ANXIOLYTICS

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
buspirone	diazepam solution, tablets	alprazolam	meprobamate	Two (2) preferred products required before a non-preferred product will be approved
chlordiazepoxide	lorazepam	diazepam intensol	oxazepam	Quantity Limits of 120 units of benzodiazepines per 30 days
clorazepate		lorazepam intensol		

MOOD STABILIZERS

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
carbamazepine tablets, chewable	lithium	carbamazepine suspension		Two (2) preferred medications are required before a non-preferred medication will be approved
carbamazepine ER, XR	valproic acid	lamotrigine ER, ODT		
divalproex sodium	**Tegretol suspension**			
lamotrigine IR				

SEDATIVE HYPNOTICS

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
temazepam 15mg, 30mg		chloral hydrate	zolpidem ER	–Dose optimization when applicable: total quantity limit of one daily covered
zaleplon		estazolam	zolpidem sublingual	
zolpidem IR tablets		eszopiclone	Belsomra	
		flurazepam	Edluar	
		ramelteon	Hetlioz	
		temazepam 7.5, 22.5 mg	Silenor	
		triazolam	Zolpimist	

ENDOCRINE AND METABOLIC DRUGS

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

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
testosterone		Androderm	Natesto	
		Androgel		

BONE RESORPTION SUPPRESSION AND RELATED AGENTS

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS **Prior authorization is required**		CRITERION
alendronate tablets	Prolia	alendronate solution	Binosto	
calcitonin-salmon nasal spray		etidronate	Evenity[NR]	
		ibandronate	Fosamax Plus D	
		raloxifene	Natpara[NR]	
		risedronate	Tymlos	
		teriparatide	Xgeva	

CONTRACEPTIVES, ORAL - BIPHASIC

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS **Prior authorization is required**		CRITERION
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	Simliya	Volnea[NR]		Class is grandfathered - patients on a non-preferred product can continue on that product
Kariva	Viorele			

CONTRACEPTIVES, ORAL - COMBINATION

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS **Prior authorization is required**		CRITERION
desogestrel-ethinyl estradiol	Kalliga	drosperinone-ethinyl estradiol-levomefolate		Two (2) preferred products required before a non-preferred product will be approved
drosperinone-ethinyl estradiol	Kelnor	Balcoltra		
ethynodiol-ethinyl estradiol	Kurvelo	Blisovi 24 Fe		Class is grandfathered - patients on a non-preferred product can continue on that product
levonorgestrel-ethinyl estradiol	Larin, Larin Fe	Junel Fe 24		
norethindrone-ethinyl estradiol	Larissia	Kaitlib Fe		
norethindrone-ethinyl estradiol-Fe	Lessina	Larin 24 Fe		
norgestimate-ethinyl estradiol	Levora-28	Loestrin/Loestrin Fe		
Afirmelle	Lillow	Loryna		
Altavera	Lo-Zumandimine	Melodetta 24 Fe		
Alyacen	Low-Ogestrel	Mibelas 24 Fe		
Apri	Lutera	Ogestrel		
Aubra, Aubra EQ	Marlissa	Syeda		
Aurovela, Aurovela Fe, Aurovela 24 Fe	**Microgestin/ Microgensin Fe**	Taytulla		
Aviane	Mili	Tydemy		
Ayuna	Mono-Linyah	Wymzya Fe		
Balziva	Necon			
Blisovi Fe	Nikki			
Briellyn	Nortrel			
Chateal, Chateal EQ	**Ocella**			
Cryselle	Orsythia			
Cyclafem	Philith			
Cyred, Cyred EQ	Pirmella			
Dasetta	Portia			
Elinest	Previfem			
Emoquette	Reclipsen			

Enskyce	Sprintec			
Estarylla	Sronyx			
Falmina	Tarina Fe, Tarina Fe			
Femynor	Vienva			
Gianvi	Vyfemla			
Hailey, Hailey 24 Fe	Vylibra			
Isibloom	Wera			
Jasmiel	Zarah			
Juleber	Zovia			
Junel, Junel Fe	Zumandimine			

CONTRACEPTIVES, ORAL - EXTENDED CYCLE

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
levonorgestrel-ethinyl estradiol extended cycle	Jolessa	Amethyst		Two (2) preferred products required before a non-preferred product will be approved
Amethia	**Loseasonique**	Fayosim		
Ashlyna	Quasense	Jamiess/LoJaimiess[NR]		
Camrese/Camrese Lo	**Seasonique**			
Daysee	Setlakin			
Introvale	Simpesse			

CONTRACEPTIVES, ORAL - PROGESTINS

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS		CRITERION
norethindrone	Jencycla	Slynd[NR]		
Camila	Lyza			
Deblitane	Nora-BE			
Errin	Norlyda			
Heather	Sharobel			
Incassia	Tulana			

CONTRACEPTIVES, ORAL – TRIPHASIC

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS		CRITERION
levonorgestrel-ethinyl estradiol	Tilia Fe			
norgestimate-ethinyl estradiol	Tri Femynor	Tri-Legest Fe		
Alyacen	Tri-Estarylla			
Aranelle	Tri-Linyah			
Cyclafem	Tri-Lo-Estarylla			
Dasetta	Tri-Lo-Marzia			
Enpresse	Tri-Lo-Mili			
Leena	Tri-Lo-Sprintec			
Levonest	Tri-Mili			
Myzilra	Tri-Previfem			
Natazia	Tri-Sprintec			
Necon	Trivora-28			
Nortrel	Tri-Vylibra, Tri-Vylibra Lo			
Pirmella	Velivet			

CONTRACEPTIVES, PROGESTIN – IUD/IMPLANT

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS		CRITERION
Kyleena	Nexplanon			
Liletta	Skyla			
Mirena				

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

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS **Prior authorization is required**		CRITERION
Genotropin		Humatrope▲	Serostim	Two (2) preferred products required before a non-preferred product will be approved
Norditropin		Nutropin AQ	Zomacton	
		Omnitrope	Zorbtive	
		Saizen		

HYPOGLYCEMICS, ALPHA-GLUCOSIDASE INHIBITORS

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS **Prior authorization is required**		CRITERION
acarbose		miglitol		

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

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
Bydureon pens, vials (step-edit)	Tradjenta (step-edit)	alogliptin ●	Kombiglyze XR	Step-edit: For preferred products, no PA required if member has Type II diagnosis and metformin use in last 90 days
Byetta (step-edit)	Victoza (step-edit)	alogliptin-metformin ●	Onglyza	●–Clinical criteria apply for non-preferred products
Janumet (step-edit) ●		alogliptin-pioglitazone ●	Rybelsus[NR]●	
Janumet XR (step-edit) ●		Adlyxin ●	Soliqua ●	
Januvia (step-edit)		Bydureon Bcise	Symlin ●	
Jentadueto (step-edit)		Jentadueto XR	Trulicity ●	
Ozempic		Juvisync ●	Xultrophy ●	

HYPOGLYCEMICS, INSULINS

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
insulin aspart	Lantus	Admelog	Humulin (except U-500)	
insulin aspart mix	Levemir	Afrezza	Novolin	
insulin lispro	Novolog	Apidra	Toujeo Solostar	
Humalog Mix	Novolog Mix	Basaglar	Tresiba Flextouch	
Humulin R U-500		Fiasp		

HYPOGLYCEMICS, MEGLITINIDES

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
nateglinide		repaglinide/metformin		
repaglinide				

HYPOGLYCEMICS, METFORMINS

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
glipizide-metformin	metformin IR	metformin ER (gen Fortamet, Glumetza)	Riomet	Two preferred products required before a non-preferred product will be approved
glyburide-metformin	metformin ER (gen Glucophage XR)		Riomet ER[NR]	

HYPOGLYCEMICS, SGLT2s

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
Farxiga		Glyxambi	Segluromet	Trial of preferred medication required before non-preferred medication will be approved
Jardiance		Invokana	Steglatro	
Synjardy		Invokamet	Trijardy XR[NR]	
		Qtern	Xigduo XR	
Synjardy XR		Steglujan		

HYPOGLYCEMICS, TZDs

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
pioglitazone		pioglitazone/ glimepepiride	Actoplus Met XR	
		pioglitazazone/ metformin	Avandia	

GLUCOCORTICOIDS, ORAL

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
budesonide ER capsule	prednisolone sodium phosphate solution	budesonide ER tablet	Dexpak	Two preferred products required before a non-preferred product will be approved
dexamethasone elixir, solution, tablet	prednisolone solution	cortisone	Dxevo	
fludrocortisone	prednisone intensol, solution, tablets	dexamethasone intensol	Millipred	
hydrocortisone		methylprednisolone 8, 16, 32 mg tablet	Rayos	
methylprednisolone dose pack		prednisolone sodium phosphate ODT	Taperdex	
methylprednisolone 4mg tablets		prednisone dose pack		

PITUITARY SUPPRESSANTS, CENTRAL PRECOCIOUS PUBERTY (CPP)

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
Lupron Depot-Ped	Synarel	Lupaneta Pack		
Supprelin LA	Triptodur			

PROGESTATIONAL AGENTS

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
medroxyprogesterone acetate tablets	progesterone IM	hydroxyprogesterone caproate	Crinone	●–Clinical PA is required
medroxyprogesterone acetate IM	Depo-SubQ Provera			
norethindrone acetate tablets	Makena ●			
progesterone capsule				

THYROID HORMONES

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS **Prior authorization is required**		CRITERION
levothyroxine sodium tablets	thyroid tablets	levothyroxine sodium injection	Thyrolar	
liothyronine sodium tablets	Armour thyroid	liothyronine sodium injection	Tirosint	

GASTROINTESTINAL AGENTS

ANTIEMETICS, ORAL/TRANSDERMAL

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
ondansetron tablets, ODT	**Diclegis •**	aprepitant	Anzemet	• Clinical criteria apply
	Transderm-Scop	doxylamine/pyridoxine	Bonjesta	
		dronabinol •	Cesamet	
		granisetron	Sancuso	
		ondansetron solution	Sustol	
		scopolamine patch	Syndros	
		trimethobenzamide	Varubi	
		Akynzeo	Zuplenz	

BILE SALTS

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
ursodiol		Chenodal	Cholbam	

CONSTIPATION – IBS – OIC, ORAL

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
Amitiza		Motegrity	Trulance	Trial of preferred medication required before non-preferred medication will be approved
Linzess		Relistor	Zelnorm	
Movantik		Symproic		

H. PYLORI TREATMENTS

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
Pylera		lansoprazole-amoxicillin-clarithromycin	Omeclamox Pak	
			Talicia[NR]	

HISTAMINE II RECEPTOR BLOCKERS

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
famotidine		cimetidine		
nizatadine				

PANCREATIC ENZYMES

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
Creon		Pancreaze	Viokace	
Zenpep		Pertzye		

PHOSPHATE BINDERS

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
calcium acetate capsules	Phoslyra	calcium acetate tablets	Auryxia	PA required for all non-calcium based products
sevelamer tablet		lanthanum	Fosrenol	
		sevelamer powder pack	Velphoro	

PROTON PUMP INHIBITORS

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS **Prior authorization is required**		CRITERION
omeprazole Rx		esomeprazole	rabeprazole	For non-preferred products, max of 60 days approval for GERD
pantoprazole		lansoprazole ●	Aciphex ▲ ●	
Nexium suspension (only for age 10 and under)		omeprazole OTC tablets	Dexilant ●	●–Clinical PA required for all products in class
Protonix suspension (only for age 10 and under)		omeprazole/sodium bicarbonate	Prilosec packets●	

ULCERATIVE COLITIS AGENTS

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS **Prior authorization is required**		CRITERION
balsalazide	sulfasalazine	mesalamine DR (except 375 mg)	Dipentum	Two (2) preferred products required before a non-preferred product will be approved
mesalamine enema, suppository	sulfasalazine DR	mesalamine enema kit	Pentasa	
mesalamine DR 375 mg	**Delzicol**			

GENITOURINARY PRODUCTS

BLADDER RELAXANT PREPARATIONS

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
oxybutynin		darifenacin	Gelnique	Two (2) preferred products required before a non-preferred product will be approved
oxybutynin ER		tolterodine	Myrbetriq	
solifenacin		trospium	Oxytrol	
			Toviaz	

BPH TREATMENTS

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
alfuzosin	tamsulosin	dutasteride	Cardura XL	Two (2) preferred products required before a non-preferred product will be approved
doxazosin	terazosin	dutasteride/tamsulosin		
finasteride		silodosin		

HEMATOLOGICAL AGENTS

ANTICOAGULANTS, ORAL/SQ

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
enoxaparin	Fragmin	fondaparinux	Iprivask	Two (2) preferred products required before a non-preferred product will be approved
warfarin	Pradaxa •	Bevyxxa[NR]	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 Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
Advate	Humate-P	Adynovate	Recombinate	Two preferred products required before a non-preferred product will be approved
Afstyla	Monoclate-P	Eloctate	Vonvendi	
Alphanate	Novoeight	Esperoct[NR]		
Hemofil M	Nuwiq	Hemlibra		
Koate-DVI	Wilate	Jivi		
Kogenate FS	Xyntha	Kovaltry		

ANTIHEMOPHILIC FACTOR IX

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
Alphanine SD	Mononine	Idelvion		Two preferred products required before a non-preferred product will be approved
Alprolix	Profilnine	Rebinyn		
Benefix	Rixubis			
Ixinity				

COLONY STIMULATING FACTORS

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
Granix		Fulphila	Nivestym	
Neupogen vials		Leukine	Udenyca	
		Neulasta	Zarxio	
		Neupogen syringes	Ziextenzo	

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

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
Epogen	Retacrit	Aranesp		
Mircera		Procrit		

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

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
icatibant	Haegarda	Kalbitor		
Berinert	Ruconest			
Cinryze	Takhzyro			
Danazol				

PLATELET AGGREGATION INHIBITORS

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
clopidogrel	**Aggrenox**	aspirin/dipyridamole	Yosprala	Two (2) preferred products required before a non-preferred product will be approved
dipyridamole	Brilinta	ticlopidine	Zontivity	
prasugrel				

MEDICAL DEVICES AND SUPPLIES

DIABETIC TESTING BLOOD GLUCOSE METERS, TEST STRIPS

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS **Prior authorization is required**		CRITERION
FreeStyle	FreeStyle Lite	All other blood glucose meters and test strips are non-preferred		
FreeStyle Freedom	FreeStyle Precision Neo (lblr 57599 only)			
FreeStyle Freedom Lite	Precision Xtra (lblr 57599 only)			
FreeStyle InsuLinx	True Metrix (lblr 56151 only)			
FreeStyle Libre				

NEUROMUSCULAR DRUGS

ANTICONVULSANTS, ORAL/RECTAL/NASAL

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
carbamazepine tablets, chewable tablets	primidone	carbamazepine suspension	Diacomit	Two (2) preferred products required before a non-preferred product will be approved
carbamazepine ER, XR	topiramate tablets, sprinkle	clonazepam ODT	Epidiolex	Quantity limits in place: 240 adjunctive anticonvulsants per 30 days. Greater quantities require prior authorization.
clobazam	valproic acid	ethosuximide caps	Equetro	
clonazepam tablet	zonisamide	felbamate	Fycompa	
diazepam rectal	Celontin	lamotrigine ER, ODT	Nayzilam[NR]	Brand name narrow therapeutic drugs automatically pay for seizure members with seizure diagnosis in medical history
divalproex sodium	Dilantin 30 mg capsule	levetiracetam ER	Oxtellar XR	
ethosuximide solution	**Gabitril**	pregabilin	Spritam	
gabapentin	Peganone	tiagabine tablets	Sympazan	
lamotrigine IR tablets, chewable tablets	**Tegretol Suspension**	topiramate ER	Trokendi XR	
levetiracetam IR, solution		vigabatrin	Valtoco[NR]	
oxcarbazepine		Aptiom	Vimpat	
phenobarbital		Banzel	Xcopri[NR]	
phenytoin		Briviact		

ANTIPARKINSON'S AGENTS, ORAL/TRANSDERMAL

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
amantadine capsules, solution		amantadine tablets	tolcapone	Two (2) preferred products required before a non-preferred product will be approved
benztropine		bromocriptine	Gocovri	
carbidopa/levodopa IR, ER		carbidopa	Nourianz[NR]	
entacapone		carbidopa/levodopa ODT	Neupro	
pramipexole IR		carbidopa/levodopa/ entacapone	Osmolex ER	
ropinirole IR		pramipexole ER	Rytary	
selegiline		rasagaline	Xadago	
trihexyphenidyl		ropinirole ER	Zelapar	
Parlodel		selegiline capsules		

SKELETAL MUSCLE RELAXANTS

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
baclofen		carisoprodol ●	metaxalone	Two (2) preferred products required before a non-preferred product will be approved
chlorzoxazone		carisoprodol compound w/codeine ●	orphenadrine	Total quantity limit of 120 units of muscle relaxants per 30 rolling days.
cyclobenzaprine 5, 10 mg		cyclobenzaprine 7.5 mg	tizanidine capsules	●–Clinical PA required:
methocarbamol		cyclobenzaprine ER	Norgesic Forte	
tizanidine tablets		dantrolene		

NUTRITIONAL PRODUCTS

PRENATAL VITAMINS

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
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 Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
donepezil 5, 10 mg		donepezil ODT	memantine XR capsules	Two (2) preferred products required before a non-preferred product will be approved
memantine tablets		donepezil 23mg	rivastigmine capsules	
rivastigmine patch		galantamine	Namzaric	
		memantine solution		

MOVEMENT DISORDER

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS **Prior authorization is required**		CRITERION
tetrabenazine	Ingrezza	Austedo		Ingrezza quantity limit - 1 capsule per day

MULTIPLE SCLEROSIS

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS **Prior authorization is required**		CRITERION
dalfampridine	Copaxone 20mg	glatiramer	Ocrevus	• Clinical PA required
Aubagio	Gilenya	Extavia	Plegridy	
Avonex	Rebif	Glatopa	Tecfidera	Preferred oral agents require a trial of a preferred injectable agent
Betaseron	Tysabri	Lemtrada	Vumerity[NR]	
		Mavenclad	Zeposia[NR]	
		Mayzent	Zinbryta	

NEUROPATHIC PAIN

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
duloxetine 20, 30, 60 mg		duloxetine 40 mg	Lyrica CR	• lidocaine 5% patch greater than two (2) patches a day requires PA
gabapentin		pregabilin	Savella	
lidocaine patch •		Drizalma[NR]	Zilacaine	
		Gralise	Ztildo	
		Horizant		

RESPIRATORY AGENTS

ANTIHISTAMINES, MINIMALLY SEDATING

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
cetirizine solution, tablets		cetirizine capsules, chewable tablets	levocetirizine	Two (2) preferred products required before a non-preferred product will be approved
loratadine solution, tablets		cetirizine-D	loratadine chewable tablets, ODT	
		desloratadine	loratadine-D	
		fexofenadine, fexofenadine-D		

BRONCHODILATORS, BETA AGONIST

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
albuterol HFA, nebulizer, solution, syrup, tablets	ProAir Respiclick	metaproterenol	Perforomist	Two (2) preferred products required before a non-preferred product will be approved
levalbuterol	**Proventil HFA**	Arcapta	Proair Digihaler	
terbutaline	Serevent	Brovana	Striverdi Respimat	
ProAir HFA	**Ventolin HFA**			

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