2020
Delaware Medicaid Preferred Drug List (PDL)

Contents

ADHD AGENTS

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

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS **Prior authorization is required**		CRITERION
dexmethylphenidate IR	methylphenidate IR	amphetamine tablets	methylphenidate chewable tablets	Two preferred products required before a non-preferred product will be approved
dextroamphetamine-amphetamine IR	methylphenidate solution	dextroamphetamine solution	Evekeo ODT	Dose optimization required.
dextroamphetamine IR tablets	**Procentra**	methamphetamine	Zenzedi	

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

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS **Prior authorization is required**		CRITERION
armodafinil	Quillichew ER	clonidine ER	Cotempla XR	PA forms available at http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core_Download&EntryId=164
atomoxetine	Quillivant XR	dextroamphetamine ER	Daytrana ●	Modafanil and Armodafinil PA forms at http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core_Download&EntryId=199
dexmethylphenidate ER	Vyvanse	methylphenidate ER 24 (generic Concerta except labeler 10147)	Dyanavel XR	
dextroamphetamine-amphetamine ER		methylphenidate LA	Jornay PM	
guanfacine ER		Adhansia XR	Mydayis	
methylphenidate CD		Adzenys ER	Sunosi[NR]	
methylphenidate ER 24 (generic Concerta) labeler 10147 only		Adzenys XR-ODT		
modafinil		Aptensio XR		

ANALGESICS

ANALGESICS, NARCOTIC LONG-ACTING (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
fentanyl transdermal 12, 25, 50, 75, 100 mcg/hr	**Butrans**	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 tablets		hydromorphone ER	Embeda	
		morphine ER capsules	Hysingla ER	
		oxycodone ER	Morphabond ER	
		oxymorphone ER	Nucynta ER	
		tramadol ER capsules	Xtampza ER	
			Zohydro ER	

ANALGESICS, NARCOTIC SHORT-ACTING, NON-INJECTABLE

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
butalbital compound/ codeine		benzhydrocodone/ APAP	pentazocine/ naloxone	
codeine		butorphanol nasal •	tramadol/APAP	Two preferred products required before a non-preferred product will be approved
codeine/APAP		carisoprodol compound	Abstral	**–Quantity limits in place:**
hydrocodone/APAP		dihydrocodeine/APAP/ caffeine	Dsuvia	Ø oxycodone 15mg maximum of 240 units a year
hydrocodone/ibuprofen		fentanyl buccal tablet, lozenge ●	Dvorah	Ø oxycodone 20mg maximum of 120 units a year
hydromorphone tablets		hydromorphone liquid, suppositories	Fentora	Ø oxycodone 30 mg maximum of 60 units a year
morphine tabs/solution		levorphanol	Lortab Solution	Ø 120 short-acting units per 30 days with a total of 720 short-acting units a year
oxycodone capsules, solution, tablets		meperidine	Nalocet	Ø DMMA recommends that first fill of new pain medication be limited to 15 supply
oxycodone/APAP		morphine concentrate, suppositories	Nucynta	●–Clinical criteria apply.
pentazocine/APAP		oxycodone/ASA	Oxaydo	Clinical PA form available at: http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core_Download&EntryId=183
tramadol		oxycodone concentrate	Primlev	Butorphanol nasal PA form available at: http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core_Download&EntryId=174
		oxycodone/ ibuprofen	Roxybond	Fentanyl transmucosal and buccal PA form available at: http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core_Download&EntryId=180
		oxymorphone	Subsys	

ANTIHYPERURICEMICS, ORAL

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS **Prior authorization is required**		CRITERION
allopurinol	probenecid	feboxustat	Gloperba[NR]	• Clinical criteria apply to colchicine with approval for treatment, not prophylaxis
colchicine •	probenecid with colchicine	Duzallo	Zurampic	

ANTIMIGRAINE AGENTS, PROPHYLAXIS - INJECTABLE

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS **Prior authorization is required**		CRITERION
Aimovig		Ajovy	Emgality	Product will be approved for patients with chronic migraine with inadequate response to three preferred oral agents
		Botox		

ANTIMIGRAINE AGENTS

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS **Prior authorization is required**		CRITERION
rizatriptan tablets, ODT		almotriptan	Cambia	Two preferred products required before a non-preferred product will be approved
sumatriptan nasal spray, tablets		dihyroergotamine	Ergomar	
sumatriptan 6 mg/0.5 ml vial		eletriptan	Migranal	**–Quantity limits in place:** Nine (9) tablets per 45 days
		ergotamine/caffeine	Migranow	
		frovatriptan	Onzetra	
		naratriptan	Sumavel Dosepro	
		sumatriptan injection (except for 6 mg/0.5 ml vial)	Tosymra[NR]	
		sumatriptan/naproxen	Treximet	
		zolmitriptan	Zembrace	
			Zomig	

CYTOKINE AND CAM ANTAGONISTS, ORAL/SQ

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
Cosentyx (after step through Humira)		Actemra	Otezla	Approved diagnosis code required on prescription and electronic submissions
Enbrel (diagnosis code required)		Amevive▲	Rinvoq ER	
Humira (diagnosis code required)		Arcalyst	Siliq	
		Cimzia	Simponi	
		Ilaris	Simponi Aria	
		Ilumya	Skyrizi	
		Kevzara	Stelara	
		Kineret	Taltz	
		Olumiant	Tremfya	
		Orencia	Xeljanz, Xeljanz XR	

NSAIDs, ORAL/TOPICAL

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
celecoxib •		diclofenac capsules, tablets, patch	oxaprozin	Two preferred products required before a non-preferred product will be approved
diclofenac drops, 1% gel		diclofenac/misoprostol	piroxicam	
ibuprofen		diflunisal	tolmetin	• Clinical PA required
indomethacin IR		etodolac	Indocin	
ketorolac		fenoprofen	Inflammacin	
meloxicam tablets		flurbiprofen	Naprelan	http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core_Download&EntryId=175
naproxen IR tablets		indomethacin ER	Pennsaid	
sulindac		ketoprofen	Qmiiz ODT	
		meclofenamate	Sprix	
		mefenamic acid	Tivorbex	
		meloxicam suspension	Vimovo	
		nabumetone	Vivlodex	
		naproxen DR, suspension	Zipsor	
		naproxen sodium	Zorvolex	

OPIATE DEPENDENCE TREATMENTS

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS **Prior authorization is required**		CRITERION
buprenorphine	Sublocade	buprenorphine/ naloxone film (except labelers 00781 and 52427)	Bunavail	
buprenorphine/naloxone film (labelers 00781 and 52427 only)	Suboxone		Lucemyra	
buprenorphine/ naloxone tablets	Vivitrol		Probuphine	
naltrexone			Zubsolv	

ANTIDOTES

OPIATE OVERDOSE TREATMENTS

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS		CRITERION
naloxone				Evzio is not covered under the Medicaid Drug Rebate Program
Narcan nasal spray				

ANTI-INFECTIVE AGENTS

ANTIBIOTICS, GI

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
metronidazole tablets	Firvanq	metronidazole capsules	Dificid	●–Clinical prior authorization is required
neomycin		paromomycin capsules	Xifaxan ▲ ●	
		vancomycin		Patients must try and fail lactulose before Xifaxan is approved for appropriate diagnoses

ANTIBIOTICS, INHALED

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
tobramycin (labeler 00093 only)	Bethkis	tobramycin (except labeler 00093)	Cayston	
	Kitabis Pak	Arikayce	TOBI Podhaler	

ANTIBIOTICS, VAGINAL

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
clindamycin	Cleocin ovules	AVC	Solosec	
metronidazole	Clindesse	Nuvessa	Vandazole	Two preferred products required before a non-preferred product will be approved

ANTIFUNGALS, ORAL

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
fluconazole		clotrimazole	Cresemba	Two preferred products required before a non-preferred product will be approved
griseofulvin suspension		flucytosine	Noxafil	
nystatin		griseofulvin tablets	Oravig	
terbinafine		itraconazole	Tolsura	
		ketoconazole		
		posaconazole		
		voriconazole		

ANTIVIRALS, ANTIRETROVIRALS

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
abacavir	Evotaz	abacavir/lamivuidine/ zidovudine	Rescriptor	Patients on non-preferred drugs will be grandfathered
abacavir/lamivudine	Genvoya	didanosine	Selzentry	
atazanavir	Isentress	fosamprenevir	Stribild	
efavirenz	Kaletra	nevirapine	Symtuza	
lamivudine	Norvir powder pack, soution	stavudine	Temixys[NR]	
lamivudine-zidovudine	Odefsey	Aptivus	Triumeq	
lopinavir-ritonavir	Prezcobix	Complera	Videx	
ritonavir	Prezista	Crixivan	Viracept	
tenofovir disoproxil fumarate	Retrovir injection	Dovato		
zidovudine	Reyataz powder pack	Fuzeon		
Atripla	Symfi/Symfi Lo	Intelence		
Biktarvy	Tivicay	Invirase		
Cimduo	Trogarzo	Isentress HD		
Delstrigo	Truvada	Juluca		
Descovy	Tybost	Lexiva		
Edurant	Viread (except 300 mg tablet)	Onmel		
Emtriva		Pifeltro		

ANTIVIRALS, HEPATITIS C 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
ribavirin tablets	Mavyret ●	ledipasvir/sofosbuvir	Rebetol	● Clinical criteria apply
sofosbuvir/velpatasvir		ribavirin capsules	Ribasphere	PA form available at
		Harvoni	Sovaldi ●	
		Pegasys▲●	Vosevi ●	http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core_Download&EntryId=536
		Peg-Intron▲ ●	Zepatier ●	

ANTIVIRALS, ORAL/INHALATION

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
acyclovir	valacyclovir	amantadine solution, tablets	Prevymis	Two preferred products required before a non-preferred product will be approved
amantadine capsules	valganciclovir	rimantadine	Sitavig	Liquid medications require prior authorization for clients over 10-years old
famciclovir	Relenza		Xofluza	–Quantity limits in place for oseltamivir and Relenza
oseltamivir				

CEPHALOSPORINS, ORAL

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
cefaclor IR	cefprozil	cefaclor ER	cephalexin tablets	Two preferred products required before a non-preferred product will be approved
cefadroxil	cefuroxime	cefixime	Ceftin	
cefdinir	cephalexin capsules, suspension	cefpodoxime	Suprax	

FLUOROQUINOLONES, ORAL

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
ciprofloxacin IR tablets		ciprofloxacin ER	ofloxacin	Two preferred products required before a non-preferred product will be
levofloxacin tablets		ciprofloxacin suspension	Baxdela	
		levofloxacin solution	Cipro	
		moxifloxacin		

LINCOSAMIDES/OXAZOLIDINONES/STREPTOGRAMINS

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
clindamycin capsules	clindamycin solution (for client <10 yr)	linezolid •	Sivextro	• Clinical criteria apply http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core_Download&EntryId=192

MACROLIDES

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
azithromycin		clarithromycin	E.E.S.	
		erythromycin (all salts)	Erythrocin	

PENICILLINS, ORAL/IM

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
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 Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
doxycycline hyclate IR		demeclocycline	tetracycline	Two preferred products required before a non-preferred product will be approved
doxycycline monohydrate 50, 100 mg capsules		doxycycline DR	Minolira ER	
doxycycline monohydrate tablets		doxycycline monohydrate 75, 150 mg capsules	Morgidox	
minocycline capsules		doxycycline suspension	Nuzyra[NR]	
		minocycline ER	Vibramycin	
		minocycline tablets	Ximino	

URINARY ANTI-INFECTIVES

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
methenamine	nitrofurantoin mono-macrocrystals (generic Macrobid)	nitrofurantoin macrocrystals (generic Macrodantin) with the exception of 25 mg dose for peds		
nitrofurantoin macrocrystals (generic Macrodantin) 25 mg dose preferred for peds only	Monurol	nitrofurantoin suspension		

ANTINEOPLASTICS

ONCOLOGY AGENTS

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS **Prior authorization is required**		CRITERION
all drug products				

CARDIOVASCULAR AGENTS

ANGIOTENSIN MODULATORS

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
benazepril, benazepril HCTZ		aliskerin	perindopril	Two preferred products required before a non-preferred product will be approved
enalapril, enalapril HCTZ		candesartan, candesartan HCTZ	quinapril, quinapril HCTZ	
Epaned		captopril, captopril HCTZ	telmisartan, telmisartan HCTZ	Dose optimization required when applicable
lisinopril, lisinopril HCTZ		eprosartan	trandolapril	
losartan, losartan HCTZ		Entresto	Edarbi / Edarbyclor	
olmesartan, olmesartan HCTZ		fosinopril, fosinopril HCTZ	Qbrelis	
ramipril		irbesartan, irbesartan HCTZ	Tekturna HCT	
valsartan, valsartan HCTZ		moexipril	Teveten, Teveten HCT	

ANGIOTENSIN MODULATOR/CALCIUM CHANNEL BLOCKER COMBINATIONS

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
amlodipine/benazepril	olmesartan/ amlodipine, olmesartan/ amlodipine/HCTZ	telmisartan/amlodipine	Prestalia	Two preferred products required before a non-preferred product will be approved
amlodipine/valsartan, amlodipine/valsartan/ HCTZ		trandolapril/verapamil		Dose optimization required when applicable

ANTIHYPERTENSIVES, SYMPATHOLYTIC

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
clonidine	methyldopa, 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 Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
atenolol, atenolol/chlorthalidone	propranolol ER	acebutolol	Bystolic	Two preferred products required before a non-preferred product will be approved
bisoprolol, bisoprolol HCTZ	sotalol	betaxolol	Hemangeol	
carvedilol IR		carvedilol ER	Inderal XL	
labetalol		metoprolol HCTZ	Innopran XL	
metoprolol		nadolol	Kaspargo	
metoprolol XL		pindolol	Levatol	
propranolol, propranolol HCTZ		timolol	Sotylize	

CALCIUM CHANNEL BLOCKERS

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
amlodipine	nifedipine ER	diltiazem ER tablets	Cardizem LA	Two preferred products required before a non-preferred product will be approved
diltiazem IR	verapamil IR	isradipine	Katerzia[NR]	–Requires dose optimization when applicable
diltiazem ER capsules	verapamil ER tablets	nimodipine^	Nymalize	^ ICD-10 code for SAH may create system-generated approval for nimodipine
felodipine	verapamil ER PM	nisoldipine		
nicardipine	Dilt-XR	verapamil ER capsules		
nifedipine IR				

DIURETICS

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
amiloride-HCTZ	indapamide	acetazolamide	metolazone	Two preferred products required before a non-preferred product will be approved
bumetanide	spironolactone, spironolactone HCTZ	amiloride	torsemide	
chlorothiazide	triamterene-HCTZ	chlorthalidone	triamterene	
furosemide	Keveyis	ethacrynic acid	Aldactazide	
hydrochlorothiazide		methazolamide	Carospir	
		methyclothiazide	Diuril	

EPINEPRINE, SELF-INJECTED

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
epinephrine auto-injector AG (labeler 49502)	Symjepi	epinephrine auto-injector (other than labeler 49502)		

LIPOTROPICS, OTHER

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
cholestyramine	gemfibrozil	colesevalam	Kynamro	Two preferred products required before a non-preferred product will be approved
colestipol	niacin ER	ezetimibe/simvastatin	Praluent	
ezetimibe	omega-3 acid ethyl esters	Antara▲	Repatha	
fenofibrate		Colestid	Vascepa	
fenofibric acid		Juxtapid		

LIPOTROPICS, STATINS

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
atorvastatin	rosuvastatin	amlodipine/atorvastatin	Ezallor^{NR}	Two preferred products required before a non-preferred product will be approved
lovastatin	simvastatin	fluvastatin, fluvastatin ER	Livalo	–Once daily dosing required
pravastatin		Altoprev	Zypitamag	

PAH AGENTS, ORAL & INHALED (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
ambrisentan	**Revatio Suspension**	bosentan	Orenitram ER	●–Clinical criteria apply
sildenafil tablets	**Tracleer Tablets ●**	tadalafil	Tracleer Tablets for Suspension	PA form available at http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core_Download&EntryId=208
	Ventavis ●	sildenafil suspension	Tyvaso ●	
		Adempas	Uptravi	
		Opsumit		

VASODILATORS, CORONARY

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
isosorbide dinitrate		nitroglycerin translingual spray	Isordil	
isosorbide mononitrate		BiDil	Nitro-Bid	
nitroglycerin patch, tablets		Dilatrate-SR	Nitromist	
ranolazine		Gonitro		

CENTRAL NERVOUS SYSTEM DRUGS

ANTIDEPRESSANTS, OTHER

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
amitriptyline	phenelzine	amitriptyline/ chlordiazepoxide	protriptyline	Two preferred products required before a non-preferred product will be approved
bupropion	tranylcypromine	amoxapine	trazodone 300 mg	DMAP requires prior authorization for all antidepressants for patients under six (6) years of age.
clomipramine AG (labeler 00406)	trazodone 50,100,150 mg	clomipramine generic (labelers except 00406)	trimipramine	Prior authorization forms available on the web at: http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core_Download&EntryId=169
doxepin	venlafaxine IR	desipramine	venlafaxine ER tablets	
imipramine HCl	venlafaxine ER caps	desvenlafaxine	Aplenzin	
mirtazapine tablet	Marplan	imipramine pamoate	Emsam	
nortriptyline	Trintellix	maprotiline	Fetzima	
		mirtazapine ODT	Pamelor	
		nefazodone	Viibryd	

ANTIDEPRESSANTS, SSRIs

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
citalopram	paroxetine IR	escitalopram solution	paroxetine ER	Two preferred products required before a non-preferred product will be approved
escitalopram tablet	sertraline	fluoxetine tablets	paroxetine mesylate	DMAP requires prior authorization for all antidepressants for patients under six (6) years of age
fluoxetine capsules, solution		fluoxetine DR	Paxil	Prior authorization forms available on the web at: http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core_Download&EntryId=169
fluvoxamine tablets		fluvoxamine ER	Pexeva	Liquid medications require prior authorization for clients over 10-years old

ANTIPSYCHOTICS, ORAL/INHALATION

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
amitriptyline/ perphenazine	quetiapine	aripiprazole ODT	Fanapt	PA required for all antipsychotics for patients under six (6) years of age
aripiprazole solution, tablets	risperidone solution, tablets	clozapine ODT	Rexulti	*Latuda requires prior trial of one (1) preferred antipsychotic
chlorpromazine	thioridazine	molindone	Saphris	
clozapine	thiothixene	olanzapine ODT	Versacloz	
fluphenazine	trifluoperazine	olanzapine / fluoxetine	Vraylar	
haloperidol concentrate, solution, tablets	ziprasidone	paliperidone ER		
loxapine	Latuda*	pimozide		
olanzapine tablets	**Orap**	risperidone ODT		
perphenazine				

ANTIPSYCHOTICS, INJECTABLE/INHALATION

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
chlorpromazine	olanzapine	Adasuve		PA required for all antipsychotics for patients under six (6) years of age
fluphenazine	Aristada	Zyprexa Relprevv		
fluphenazine decanoate	Invega Sustenna			
Geodon IM	Invega Trinza			
haloperidol decanoate	Perseris			
haloperidol lactate	Risperdal Consta			
Abilify Maintena				

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		PA form available at: http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core_Download&EntryId=165

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	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 Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS **Prior authorization is required**		CRITERION
alendronate tablets	Prolia	alendronate solution	Evenity[NR]	
calcitonin-salmon nasal spray		etidronate	Forteo	
		ibandronate	Fosamax Plus D	
		raloxifene	Natpara[NR]	
		risedronate	Tymlos	
		Binosto	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			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			
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	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 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 client 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]●	PA forms available at: http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core_Download&EntryId=188
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 lispro	Novolog	Admelog	Humulin R U-100	
Humalog Mix▲	Novolog Mix	Afrezza	Novolin	
Humulin R U-500		Apidra	Toujeo Solostar	
Lantus		Basaglar	Tresiba Flextouch	
Levemir		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)			

HYPOGLYCEMICS, SGLT2s

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
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 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			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 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	Prior authorization forms available at: http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core_Download&EntryId=197
		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	

HISTAMINE II RECEPTOR BLOCKERS

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
famotidine tablets		cimetidine	nizatadine	
ranitidine syrup, tablets		famotidine suspension	ranitidine capsules	

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	PA form available: at: http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core_Download&EntryId=203
		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●	PA form available at http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core_Download&EntryId=207

ULCERATIVE COLITIS AGENTS

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS **Prior authorization is required**		CRITERION
balsalazide	sulfasalazine DR	mesalamine DR	Dipentum	Two (2) preferred products required before a non-preferred product will be approved
mesalamine enema, suppository	Apriso▲	mesalamine enema kit	Pentasa	
sulfasalazine	**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	Vonvendi	Two preferred products required before a non-preferred product will be approved
Afstyla	Monoclate-P	Eloctate		
Alphanate	Novoeight	Hemlibra		PA form available at:
Hemofil M	Nuwiq	Jivi		http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=C
Koate-DVI	Wilate	Kovaltry		
Kogenate FS	Xyntha	Recombinate		

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		PA form available at: http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core_Download&EntryId=182
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		PA forms available at: http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core_Download&EntryId=179
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			
FreeStyle Freedom	FreeStyle Precision Neo (lblr 57599 only)	All other blood glucose meters and test strips are non-preferred		
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	phenobarbital	carbamazepine suspension	Briviact	Two (2) preferred products required before a non-preferred product will be approved
carbamazepine ER, XR	phenytoin	clonazepam ODT	Diacomit	Quantity limits in place: 240 adjunctive anticonvulsants per 30 days. Greater quantities require prior authorization.
clobazam	primidone	ethosuximide caps	Epidiolex	
clonazepam tablet	topiramate tablets, sprinkle	felbamate	Equetro	
diazepam rectal	valproic acid	lamotrigine ER, ODT	Fycompa	Brand name narrow therapeutic drugs automatically pay for seizure clients with seizure diagnosis in medical history
divalproex sodium	zonisamide	levetiracetam ER	Nayzilam[NR]	
ethosuximide solution	Celontin	pregabilin	Oxtellar XR	
gabapentin	Dilantin 30 mg capsule	tiagabine tablets	Spritam	
lamotrigine IR tablets, chewable tablets	**Gabitril**	topiramate ER	Sympazan	
levetiracetam IR, solution	Peganone▲	vigabatrin	Trokendi XR	
oxcarbazepine	**Tegretol Suspension**	Aptiom	Vimpat	
		Banzel ▲		

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	PA criteria available at http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core_Download&EntryId=177
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	PA form available at: http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core_Download&EntryId=167
		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	PA forms available at http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core_Download&EntryId=166
Avonex ▲	Rebif	Glatopa	Tecfidera	Preferred oral agents require a trial of a preferred injectable agent
Betaseron	Tysabri	Lemtrada	Vumerity[NR]	
		Mavenclad	Zinbryta	
		Mayzent		

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 PA form available at: http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core_Download&EntryId=547
lidocaine patch •		Drizalma[NR]	Zilacaine	
		Gralise	Ztildo	Lyrica CR and Savella PA form available at: http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core_Download&EntryId=206
		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 nebulizer, solution, syrup	ProAir Respiclick	albuterol HFA	Arcapta	Two (2) preferred products required before a non-preferred product will be approved
terbutaline	**Proventil HFA**	albuterol tablets	Brovana	
ProAir HFA	Serevent	levalbuterol	Perforomist	
		metaproterenol	Proair Digihaler	
			Striverdi Respimat	

COPD AGENTS

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
albuterol/ipratropium nebulizer solution		Anoro Ellipta	Spiriva Respimat	
ipratropium nebulizer solution		Atrovent HFA	Stiolto Respimat	
Bevespi		Daliresp	Tudorza	
Combivent		Duaklir[NR]	Trelegy	
Spiriva Handihaler		Incruse Ellipta	Utibron Neohaler	
		Lonhala	Yupelri	
		Seebri Neohaler		

COUGH and COLD

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
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	promethazine/ codeine syrup			**Quantity limits in place:**
guaifenesin DM liquid	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 Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS **Prior authorization is required**		CRITERION
budesonide inhalation solution 0.25, 0.5 mg^	Flovent Diskus, HFA	budesonide inhalation solution 1 mg	Breo Ellipta	^ Approval for budesonide may be generated by system for patients:
Advair Diskus (step-edit)•	Pulmicort Flexhaler	fluticasone/salmeterol	Wixela Inhub	- Aged 6 years and older and with
Arnuity Ellipta	QVAR Redihaler	Advair HFA		- Diagnosis on file indicating developmental delay
Asmanex Twisthaler	Symbicort	Alvesco		PA form available at: http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core_Download&EntryId=193
Dulera		Asmanex HFA▲		

INTRANASAL RHINITIS AGENTS

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS **Prior authorization is required**		CRITERION
azelastine (generic Astelin)		azelastine (generic Astepro)	Dymista	Two (2) preferred products required before a non-preferred product will be approved
budesonide		flunisolide	Omnaris	
fluticasone Rx		fluticasone OTC	Qnasl	
ipratropium		mometasone	Ticanase	
triamcinolone		olopatadine	Xhance	
		Beconase AQ	Zetonna	

LEUKOTRIENE RECEPTOR ANTAGONISTS

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS **Prior authorization is required**		CRITERION
montelukast tablet, chewable tablets		montelukast granules ●	zileuton ER	Trial of preferred medication required before a non-preferred will be approved
		zafirlukast ●	Zyflo	●**–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 Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
clindamycin gel, solution	Azelex	adapalene	tretinoin microsphere	Two (2) preferred products required before a non-preferred product will be approved
clindamycin/benzoyl peroxide 1%/5%, 1.2%/5%		adapalene/ benzoyl peroxide	Aczone	
erythromycin gel, solution		benzoyl peroxide	Aklief[NR]	
tretinoin cream		clindamycin foam, lotion, swab	Altreno	
tretinoin 0.01, 0.025% gel		clindamycin/benzoyl peroxide 1.2%/2.5%	Clindacin ETZ/PAC	Class only covered up to 20 years old; use in older patients is considered cosmetic.
		clindamycin/tretinoin	Differin	Medical necessity PA form available at
		dapsone	Epiduo Forte▲	
		erythromycin swab	Fabior	
		erythromycin/benzoyl peroxide	Inova	
		sulfacetamide sodium	Neuac	http://medicaidpublications.dhss.delaware.gov/dotnetnuke/search?Command=Core_Download&EntryId=202
		sodium sulfacetamide/ sulfur	Onexton	
		tretinoin 0.05% gel	Tretin-X	

ANTIBIOTICS, TOPICAL

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
bacitracin	mupirocin ointment	mupirocin cream	Cortisporin	Two preferred products required before a non-preferred product will be approved
bacitracin/polymyxin	neomycin/bacitracin/ polymyxin	neomycin/bacitracin/ polymyxin/pramoxine	Neo-Synalar	
gentamicin		neomycin/polymyxin/ pramoxine		

ANTIFUNGALS, TOPICAL

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
ciclopirox cream, solution		butenafine	terbinafine	Two preferred products required before a non-preferred product will be approved
clotrimazole cream		ciclopirox gel, shampoo, suspension	tolnaftate	
clotrimazole/ betamethasone cream		clotrimazole solution	Alevazol	
ketoconazole cream, shampoo		clotrimazole/ betamethasone lotion	DermacinRx	
nystatin		econazole	Ertaczo	
nystatin/triamcinolone ointment		hydrocortisone/ iodoquinol	Exelderm	
		ketoconazole foam	Jublia	
		luliconazole	Kerydin	
		miconazole	Loprox	
		naftifine	Oxistat	
		nystatin/triamcinolone cream	Vusion	
		oxiconazole		

ANTIPARASITICS, TOPICAL

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
permethrin	**Natroba**	crotamiton	Eurax▲	
piperonyl butoxide/ pyrethrins		lindane	Sklice	
		malathion	Vanalice	
		spinosad		

ANTIPSORIATIC AGENTS, ORAL

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
Soriatane		acitretin	methoxsalen	

ANTIPSORIATIC AGENTS, TOPICAL

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
calcipotriene		acitretin	Duobrii	
		calcipotriene/ betamethasone	Enstilar	
		calcitriol	Sorilux	
		methoxsalen	Taclonex	
		tazarotene	Tazorac	

ANTIVIRALS, TOPICAL

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
Abreva		acyclovir	Denavir	
			Xerese	

IMMUNOMODULATORS, ATOPIC DERMATITIS (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
pimecrolimus (labeler 68682 only)		pimecrolimus (except labeler 68682)	Dupixent	●–Clinical criteria apply
Eucrisa		tacrolimus ●		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 Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
imiquimod		Veregen[NR]	Zyclara	

OPHTHALMICS, ALLERGIC CONJUNCTIVITIS

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
azelastine		epinastine	Bepreve	Two (2) preferred products required before a non-preferred product will be approved
cromolyn		ketotifen	Emadine	
olopatadine 0.1%		olopatadine 0.2%	Lastacaft	
		Alocril	Pazeo	
		Alomide		

OPHTHALMICS, ANTIBIOTICS

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
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	Gentak ointment	neomycin/polymyxin/ gramicidin	Tobrex	
		sulfacetamide		

OPHTHALMICS, ANTIBIOTIC-STEROID COMBINATIONS

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
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 Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
dexamethasone	Alrex	bromfenac	Inveltys	
diclofenac	Durezol	ketorolac 0.4%	Lotemax	Two (2) preferred products required before a non-preferred product will be approved
fluorometholone	Flarex	loteprednol	Lotemax SM	
flurbiprofen	Ilevro	prednisolone/ nepafenac	Nevanac	
ketorolac 0.5%	Maxidex	Acuvail	Ozurdex	
prednisolone	Pred Mild	Bromsite	Prolensa	
		Dextenza[NR]	Retisert	
		Dexycu	Triesence	
		FML	Yutiq	
		Iluvien		

OPHTHALMICS, GLAUCOMA AGENTS

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
brimonidine 0.2%	**Alphagan P**	apraclonidine	Cosopt	Two (2) preferred products required before a non-preferred product will be approved
carteolol	Betimol	betaxolol	Iopidine	
dorzolamide	Combigan	bitamoprost	Lumify	Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
dorzolamide/timolol	Rhopressa	brimonidine 0.15%	Lumigan	
latanoprost	Rocklatan	phospholine iodide	Vyzulta	
levobunolol	Simbrinza	timolol gel	Xelpros	
pilocarpine	Travatan Z	Azopt	Zioptan	
timolol solution		Betoptic S		

OPHTHALMICS, IMMUNOMODULATORS

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
Restasis		Cequa	Xiidra	
		Restasis Multidose		

OTIC ANTIBIOTICS

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
neomycyin/polymyxin/ hydrocortisone		ciprofloxacin	Cortisporin-TC	
Ciprodex		Cipro HC	Otiprio	
ofloxacin		Coly-Mycin S	Otovel	

OTIC ANTI-INFECTIVES, ANESTHETICS

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
acetic acid		acetic acid/ hydrocortisone		Two (2) preferred products required before a non-preferred product will be approved

STEROIDS, TOPICAL

PREFERRED AGENTS Preferred status implementation: 1/1/20		NON-PREFERRED AGENTS Prior authorization is required		CRITERION
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	
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, spray	Ellzia Pak	
mometasone		clocortolone	Halog	

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	