

2019

Delaware Medicaid Preferred Drug List (PDL)

Contents

ADHD AGENTS.....	1
STIMULANTS AND RELATED AGENTS – SHORT-ACTING	1
STIMULANTS AND RELATED AGENTS – LONG-ACTING.....	1
ANALGESICS	2
ANALGESICS, NARCOTIC LONG-ACTING	2
ANALGESICS, NARCOTIC SHORT-ACTING.....	3
ANTIHYPURICEMICS, ORAL	3
ANTIMIGRAINE AGENTS, PROPHYLAXIS - INJECTABLE	4
ANTIMIGRAINE AGENTS, TRIPTANS	4
CYTOKINE AND CAM ANTAGONISTS	5
NSAIDs, ORAL/TOPICAL	6
OPIATE DEPENDENCE TREATMENTS	6
ANTIDOTES.....	7
OPIATE OVERDOSE TREATMENTS.....	7
ANTI-INFECTIVE AGENTS.....	8
ANTIBIOTICS, GI.....	8
ANTIBIOTICS, INHALED	8
ANTIBIOTICS, TOPICAL	8
ANTIBIOTICS, VAGINAL	9
ANTIFUNGALS, ORAL	9
ANTIVIRALS, ANTIRETROVIRALS	10
ANTIVIRALS, HEPATITIS C AGENTS.....	11
ANTIVIRALS, ORAL	11
CEPHALOSPORINS.....	11
FLUOROQUINOLONES	12
LINCOSAMIDES/OXAZOLIDINONES/STREPTOGRAMINS	12
MACROLIDES	12
PENICILLINS.....	13
TETRACYCLINES	13
URINARY ANTI-INFECTIVES.....	13
ANTINEOPLASTICS	14
ONCOLOGY AGENTS.....	14

CARDIOVASCULAR AGENTS.....	15
ANGIOTENSIN MODULATORS	15
ANGIOTENSIN MODULATOR/CALCIUM CHANNEL BLOCKER COMBINATIONS.....	15
ANTIHYPERTENSIVES, SYMPATHOLYTIC.....	16
BETA BLOCKERS	16
CALCIUM CHANNEL BLOCKERS.....	17
DIURETICS	17
EPINEPRINE, SELF-INJECTED	17
LIPOTROPICS, OTHER	18
LIPOTROPICS, STATINS.....	18
PAH AGENTS, ORAL & INHALED.....	18
VASODILATORS, CORONARY.....	19
CENTRAL NERVOUS SYSTEM DRUGS.....	20
ANTIDEPRESSANTS, OTHER.....	20
ANTIDEPRESSANTS, SSRIs	20
ANTIPSYCHOTICS, ORAL.....	21
ANTIPSYCHOTICS, INJECTABLE	21
ANXIOLYTICS	22
MOOD STABILIZERS.....	22
SEDATIVE HYPNOTICS	22
ENDOCRINE AND METABOLIC DRUGS	23
ANDROGENIC AGENTS, TOPICAL.....	23
BONE RESORPTION SUPPRESSION AND RELATED AGENTS.....	23
CONTRACEPTIVES, ORAL - BIPHASIC.....	23
CONTRACEPTIVES, ORAL - COMBINATION.....	24
CONTRACEPTIVES, ORAL - EXTENDED CYCLE	25
CONTRACEPTIVES, ORAL - PROGESTINS	25
CONTRACEPTIVES, ORAL – TRIPHASIC.....	26
CONTRACEPTIVES, PROGESTIN – IUD/IMPLANT	27
GROWTH HORMONES.....	27
HYPOGLYCEMICS, ALPHA-GLUCOSIDASE INHIBITORS	27
HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS.....	28
HYPOGLYCEMICS, INSULINS	28
HYPOGLYCEMICS, MEGLITINIDES.....	29
HYPOGLYCEMICS, METFORMINS	29
HYPOGLYCEMICS, SGLT2s.....	29
HYPOGLYCEMICS, TZDs	29
GLUCOCORTICOIDs, ORAL	30

PITUITARY SUPPRESSANTS, CENTRAL PRECOCIOUS PUBERTY (CPP).....	30
PROGESTATIONAL AGENTS.....	30
THYROID HORMONES.....	31
GASTROINTESTINAL AGENTS.....	32
ANTIEMETICS.....	32
BILE SALTS.....	32
CONSTIPATION – IBS - OIC.....	32
H. PYLORI TREATMENTS.....	33
HISTAMINE II RECEPTOR BLOCKERS.....	33
PANCREATIC ENZYMES.....	33
PHOSPHATE BINDERS.....	33
PROTON PUMP INHIBITORS.....	34
ULCERATIVE COLITIS AGENTS.....	34
GENITOURINARY PRODUCTS.....	35
BLADDER RELAXANT PREPARATIONS.....	35
BPH TREATMENTS.....	35
HEMATOLOGICAL AGENTS.....	36
ANTICOAGULANTS, ORAL/SQ.....	36
ANTIHEMOPHILIC FACTOR VIII/vWF.....	36
ANTIHEMOPHILIC FACTOR IX.....	36
COLONY STIMULATING FACTORS.....	37
ERYTHROPOIESIS STIMULATING PROTEINS.....	37
HAE TREATMENTS.....	37
PLATELET AGGREGATION INHIBITORS.....	37
MEDICAL DEVICES AND SUPPLIES.....	38
DIABETIC TESTING BLOOD GLUCOSE METERS, TEST STRIPS, LANCETS.....	38
NEUROMUSCULAR DRUGS.....	39
ANTICONVULSANTS, ORAL/RECTAL.....	39
ANTIPARKINSON'S AGENTS, ORAL/TRANSDERMAL.....	40
SKELETAL MUSCLE RELAXANTS.....	40
NUTRITIONAL PRODUCTS.....	41
PRENATAL VITAMINS.....	41
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS.....	42
ALZHEIMER'S AGENTS.....	42
MOVEMENT DISORDER.....	42
MULTIPLE SCLEROSIS.....	42
NEUROPATHIC PAIN.....	43
RESPIRATORY AGENTS.....	44

ANTI-HISTAMINES, MINIMALLY SEDATING.....	44
BRONCHODILATORS, BETA AGONIST.....	44
COPD AGENTS.....	45
COUGH and COLD.....	45
GLUCOCORTICOIDS, INHALED.....	46
INTRANASAL RHINITIS AGENTS.....	46
LEUKOTRIENE RECEPTOR ANTAGONISTS.....	47
TOPICAL PRODUCTS.....	48
ACNE AGENTS, TOPICAL.....	48
ANTIFUNGALS, TOPICAL.....	49
ANTIPARASITICS, TOPICAL.....	49
ANTIPSORIATIC AGENTS, ORAL.....	50
ANTIPSORIATIC AGENTS, TOPICAL.....	50
ANTIVIRALS, TOPICAL.....	50
IMMUNOMODULATORS, ATOPIC DERMATITIS.....	50
IMMUNOMODULATORS, TOPICAL.....	51
OPHTHALMICS, ALLERGIC CONJUNCTIVITIS.....	51
OPHTHALMICS, ANTIBIOTICS.....	51
OPHTHALMICS, ANTIBIOTIC-STEROID COMBINATIONS.....	52
OPHTHALMICS, ANTI-INFLAMMATORIES.....	52
OPHTHALMICS, GLAUCOMA AGENTS.....	53
OPHTHALMICS, IMMUNOMODULATORS.....	53
OTIC ANTIBIOTICS.....	53
OTIC ANTI-INFECTIVES, ANESTHETICS.....	54
STEROIDS, TOPICAL.....	54

ADHD AGENTS

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

PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
amphetamine salt combo IR §	methylphenidate IR §	dextroamphetamine solution	methylphenidate solution §	§–Clinical criteria applies for clients over age 21
dexmethylphenidate IR §	Methylin solution §	methamphetamine §	Evekeo	Two preferred products required before a non-preferred product will be approved
dextroamphetamine IR tablets §	Procentra §	methylphenidate chewable tablets	Zenzedi	Dose optimization required.

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

PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
amphetamine salt combo ER §	methylphenidate LA	clonidine ER	Adzenys ER	§–Clinical criteria applies for clients over age 21
armodafinil	modafinil	dexmethylphenidate ER	Adzenys XR-ODT	PA forms available at http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core_Download&EntryId=164
atomoxetine	Aptensio XR	dextroamphetamine ER§	Cotempla XR	Modafinil and Armodafinil PA forms at http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core_Download&EntryId=199
dextroamphetamine-amphetamine ER	Daytrana •	methylphenidate ER 24 tablets (labeler 00406, 13811 and 00378)	Dyanavel	
guanfacine ER §	Focalin XR §	methylphenidate ER 72 mg	Mydayis	
methylphenidate CD	Quillichew ER			
methylphenidate ER 24 tablets (labeler 00591 or 62175) §	Quillivant XR §			
methylphenidate ER tablets (generic Ritalin SR)	Vyvanse §			

ANALGESICS

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

PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
fentanyl transdermal 12, 25, 50, 75, 100 mcg/hr	Embeda	buprenorphine patches	Arymo ER	Two preferred products required before a non-preferred product will be approved
morphine ER tablets		fentanyl transdermal 37.5, 62.5, 87.5 mcg/hr	Belbuca	PA form available at: http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core_Download&EntryId=183
tramadol ER (generic Ultram ER)		hydromorphone ER	Hysingla ER	
		morphine ER capsules	Morphabond ER	
		oxycodone ER	Nucynta ER	
		oxymorphone ER	Xartemis XR	
		tramadol ER capsules	Xtampza ER	
			Zohydro ER	

ANALGESICS, NARCOTIC SHORT-ACTING				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
butalbital compound/ codeine		butorphanol nasal •	oxycodone/ ibuprofen	Two preferred products required before a non-preferred product will be approved
codeine		carisoprodol compound	oxymorphone	–Quantity limits in place:
codeine/APAP		dihydrocodeine/APAP/ caffeine	pentazocine/ naloxone	Ø oxycodone 15mg maximum of 240 units a year
hydrocodone/APAP		dihydrocodeine/ASA/ caffeine	tramadol/APAP	Ø oxycodone 20mg maximum of 120 units a year
hydrocodone/ibuprofen		fentanyl lozenge •	Abstral	Ø oxycodone 30 mg maximum of 60 units a year
hydromorphone tablets		hydromorphone liquid, suppositories	Capital with Codeine	Ø 120 short-acting units per 30 days with a total of 720 short-acting units a year
morphine tabs/solution		levorphanol	Fentora	Ø DMMA recommends that first fill of new pain medication be limited to 15 supply
oxycodone capsules, solution, tablets		meperidine	Nucynta	•–Clinical criteria apply.
oxycodone/APAP		morphine concentrate, suppositories	Oxaydo	Clinical PA form available at: http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core_Download&EntryId=183
pentazocine/APAP		oxycodone/ASA	Primlev	Butorphanol nasal PA form available at: http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core_Download&EntryId=174
tramadol		oxycodone concentrate	Roxybond	Fentanyl transmucosal and buccal PA form available at: http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core_Download&EntryId=180
ANTIHYPERTENSIVES, ORAL				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
allopurinol	probenecid	Duzallo	Mitigare	• Clinical criteria apply to colchicine with approval for treatment, not prophylaxis
colchicine •	probenecid with colchicine	Mitigate	Zurampic	

ANTIMIGRAINE AGENTS, PROPHYLAXIS - INJECTABLE

PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
		Aimovig	Botox	Product will be approved for patients with chronic migraine with inadequate response to three preferred oral agents
		Ajovy ^{NR}	Emgality ^{NR}	

ANTIMIGRAINE AGENTS, TRIPTANS

PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
rizatriptan, rizatriptan ODT		almotriptan	Cambia	Two preferred products required before a non-preferred product will be approved
sumatriptan nasal spray, tablets		dihydroergotamine	Ergomar	
sumatriptan 6 mg/0.5 ml vial		eletriptan	Migergot	-Quantity limits in place: Nine (9) tablets per 45 days
		frovatriptan	Onzetra	
		naratriptan	Sumavel Dosepro	
		sumatriptan injection (except for 6 mg/0.5 ml vial)	Treximet	
		sumatriptan/naproxen	Zembrace	
		zolmitriptan	Zomig	

CYTOKINE AND CAM ANTAGONISTS				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
Cosentyx (after step through Humira)		Actemra	Orencia	Approved diagnosis code required on prescription and electronic submissions
Enbrel (diagnosis code required)		Amevive▲	Otezla	
Humira (diagnosis code required)		Arcalyst	Remicade	
		Cimzia	Siliq	
			Simponi	
		Entyvio	Simponi Aria	
		Ilaris	Stelara	
		Inflectra ^{NR}	Taltz	
		Kevzara	Tremfya	
		Kineret	Xeljanz	
		Olumiant ^{NR}	Xeljanz XR	

NSAIDs, ORAL/TOPICAL				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
celecoxib •		diclofenac	oxaprozin	Two preferred products required before a non-preferred product will be approved
ibuprofen		diclofenac/misoprostol	piroxicam	
indomethacin IR		diflunisal	tolmetin	• Clinical PA required
ketorolac		etodolac	Duexis	
meloxicam tablets		fenoprofen	Flector	http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core_Download&EntryId=175
naproxen IR tablets		flurbiprofen	Indocin	
sulindac		indomethacin ER	Pennsaid	
		ketoprofen	Sprix	
		meclofenamate	Tivorbex	
		mefenamic acid	Vimovo	
		meloxicam suspension	Vivlodex	
		nabumetone	Zipsor	
		naproxen DR, suspension	Zorvolex	
		naproxen sodium		
OPIATE DEPENDENCE TREATMENTS				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
buprenorphine	Sublocade	Bunavail		
buprenorphine/naloxone	Suboxone	Lucemyra		
naltrexone	Vivitrol	Zubsolv		

ANTIDOTES

OPIATE OVERDOSE TREATMENTS

PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19				
naloxone				Evzio is not covered under the Medicaid Drug Rebate Program
Narcan nasal spray				

ANTI-INFECTIVE AGENTS

ANTIBIOTICS, GI

PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
metronidazole tablets		metronidazole capsules	Aemcolo ^{NR}	●—Clinical prior authorization is required
neomycin		paromomycin capsules	Dificid	
		vancomycin	Firvanq	Patients must try and fail lactulose before Xifaxan is approved for appropriate diagnoses
			Xifaxan ▲ ●	

ANTIBIOTICS, INHALED

PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
tobramycin (labeler 00093 only)	Bethkis	tobramycin (except labeler 00093)	Cayston	
	Kitabis Pak	Amikayce ^{NR}	TOBI Podhaler	

ANTIBIOTICS, TOPICAL

PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
bacitracin	mupirocin ointment	mupirocin cream	Centany	Two preferred products required before a non-preferred product will be approved
bacitracin/polymyxin	triple antibiotic ointment	neomycin/bacitracin/polymyxin/pramoxine	Cortisporin	
gentamicin		neomycin/polymyxin/pramoxine	Neo-Synalar	
			Xepi ^{NR}	

ANTIBIOTICS, VAGINAL				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
clindamycin	Cleocin ovules	Nuessa	Vandazole	Two preferred products required before a non-preferred product will be approved
metronidazole	Clindesse	Solosec		
ANTIFUNGALS, ORAL				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
benznidazole		clotrimazole	voriconazole	Two preferred products required before a non-preferred product will be approved
fluconazole		flucytosine	Cresemba	
griseofulvin suspension		griseofulvin tablets	Noxafil ▲	
nystatin		itraconazole	Onmel	
terbinafine		ketoconazole	Oravig	
		Lamsil	Sporanox	

ANTIVIRALS, ANTIRETROVIRALS				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
abacavir	Isentress	abacavir/lamivudine/ zidovudine	Invirase	Patients on non-preferred drugs will be grandfathered
abacavir/lamivudine	Kaletra	efavirenz	Isentress HD	
atazanavir	Norvir	didanosine	Juluca	
lamivudine	Odefsey	fosamprenavir	Lexiva	
lamivudine-zidovudine	Prezcobix	lopinavir-ritonavir	Pifeltro ^{NR}	
lopinavir-ritonavir	Prezista	nevirapine	Rescriptor	
tenofovir disoproxil fumarate	Retrovir	ritonavir	Selzentry	
zidovudine	Reyataz powder pack	stavudine	Stribild	
Atripla	Sustiva	Aptivus	Symtuza	
Biktarvy	Symfi/Symfi Lo	Complera	Triumeq	
Cimduo	Tivicay	Crixivan	Videx	
Descovy	Trogarzo	Delstrigo ^{NR}	Viracept	
Edurant	Truvada	Fuzeon	Zerit solution	
Emtriva	Tybost	Intelence		
Evotaz	Viread (except 300 mg tablet)			
Genvoya	Vitekta			

ANTIVIRALS, HEPATITIS C AGENTS (Clinical criteria apply to class. All agents require a prior authorization.)				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
ribavirin tablets		ribavirin capsules	Rebetol	• Clinical criteria apply
Eplclusa •		Daklinza •	Ribasphere	PA form available at
Mavyret •		Harvoni •	Sovaldi •	http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core_Download&EntryId=536
Zepatier •		Pegasys▲•	Vosevi •	
		Peg-Intron▲•		
ANTIVIRALS, ORAL				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
acyclovir	valacyclovir	amantadine solution, tablets	Prevymis	Two preferred products required before a non-preferred product will be approved
amantadine capsules	Relenza	rimantadine	Sitavig	Liquid medications require prior authorization for clients over 10-years old
famciclovir	Valcyte		Xofluza ^{NR}	–Quantity limits in place for oseltamivir and Relenza
oseltamivir				
CEPHALOSPORINS				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
cefaclor IR	cefprozil	cefaclor ER	cephalexin tablets	Two preferred products required before a non-preferred product will be approved
cefadroxil	cefuroxime	cefixime	Ceftin	
cefдинир	cephalexin capsules, suspension	cefподoxime	Daxbia	
		ceftibuten	Suprax	

FLUOROQUINOLONES

PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
ciprofloxacin IR tablets		ciprofloxacin ER	moxifloxacin	Two preferred products required before a non-preferred product will be approved
levofloxacin tablets		ciprofloxacin suspension	ofloxacin	
		levofloxacin solution	Baxdela	

LINCOSAMIDES/OXAZOLIDINONES/STREPTOGRAMINS

PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
clindamycin capsules	clindamycin solution (for client <10 yr)	Linezolid •	Sivextro	<ul style="list-style-type: none"> Clinical criteria apply http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core.Download&EntryId=192

MACROLIDES

PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
azithromycin		clarithromycin	Ery-Tab	
		erythromycin	Erythrocin	
		E.E.S.	PCE	
		Eryped	Zmax	

PENICILLINS				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
amoxicillin	penicillin	amoxicillin/clavulanate 250 suspension, tablets		
amoxicillin/clavulanate (except 250 susp, tabs)	penicillin G procaine	amoxicillin/clavulanate XR		
ampicillin	Bicillin CR			
dicloxacillin	Bicillin LA			
TETRACYCLINES				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
doxycycline hyclate	doxycycline monohydrate tablets	demeclocycline	tetracycline	Two preferred products required before a non-preferred product will be approved
doxycycline monohydrate 50, 100 mg capsules	minocycline capsules	doxycycline DR	Doryx	
		doxycycline IR-DR	Monolira ^{NR}	
		doxycycline monohydrate 75 mg capsules	Morgidox	
		doxycycline suspension	Seysara ^{NR}	
		minocycline ER	Vibramycin	
		minocycline tablets	Ximino	
URINARY ANTI-INFECTIVES				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
methenamine	Monurol	nitrofurantoin suspension		
nitrofurantoin mono- macrocrystals		nitrofurantoin macrocrystals		

ANTINEOPLASTICS**ONCOLOGY AGENTS**

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION
Preferred status implementation: 1/1/19	Prior authorization is required	
all drug products		

CARDIOVASCULAR AGENTS

ANGIOTENSIN MODULATORS

PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
benazepril / HCTZ		candesartan / HCTZ	quinapril / HCTZ	Two preferred products required before a non-preferred product will be approved
enalapril / HCTZ		captopril / HCTZ	telmisartan / HCTZ	
Epaned		eprosartan	trandolapril	Dose optimization required when applicable
lisinopril / HCTZ		Entresto	Edarbi / Edarbyclor	
losartan / HCTZ		fosinopril / HCTZ	Qbrelis	
olmesartan / HCTZ		irbesartan / HCTZ	Tekturna / HCT	
ramipril		moexipril / HCTZ	Teveten / HCT	
valsartan / HCTZ		perindopril		

ANGIOTENSIN MODULATOR/CALCIUM CHANNEL BLOCKER COMBINATIONS

PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
amlodipine/benazepril	olmesartan/ amlodipine	telmisartan/amlodipine	Prestalia	Two preferred products required before a non-preferred product will be approved
amlodipine/valsartan	olmesartan/ amlodipine/HCTZ	trandolapril/verapamil	Tekamlo	
amlodipine/valsartan/ HCTZ			Valturna	Dose optimization required when applicable

ANTIHYPERTENSIVES, SYMPATHOLYTIC

PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
clonidine	methyldopa / HCTZ	clonidine transdermal		Two preferred products required before a non-preferred product will be approved
doxazosin	prazosin			
guanfacine	terazosin			
methyldopa	Catapres-TTS			

BETA BLOCKERS

PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
atenolol	metoprolol	acebutolol	Bystolic	Two preferred products required before a non-preferred product will be approved
atenolol/chlorthalidone	metoprolol XL	betaxolol	Byvalson	
bisoprolol	propranolol	carvedilol ER	Dutoprol	
bisoprolol/HCTZ	propranolol/HCTZ	metoprolol/HCTZ	Hemangeol	
carvedilol IR	propranolol ER	nadolol	Kaspargo	
labetalol	sotalol	nadolol/ bendroflumethiazide	LevatoI	
		pindolol	Sotylize	
		timolol		

CALCIUM CHANNEL BLOCKERS

PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
amlodipine	nifedipine IR	diltiazem ER tablets	verapamil SR capsules	Two preferred products required before a non-preferred product will be approved
diltiazem IR	nifedipine ER	isradipine	Nymalize	–Requires dose optimization when applicable
diltiazem ER capsules	verapamil IR	nimodipine^		^ ICD-10 code for SAH may create system-generated approval for nimodipine
felodipine	verapamil ER tablets	nisoldipine		
nicardipine	verapamil ER PM			

DIURETICS

PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
amiloride-HCTZ	indapamide	acetazolamide	metolazone	Two preferred products required before a non-preferred product will be approved
bumetanide	spironolactone	amiloride	toremide	
chlorothiazide	spiroloactone-HCTZ	chlorthalidone	Carospir	
furosemide	triamterene-HCTZ	ethacrynic acid	Diuril	
hydrochlorothiazide		methazolamide	Dyrenium	
		methyclothiazide		

EPINEPRINE, SELF-INJECTED

PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
epinephrine auto-injector AG (labeler 49502)		epinephrine auto-injector (labeler 00115)		

LIPOTROPICS, OTHER				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
cholestyramine	gemfibrozil	colesevalam	Niacor	Two preferred products required before a non-preferred product will be approved
colestipol	niacin ER	Antara ▲	Repatha	
ezetimibe	omega-3 acid ethyl esters	Juxtapid	Triglide	
fenofibrate	Praluent	Kynamro	Vascepa	
fenofibric acid				
LIPOTROPICS, STATINS				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
atorvastatin	rosuvastatin	amlodipine/atorvastatin	Altprev	Two preferred products required before a non-preferred product will be approved
lovastatin	simvastatin	fluvastatin	Livalo	
pravastatin		fluvastatin ER	Zypitamag	–Once daily dosing required
PAH AGENTS, ORAL & INHALED (Clinical criteria apply to class. All agents require a prior authorization.)				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
sildenafil	Letairis ●▲	tadalafil	Revatio	●–Clinical criteria apply
	Tracleer Tablets ●	Adempas	Tracleer Tablets for Suspension	PA form available at
	Ventavis ●	Opsumit	Tyvaso ●	
		Orenitram ER		http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core_Download&EntryId=208

VASODILATORS, CORONARY				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
isosorbide dinitrate IR	Nitrostat	isosorbide dinitrate ER	Gonitro	
isosorbide mononitrate	Ranexa	nitroglycerin ER	Isordil	
isosorbide mononitrate ER		nitroglycerin translingual spray	Nitro-Bid ointment	
nitroglycerin transdermal		BiDil	Nitrolingual spray	
		Dilatrate		

CENTRAL NERVOUS SYSTEM DRUGS

ANTIDEPRESSANTS, OTHER

PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
amitriptyline	phenelzine	amoxapine	trazodone 300 mg	Two preferred products required before a non-preferred product will be approved
bupropion	tranylcypromine	clomipramine generic (labelers except 00406)	trimipramine	DMAP requires prior authorization for all antidepressants for patients under six (6) years of age.
clomipramine AG (labeler 00406)	trazodone 50,100,150 mg	desipramine	venlafaxine ER tablets	Prior authorization forms available on the web at: http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core_Download&EntryId=169
doxepin	venlafaxine IR	desvenlafaxine ER	Aplenzin	
imipramine tablet	venlafaxine ER caps	desvenlafaxine fumarate ER	Emsam	
mirtazapine tablet	Marplan	imipramine pamoate	Fetzima	
nortriptyline	Trintellix	maprotiline	Forfivo XL	
		mirtazapine ODT	Pamelor	
		nefazodone	Viibryd	
		protriptyline		

ANTIDEPRESSANTS, SSRIs

PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
citalopram	sertraline	escitalopram solution	paroxetine CR	Two preferred products required before a non-preferred product will be approved
escitalopram tablet		fluoxetine tablet	paroxetine mesylate	DMAP requires prior authorization for all antidepressants for patients under six (6) years of age
fluoxetine capsules		fluoxetine 60mg	Paxil	Prior authorization forms available on the web at: http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core_Download&EntryId=169
fluvoxamine tablets		fluoxetine weekly	Pexeva	Liquid medications require prior authorization for clients over 10-years old
paroxetine IR		fluvoxamine ER		

ANTIPSYCHOTICS, ORAL				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
amitriptyline/ perphenazine	quetiapine IR	aripiprazole ODT	Adasuve	PA required for all antipsychotics for patients under six (6) years of age
aripiprazole solution, tablets	quetiapine ER	clozapine ODT	Fanapt	
chlorpromazine	risperidone solution, tablets	molindone	Latuda*	
clozapine	thioridazine	olanzapine ODT	Rexulti	
fluphenazine	thiothixene	olanzapine / fluoxetine	Saphris	-
haloperidol concentrate, solution, tablets	trifluoperazine	paliperidone ER	Versacloz	
loxapine	ziprasidone	pimozide		
olanzapine tablets	Moban	risperidone ODT		
perphenazine	Orap			
ANTIPSYCHOTICS, INJECTABLE				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
chlorpromazine	olanzapine	Perseris		PA required for all antipsychotics for patients under six (6) years of age
fluphenazine	Abilify Maintena	Zyprexa Relprevv		
fluphenazine decanoate	Aristada			
Geodon IM	Invega Sustenna			
haloperidol decanoate	Invega Trinza			
haloperidol lactate	Risperdal Consta			

ANXIOLYTICS				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
buspirone	diazepam solution	alprazolam	meprobamate	Two (2) preferred products required before a non-preferred product will be approved
chlordiazepoxide	diazepam tablets	diazepam intensol	oxazepam	Quantity Limits of 120 units of benzodiazepines per 30 days
clorazepate	lorazepam	lorazepam intensol		PA form available at: http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core_Download&EntryId=165
MOOD STABILIZERS				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
carbamazepine tablets, chewable	lithium	carbamazepine suspension		Two (2) preferred medications are required before a non-preferred medication will be approved
carbamazepine ER, XR	valproic acid	lamotrigine ER, ODT		
divalproex sodium	Tegretol suspension			
lamotrigine IR				
SEDATIVE HYPNOTICS				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
temazepam 15mg, 30mg		chloral hydrate	zolpidem sublingual	-Dose optimization when applicable: total quantity limit of one daily covered
zaleplon		estazolam	Belsomra	
zolpidem IR tablets		eszopiclone	Edluar	
		flurazepam	Hetlioz	
		temazepam 7.5, 22.5mg	Rozerem	
		triazolam	Silenor	
		zolpidem ER	Zolpimist	

ENDOCRINE AND METABOLIC DRUGS

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

PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
testosterone		Androderm	Natesto	PA form available at
		Androgel		http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core_Download&EntryId=209

BONE RESORPTION SUPPRESSION AND RELATED AGENTS

PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
alendronate tablets	Prolia	alendronate solution	Binosto	
calcitonin-salmon nasal spray		etidronate	Forteo	
		ibandronate	Fosamax Plus D	
		raloxifene	Tymlos	
		risedronate	Xgeva	

CONTRACEPTIVES, ORAL - BIPHASIC

PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
desogestrel-ethinyl estradiol-eth estradiol	Kimidess	Lo Loestrin Fe		Two (2) preferred products required before a non-preferred product will be approved
Azurette	Pimtrea	Mircette		
Bekyree	Viorele			Class is grandfathered - patients on a non-preferred product can continue on that product
Kariva				

CONTRACEPTIVES, ORAL - COMBINATION

PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
desogestrel-ethinyl estradiol	Larissia	drosperinone-ethinyl estradiol-levomefolate		Two (2) preferred products required before a non-preferred product will be approved
drosperinone-ethinyl estradiol	Larin Fe	norethindrone-ethinyl estradiol-Fe		
ethynodiol-ethinyl estradiol	Lessina	Balcoltra		Class is grandfathered - patients on a non-preferred product can continue on that product
levonorgestrel-ethinyl estradiol	Levora-28	Blisovi 24 Fe		
norethindrone-ethinyl estradiol	Lillow	Falessa		
norgestimate-ethinyl estradiol	Low-Ogestrel	Junel Fe 24		
Altavera	Lutera	Kaitlib Fe		
Alyacen	Marlissa	Larin 24 Fe		
Apri	Microgestin/	Loestrin/Loestrin Fe		
Aubra	Mili	Lomedia 24 Fe		
Aviane	Mono-Linyah	Loryna		
Balziva	Mononessa	Melodetta 24 Fe		
Blisovi Fe	Necon	Mibelas 24 Fe		
Briellyn	Nikki	Ogestrel		
Chateal	Nortrel	Ovcon		
Cryselle	Ocella	Rajani		
Cyclafem	Orsythia	Syeda		
Cyred	Philith	Taytulla		
Dasetta	Pirmella	Tydemy		
Elinest	Portia	Wymzya Fe		
Emoquette	Previfem	Zenchent		
Enskyce	Reclipsen			
Estarylla	Sprintec			
Falmina	Sronyx			
Femynor	Tarina Fe			
Gianvi	Vestura			

Isibloom	Vienva			
Juleber	Vyfemla			
Junel	Vylibra			
Junel Fe	Wera			
Kelnor	Zarah			
Kurvelo	Zovia			
Larin				

CONTRACEPTIVES, ORAL - EXTENDED CYCLE

PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
levonorgestrel-ethinyl estradiol extended cycle	Loseasonique	Amethia/Amethia Lo	Daysee	Two (2) preferred products required before a non-preferred product will be approved
Camrese	Quasense	Amethyst	Fayosim	
Jolessa	Setlakin	Ashlyna	Introvale	
		Camrese Lo		

CONTRACEPTIVES, ORAL - PROGESTINS

PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19				
norethindrone	Jolivette			
Camila	Lyza			
Deblitane	Nora-BE			
Errin	Nortyda			
Heather	Sharobel			
Incassia	Tulana			
Jencycla				

CONTRACEPTIVES, ORAL – TRIPHASIC				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19				
levonorgestrel-ethinyl estradiol	Tri Femynor	Tilia Fe		
norgestimate-ethinyl estradiol	Tri-Estarylla	Tri-Legest Fe		
Alyacen	Tri-Linyah			
Aranelle	Tri-Lo-Estarylla			
Cyclafem	Tri-Lo-Marzia			
Dasetta	Tri-Lo-Sprintec			
Enpresse	Trinessa			
Leena	Trinessa Lo			
Levonest	Tri-Previfem			
Myzilra	Tri-Sprintec			
Natazia	Trivora-28			
Necon	Tri-Vylibra			
Nortrel	Velivet			
Pimella				

CONTRACEPTIVES, PROGESTIN – IUD/IMPLANT				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19				
Kyleena				
Liletta				
Mirena				
Nexplanon				
Skyla				
GROWTH HORMONES (Clinical criteria apply to class. All agents require a prior authorization.)				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
Genotropin		Humatrope ▲	Serostim	Two (2) preferred products required before a non-preferred product will be approved
Norditropin		Nutropin AQ	Zomacton	PA form available at: http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core_Download&EntryId=181
		Omnitrope	Zorbtive	
		Saizen		
HYPOGLYCEMICS, ALPHA-GLUCOSIDASE INHIBITORS				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
acarbose		miglitol		

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

PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
Bydureon pens, vials (step-edit)	Januvia	alogliptin •	Kombiglyze XR	Step-edit: For preferred products, no PA required if client has Type II diagnosis and metformin use in last 90 days
Byetta (step-edit)	Jentadueto (step-edit)	alogliptin-metformin •	Onglyza	•—Clinical criteria apply for non-preferred products
Janumet •	Tradjenta (step-edit)	alogliptin-pioglitazone •	Ozempic	PA forms available at: http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core_Download&EntryId=188
Janumet XR •	Victoza (step-edit)	Adlyxin •	Soliqua •	
		Bydureon Bcise	Symlin •	
		Jentadueto XR	Trulicity •	
		Juvisync •	Xultrophy •	

HYPOGLYCEMICS, INSULINS

PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
Humalog▲	Levemir	Admelog	Fiasp	
Humalog Mix▲	Novolin	Afrezza	Humulin R 500 Kwikpen	
Humulin▲	Novolog	Apidra	Toujeo Solostar	
Lantus	Novolog Mix	Basaglar	Tresiba Flextouch	

HYPOGLYCEMICS, MEGLITINIDES

PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
nateglinide		repaglinide/metformin		
repaglinide				

HYPOGLYCEMICS, METFORMINS

PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
glipizide-metformin	metformin IR	metformin ER (gen Fortamet, Glumetza)	Riomet	Two preferred products required before a non-preferred product will be approved
glyburide-metformin	metformin ER (gen Glucophage XR)			

HYPOGLYCEMICS, SGLT2s

PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
Farxiga		Glyxambi	Steglujan	Trial of preferred medication required before non-preferred medication will be approved
Jardiance		Invokana	Segluromet	
Synjardy		Invokamet	Steglatro	
Synjardy XR		Qtern	Xigduo XR	

HYPOGLYCEMICS, TZDs

PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
pioglitazone		pioglitazone/ glimepiride	Actoplus Met XR	
		pioglitazone/ metformin	Avandia	

GLUCOCORTICOIDS, ORAL				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
budesonide ER capsule	prednisolone sodium phosphate	budesonide ER tablet	Dexpak	Two preferred products required before a non-preferred product will be approved
dexamethasone elixir, solution, tablet	prednisolone solution	cortisone	Millipred	
fludrocortisone	prednisone intensol, solution, tablets	dexamethasone intensol	Rayos	
hydrocortisone	Orapred ODT	methylprednisolone 8, 16, 32 mg tablet	Taperdex	
methylprednisolone dose pack		prednisolone sodium phosphate ODT	Zodex	
methylprednisolone 4mg tablets		prednisone dose pack		
PITUITARY SUPPRESSANTS, CENTRAL PRECOCIOUS PUBERTY (CPP)				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
Lupron Depot-Ped	Synarel			
Supprelin LA	Triptodur			
PROGESTATIONAL AGENTS				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
medroxyprogesterone acetate tablets	progesterone IM	hydroxyprogesterone caproate	Crinone	•–Clinical PA is required
medroxyprogesterone acetate IM	Depo-SubQ Provera			PA form available at
norethindrone acetate tablets	Makena •			http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core_Download&EntryId=163
progesterone capsule				

THYROID HORMONES				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
levothyroxine sodium tablets	Armour thyroid	levothyroxine sodium injection	Thyrolar	
liothyronine sodium tablets		liothyronine sodium injection	Tirosint	

GASTROINTESTINAL AGENTS

ANTIEMETICS				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
ondansetron ODT	Diclegis •	aprepitant	Bonjesta	• Clinical criteria apply
ondansetron tablets	Transderm-Scop	dronabinol •	Cesamet	Prior authorization forms available at: http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core_Download&EntryId=197
		granisetron	Sancuso	
		ondansetron solution	Syndros	
		Akynzeo	Varubi	
		Anzemet	Zuplenz	
BILE SALTS				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
ursodiol		Chenodal	Cholbam	
CONSTIPATION – IBS - OIC				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
Amitiza	Movantik	alosetron	Symproic	Trial of preferred medication required before non-preferred medication will be approved
Linzess		Relistor	Viberzi	

H. PYLORI TREATMENTS				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
Pylera		lansoprazole- amoxicillin- clarithromycin	Omeclamox Pak	
HISTAMINE II RECEPTOR BLOCKERS				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
famotidine tablets		cimetidine	nizatadine	
ranitidine syrup, tablets		famotidine suspension	ranitidine capsules	
PANCREATIC ENZYMES				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
Creon		Pancreaze	Viokace	
Zenpep		Pertzye		
PHOSPHATE BINDERS				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
calcium acetate capsules	Phoslyra	calcium acetate tablets	Auryxia	PA required for all products in class
sevelamer tablet		lanthanum	Fosrenol	PA form available: at: http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core.Download&EntryId=203
		sevelamer powder pack	Renagel▲	
			Velphoro	

PROTON PUMP INHIBITORS				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
omeprazole Rx		esomeprazole magnesium	omeprazole magnesium OTC	For non-preferred products, max of 60 days approval for GERD
pantoprazole		esomeprazole strontium	rabeprazole tablets	
Nexium suspension (only for age 10 and under)		lansoprazole ●	Aciphex Sprinkle ▲ ●	●—Clinical PA required for all products in class
Protonix suspension (only for age 10 and under)		omeprazole OTC tablets	Dexilant ●	PA form available at http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core_Download&EntryId=207
		omeprazole/sodium bicarbonate	Prevacid Solutab	
		omeprazole suspension	Prilosec packets●	
ULCERATIVE COLITIS AGENTS				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
balsalazide	Apriso ▲	mesalamine DR	Dipentum	Two (2) preferred products required before a non-preferred product will be approved
mesalamine enema	Canasa	mesalamine enema kit	Giazo	
sulfasalazine	Delzicol		Lialda	
sulfasalazine DR			Pentasa	

GENITOURINARY PRODUCTS

BLADDER RELAXANT PREPARATIONS

PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
oxybutynin	Toviaz	darifenacin	Gelnique	Two (2) preferred products required before a non-preferred product will be approved
oxybutynin ER	Vesicare	tolterodine	Myrbetriq	
		trospium	Oxytrol	

BPH TREATMENTS

PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
alfuzosin	tamsulosin	dutasteride	Cardura XL	Two (2) preferred products required before a non-preferred product will be approved
doxazosin	terazosin	dutasteride/tamsulosin	Rapaflo	
finasteride				

HEMATOLOGICAL AGENTS

ANTICOAGULANTS, ORAL/SQ

PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
enoxaparin	Fragmin▲	fondaparinux	Iprivask	Two (2) preferred products required before a non-preferred product will be approved
warfarin	Pradaxa•		Savaysa	–Quantity limits in place on injectable formulations: 10 days allowed without prior authorization
Eliquis•	Xarelto•			• Eliquis, Pradaxa and Xarelto require diagnosis code

ANTIHEMOPHILIC FACTOR VIII/vWF

PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
Advate	Monoclate-P	Adynovate	Kogenate FS	Two preferred products required before a non-preferred product will be approved
Alphanate	Novoeight	Afstyla	Kovaltry	PA form available at:
Hemofil M	Nuwiq	Eloctate	Recombinate	http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=C
Koate-DVI	Wilate	Jivi ^{NR}		
Humate-P	Xyntha			

ANTIHEMOPHILIC FACTOR IX

PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
Alphanine SD	Mononine	Idelvion		Two preferred products required before a non-preferred product will be approved
Alprolix	Profilnine	Rebinyn		PA form available at: http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=C ore_Download&EntryId=182
Benefix	Rixubis			
Ixinity				

COLONY STIMULATING FACTORS				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
Granix		Fulphila	Nivestym ^{NR}	
Neupogen vials		Leukine	Udenyca ^{NR}	
		Neulasta	Zarxio	
		Neupogen syringes		
ERYTHROPOIESIS STIMULATING PROTEINS (Clinical criteria apply to class. All agents require a prior authorization.)				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19				
Epogen	Procrit	Aranesp		PA forms available at: http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core_Download&EntryId=179
Mircera	Retacrit			
HAE TREATMENTS (Clinical criteria apply to class. All agents require a prior authorization.)				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
Berinert	Firazyr	Cinryze	Ruconest	
Danazol	Haegarda	Kalbitor	Takhzyro	
PLATELET AGGREGATION INHIBITORS				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
clopidogrel	prasugrel	aspirin/dipyridamole	Durlaza	Two (2) preferred products required before a non-preferred product will be approved
clopidogrel/ASA pack	Aggrenox	ticlopidine	Yosprala	
dipyridamole	Brilinta		Zontivity	

MEDICAL DEVICES AND SUPPLIES

DIABETIC TESTING BLOOD GLUCOSE METERS, TEST STRIPS, LANCETS

PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
FreeStyle Freedom Lite meters/strips	FreeStyle Precision Neo meters/strips	All other diabetic meters and test strips are non-preferred		
FreeStyle InsuLinx meters/strips	Precision Xtra meters/strips			
FreeStyle lancets	True Metrix meters/strips			
FreeStyle Libre readers/sensors				

NEUROMUSCULAR DRUGS

ANTICONVULSANTS, ORAL/RECTAL

PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
carbamazepine tablets, chewable	phenytoin	carbamazepine suspension	Epitol	Two (2) preferred products required before a non-preferred product will be approved
carbamazepine ER, XR	primidone	carbamazepine XR (generic Carbatrol)	Equetro	Quantity limits in place: 240 adjunctive anticonvulsants per 30 days. Greater quantities require prior authorization.
clonazepam tablet	topiramate tablets, sprinkle	clonazepam ODT	Fycompa	Brand name narrow therapeutic drugs automatically pay for seizure clients with seizure diagnosis in medical history
diazepam rectal	valproic acid	ethosuximide caps	Gralise	
divalproex sodium	zonisamide	felbamate	Lyrica	
ethosuximide solution	Celontin	lamotrigine ER, ODT	Onfi	
gabapentin	Dilantin 30 mg capsule	levetiracetam ER	Oxtellar XR	
lamotrigine IR	Gabitril	tiagabine tablets	Potiga	
levetiracetam IR, solution	Peganone ▲	topiramate ER	Sabril	
oxcarbazepine	Tegretol Suspension	vigabatrin	Spritam	
phenobarbital		Aptiom	Stavzor	
		Banzel ▲	Trokendi XR	
		Briviact	Vimpat	
		Epidiolex ^{NR}		

ANTIPARKINSON'S AGENTS, ORAL/TRANSDERMAL

PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
amantadine capsules, solution		amantadine tablets	tolcapone	Two (2) preferred products required before a non-preferred product will be approved
benztropine		bromocriptine	Duopa	
carbidopa/levodopa IR, ER		carbidopa	Gocovri	
entacapone		carbidopa/levodopa ODT	Neupro	
pramipexole IR		carbidopa/levodopa/entacapone	Osmolex ER	
ropinirole IR		pramipexole ER	Rytary	
selegiline		rasagaline	Xadago	
trihexyphenidyl		ropinirole XL	Zelapar	
Parlodel		selegiline capsules		

SKELETAL MUSCLE RELAXANTS

PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
baclofen		carisoprodol •	metaxalone	Two (2) preferred products required before a non-preferred product will be approved
chlorzoxazone		carisoprodol compound	orphenadrine	
cyclobenzaprine 5, 10 mg		carisoprodol compound w/codeine •	tizanidine capsules	Total quantity limit of 120 units of muscle relaxants per 30 rolling days.
methocarbamol		cyclobenzaprine 7.5 mg	Amrix	•–Clinical PA required:
tizanidine tablets		cyclobenzaprine ER	Lorzone	PA criteria available at http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core_Download&EntryId=177
		dantrolene		

NUTRITIONAL PRODUCTS

PRENATAL VITAMINS

PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
Complete Natal DHA	Prenatal Vitamin plus Low Iron	All other prenatal products non-preferred		Two preferred products required before a non-preferred product will be approved
Concept DHA	Preplus			
Concept OB	Pretab			
Inatal Ultra	Purefe OB Plus			
Niva-Plus	Trinatal GT			
O-Cal	Trinatal Rx1			
O-Cal FA	Triveen-Duo DHA			
PNV 29-1	Virt-Advance			
PNV Folic Acid+Iron	Virt-Nate			
PNV Ferrous Fumarate-Docusate-FA	Virt-Vite GT			
PNV-VP-U	Vol-Nate			
Prenata chewable	Vol-Plus			
Prenatal Plus	Vol-Tab Rx			

PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS

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

PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
donepezil 5, 10 mg		donepezil ODT	memantine solution	Two (2) preferred products required before a non-preferred product will be approved
memantine tablets		donepezil 23mg	memantine XR	
rivastigmine patch		galantamine	rivastigmine capsules	PA form available at: http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core_Download&EntryId=167
		galantamine ER	Namzaric	

MOVEMENT DISORDER

PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
Austedo	tetrabenazine	Ingrezza		Ingrezza quantity limit - 1 capsule per day

MULTIPLE SCLEROSIS

PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
Aubagio	Rebif	dalfampridine	Ocrevus	• Clinical PA required
Avonex ▲	Tysabri	glatiramer	Plegridy	PA forms available at http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core_Download&EntryId=166
Betaseron		Extavia	Tecfidera	Preferred oral agents require a trial of a preferred injectable agent
Copaxone 20mg		Glatopa	Zinbryta	
Gilenya		Lemtrada		

NEUROPATHIC PAIN				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
duloxetine 20, 30, 60 mg		duloxetine 40 mg	Lyrica CR	• lidocaine 5% patch greater than two (2) patches a day requires PA
gabapentin		Gralise	Qutenza	
lidocaine 5% patch •		Horizant	Savella	Lidocaine patch PA form available at: http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core_Download&EntryId=547
		Lyrica		Lyrica and Savella PA form available at: http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core_Download&EntryId=206

RESPIRATORY AGENTS

ANTI-HISTAMINES, MINIMALLY SEDATING

PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
cetirizine solution OTC / Rx		cetirizine capsules, chewable	levocetirizine syrup, tablets	Two (2) preferred products required before a non-preferred product will be approved
cetirizine tablets OTC		cetirizine-D OTC	loratadine ODT	
loratadine capsules, tablets OTC, solution		desloratadine	loratadine-D OTC	
		desloratadine ODT	Clarinetx ▲	
		fexofenadine OTC	Clarinetx-D▲	
		fexofenadine / fexofenadine-D		

BRONCHODILATORS, BETA AGONIST

PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
albuterol nebulizer, solution, syrup	ProAir HFA	albuterol ER	Arcapta	Two (2) preferred products required before a non-preferred product will be approved
terbutaline	ProAir Respiclick	albuterol tablets	Brovana	
	Proventil HFA	levalbuterol	Perforomist	
	Serevent	metaproteranol	Striverdi Respimat	
			Ventolin HFA	

COPD AGENTS				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
albuterol/ipratropium nebulizer solution		Anoro Ellipta	Seebri Neohaler	
ipratropium nebulizer solution		Atrovent HFA	Spiriva Respimat	
Bevespi		Combivent	Stiolto Respimat	
Spiriva Handihaler		Daliresp	Tudorza	
		Incruse Ellipta	Utibron Neohaler	
		Lonhala	Yupelri ^{NR}	
COUGH and COLD				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
benzonatate	hydrocodone/ homatropine syrup	All other cough/cold products non-preferred		Two preferred products required before a non-preferred product will be approved
brompheniramine/ pseudoephedrine/DM syrup	promethazine DM syrup			
guaifenesin liquid OTC	promethazine/ codeine syrup			Quantity limits in place:
guaifenesin DM liquid OTC	phenylephrine tablets			Narcotic antitussives - 240ml per 30 days and 480ml per 90 days without a comorbid diagnosis
guaifenesin ER tablets	pseudoephedrine liquid, tablets			Tussinex - 120ml per 84 days and 900ml per year
guaifenesin/codeine syrup	Bromfed DM syrup			
hydrocodone/ chlorpheniramine susp	Mucinex ER tablet			

GLUCOCORTICOIDS, INHALED				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
budesonide inhalation solution 0.25, 0.5 mg [^]	Flovent HFA	budesonide inhalation solution 1 mg	Arnuity Ellipta	[^] Approval for budesonide may be generated by system for patients:
Advair Diskus (step-edit) [•]	QVAR Redihaler	fluticasone/salmeterol	Asmanex HFA	- Aged 6 years and older and with
Dulera	Symbicort (step-edit) [•]	Advair HFA	Asmanex ▲	- Diagnosis on file indicating developmental delay
Pulmicort Flexhaler		Aerospan	Breo Ellipta	PA form available at: http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core_Download&EntryId=193
		Alvesco	Flovent Diskus	
		Armonair	Trelegy	
INTRANASAL RHINITIS AGENTS				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
azelastine (gen. Astelin)		azelastine (generic Astepro)	Omnaris	Two (2) preferred products required before a non-preferred product will be approved
budesonide		flunisolide	Qnasl	
fluticasone Rx		fluticasone OTC	Veramyst	
ipratropium		mometasone	Ticanase	
triamcinolone		olopatadine	Xhance	
		Beconase AQ	Zetonna	
		Dymista		

LEUKOTRIENE RECEPTOR ANTAGONISTS				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
montelukast tablet, chew tabs		montelukast granules •	zileuton ER	Trial of preferred medication required before a non-preferred will be approved
		zafirlukast •		•–Clinical criteria apply. ICD-10 code for asthma indication may create a system-generated approval

TOPICAL PRODUCTS

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

PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
clindamycin gel, solution	Azelex	adapalene	tretinoin microsphere	Two (2) preferred products required before a non-preferred product will be approved
clindamycin/benzoyl peroxide		adapalene/ benzoyl peroxide	Acanya	
erythromycin gel, solution		benzoyl peroxide	Aczone	
tretinoin cream		clindamycin foam, lotion, swab	Benzamycin Pak	Class only covered up to 20 years old; use in older patients is considered cosmetic.
tretinoin 0.01, 0.025% gel		clindamycin/tretinoin	Altreno ^{NR}	Medical necessity PA form available at
		dapsone	Clindacin ETZ/PAC	
		erythromycin swab	Epiduo Forte ▲	
		erythromycin/benzoyl peroxide	Fabior	http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core_Download&EntryId=202
		sulfacetamide sodium	Neuac	
		sodium sulfacetamide/ sulfur	Onexton	
		tretinoin 0.05% gel		

ANTIFUNGALS, TOPICAL				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
		butenafine	Alevazol	
ciclopirox cream		ciclopirox cream, gel, shampoo, suspension	Ertaczo	Two (2) preferred products required before a non-preferred product will be approved
ciclopirox solution		clotrimazole solution	Exelderm	
clotrimazole cream		clotrimazole/ betamethasone solution	Fungoid	
clotrimazole/ betamethasone cream		econazole	Jublia	
ketoconazole cream, shampoo		ketoconazole foam	Kerydin	
nystatin		miconazole	Lamisil	
nystatin/triamcinolone ointment		naftifine	Luzu	
		nystatin/triamcinolone cream	Mentax	
		oxiconazole	Naftin	
		terbinafine	Oxistat	
		tolnaftate	Vusion	
ANTIPARASITICS, TOPICAL				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
permethrin	Natroba	lindane	spinosad	
piperonyl butoxide/ pyrethrins	Sklice	malathion	Eurax▲	

ANTIPSORIATIC AGENTS, ORAL				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
Soriatane		acitretin	methoxsalen	
ANTIPSORIATIC AGENTS, TOPICAL				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
calcipotriene		acitretin	Enstilar	
		calcipotriene/ betamethasone	Sorilux	
		calcitriol	Taclonex	
		methoxsalen	Tazorac	
		tazarotene		
ANTIVIRALS, TOPICAL				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
Abreva		acyclovir ointment	Xerese	
		Denavir	Zovirax	
IMMUNOMODULATORS, ATOPIC DERMATITIS (Clinical criteria apply to class. All agents require a prior authorization.)				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
Elidel •		tacrolimus •	Dupixent	•—Clinical criteria apply
Eucrisa				Eucrisa will be electronically approved after trial of a preferred topical steroid or immunomodulator
Protopic				PA form available at: http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core_Download&EntryId=186
				– Quantity limits are in place: 400 grams per year

IMMUNOMODULATORS, TOPICAL

PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
imiquimod		Zyclara		

OPHTHALMICS, ALLERGIC CONJUNCTIVITIS

PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
azelastine		epinastine	Bepreve	Two (2) preferred products required before a non-preferred product will be approved
cromolyn		olopatadine 0.2%	Emadine	
olopatadine 0.1%		Alocril	Lastacaft	
		Alomide	Pazeo	

OPHTHALMICS, ANTIBIOTICS

PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
bacitracin/polymyxin	ofloxacin	bacitracin	Azasite	Two (2) preferred products required before a non-preferred product will be approved
ciprofloxacin	polymyxin/ trimethoprim	gatifloxacin	Besivance	
erythromycin	tobramycin	levofloxacin	Moxeza	
gentamicin	Ciloxan ointment	neomycin/bacitracin/ polymyxin	Natacyn	
moxifloxacin		neomycin/polymyxin/ gramicidin	Tobrex	
		sulfacetamide		

OPHTHALMICS, ANTIBIOTIC-STEROID COMBINATIONS

PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
neomycin/polymyxin/ dexamethasone	Pred-G	neomycin/polymyxin/HC	Blephamide SOP	Two (2) preferred products required before a non-preferred product will be approved
sulfacetamide/ prednisolone	Tobradex ointment	neomycin/bacitracin/ polymyxin/HC	Tobradex ST	
Blephamide drops	Tobradex suspension	tobramycin/ dexamethasone	Zylet	

OPHTHALMICS, ANTI-INFLAMMATORIES

PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
dexamethasone	Alrex	bromfenac	Lotemax	Two (2) preferred products required before a non-preferred product will be approved
diclofenac	Durezol	ketorolac LS	Nevanac	
fluorometholone	Flarex	Acuvail	Ozurdex	
flurbiprofen	Ilevro	Bromsite	Prolensa	
ketorolac	Maxidex	FML	Retisert	
prednisolone acetate	Pred Mild	Iluvien	Triesence	
prednisolone sodium phosphate			Yutiq ^{NR}	

OPHTHALMICS, GLAUCOMA AGENTS				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
brimonidine 0.2%	Alphagan P	apraclonidine	Betoptic S	Two (2) preferred products required before a non-preferred product will be approved
carteolol	Betimol	betaxolol	Cosopt PF	
dorzolamide	Combigan	bitamoprost	lopidine	Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
dorzolamide/timolol	Istalol	brimonidine 0.15%	Lumigan	
latanoprost	Rhopressa	metipranolol	Rescula	
levobunolol	Simbrinza	phospholine iodide	Vyzulta	
pilocarpine	Travatan Z	timolol gel	Zioptan	
timolol solution		Azopt		
OPHTHALMICS, IMMUNOMODULATORS				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
Restasis		Restasis Multidose	Xiidra	
OTIC ANTIBIOTICS				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
neomycin/polymyxin/hydrocortisone		ciprofloxacin	Otiprio	
Ciprodex		Cipro HC	Otovel	
ofloxacin		Coly-Mycin S		

OTIC ANTI-INFECTIVES, ANESTHETICS				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
acetic acid		acetic acid/ hydrocortisone		Two (2) preferred products required before a non-preferred product will be approved
STERIODS, TOPICAL				
PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION
Preferred status implementation: 1/1/19		Prior authorization is required		
clobetasol ointment, solution	Capex shampoo ▲	alclometasone	Apexicon E	Two (2) preferred products required before a non-preferred product will be approved
fluocinolone oil	Scalpicin	amcinonide	Bryhali ^{NR}	
fluocinonide ointment 0.05%		betamethasone dipropionate	Cordran	
fluticasone cream, ointment		betamethasone dipropionate/propylene glycol	DermacinRx	
hydrocortisone		betamethasone valerate	Dermasorb	
hydrocortisone acetate		clobetasol cream, foam, gel, lotion, shampoo	Halog	
mometasone		clocortolone	Impoyz	
triamcinolone cream, lotion, ointment		desonide	Pandel	
		desoximetasone	Pediaderm	
		diflorasone	SanadermRx	
		fluocinolone cream, ointment, shampoo, solution	Silazone	
		fluocinonide (except 0.05% ointment)	Sernivo	
		flurandrenolide	Synalar	
		fluticasone lotion	Temovate	
		halobetasol	Texacort	

		hydrocortisone butyrate	Topicort	
		hydrocortisone valerate	Ultravate	
		prednicarbate	U-Cort	
		triamcinolone aerosol		