clindamycin) linezolid * SIVEXTRO (tedizolid) * ZYVOX (linezolid) *	• One (1) preferred product required before a non-preferred product will be approved. • * Clinical criteria applies
MACROLIDES		**Review Schedule: 4th Quarter**
azithromycin clarithromycin tablet 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, tablet) ampicillin BICILLIN C-R BICILLIN L-A dicloxacillin penicillin penicillin G procaine	amoxicillin/clavulanate 250 mg suspension, tablet 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.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
TETRACYCLINES		**Review Schedule: 4th Quarter**
doxycycline hyclate 20, 100 mg tablet doxycycline hyclate capsule (all strengths besides 75mg) doxycycline monohydrate 50, 100 mg capsule doxycycline monohydrate tablet minocycline capsule	demeclocycline DORYX (doxycycline hyclate) doxycycline DR doxycycline hyclate 50, 75, 150 mg tablet doxycycline hyclate 75 mg capsule doxycycline monohydrate 75, 150 mg capsule doxycycline suspension minocycline ER minocycline tablet NUZYRA (omadacycline) TARGADOX (doxycycline hyclate) tetracycline XIMINO (minocycline)	• Two (2) preferred products required before a non-preferred product will be approved.
URINARY ANTI-INFECTIVES		**Review Schedule: 1st Quarter**
methenamine hippurate nitrofurantoin macrocrystals (generic MACRODANTIN) nitrofurantoin monohydrate-macrocrystals (generic MACROBID)	BLUJEPA (gepotidacin) fosfomycin tromethamine MACROBID (nitrofurantoin monohydrate-macrocrystals) nitrofurantoin suspension ORLYNVAH (sulopenem etzadroxil/probenecid) PIVYA (pivmecillinam)	• 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) bosutinib tablets CASODEX (bicalutamide) CAVHANZA (nilotinib) * CYTOXAN (cyclophosphamide) DANZITEN (nilotinib) * dasatinib EULEXIN (flutamide) FARESTON (toremifene) FAVLYXA (fluorouracil) [α] GILOTRIF (afatinib) GLEEVEC (imatinib) GLEOSTINE (lomustine) HYDREA (hydroxyurea) IRESSA (gefitinib) MESNEX (mesna) NEXAVAR (sorafenib)	• 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.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
	nilotinib HCl (generic Tasigna) nilotinib tartrate * NOLVADEX (tamoxifen) POMALYST (pomalidomide) PURINETHOL (mercaptopurine) REVLIMID (lenalidomide) SPRYCEL (dasatinib) SUTENT (sunitinib) TEMODAR (temozolomide) THALOMID (thalidomide) TYKERB (lapatinib) VOTRIENT (pazopanib) YULITHIRA (everolimus) ZORTRESS (everolimus) ZYTIGA (abiraterone acetate)	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. • α: PA required, to include reason why preferred fluorouracil products cannot be used, prior to approval
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 tablet valsartan/HCTZ	ACCUPRIL (quinapril) ACCURETIC (quinapril/HCTZ) aliskerin ALTACE (ramipril) ATACAND (candesartan) ATACAND HCT (candesartan/HCTZ) AVALIDE (irbesartan/HCTZ) AVAPRO (irbesartan) azilsartan 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	• Two (2) preferred products required before a non-preferred product will be approved. Additional requirements are as follows: • Dose optimization required when applicable.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
	QBRELIS (lisinopril) TEKTURNA (aliskiren) telmisartan telmisartan/HCTZ valsartan solution ZESTORETIC (lisinopril/HCTZ) ZESTRIL (lisinopril)	
ANGIOTENSIN MODULATOR/CALCIUM CHANNEL BLOCKER COMBINATIONS		**Review Schedule: 1st Quarter**
amlodipine/benazepril amlodipine/valsartan amlodipine/valsartan/ HCTZ olmesartan/amlodipine olmesartan/amlodipine/HCTZ	AZOR (amlodipine/olmesartan) EXFORGE (amlodipine/valsartan) EXFORGE HCT (amlodipine/valsartan/HCTZ) telmisartan/amlodipine trandolapril/verapamil TRIBENZOR (olmesartan/amlodipine/HCTZ) WIDAPLIK (telmisartan/amlodipine/indapamine)	• Two (2) preferred products required before a non-preferred product will be approved. Additional requirements are as follows: • Dose optimization required when applicable.
ANTIARRHYTHMICS		**Review Schedule: 4th Quarter**
MULTAQ		
ANTIHYPERTENSIVES, SYMPATHOLYTIC		**Review Schedule: 1st Quarter**
clonidine patch, IR tablet doxazosin guanfacine methyldopa prazosin terazosin	CARDURA (doxazosin) clonidine 0.05mg tablet * clonidine ER (generic NEXICLON XR) JAVADIN (clonidine) * 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 preferred clonidine product cannot be used, before product will be approved • ** PA required, to include reason terazosin capsule cannot be used, before product will be approved.
BETA BLOCKERS		**Review Schedule: 2nd Quarter**
atenolol atenolol/chlorthalidone bisoprolol 5 mg, 10 mg tablet bisoprolol/HCTZ carvedilol IR labetalol 100 mg, 200 mg, 300 mg tablet metoprolol IR (except 12.5 mg) metoprolol ER nadolol nebivolol propranolol propranolol ER sotalol	acebutolol BETAPACE (sotalol) betaxolol bisoprolol 2.5 mg tablet BYSTOLIC (nebivolol) carvedilol ER HEMANGEOL (propranolol) INDERAL LA (propranolol) INDERAL XL (propranolol) INNOPRAN XL (propranolol) KAPSPARGO (metoprolol) labetalol 400 mg tablet* LOPRESSOR (metoprolol) solution **, tablet	• Two (2) preferred products required before a non-preferred product will be approved. Additional requirements are as follows: • * PA required, to include reason labetalol 2 x 200 mg tablets cannot be used, before product will be approved. • ** PA required, to include reason preferred metoprolol product and propranolol solution cannot be used, before product will be approved.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
	LOPRESSOR HCT (metoprolol/HCTZ) metoprolol 12.5 mg tablet *** metoprolol/HCTZ pindolol SOTYLIZE (sotalol) TENORETIC (atenolol/chlorthalidone) TENORMIN (atenolol) timolol TOPROL XL (metoprolol ER) ZIAC (bisoprolol/HCTZ)	• *** PA required, to include reason preferred metoprolol 25 mg tablet 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 capsule diltiazem IR felodipine nifedipine ER nifedipine IR nimodipine * NORLIQVA (amlodipine) TAZTIA XT (diltiazem ER) TIADYLT ER (diltiazem ER) verapamil ER tablet, capsule verapamil IR	CARDAMYST (etripamil) diltiazem ER tablet isradipine KATERZIA (amlodipine) β levamlodipine maleate MATZIM LA (diltiazem ER) nicardipine nisoldipine ER NORVASC (amlodipine) NYMALIZE (nimodipine) PROCARDIA (nifedipine) PROCARDIA XL (nifedipine ER) SDAMLO (amlodipine) ** SULAR (nisoldipine) verapamil ER PM verapamil SR pellet	• 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.** • ** PA required, to include reason preferred amlodipine product cannot be used, before product will be approved. • β One of two (2) preferred products is required to be Norliqva (amlodipine)
DIURETICS		**Review Schedule: 1st Quarter**
acetazolamide tablet acetazolamide ER capsule amiloride amiloride/HCTZ bumetanide chlorothiazide chlorthalidone furosemide hydrochlorothiazide (HCTZ) indapamide metolazone spironolactone spironolactone/HCTZ torsemide triamterene/HCTZ	ALDACTAZIDE (spironolactone/HCTZ) ALDACTONE (spironolactone) CAROSPIR (spironolactone) dichlorphenamide ENBUMYST (bumetanide) eplerenone ** ethacrynic acid HEMICLOR (chlorthalidone) * INSPRA (eplerenone) ** INZIRQO (HCTZ) KERENDIA (finerenone) ** KEVEYIS (dichlorphenamide) LASIX (furosemide) LASIX ONYU (furosemide) MAXZIDE (triamterene/HCTZ) methazolamide THALITONE (chlorthalidone) triamterene	• Two (2) preferred products required before a non-preferred product will be approved. Additional requirements are as follows: • * PA required, to include reason chlorthalidone 25 mg tablet cannot be used, before product will be approved. • ** Two (2) preferred products, one (1) of which must be a preferred spironolactone product, required before a non-preferred product will be approved.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
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**
sacubitril /valsartan tablet	ENTRESTO (sacubitril /valsartan) TABLET INPEFA (sotagliflozin) VERQUVO (vericiguat) ENTRESTO (sacubitril /valsartan) SPRINKLE	• One (1) preferred product required before a non-preferred product will be approved.
LIPOTROPICS, OTHER (Clinical criteria applies to individual agents in class.)		**Review Schedule: 4th Quarter**
cholestyramine cholestyramine light colesevelam tablet colestipol ezetimibe fenofibrate (gen LOFIBRA) fenofibrate (gen TRICOR) gemfibrozil niacin ER RX 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) fenofibric acid (gen FIBRICOR) fenofibric acid (gen TRILIPIX) icosapent ethyl JUXTAPID (lomitapide) LEQVIO (inclisiran) LIPFENDRA (enlicitide) LIPOFEN (fenofibrate) LOPID (gemfibrozil) NEXLETOL (bempedoic acid) NEXLIZET (bempedoic acid/ezetimibe) NIASPAN (niacin) REDEMPLO (plozasiran) TRICOR (fenofibrate) 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	amlodipine/atorvastatin	

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
pravastatin rosuvastatin simvastatin	ATORVALIQ (atorvastatin) suspension CADUET (amlodipine/atorvastatin) CRESTOR (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. Additional requirements are as follows: • Dose optimization to 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 tablet sildenafil 20 mg tablet sildenafil 10 mg/mL suspension tadalafil 20 mg tablet (generic ADCIRCA)	ADCIRCA (tadalafil) ADEMPAS (riociguat) ALYQ (tadalafil) bosentan soluble tablet LETAIRIS (ambrisentan) macitentan OPSUMIT (macitentan) OPSYNVI (macitentan/tadalafil) ORENITRAM ER (treprostinil) REVATIO (sildenafil) riociguat TADLIQ (tadalafil) suspension TRACLEER (bosentan) treprostinil TYVASO (treprostinil) TYVASO DPI (treprostinil) UPTRAVI 100mcg and 150mcg (selexipag) µ UPTRAVI (selexipag) all other strengths WINREVAIR (sotatercept) YUTREPIA (treprostinil)	• Two (2) preferred products required before a non-preferred product will be approved. Additional requirements are as follows: • µ PA required for those 18 years and older
VASODILATORS, CORONARY		**Review Schedule: 1st Quarter**
hydralazine isosorbide dinitrate isosorbide mononitrate isosorbide mononitrate ER nitroglycerin patch, tablet ranolazine ER	ASPRUZYO (ranolazine) BIDIL (isosorbide dinitrate/hydralazine) GONITRO (nitroglycerin) isosorbide dinitrate/hydralazine NITRO-BID (nitroglycerin) ointment NITRO-DUR (nitroglycerin) patch nitroglycerin ointment, translingual spray NITROLINGUAL (nitroglycerin) spray NITROMIST (nitroglycerin) NITROSTAT (nitroglycerin) tablet	• Two (2) preferred products required before a non-preferred product will be approved.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
CENTRAL NERVOUS SYSTEM DRUGS		
ANTIDEPRESSANTS, OTHER		**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 capsule venlafaxine IR	amitriptyline/chlordiazepoxide amoxapine ANAFRANIL (clomipramine) AUVELITY (dextromethorphan HBr/bupropion) bupropion XL 450 mg desipramine desvenlafaxine ER 50 mg, 100 mg (unbranded) DRIZALMA (duloxetine) duloxetine 40 mg, 80 mg[α], 90 mg[α], 120 mg[α] EFFEXOR XR (venlafaxine ER) CAPSULE EMSAM (selegiline) EXXUA ER (gepirone) FETZIMA (levomilnacipran) imipramine pamoate mirtazapine ODT NARDIL (phenelzine) nefazodone NORPRAMIN (desipramine) PAMELOR (nortriptyline) PRISTIQ (desvenlafaxine) protriptyline RALDESY (trazodone) REMERON (mirtazapine) REMERON SOLUTAB (mirtazapine) trazodone 25mg[±], 75 mg[±], 300 mg trimipramine TRINTELLIX (vortioxetine) venlafaxine HCL ER tablet venlafaxine besylate ER VIIBRYD (vilazodone HCl) vilazodone ZURZUVAE (zuranolone)	• Two (2) preferred products required before a non-preferred product will be approved. Additional requirements are as follows: • DMAP requires prior authorization for all antidepressants for patients under six (6) years of age. • *** Clinical criteria applies** • [α]: medical rationale for why a preferred Duloxetine product cannot be used is required, prior to approval • [±] PA required for a clinical rationale to why a preferred trazodone product cannot be used
ANTIDEPRESSANTS, SSRIs		**Review Schedule: 4th Quarter**
citalopram solution, tablet escitalopram tablet fluoxetine capsule, solution fluvoxamine tablet paroxetine IR tablet sertraline concentrate, tablet	CELEXA (citalopram) citalopram capsule escitalopram capsule, solution * fluoxetine tablet fluoxetine DR fluvoxamine ER LEXAPRO (escitalopram) paroxetine CR, ER paroxetine capsule, suspension * PAXIL (paroxetine)	• 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 ≥ 10-years old.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
	PEXEVA (paroxetine) sertraline capsule ZOLOFT (sertraline)	• * PA required, to include reason IR tablet formulations cannot be used, before product will be approved.
ANTIPSYCHOTICS, ORAL		**Review Schedule: 4th Quarter**
amitriptyline/perphenazine aripiprazole solution, tablet clozapine haloperidol concentrate, solution, tablet loxapine lurasidone olanzapine tablet paliperidone ER perphenazine pimozide quetiapine quetiapine XR risperidone solution, tablet thioridazine thiothixene trifluoperazine VRAYLAR (cariprazine) ziprasidone	ABILIFY (aripiprazole) aripiprazole ODT asenapine sublingual tablet BYSANTI (milsaperidone) CAPLYTA (lumateperone) chlorpromazine clozapine ODT CLOZARIL (clozapine) COBENFY (xanomeline/trospium) FANAPT (iloperidone) fluphenazine GEODON (ziprasidone) capsule INVEGA (paliperidone) tablet LATUDA (lurasidone) LYBALVI (olanzapine/samidorphan) molindone NUPLAZID (pimavanserin tartrate) OPIPZA (aripiprazole) * olanzapine ODT olanzapine/fluoxetine REXULTI (brexpiprazole) RISPERDAL (risperidone) risperidone ODT SAPHRIS (asenapine) SECUADO (asenapine) SEROQUEL (quetiapine) SEROQUEL XR (quetiapine) VERSACLOZ (clozapine) ZYPREXA (olanzapine) tablet	• Two (2) preferred products required before a non-preferred product will be approved. Additional requirements are as follows: • * Two (2) preferred products, one (1) of which must be aripiprazole solution, required before product will be approved. • PA required for all antipsychotics for patients under eighteen (18) years of age.
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)	ADASUVE (loxapine) ERZOFRI (paliperidone) GEODON IM (ziprasidone) PERSERIS (risperidone) risperidone ER vial RYKINDO (risperidone microspheres) WELTRUZA (olanzapine) ZYPREXA (olanzapine) ZYPREXA RELPREVV (olanzapine) ZYPREXA ZYDIS (olanzapine)	• Two (2) preferred products required before a non-preferred product will be approved. Additional requirements are as follows: • PA required for all antipsychotics for patients under eighteen (18) years of age.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
olanzapine RISPERDAL CONSTA (risperidone) UZEDY (risperidone) ziprasidone mesylate IM		
ANXIOLYTICS		**Review Schedule: 2nd Quarter**
buspirone 5mg, 10mg, 15mg, 30mg chlordiazepoxide clorazepate diazepam solution, tablet hydroxyzine pamoate hydroxyzine HCl solution, tablet lorazepam tablet	alprazolam ER/XR, IR, intensol, ODT BUCAPSOL (buspirone) * buspirone 2.5mg, 12.5mg * diazepam intensol LIBRIUM (chlordiazepoxide) lorazepam intensol LOREEV XR (lorazepam) meprobamate oxazepam VALIUM (diazepam) XANAX (alprazolam) XANAX XR (alprazolam)	• Two (2) preferred products required before a non-preferred product will be approved. Additional requirements are as follows: • * PA required, to include why a preferred buspirone tablet cannot be used, before product will be approved. • **Quantity Limits of 120 units of benzodiazepines per 30 days**
MOOD STABILIZERS		**Review Schedule: 4th Quarter**
carbamazepine 100 mg chewable tablet, tablet carbamazepine ER, XR carbamazepine suspension divalproex sodium lamotrigine IR lithium IR lithium ER SUBVENITE (lamotrigine) tablet valproic acid	carbamazepine 200 mg chewable tablet * DEPAKOTE (divalproex) DEPAKOTE ER (divalproex) LAMICTAL (lamotrigine) LAMICTAL ODT (lamotrigine) LAMICTAL XR (lamotrigine) lamotrigine ER, ODT LITHOBID (lithium) SUBVENITE (lamotrigine) solution ** TEGRETOL (carbamazepine) suspension, tablet TEGRETOL-XR (carbamazepine) TERIL (carbamazepine) suspension	• Two (2) preferred products required before a non-preferred product will be approved. Additional requirements are as follows: • * PA required, to include reason carbamazepine 2 x 100 mg chewable tablets cannot be used, before product will be approved. • ** PA required, to include reason preferred lamotrigine agent cannot be used, before product will be approved.
PSEUDOBULBAR AFFECT (PBA) AGENTS		**Review Schedule: 4th Quarter**
NUEDEXTA	dextromethorphan Hbr/quinidine	• One (1) preferred product required before a non-preferred product will be approved
SEDATIVE HYPNOTICS		**Review Schedule: 2nd Quarter**
eszopiclone temazepam 15mg, 30mg zaleplon zolpidem IR tablet	AMBIEN (zolpidem) AMBIEN CR (zolpidem) BELSOMRA (suvorexant) DAYVIGO (lemborexant) DORAL (quazepam)	• Two (2) preferred products required before a non-preferred product will be approved. Additional requirements are as follows: • Dose optimization required when applicable.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
	doxepin 3mg, 6 mg EDLUAR (zolpidem) estazolam flurazepam HALCION (triazolam) HETLIOZ (tasimelteon) capsule, suspension IGALMI (dexmedetomidine HCl) LUNESTA (eszopiclone) quazepam QUVIVIQ (daridorexant HCl)* ramelteon RESTORIL (temazepam) ROZEREM (ramelteon) SILENOR (doxepin) SONATA (zaleplon) tasimelteon temazepam 7.5mg, 22.5mg triazolam zolpidem ER zolpidem IR capsule	• Quantity limits – 30 units per 30 days • * Three (3) products, two (2) of which must be preferred agents and one (1) of which must be Belsomra, before a non-preferred product will be approved.
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 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	ANDROID 25 (methyltestosterone) AVEED (testosterone undecanoate) AZMIRO (testosterone cypionate) JATENZO (testosterone undecanoate) KYZATREX (testosterone undecanoate) METHITEST (methyltestosterone) methyltestosterone NATESTO (testosterone) TESTIM (testosterone) testosterone gel (except preferred formulation) TLANDO (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		**Review Schedule: 4th Quarter**

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
alendronate tablet calcitonin-salmon nasal spray ibandronate JUBBONTI (denosumab-bbdz) * raloxifene teriparatide * WYOST (denosumab-bbdz) *	ACTONEL (risedronate) alendronate solution ATELVIA (risedronate) AUKELSO (denosumab-kyqq) * BILDYOS (denosumab-nxxp) * BILPREVDA (denosumab-nxxp) * BINOSTO (alendronate) BOMYNTRA (denosumab-bnht) * BONSITY (teriparatide) * BOSAYA (denosumab-kyqq) * CONEXXENCE (denosumab-bnht) * ENOBY (denosumab-qbde) * EVENITY (romosozumab-aqqg) * EVISTA (raloxifene) FORTEO (teriparatide) * FOSAMAX (alendronate) FOSAMAX PLUS D (alendronate/vitamin D) JUBEREQ (denosumab-desu)* OSENVELT (denosumab-bmwo) * OSVYRTI (denosumab-desu)* PROLIA (denosumab) * risedronate STOBOCLO (denosumab-bmwo) * TYMLOS (abaloparatide) * XGEVA (denosumab) * XTRENBO (denosumab-qbde) * YORVIPATH (palopegteriparatide) *	• Two (2) preferred products required before a non-preferred product will be approved. Additional requirements are as follows: • *** Clinical PA is required for injectable medications in this class**
CALCIMIMETIC,PARATHYROID CALCIUM ENHANCER		**Review Schedule: 4th Quarter**
PARSABIV (etelcalcetide hydrochloride)		
CONTRACEPTIVES, ORAL – MONOPHASIC + ESTROGEN SUPPLEMENTATION		**Review Schedule: 1st Quarter**
AZURETTE (desogestrel/ethinyl estradiol) desogestrel/ethinyl estradiol KARIVA (desogestrel/ethinyl estradiol) PIMTREA (desogestrel/ethinyl estradiol) SIMLIYA (desog-e.estradiol/e.estradiol) VIORELE (desogestrel/ethinyl estradiol) VOLNEA (desogestrel/ethinyl estradiol)	LO LOESTRIN FE (norethindrone-ethinyl estradiol-FE) MIRCETTE (desog-e.estradiol/e.estradiol)	• Two (2) preferred products required before a non-preferred product will be approved.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
CONTRACEPTIVES, ORAL - MONOPHASIC		**Review Schedule: 1st Quarter**
ALFFIRMELLE (levonorgestrel-ethinyl estradiol) ALTAVERA (levonorgestrel-ethinyl estradiol) ALYACEN (norethindrone-ethinyl estradiol) APRI (desogestrel-ethinyl estradiol) AUBRA (levonorgestrel-ethinyl estradiol) AUBRA EQ (levonorgestrel-ethinyl estradiol) AUROVELA (norethindrone-ethinyl estradiol) AUROVELA FE (norethindrone-ethinyl estradiol-FE) AUROVELA 24 FE (norethindrone-ethinyl estradiol-FE) AVIANE (levonorgestrel-ethinyl estradiol) AYUNA (levonorgestrel-ethinyl estradiol) BALZIVA (norethindrone-ethinyl estradiol) BLISOVI FE (norethindrone-ethinyl estradiol-FE) BLISOVI 24 FE (norethindrone-ethinyl estradiol-FE) BRIELLYN (norethindrone-ethinyl estradiol) CHARLOTTE 24 FE (norethindrone-ethinyl estradiol-FE) CHATEL EQ (levonorgestrel-ethinyl estradiol) CRYSELLE (norgestrel-ethinyl estradiol) CYRED EQ (desogestrel-ethinyl estradiol) DASETTA (norethindrone-ethinyl estradiol) desogestrel-ethinyl estradiol drosperinone-ethinyl estradiol ELINEST (norgestrel-ethinyl estradiol) ENSKYCE (desogestrel-ethinyl estradiol) ESTARYLLA (norgestimate-ethinyl estradiol) ethynodiol-ethinyl estradiol FALMINA (levonorgestrel-ethinyl estradiol) FEIRZA (norethindrone-ethinyl estradiol) FEMYNOR (norgestimate-ethinyl estradiol) FINZALA (norethindrone-ethinyl estradiol-FE) HAILEY (norethindrone-ethinyl estradiol) HAILEY FE (norethindrone-ethinyl estradiol-FE) HAILEY 24 FE (norethindrone-ethinyl estradiol-FE) ISIBLOOM (desogestrel-ethinyl estradiol) JASMIEL (drosperinone-ethinyl estradiol) JULEBER (desogestrel-ethinyl estradiol) JUNEL (norethindrone-ethinyl estradiol) JUNEL FE (norethindrone-ethinyl estradiol-FE) JUNEL FE 24 (norethindrone-ethinyl estradiol-FE) KALLIGA (desogestrel-ethinyl estradiol) KELNOR (ethynodiol-ethinyl estradiol) KURVELO (levonorgestrel-ethinyl estradiol) LARIN (norethindrone-ethinyl estradiol) LARIN FE (norethindrone-ethinyl estradiol-FE) LARIN 24 FE (norethindrone-ethinyl estradiol-FE) levonorgestrel-ethinyl estradiol LESSINA (levonorgestrel-ethinyl estradiol) LORYNA (drosperinone-ethinyl estradiol) LOW-OGESTREL (norgestrel-ethinyl estradiol)	AVERI (desogestrel-ethinyl estradiol-FE) BALCOLTRA (levonorgestrel-ethinyl estradiol-FE) BEYAZ (drosperinone-ethinyl estradiol-levomefolate) drosperinone-ethinyl estradiol-levomefolate FEMLYV (norethindrone-ethinyl estradiol) GALBRIELA (norethindrone-ethinyl estradiol-FE) GEMMILY (norethindrone-ethinyl estradiol-FE) JOYEAUX (levonorgestrel-ethinyl estradiol-FE) KAITLIB FE (norethindrone-ethinyl estradiol-FE) LAYOLIS FE (norethindrone-ethinyl estradiol-FE) levonorgestrel-ethinyl estradiol-FE LOESTRIN (norethindrone-ethinyl estradiol) LOESTRIN FE (norethindrone-ethinyl estradiol-FE) MERZEE (norethindrone-ethinyl estradiol-FE) MIBELAS 24 FE (norethindrone-ethinyl estradiol-FE) MINZOYA (levonorgestrel-ethinyl estradiol-FE) NEXTSTELLIS (drospirenone-estetrol) SAFYRAL (drosperinone-ethinyl estradiol-levomefolate) TAYTULLA (norethindrone-ethinyl estradiol) TURQOZ (norgestrel-ethinyl estradiol) TYDEMY (drospir/eth estra/levomefol Ca) YASMIN (drosperinone-ethinyl estradiol) YAZ (drosperinone-ethinyl estradiol) ZOVIA (ethynodiol-ethinyl estradiol)	• Two (2) preferred products required before a non-preferred product will be approved.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
LO-ZUMANDIMINE (drosperinone-ethinyl estradiol) LUIZZA (norethindrone-ethinyl estradiol) LUTERA (levonorgestrel-ethinyl estradiol) MARLISSA (levonorgestrel-ethinyl estradiol) MICROGESTIN (norethindrone-ethinyl estradiol) MICROGESTIN FE (norethindrone-ethinyl estradiol-FE) MILI (norgestimate-ethinyl estradiol) MONO-LINYAH (norgestimate-ethinyl estradiol) NECON (norethindrone-ethinyl estradiol) NIKKI (drosperinone-ethinyl estradiol) NYLIA (norethindrone-ethinyl estradiol) norethindrone-ethinyl estradiol norethindrone-ethinyl estradiol-FE tablet, capsule, chewable norgestimate-ethinyl estradiol norgestrel-ethinyl estradiol NORTREL (norethindrone-ethinyl estradiol) NYMO (norgestimate-ethinyl estradiol) OCELLA (drosperinone-ethinyl estradiol) PHILITH (norethindrone-ethinyl estradiol) PORTIA (levonorgestrel-ethinyl estradiol) RECLIPSEN (desogestrel-ethinyl estradiol) SPRINTEC (norgestimate-ethinyl estradiol) SRONYX (levonorgestrel-ethinyl estradiol) SYEDA (drosperinone-ethinyl estradiol) TARINA FE (norethindrone-ethinyl estradiol-FE) TARINA 24 FE (norethindrone-ethinyl estradiol-FE) TYBLUME (levonorgestrel-ethinyl estradiol) VALTYA (ethynodiol-ethinyl estradiol) VESTURA (drosperinone-ethinyl estradiol) VIENVA (levonorgestrel-ethinyl estradiol) VYFEMLA (norethindrone-ethinyl estradiol) VYLIBRA (norgestimate-ethinyl estradiol) WERA (norethindrone-ethinyl estradiol) WYMZYA FE (norethindrone-ethinyl estradiol-FE) XELRIA FE (norethindrone-ethinyl estradiol-FE) ZARAH (drosperinone-ethinyl estradiol) ZUMANDIMINE (drosperinone-ethinyl estradiol)		
CONTRACEPTIVES, ORAL - EXTENDED / CONTINUOUS CYCLE		**Review Schedule: 1st Quarter**
AMETHIA (levonorgestrel-ethinyl estradiol) AMETHIA LO (levonorgestrel-ethinyl estradiol) ASHLYNA (levonorgestrel-ethinyl estradiol) CAMRESE (levonorgestrel-ethinyl estradiol) CAMRESE LO (levonorgestrel-ethinyl estradiol-ethinyl estradiol) DAYSEE (levonorgestrel-ethinyl estradiol) ICLEVIA (levonorgestrel-ethinyl estradiol)	AMETHYST (levonorgestrel-ethinyl estradiol) DOLISHALE (levonorgestrel-ethinyl estradiol) levonorgestrel-ethinyl estradiol 0.09-0.02 mg levonorgestrel-ethinyl estradiol-ethinyl estradiol 0.15-0.02-0.025-0.03 mg JAIMIESS (levonorgestrel-ethinyl estradiol-ethinyl estradiol) LOSEASONIQUE (levonorgestrel-ethinyl estradiol) QUARTETTE (L-norgest/e.estradiol-e.estrad)	• Two (2) preferred products required before a non-preferred product will be approved.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
INTROVALE (levonorgestrel-ethinyl estradiol) JOLESSA (levonorgestrel-ethinyl estradiol) levonorgestrel-ethinyl estradiol 0.15-0.03 mg, 0.1-0.02 mg levonorgestrel-ethinyl estradiol-ethinyl estradiol 0.15-0.03-0.01 mg, 0.1-0.02-0.01 mg LOJAIMIESS (levonorgestrel-ethinyl estradiol-ethinyl estradiol) SETLAKIN (levonorgestrel-ethinyl estradiol) SIMPESSE (levonorgestrel-ethinyl estradiol)	RIVELSA (levonorgestrel-ethinyl estradiol-ethinyl estradiol) ROSYRAH (levonorgestrel-ethinyl estradiol-ethinyl estradiol) SEASONIQUE (levonorgestrel-ethinyl estradiol)	
CONTRACEPTIVES,ORAL – QUADRIPHASIC		**Review Schedule: 1st Quarter**
NATAZIA (estradiol valerate-estradiol valerate-dienogest)		
CONTRACEPTIVES, ORAL - PROGESTINS		**Review Schedule: 1st Quarter**
CAMILA (norethindrone) DEBITANE (norethindrone) EMZAHH (norethindrone) ERRIN (norethindrone) HEATHER (norethindrone) INCASSIA (norethindrone) JENCYCLA (norethindrone) LYLEQ (norethindrone) LYZA (norethindrone) MELEYA (norethindrone) NORA-BE (norethindrone) norethindrone OPILL (norgestrel) ORQUIDEA (norethindrone) SHAROBEL (norethindrone) SLYND (drospirenone) TULANA (norethindrone)		
CONTRACEPTIVES, ORAL – TRIPHASIC		**Review Schedule: 1st Quarter**
ALYACEN 7/7/7 (norethindrone-ethinyl estradiol) ARANELLE (norethindrone-ethinyl estradiol) CAZIANT (desogestrel-ethinyl estradiol) DASETTA (norethindrone-ethinyl estradiol) ENPRESSE (levonorgestrel-ethinyl estradiol) LEENA (norethindrone-ethinyl estradiol) LEVONEST (levonorgestrel-ethinyl estradiol) levonorgestrel-ethinyl estradiol NORTREL (norethindrone-ethinyl estradiol) norethindrone-ethinyl estradiol-iron norgestimate-ethinyl estradiol NYLIA (norethindrone-ethin. Estradiol) TILIA FE (norethindrone-ethinyl estradiol-iron)	ORTHO-NOVUM (norethindrone-ethinyl estradiol) ORTHO TRI-CYCLEN (norgestimate-ethinyl estradiol) TRI-LEGEST FE (norethindrone-ethinyl estradiol-iron)	• Two (2) preferred products required before a non-preferred product will be approved.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
TRI-ESTARYLLA (norgestimate-ethinyl estradiol) TRI-LINYAH (norgestimate-ethinyl estradiol) TRI-LO-ESTARYLLA (norgestimate-ethinyl estradiol) TRI-LO-MARZIA (norgestimate-ethinyl estradiol) TRI-LO-MILI (norgestimate-ethinyl estradiol) TRI-LO-SPRINTEC (norgestimate-ethinyl estradiol) TRI-MILI (norgestimate-ethinyl estradiol) TRI-SPRINTEC (norgestimate-ethinyl estradiol) TRI-VYLIBRA (norgestimate-ethinyl estradiol) TRI-VYLIBRA LO (norgestimate-ethinyl estradiol) TRIVORA (levonorgestrel-ethinyl estradiol) VELIVET (desogestrel-ethinyl estradiol) XARAH FE (norethindrone-ethinyl estradiol-iron)		
CONTRACEPTIVES – IUDs / IMPLANTS		**Review Schedule: 1st Quarter**
KYLEENA (levonorgestrel) LILETTA (levonorgestrel) MIRENA (levonorgestrel) MIUDELLA NEXPLANON (etonogestrel) PARAGARD		
CONTRACEPTIVES – PATCHES		**Review Schedule: 1st Quarter**
ethinyl estradiol-norelgestromin XULANE (ethinyl estradiol-norelgestromin) ZAFEMY (ethinyl estradiol-norelgestromin)	GWYN LO (norelgestromin-ethinyl estradiol) TWIRLA (levonorgestrel-ethinyl estradiol)	• One (1) preferred product required before a non-preferred product will be approved.
CONTRACEPTIVES – VAGINAL RINGS		**Review Schedule: 1st Quarter**
ELURYNG (etonogestrel-ethinyl estradiol) ENILLORING (etonogestrel-ethinyl estradiol) etonogestrel-ethinyl estradiol HALOETTE (etonogestrel-ethinyl estradiol)	ANNOVERA (ethinyl estradiol-segesterone)	• One (1) preferred product required before a non-preferred product will be approved.
GROWTH HORMONES **(Clinical criteria applies to class. All agents require a prior authorization.)**		**Review Schedule: 4th Quarter**
GENOTROPIN (somatropin) NGENLA (somatrogon-ghla) NORDITROPIN (somatropin) SOGROYA (somapacitan-beco)	NUTROPIN AQ (somatropin) OMNITROPE (somatropin) SAIZEN (somatropin) SEROSTIM (somatropin) SKYTROFA (lonapegsomatropin-tcgd) ZOMACTON (somatropin) ZORBTIVE (somatropin)	• Two (2) preferred products required before a non-preferred product will be approved.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
GROWTH HORMONES FOR ACROMEGALY		**Review Schedule: 4th Quarter**
SOMAVERT (pegvisomant)		
HYPERPARATHYROIDS		**Review Schedule: 4th Quarter**
calcitriol capsule cinacalcet tablet	calcitriol solution doxercalciferol paricalcitol capsule SENSIPAR (cinacalcet) RAYALDEE (calcifediol) ROCALTROL (calcitriol) ZEMPLAR (paricalcitol) capsule, vial	• Two (2) preferred products required before a non-preferred product will be approved.
HYPOGLYCEMIA TREATMENTS		**Review Schedule: 4th Quarter**
BAQSIMI (glucagon) (Amphastar – labeler code 00548) glucagon PROGLYCEM (diazoxide) ZEGALOGUE autoinjector (dasiglucagon) (Novo Nordisk – labeler code 00169) ZEGALOGUE syringe (dasiglucagon) (Novo Nordisk – labeler code 00169)	BAQSIMI (glucagon) (Lilly – labeler code 00002) diazoxide 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: DPP-4 INHIBITORS **(Clinical criteria applies to class. All agents require a prior authorization.)**		**Review Schedule: 4th Quarter**
JANUVIA (sitagliptin phos) JENTADUETO (linagliptin/metformin) sitagliptin phos/metformin (gen JANUMET) sitagliptin phos/metformin ER (gen JANUMET XR) TRADJENTA (linagliptin)	alogliptin alogliptin/metformin alogliptin/pioglitazone BRYNOVIN (sitagliptin) JANUMET (sitagliptin phos/metformin) JANUMET XR (sitagliptin phos/metformin) JENTADUETO XR (linagliptin/metformin) KOMBIGLYZE XR (saxagliptin/metformin) linagliptin/metformin NESINA (alogliptin) OSENI (alogliptin/pioglitazone) saxagliptin saxagliptin/metformin	• Two (2) preferred products required before a non-preferred product will be approved.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
	sitagliptin (gen ZITUVIO) sitagliptin phos (gen JANUVIA) sitagliptin/metformin (gen ZITUVIMET) sitagliptin/metformin ER (gen ZITUVIMET XR) 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**
MOUNJARO (tirzepatide) OZEMPIC injection (semaglutide) TRULICITY (dulaglutide)	exenatide liraglutide OZEMPIC tablet (semaglutide)* RYBELSUS (semaglutide) SOLIQUA (insulin glargine/lixisenatide) VICTOZA (liraglutide) XULTOPHY (insulin degludec/liraglutide)	• Two (2) preferred products required before a non-preferred product will be approved. Additional requirements are as follows: • * Medical reason for why the injectable Ozempic cannot be used is required before Ozempic tablets 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 glargine-YFGNμ insulin lispro insulin lispro mix LANTUS (insulin glargine) LANTUS SOLOSTAR (insulin glargine) NOVOLIN N (insulin isophane) NOVOLIN R (insulin) NOVOLOG (insulin aspart) NOVOLOG MIX 70/30 TOUJEO SOLOSTAR (insulin glargine) TOUJEO SOLOSTAR MAX (insulin glargine)	ADMELOG (insulin lispro) AFREZZA (insulin) APIDRA (insulin glulisine) AWIQLI (insulin icodec) * 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 aspart insulin aspart mix insulin degludec insulin glargine SOLOSTAR (gen TOUJEO) Insulin glargine SOLOSTAR MAX (gen TOUJEO) insulin glargine KIRSTY (insulin aspart-xjhz) LYUMJEV (insulin lispro) MERILOG (insulin aspart-szjj) MERILOG SOLOSTAR (insulin aspart-szjj) NOVOLIN N (insulin isophane) vial NOVOLIN R (insulin) vial NOVOLIN 70/30 RELION NOVOLIN N, NOVOLIN R, NOVOLOG	• Two (2) preferred products required before a non-preferred product will be approved. Additional requirements are as follows: • * Long-acting products, Lantus and Toujeo, would be required prior to approval • μ Temporary preferred agent due to national shortage of Lantus (insulin glargine)

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
	REZVOGLAR KWIKPEN (insulin glargine-aglr) SEMGLEE (insulin glargine) TRESIBA (insulin degludec)	
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)	metformin ER (generic FORTAMET, GLUMETZA) metformin IR solution metformin IR 625 mg, 750 mg * RIOMET (metformin IR)	• Two (2) preferred products required before a non-preferred product will be approved. Additional requirements are as follows: • * PA required, to include reason preferred metformin product, cannot be used, before product will be approved.
HYPOGLYCEMICS, SGLT2 INHIBITORS		**Review Schedule: 4th Quarter**
dapagliflozin dapagliflozin/metformin INVOKAMET (canagliflozin/metformin) INVOKAMET XR (canagliflozin/metformin) INVOKANA (canagliflozin) JARDIANCE (empagliflozin) SYNJARDY (empagliflozin/metformin) XIGDUO XR 2.5-1000mg (dapagliflozin/metformin)	FARXIGA (dapagliflozin) GLYXAMBI (empagliflozin/linagliptin) SEGLUROMET (ertugliflozin/metformin) STEGLATRO (ertugliflozin) STEGLUJAN (ertugliflozin/sitagliptin) SYNJARDY XR (empagliflozin/metformin) TRIJARDY XR (empagliflozin/linagliptin/metformin) XIGDUO XR all strengths, except 2.5-1000mg (dapagliflozin/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.
GLUCOCORTICOIDS, ORAL		**Review Schedule: 4th Quarter**
dexamethasone elixir, intensol, solution, tablet fludrocortisone hydrocortisone methylprednisolone dose pack	AGAMREE (vamorolone) * ALKINDI SPRINKLES (hydrocortisone) granules CORTEF (hydrocortisone) cortisone	• Two (2) preferred products required before a non-preferred product will be approved. Additional requirements are as follows:

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
methylprednisolone 4mg tablet prednisolone solution prednisolone sodium phosphate solution prednisone dose pack, IR tablet	deflazacort dexamethasone dose pack DEXLYT (dexamethasone) EMFLAZA (deflazacort) EOHILIA (budesonide) HEMADY (dexamethasone) JAYTHARI (deflazacort) KYMBEE (deflazacort) suspension KHINDIVI (hydrocortisone) MEDROL (methylprednisolone) methylprednisolone 8, 16, 32 mg tablet prednisolone tablet prednisolone sodium phosphate ODT prednisone intensol, solution, DR tablet PYQUVI (deflazacort) TARPEYO (budesonide)	• * Step through 3-month trial of prednisone and 3-month trial of Emflaza required before product will be approved.
METABOLIC DYSFUNCTION-ASSOCIATED STEATOHEPATITIS (MASH) 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) (Clinical criteria applies to class.)		**Review Schedule: 4th Quarter**
FENSOLVI (leuprolide acetate) LUPRON DEPOT–PED 1-month (leuprolide) SYNAREL (nafarelin)	LUPRON DEPOT–PED 3-month, 6-month (leuprolide) SUPPRELIN LA (histrelin) 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) sodium polystyrene sulfonate VELTASSA (patiromer calcium sorbitex)		
PROGESTATIONAL AGENTS		**Review Schedule: 2nd Quarter**

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
medroxyprogesterone acetate tablet medroxyprogesterone acetate IM norethindrone acetate tablet progesterone capsule progesterone IM	CRINONE (progesterone) DEPO-PROVERA (medroxyprogesterone) progesterone insert 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) LEVO-T (levothyroxine sodium) levothyroxine sodium tablet liothyronine sodium tablet LIOMNY (liothyronine sodium) NP THYROID (thyroid desiccated)	ADTHYZA (thyroid desiccated) AMERITHROID (thyroid desiccated) CYTOMEL (liothyronine sodium) EVEXITHROID (thyroid desiccated) levothyroxine sodium injection LEVOXYL (levothyroxine sodium) liothyronine sodium injection RENTHYROID (thyroid desiccated) SYNTHROID (levothyroxine sodium) THYQUIDITY (levothyroxine sodium) UNITHROID (levothyroxine sodium)	• Two (2) preferred products required before a non-preferred product will be approved.
TRANSTHYRETIN AMYLOIDOSIS AGENTS (Clinical criteria applies to class.)		**Review Schedule: 2nd Quarter**
ATTRUBY (acoramidis) ONPATTRO (patisiran) VYNDAMAX (tafamidis)	AMVUTTRA (vutrisan) WAINUA (eplontersen)	• One (1) preferred product 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) RAVICTI (glycerol phenylbutyrate) sodium phenylbutyrate powder, tabs	BUPHENYL powder, tabs (sodium phenylbutyrate) CARBAGLU (carglumic acid) carglumic acid (Burel – labeler code 35573) glycerol phenylbutyrate LOARGYS (pegzilarginase-nbln) OLPRUVA (sodium phenylbutyrate)	• Two (2) preferred products required before a non-preferred product will be approved.
VASOMOTOR SYMPTOMS		**Review Schedule: 4th Quarter**
	LYNKUET (elinzanetant) VEOZAH (fezolinetant)	
GASTROINTESTINAL AGENTS		
ANTIEMETICS, ORAL/TRANSDERMAL		**Review Schedule: 4th Quarter**

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
DICLEGIS (doxylamine/pyridoxine) ondansetron tablet, ODT (4mg, 8 mg), solution scopolamine patch	AKYNZEO (netupitant/palonosetron) aprepitant BONJESTA (doxylamine/pyridoxine) doxylamine/pyridoxine dronabinol capsule,solution* EMEND (aprepitant) capsule, suspension granisetron GRANISOL (granistron) solution MARINOL (dronabinol) * NEREUS (tradipitant)* ondansetron ODT 16 mg SANCUSO (granisetron) TRANSDERM-SCOP (scopolamine) trimethobenzamide	• Two (2) preferred products required before a non-preferred product will be approved. Additional requirements are as follows: • *** Clinical criteria applies**
BILE SALTS		**Review Schedule: 4th Quarter**
ursodiol capsule, tablet	CHOLBAM (cholic acid) IQIRVO (elafibranor) LYNAVOY (linerixibat)* LIVDELZI (seladelpar) RELTONE (ursodiol) URSO FORTE (ursodiol) URSOLIGNμ	• One (1) preferred product required before a non-preferred product will be approved. • * Lynavoy requires a step through Livdelzi prior to approval • μ Clinical rationale to why a preferred ursodiol product cannot be used is required prior to approval
BOWEL PREP		**Review Schedule: 4th Quarter**
CLENPIQ GAVILYTE-C GAVILYTE-G GOLYTELY NULYTELY PEG 3350 PEG 3350-ELECTROLYTE PEG 3350-Sod Sul-NACL-KCL- ASB-C 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) prucalopride	ISBRELA (tenapanor) MOTEGRITY (prucalopride) SYMPROIC (naldemedine)	• Two (2) preferred products required before a non-preferred product will be approved.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
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 OMECLAMOX PAK (omeprazole-clarithromycin-amoxicillin) TALICIA (omeprazole magnesium-amoxicillin-rifabutin) VOQUEZNA DUAL PAK (vonoprazan-amoxicillin) VOQUEZNA TRIPLE PAK (vonoprazan-amoxicillin-clarithromycin)	• One (1) preferred product required before a non-preferred product will be approved.
HISTAMINE II RECEPTOR BLOCKERS		**Review Schedule: 1st Quarter**
famotidine nizatidine	cimetidine ranitidine	• 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. Additional requirements are as follows: • PA required for all non-calcium-based products.
HYPERPHOSPHATEMIA AGENTS, PHOSPHATE BINDERS		**Review Schedule: 1st Quarter**
calcium acetate capsule sevelamer carbonate tablet	AURYXIA (ferric citrate) calcium acetate tablet 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. Additional requirements are as follows: • PA required for all non-calcium based products.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
INFLAMMATORY BOWEL DISEASE AGENTS-ORAL		**Review Schedule: 3rd Quarter**
balsalazide budesonide ER capsule mesalamine DR 1.2 gm tablet mesalamine ER 375 mg capsule PENTASA (mesalamine) sulfasalazine sulfasalazine DR	AZULFIDINE (sulfasalazine) budesonide ER tablet * DIPENTUM (olsalazine) LIALDA (mesalamine) mesalamine ER 250mg capsules mesalamine DR 400 mg capsule mesalamine DR 800 mg tablet mesalamine ER 500 mg capsule	• Two (2) preferred products required before a non-preferred product will be approved. • * One (1) preferred 5-ASA product will be required prior to approval
INFLAMMATORY BOWEL DISEASE AGENTS-RECTAL		**Review Schedule: 3rd Quarter**
mesalamine enema, suppository	budesonide foam CANASA (mesalamine) mesalamine enema kit ROWASA (mesalamine)	• One (1) preferred product required before a non-preferred product will be approved.
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**
esomeprazole packet omeprazole RX pantoprazole tablet PROTONIX (pantoprazole) granules	DEXILANT (dexlansoprazole) dexlansoprazole esomeprazole capsule, tablet KONVOMEP (omeprazole/sodium bicarbonate) lansoprazole NEXIUM (esomeprazole) omeprazole OTC omeprazole/sodium bicarbonate pantoprazole granules PREVACID (lansoprazole) PRILOSEC (omeprazole) packet PROTONIX (pantoprazole) tablet	• Two (2) preferred products required before a non-preferred product will be approved. Additional requirements are as follows: • Quantity limits apply to class.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
	rabeprazole VOQUENZA (vonoprazan)	
GENE THERAPY		
CENTRAL NERVOUS SYSTEM, SPINAL MUSCULAR ATROPHY **(Clinical criteria applies to class. All agents require a prior authorization.)**		**Review Schedule: 4th Quarter**
ITVISMA (onasemnogene abeparvovec-brve) ZOLGENSMA (onasemnogene abeparvovec-xioi)		
GENE THERAPIES FOR HEMOLYTIC ANEMIAS **(Clinical criteria applies to class. All agents require a prior authorization.)**		**Review Schedule: 4th Quarter**
CASGEVY (exagamglogene autotemcel) LYFGENIA (lovotibeglogene autotemcel) ZYNTEGLO (betibeglogene autotemcel)		
GENITOURINARY PRODUCTS		
BLADDER RELAXANT PREPARATIONS		**Review Schedule: 4th Quarter**
MYRBETRIQ (mirabegron) tablet oxybutynin 5 mg oxybutynin ER oxybutynin syrup solifenacin	darifenacin fesoterodine GEMTESA (vibegron) mirabegron tablet, suspension MYRBETRIQ (mirabegron) suspension oxybutynin 2.5 mg OXYTROL (oxybutynin) tolterodine TOVIAZ (fesoterodine) trospium VESICARE (solifenacin) tablet VESICARE LS (solifenacin) suspension	• Two (2) preferred products required before a non-preferred product will be approved.
BPH TREATMENTS		**Review Schedule: 2nd Quarter**
finasteride 5 mg tamsulosin	CARDURA XL (doxazosin) dutasteride dutasteride/tamsulosin PROSCAR (finasteride) silodosin tadalafil 5 mg *	• Two (2) preferred products required before a non-preferred product will be approved. Additional requirements are as follows: • * For BPH diagnosis only

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
HEMATOLOGICAL AGENTS		
ANTICOAGULANTS, ORAL/SQ		**Review Schedule: 4th Quarter**
dabigatran ELIQUIS (apixaban) tablet enoxaparin JANTOVEN (warfarin) warfarin rivaroxaban tablet XARELTO (rivaroxaban) tablet (except 2.5 mg)	ARIXTRA (fondaparinux) ELIQUIS (apixaban) sprinkle, tablet for suspension fondaparinux FRAGMIN (dalteparin) LOVENOX (enoxaparin) PRADAXA (dabigatran) rivaroxaban suspension SAVAYSA (edoxaban) XARELTO (rivaroxaban) 2.5 mg tablet, suspension	• Two (2) preferred products required before a non-preferred product will be approved. Additional requirements are as follows: • 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) XYNTHA SOLOFUSE (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. Additional requirements are as follows: • * Approval criteria dependent on diagnosis (Dx) ○ Dx hemophilia B – use of preferred product not required prior to approval. ○ Dx hemophilia A – use of or contraindication to Hemlibra required before non-preferred product will be approved.
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.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
COLONY STIMULATING FACTORS		**Review Schedule: 4th Quarter**
FULPHILA (pegfilgrastim-jmdb) NEUPOGEN (filgrastim) NYVEPRIA (pegfilgrastim-apgf)	ARMLUPEG (pegfilgrastim-unne) FILKRI (filgrastim-laha) FYLNETRA (pegfilgrastim-pbbk) GRANIX (tbo-filgrastim) LEUKINE (sargramostim) NEULASTA (pegfilgrastim) NIVESTYM (figrastim-aafi) vial, syringe NYPOZI (filgrastim-txid) RELEUKO (filgrastim-ayow) ROLVEDON (eflapegrastim-xnst) RYZNEUTA (efbemalenograstim alfa-vuxw) 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) capsule RUCONEST (recombinant C1 esterase inhibitor) TAKHZYRO (lanadelumab-flyo)	ANDEMBRY (garadaciman-gxii) DAWNZERA (donidalorsen) EKTERLY (sebetralstat) FIRAZYR (icatibant) ORLADEYO (berotralstat) pellets SAJAZIR (icatibant)	• Two (2) preferred products required before a non-preferred product will be approved.
PLATELET AGGREGATION INHIBITORS		**Review Schedule: 4th Quarter**
aspirin/dipyridamole clopidogrel dipyridamole prasugrel ticagrelor	aspirin/omeprazole BRILINTA (ticagrelor) EFFIENT (prasugrel) PLAVIX (clopidogrel) ticlopidine YOSPRALA (aspirin/omeprazole) ZONTIVITY (vorapaxar)	• Two (2) preferred products required before a non-preferred product will be approved.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
SICKLE CELL ANEMIA AGENTS		**Review Schedule: 4th Quarter**
DROXIA (hydroxyurea) hydroxyurea XROMI (hydroxyurea) *	ADAKVEO (crizanlizumab-tmca) vial β ENDARI (glutamine) β HYDREA (hydroxyurea) SIKLOS (hydroxyurea)	• Two (2) preferred products required before a non-preferred product will be approved. Additional requirements are as follows: • * Requires prior authorization for members ≥ 10-years old • β Trial of only one (1) preferred agent will be required prior to approval.
THROMBOPOIETICS		**Review Schedule: 2nd Quarter**
eltrombopag olamine NPLATE (romiplostim)	ALVAIZ (eltrombopag choline) DOPTELET (avatrombopag maleate) MULPLETA (lusutrombopag) PROMACTA (eltrombopag olamine) TAVALISSE (fostanatiniv disodium) WAYRILZ (rilzabrutinib)	• Two (2) preferred products required before a non-preferred product will be approved.
THROMBOLYTIC ENZYMES		**Review Schedule: 4th Quarter**
CATHFLO ACTIVASE		
IMMUNE GLOBULINS		
IMMUNE GLOBULINS		**Review Schedule: 4th Quarter**
BIVIGAM GAMMAGARD GAMMAGARD S-D GAMMAGARD ERC GAMUNEX-C OCTAGAM PRIVIGEN XEMBIFY	ALYGLO ASCENIV CUTAQUIG CUVITRU GAMASTAN GAMMAKED GAMMAPLEX HIZENTRA HYQVIA PANZYGA QIVIGY	• 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**
brivaracetam carbamazepine 100 mg chewable tablet, tablet carbamazepine ER, XR carbamazepine suspension clobazam clonazepam tablet diazepam rectal DILANTIN (phenytoin) 30 mg capsule divalproex sodium ethosuximide solution gabapentin	APTIOM (eslicarbazepine acetate) BANZEL (rufinamide) BRIVIACT (brivaracetam) carbamazepine 200 mg chewable tablet CARBATROL (carbamazepine) CELONTIN (methsuxamide) clonazepam ODT clonazepam 0.25 mg tablet DEPAKOTE (divalproex sodium) tablet, sprinkles DEPAKOTE ER (divalproex sodium) DIACOMIT (stiripentol)	• Two (2) preferred products required before a non-preferred product will be approved. Additional requirements are as follows: • Quantity limits in place: 240 adjunctive anticonvulsants per 30 days. Greater quantities require prior authorization.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
lacosamide solution, tablet lamotrigine IR tablet, chewable levetiracetam IR tablet, solution NAYZILAM (midazolam) oxcarbazepine tablet, suspension phenobarbital phenytoin pregabalin primidone SUBVENITE (lamotrigine) topiramate tablet valproic acid VALTOCO (diazepam) zonisamide	DILANTIN (phenytoin) 100 mg capsule, chewable, suspension EPIDIOLEX (cannabidiol) EPRONTIA (topiramate) EQUETRO (carbamazepine) eslicarbazepine acetate ethosuximide capsule felbamate FELBATOL (felbamate) FINTEPLA (fenfluramine) FYCOMPA (perampanel) GABITRIL (tiagabine) GABARONE (gabapentin) tablet KEPPRA (levetiracetam) KEPPRA XR (levetiracetam) KLONOPIN (clonazepam) LAMICTAL (lamotrigine) LAMICTAL XR (lamotrigine) lamotrigine ER, ODT levetiracetam ER, tablet for oral suspension LYRICA (pregabalin) LYRICA CR (pregabalin) methsuxamide MOTPOLY XR (lacosamide) NEURONTIN (gabapentin) ONFI (clobazam) oxcarbazapine ER OXTELLAR XR (oxcarbazapine) perampanel PHENYTEK (phenytoin) rufinamide SABRIL (vigabatrin) SPRITAM (levetiracetam) SYMPAZAN (clobazam) TEGRETOL (carbamazepine) suspension, tablet TEGRETOL XR (carbamazepine) tiagabine tablet TOPAMAX (topiramate) topiramate ER topiramate solution topiramate sprinkle capsule * TRILEPTAL (oxcarbazepine) suspension, tablet TROKENDI XR (topiramate) vigabatrin VIGADRONE (vigabatrin) VIGAFYDE (vigabatrin) ** VIMPAT (lacosamide) XCOPRI (cenobamate) ZARONTIN (ethosuximide) ZONISADE (zonisamide) ZTALMY (ganaxolone)	• * PA required, to include reason topiramate 2 x 25 mg capsules cannot be used, before product will be approved. • ** Step through vigabatrin powder packets required.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
ANTIPARKINSON'S AGENTS, ORAL/TRANSDERMAL		**Review Schedule: 1st Quarter**
amantadine capsule, solution benztropine bromocriptine carbidopa/levodopa IR, ER tablet entacapone pramipexole IR ropinirole IR selegiline capsule, tablet trihexyphenidyl	amantadine tablet AZILECT (rasagiline) carbidopa carbidopa/levodopa ER capsule, ODT carbidopa/levodopa/entacapone COMTAN (entacapone) CREXONT ER (carbidopa/levodopa) DHIVY (carbidopa/levodopa) DUOPA (carbidopa/levodopa) GOCOVRI (amantadine) INBRIJA (levodopa) JUVMO (tavapadon) NEUPRO (rotigotine) NOURIANZ (istradefylline) ONAPGO (apomorphine) ONGENTYS (opicapone) pramipexole ER rasagiline ropinirole ER RYTARY (carbidopa/levodopa) SINEMET 10-100 (carbidopa/levodopa) STALEVO (carbidopa/levodopa/entacapone) VYALEV (foscarbidopa/foslevodopa) XADAGO (safinamide)	• Two (2) preferred products required before a non-preferred product will be approved.
SKELETAL MUSCLE RELAXANTS		**Review Schedule: 3rd Quarter**
baclofen 5 mg, 10 mg, 20 mg tablet cyclobenzaprine 5 mg, 10 mg tablet methocarbamol 500 mg, 750 mg tablet tizanidine tablet	AMRIX (cyclobenzaprine) ATMEKSI (methocarbamol) ± baclofen 15 mg tablet, solution **, suspension carisoprodol *** carisoprodol compound with codeine chlorzoxazone cyclobenzaprine 7.5 mg tablet cyclobenzaprine ER DANTRIUM (dantrolene) dantrolene FEXMID (cyclobenzaprine) FLEQSUVY (baclofen) LYVISPAH (baclofen) granule packets metaxalone ^ methocarbamol 1000 mg tablet ONTRALFY (tizanidine) ^^ orphenadrine orphenadrine, aspirin, caffeine OZOBAX (baclofen) OZOBAX DS (baclofen) SOMA (carisoprodol) ***	• Two (2) preferred products required before a non-preferred product will be approved. Additional requirements are as follows: • Total quantity limit of 120 units of muscle relaxants, with the exception of baclofen products, per 30 rolling days. • ** PA required, to include reason baclofen suspension cannot be used, before product will be approved. • ***Carisoprodol quantity limit – 84 units per 90 days • ^ PA required for 640 mg, to include reason 400 mg or 800 mg tablets cannot be used, before product will be approved.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
	TANLOR (methocarbamol) tizanidine capsule ^^ TONMYA (cyclobenzaprine) ^^ ZANAFLEX (tizanidine) capsule ^^, tablet	• ^^ PA required, to include reason why the preferred same chemical entity cannot be used, before the 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 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) FOUNDAYO (orforglipron) tablet phentermine capsule, 37.5 mg tablet WEGOVY (semaglutide) pen-injector WEGOVY HD (semaglutide) pen-injector ZEPBOUND (tirzepatide) auto-injector ZEPBOUND KWIKPEN (tirzepatide)	ADIPEX-P (phentermine) benzphetamine HCl diethylpropion HCl diethylpropion HCl ER liraglutide pen injector LOMAIRA (phentermine) orlistat phendimetrazine tartrate phendimetrazine tartrate ER phentermine 8 mg tablet phentermine/topiramate ER SAXENDA (liraglutide) pen injector WEGOVY (semaglutide) tablet XENICAL (orlistat)	• Two (2) preferred products required before a non-preferred product will be approved.
OVER THE COUNTER DRUGS		
		Review Schedule: 3rd Quarter

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
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		**Review Schedule: 3rd Quarter**
donepezil 5 mg, 10 mg tablet memantine tablet rivastigmine patch	ARICEPT (donepezil) donepezil ODT donepezil 23 mg tablet EXELON (rivastigmine) patch galantamine LEQEMBI (lecanemab-irmb) memantine capsule, solution memantine/donepezil ER NAMENDA XR (memantine) NAMZARIC (memantine/donepezil) RAZADYNE ER (galantamine) rivastigmine capsule ZUNVEYL DR (benzgalantamine)	• 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. Additional requirements are as follows: • * Ingrezza quantity limit – 1 capsule per day
MULTIPLE SCLEROSIS		**Review Schedule: 4th Quarter**
AVONEX (interferon beta-1a) * BRIUMVI (ublituximab-xiiy) 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) * cladribine 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)	• Two (2) preferred products required before a non-preferred product will be approved. Additional requirements are as follows: • * Clinical criteria applies

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
	TASCENSO ODT (fingolimod) TECFIDERA (dimethyl fumarate) TYRUKO (natalizumab-sztn) *VUMERITY (diroximel fumarate) ZEPOSIA (ozanimod)	
NEUROPATHIC PAIN		**Review Schedule: 1st Quarter**
gabapentin IR lidocaine patch 4%, 5% pregabalin RELGAABI (gabapentin) 300mg, 400mg	gabapentin 200mg (gen Relgaabi) gabapentin ER GRALISE (gabapentin) HORIZANT (gabapentin enacarbil) LYRICA CR (pregabalin) milnacipran NEURONTIN (gabapentin) pregabalin ER RELGAABI (gabapentin) 200mg * QUTENZA KIT (capsaicin/skin cleanser) SAVELLA (milnacipran HCl) ZTLIDO (lidocaine)	• Two (2) preferred products required before a non-preferred product will be approved. Additional requirements are as follows: • * PA required, to include reason 2 x 100 mg gabapentin capsules cannot be used, before product will be approved.
RESPIRATORY AGENTS		
ANTIHISTAMINES, MINIMALLY SEDATING		**Review Schedule: 3rd Quarter**
cetirizine 120mL solution RX, tablet levocetirizine RX/OTC loratadine solution, tablet fexofenadine tablet	cetirizine capsule, chewable tablet, solution (OTC and all other RX package sizes EXCEPT 120mL) cetirizine-D CLARINEX (desloratadine) CLARINEX-D (desloratadine/pseudoephedrine) desloratadine fexofenadine ODT, solution fexofenadine-D loratadine chewable tablet, 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 tablet arformoterol vial BROVANA (arformoterol tartrate) formoterol vial levalbuterol HFA, vial PERFOROMIST (formoterol fumarate) PROAIR RESPICLICK (albuterol sulfate) XOPENEX HFA (levalbuterol)	• Two (2) preferred products required before a non-preferred product will be approved.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
COPD AGENTS, SINGLE & DUAL AGENT COMBINATIONS		**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) STIOLTO RESPIMAT (tiotropium bromide/olodaterol)	BEVESPI (glycopyrrolate/formoterol fumarate) DALIRESP (roflumilast) DUAKLIR (aclidinium/formoterol) ipratropium bromide inhaler OHTUVAYRE (ensifentrine) * roflumilast tablet tiotropium bromide HFA TUDORZA (aclidinium bromide) umeclidinum umeclidinium/vilanterol YUPELRI (revefenacin)	• Two (2) preferred products required before a non-preferred product will be approved. Additional requirements are as follows: • * Step through 3-month trial LABA + LAMA dual therapy, with or without ICS, required. Abbreviations: LABA – long-acting beta$_2$ agonist LAMA – long-acting muscarinic antagonist ICS – inhaled corticosteroid
COPD AGENTS, TRIPLE AGENT COMBINATIONS		**Review Schedule: 4th Quarter**
TRELEGY (fluticasone furoate, umeclidinium, vilanterol) *	BREZTRI (budesonide, glycopyrrolate, formoterol fumarate)	• One (1) preferred products required before a non-preferred product will be approved. Additional requirements are as follows: • * Step through 3-month trial LABA + LAMA dual therapy, with or without ICS, required. 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
chlorpheniramine syrup, IR tablet
dextromethorphan 15 mg capsule
diphenhydramine capsule, liquid, tablet
guaifenesin liquid
guaifenesin DM liquid, 400-20 mg tablet
guaifenesin ER 600mg tablet
guaifenesin/codeine syrup
hydrocodone/homatropine syrup
promethazine DM syrup
promethazine/codeine syrup
phenylephrine tablet
pseudoephedrine liquid, IR tablet
	All other cough and cold products are non-preferred	• Two (2) preferred products required before a non-preferred product will be approved. Additional requirements are as follows:
		• Quantity limits in place:
		  ○ Narcotic antitussives – 240 mL per 30 days and 480mL per 90 days without a comorbid diagnosis
		  ○ Tussionex – 120 mL per 84 days and 480 mL per year

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
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) (H2 Pharma – labeler 61269) QVAR REDIHALER (beclomethasone dipropionate) SYMBICORT (budesonide/formoterol fumarate dihydrate)	AIRSUPRA (albuterol sulfate/budesonide) ALVESCO (ciclesonide) beclomethasone HFA BREO ELLIPTA (fluticasone furoate/vilanterol) BREYNA (budesonide/formoterol fumarate) budesonide inhalation solution 1 mg budesonide/formoterol fumarate dihydrate fluticasone furoate Ellipta 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. Additional requirements are as follows: • * Approval for budesonide may be generated by system for patients: ○ Aged 6 years and older AND with ○ Diagnosis on file indicating developmental delay • * Prior authorization required for ≥ 18 years of age.
IDIOPATHIC PULMONARY FIBROSIS AGENTS		**Review Schedule: 2nd Quarter**
nintedanib pirfenidone 267mg, 801mg	ESBRIET (pirfenidone) JASCAYD (nerandomilast) OFEV (nintedanib) pirfenidone 534mg*	• Two (2) preferred products required before a non-preferred product will be approved. Additional requirements are as follows: • * PA required, to include reason 267mg preferred product cannot be used, before product will be approved.
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 NASACORT OTC (triamcinolone) NASONEX OTC (mometasone) olopatadine OMNARIS (ciclesonide) QNASL (beclomethasone dipropionate) RYALTRIS (olopatadine HCl/mometasone) SINUVA (mometasone) triamcinolone XHANCE (fluticasone propionate)	• Two (2) preferred products required before a non-preferred product will be approved.
LEUKOTRIENE RECEPTOR ANTAGONISTS		**Review Schedule: 4th Quarter**
montelukast tablet, chewable tablet	montelukast granules	

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
	SINGULAIR (montelukast) zafirlukast zileuton ER	• 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) EXDENSUR (depemokimab-ulaa) OMLYCLO (omalizumab-igec) RHAPSIDO (remibrutinib)	• 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. Additional requirements are as follows: • * Three (3) products, two (2) of which must be a preferred product and one (1) of which must be Sunosi, required before product will be approved.
STIMULANTS AND RELATED AGENTS – LONG-ACTING, AMPHETAMINE-LIKE AGENTS **(Clinical criteria applies for members over age 21.)**		**Review Schedule: 4th Quarter**
dextroamphetamine ER dextroamphetamine-amphetamine ER DYANAVEL XR (amphetamine/dextroamphetamine SR) suspension VYVANSE (lisdexamfetamine) capsule	ADDERALL XR (amphetamine/ dextroamphetamine SR 24 HR, IR/ER, 50:50%) ADZENYS XR ODT (amphetamine SR 24 HR, IR/ER, 50:50%) amphetamine ER ODT (generic ADZENYS XR ODT) ARYNTA (lisdexamphetamine) DYANAVEL XR (amphetamine/dextroamphetamine SR) tablet lisdexamfetamine MYDAYIS (mixed amphetamine salts) VYVANSE (lisdexamfetamine) chewable tablet* XELSTRYM (dextroamphetamine) patch*	• Three (3) preferred products, which includes at least one (1) from the long-acting, methylphenidate-like class, required before a non-preferred product will be approved. Additional requirements are as follows: • * Three (3) preferred products, one (1) of which must be a preferred product of the same dosage form from the long-acting amphetamine-like or methylphenidate classes, required before a non-preferred product will be approved.
STIMULANTS AND RELATED AGENTS – LONG-ACTING, METHYLPHENIDATE-LIKE AGENTS **(Clinical criteria applies for members over age 21.)**		**Review Schedule: 4th Quarter**

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
dexmethylphenidate 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%)	APTENSIO XR (methylphenidate) AZSTARYS (serdexmethylphenidate/ dexmethylphenidate) CONCERTA (methylphenidate SA OSM IR/ER, 22:78%) COTEMPLA XR (methylphenidate IR/ER 25:75%) DAYTRANA (methylphenidate) patch* FOCALIN XR (dexmethylphenidate SR 24 HR) JORNAY PM (methylphenidate ER) methylphenidate XR (generic Aptensio XR) methylphenidate IR/ER 25:75% (generic Cotempla XR) methylphenidate (transdermal) patch TD24 RELEXXII ER 24 (methylphenidate ER OSM IR/ER, 22:78%	• Three (3) preferred products, which includes at least one (1) from the long-acting, amphetamine-like class, required before a non-preferred product will be approved. Additional requirements are as follows: • * Three (3) preferred products, one (1) of which must be a preferred product of the same dosage form from the long-acting amphetamine-like or methylphenidate classes, required before a non-preferred product will be approved.
STIMULANTS AND RELATED AGENTS – LONG-ACTING, NON-STIMULANTS		**Review Schedule: 4th Quarter**
atomoxetine capsules clonidine ER 0.1 mg tablet guanfacine ER	atomoxetine solution (generic Atoncy) ATONCY solution (atomoxetine) INTUNIV (guanfacine ER) ONYDA XR (clonidine hydrochloride) QELBREE (viloxazine hydrochloride)	• Two (2) preferred products required before a non-preferred product will be approved. Additional requirements are as follows:
STIMULANTS AND RELATED AGENTS – SHORT-ACTING, AMPHETAMINE-LIKE AGENTS **(Clinical criteria applies for members over age 21.)**		**Review Schedule: 4th Quarter**
dextroamphetamine/amphetamine IR dextroamphetamine IR tablet PROCENTRA (dextroamphetamine)	ADDERALL (amphetamine/dextroamphetamine) amphetamine tablet dextroamphetamine solution EVEKEO (amphetamine) ODT, tablet methamphetamine ZENZEDI (dextroamphetamine)	• Two (2) preferred products required before a non-preferred product will be approved. Additional requirements are as follows: • Dose optimization required
STIMULANTS AND RELATED AGENTS – SHORT-ACTING, METHYLPHENIDATE-LIKE AGENTS **(Clinical criteria applies for members over age 21.)**		**Review Schedule: 4th Quarter**
dexmethylphenidate IR methylphenidate IR methylphenidate solution	FOCALIN (dexmethylphenidate) METHYLIN (methylphenidate) solution methylphenidate chewable tablet RITALIN (methylphenidate)	• Two (2) preferred products required before a non-preferred product will be approved.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
SMOKING CESSATION		
SMOKING CESSATION PRODUCTS		**Review Schedule: 1st Quarter**
bupropion SR nicotine lozenge, gum, patch varenicline	CHANTIX (varenicline) NICOTROL NS	• Two (2) preferred products required before a non-preferred product will be approved.
TOPICAL PRODUCTS		
ANTIBIOTICS, TOPICAL		**Review Schedule: 1st Quarter**
bacitracin bacitracin zinc bacitracin/polymyxin gentamicin mupirocin ointment neomycin/bacitracin/polymyxin	bacitracin/pramoxine 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 cream ketoconazole cream, shampoo miconazole nitrate solution w/ applicator nystatin nystatin/triamcinolone ointment	ALEVAZOL (clotrimazole) CICLODAN (ciclopirox) ciclopirox gel, shampoo, suspension clotrimazole solution econazole foam ERTACZO (sertaconazole) EXELDERM (sulconazole) ketoconazole foam KETODAN (ketoconazole) LOPROX (ciclopirox) 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	CROTAN (crotamiton) ivermectin lotion	• Two (2) preferred products required before a non-preferred product will be approved.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
piperonyl butoxide/pyrethrins	malathion OVIDE (malathion) lotion SKLICE (ivermectin) spinosad VANALICE (pyrethrins/piperonyl butoxide)	
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: 4th Quarter**
calcipotriene cream, ointment, solution ZORYVE 0.3% (roflumilast) *	calcipotriene foam calcipotriene/betamethasone calcitriol ENSTILAR (calcipotriene/betamethasone) SORILUX (calcipotriene) tazarotene cream, gel TAZORAC (tazarotene) VECTICAL (calcitriol) VTAMA (tapinarof) **	• Two (2) preferred products required before a non-preferred product will be approved. Additional requirements are as follows: • * Step through a preferred topical corticosteroid or preferred topical calcipotriene product required. • ** Two (2) products, one (1) of which must be a preferred calcipotriene product and one (1) of which must be Zoryve 0.3%, required before product will be approved.
ANTIVIRALS, TOPICAL		**Review Schedule: 4th Quarter**
acyclovir ointment docosanol	acyclovir cream DENAVIR (penciclovir) penciclovir cream	• 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**
EUCRISA (crisaborole) * pimecrolimus tacrolimus ZORYVE 0.05%, 0.15% (roflumilast) *	ADBRY (tralokinumab-ldrm) ADQUEY (difamilast) µ ANZUPGO (delgocitinib) CIBINQO (abrocitinib) EBGLYSS (lebrikizumab-lbkz) NEMLUVIO (nemolizumab-ilto) OPZELURA (ruxolitinib)	• Two (2) preferred products required before a non-preferred product will be approved. Additional requirements are as follows: • Quantity limits are in place: 400 grams per year • * Step through a topical corticosteroid or topical calcineurin product required • µ PA required to give a clinical rationale to why both Eucrisa and Zoryve cannot be used

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
IMMUNOMODULATORS, TOPICAL		**Review Schedule: 3rd Quarter**
imiquimod 3.75% cream imiquimod 5% cream packet	imiquimod cream pump VEREGEN (sinecatechins)	• Two (2) preferred products required before a non-preferred product will be approved.
OPHTHALMICS, ALLERGIC CONJUNCTIVITIS		**Review Schedule: 3rd Quarter**
ALAWAY (ketotifen) azelastine cromolyn ketotifen olopatadine 0.1%, 0.2% OTC olopatadine 0.2% RX	ALREX (loteprednol) bepotastine BEPREVE (bepotastine) epinastine LASTACAFT OTC (alcaftadine) olopatadine 0.1% RX olopatadine 0.7% PATADAY (olopatadine) ZADITOR (ketotifen) ZERVIATE (cetirizine)	• Two (2) preferred products required before a non-preferred product will be approved.
OPHTHALMICS, ANTIBIOTICS		**Review Schedule: 3rd Quarter**
bacitracin/polymyxin CILOXAN (ciprofloxacin) ointment ciprofloxacin erythromycin gentamicin moxifloxacin (generic VIGAMOX) ofloxacin POLYCIN (bacitracin/polymyxin) polymyxin/trimethoprim tobramycin XDEMVY (lotilaner) *	AZASITE (azithromycin) bacitracin bacitracin/polymyxin besifloxacin 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) ZYMAXID (gatifloxacin)	• Two (2) preferred products required before a non-preferred product will be approved. • *Requires documentation of demodex blepharitis
OPHTHALMICS, ANTIBIOTIC-STEROID COMBINATION		**Review Schedule: 3rd Quarter**
neomycin/polymyxin/dexamethasone sulfacetamide/prednisolone TOBRADEX (tobramycin/dexamethasone) ointment	neomycin/bacitracin/polymyxin/HC neomycin/polymyxin/HC NEO-POLYCIN HC (neomycin/bacitracin/ polymyxin/HC) TOBRADEX ST (tobramycin/dexamethasone) tobramycin/dexamethasone tobramycin/loteprednol ZYLET (tobramycin/loteprednol)	• Two (2) preferred products required before a non-preferred product will be approved.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
OPHTHALMICS, ANTI-INFLAMMATORIES		**Review Schedule: 3rd Quarter**
dexamethasone diclofenac FLAREX (fluorometholone) fluorometholone flurbiprofen FML FORTE (fluorometholone) ketorolac (all strengths) LOTEMAX (loteprednol) ointment MAXIDEX (dexamethasone) NEVANAC (nepafenac) PRED MILD (prednisolone) prednisolone	ACULAR (ketorolac) ACULAR LS (ketorolac) ACUVAIL (ketorolac) bromfenac BROMSITE (bromfenac) BYQLOVI (clobetasol) clobetasol DEXTENZA (dexamethasone) difluprednate DUREZOL (difluprednate) EYSUVIS (loteprednol) FML LIQUFILM (fluorometholone) ILEVRO (nepafenac) ILUVIEN (fluocinolone acetate) INVELTYS (loteprednol) LOTEMAX (loteprednol) gel LOTEMAX SM (loteprednol) 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		**Review Schedule: 3rd Quarter**
ALPHAGAN P (brimonidine) brimonidine 0.2% carteolol COMBIGAN (brimonidine/timolol) dorzolamide dorzolamide/timolol drops 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 (PF) droperette iDOSE (travoprost) iopidine ISTALOL (timolol maleate) IYUZEH (latanoprost/PF) LUMIGAN (bimatoprost) phospholine iodine RHOPRESSA (netarsudil) ROCKLATAN (netarsudil/latanoprost)	• Two (2) preferred products required before a non-preferred product will be approved.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
	tafluprost (PF) droperette timolol hemihydrate timolol maleate gel timolol maleate drop daily timolol maleate (PF) droperette TIMOPTIC (timolol) TIMOPTIC XE (timolol) TRAVATAN Z (travoprost) VYZULTA (latanoprostene bunod) XALATAN (latanoprost) XELPROS (latanoprost) ZIOPTAN (tafluprost) ZOLYBUS (bimatoprost PF)	
OPHTHALMICS, IMMUNOMODULATORS		**Review Schedule: 4thQuarter**
RESTASIS (cyclosporine) vial XIIDRA (lifitegrast)	CEQUA (cyclosporine) cyclosporine droperettes MIEBO (perfluorohexyloctane) RESTASIS MULTIDOSE (cyclosporine) TRYPTYR (acoltremon) TYRVAYA (varenicline) VERKAZIA (cyclosporine) VEVYE (cyclosporine)	• Two (2) 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 ciprofloxacin/hydrocortisone 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)	• Two (2) preferred products required before a non-preferred product will be approved.

PREFERRED AGENTS	NON-PREFERRED AGENTS Prior authorization is required	CRITERION
	oxymetazoline (generic Rhofade) RHOFADE (oxymetazoline) ROSADAN (metronidazole) SOOLANTRA (ivermectin)	
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) triamcinolone cream, lotion, 0.025%, 0.1%, 0.5% ointment	alclometasone amcinonide betamethasone dipropionate betamethasone dipropionate/propylene glycol betamethasone valerate clobetasol cream, foam, gel, lotion, shampoo, spray clocortolone CLOBEX (clobetasol) CLODAN (clobetasol) CORDRAN (fludroxycortide) DERMACINRX DERMA-SMOOTHE FS (fluocinolone) DERMASORB (triamcinolone) 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) prednicarbate SERNIVO (betamethasone dipropionate) SYNALAR (fluocinolone) TEXACORT (hydrocortisone) TOPICORT (desoximetasone) TOVET (clobetasol) triamcinolone 0.05% ointment, aerosol ULTRAVATE (halobetasol)	• Two (2) preferred products required before a non-preferred product will be approved.