TEXAS
Health and Human Services

Medicaid Pharmacy Prior Authorization and Preferred Drug List

Contents

Pharmacy Prior Authorization

- People enrolled in traditional Medicaid and Medicaid managed care adhere to the same formulary. Some drugs on the formulary may require pharmacy prior authorization.
    - MCOs administer prior authorization services for people enrolled in Medicaid managed care
    - The Texas Prior Authorization Call Center administers traditional Medicaid prior authorizations.

Formulary

- The Medicaid formulary includes legend and over-the-counter drugs. Also, certain supplies and select vitamin and mineral products are also available as a pharmacy benefit. Some drugs are subject to one or both types of prior authorization: clinical or non-preferred.
    - The Formulary Search identifies the list of Medicaid-covered drugs and whether it requires prior authorization.
    - txvendordrug.com/formulary/formulary-search.

Preferred Drug List

- HHSC arranges the preferred drug list by therapeutic class. The PDL contains a subset of many, but not all, drugs on the Medicaid formulary and identifies them as "preferred" or "non-preferred". Drugs identified as "preferred" are available without prior authorization unless there is a clinical prior authorization associated with the drug. Some drugs are subject to both non-preferred and clinical prior authorizations. (CHIP drugs are not subject to PDL requirements.)
    - txvendordrug.com/formulary/prior-authorization/preferred-drugs
- The **PDL Prior Authorization Criteria Guide** explains the criteria used to evaluate prior authorization requests
    - paxpress.txpa.hidinc.com/pdl_crit_guide.pdf
- Drugs requiring clinical prior authorization are hyperlinked within the list, as shown in Table 1. Links will take the user to the specific clinical prior authorization criteria with a narrative explaining the purpose and requirements.

Table 1: PDL Example

THERAPEUTIC CLASS NAME		
Preferred Agents	***Non-Preferred Agents***	**Prior Authorization Criteria**
bacitracin ointment BACTROBAN (mupirocin) cream	**BACITRACIN PACKET** BACTROBAN (mupirocin) ointment	• Treatment failure with preferred drugs within any subclass • Contraindication to preferred drugs • Allergic reaction to preferred drugs • Treatment of stage-four advanced, metastatic cancer and associated conditions • Clinical Prior Authorization applies

Clinical Prior Authorization

- **Clinical prior authorizations** may apply to any individual drug or an entire drug class on the formulary, including some preferred and non-preferred drugs. Specific clinical prior authorizations all managed care organizations are required to perform. Usage of all other clinical prior authorizations will vary between MCOs at each MCO's discretion.
- The Texas Medicaid Drug Utilization Board approves all prior authorization criteria.
- For Medicaid managed care:
  - txvendordrug.com/formulary/prior-authorization/mco-clinical-pa
- Traditional Medicaid:
  - txvendordrug.com/formulary/prior-authorization/ffs-clinical-pa
- The Clinical Prior Authorization Assistance Chart identifies which MCO utilizes each clinical prior authorization:
  - txvendordrug.com/sites/txvendordrug/files/docs/prior-authorization/cpa-assistance-chart.pdf

PDL Prior Authorization

- Drugs identified as "non-preferred" require a PDL prior authorization. The PDL Prior Authorization Criteria Guide explains the criteria used to evaluate the non-preferred prior authorization requests.

Obtaining Prior Authorization

As a prescribing provider, you can help people enrolled in Medicaid receive medications quickly and conveniently with a few simple steps. Prescribing providers or their representatives should contact one of the following authorization authorities:

Medicaid Managed Care

- Pharmacy prior authorization call centers vary by MCO. The **Prescriber MCO Assistance Chart** identifies each MCO and its prior authorization and member call center phone numbers.
    - txvendordrug.com/sites/txvendordrug/files/docs/managed-care/prescriber-assistance-chart.pdf

Traditional Medicaid

- The **Texas Prior Authorization Call Center** accepts prior authorization requests by phone at 1-877-PA-TEXAS (1-877-728-3927) or online. Online submission is only available for non-preferred prior authorization requests.
    - Texas Prior Authorization Call Center: txvendordrug.com/about/contact-us/prior-authorization
        - Account Registration Instructions: paxpress.txpa.hidinc.com/Account_Reg_Instructions.pdf
        - Provider Quick Reference: paxpress.txpa.hidinc.com/Provider_Quick_Ref_Guide.pdf
    - Xenical requires prior authorization but is reviewed internally by HHS staff.
        - Download form from txvendordrug.com/formulary/prior-authorization/medicaid-ffs-forms

Texas Medicaid Drug Utilization Review Board

The board makes recommendations for the PDL and clinical prior authorizations four times a year. Close to 75 therapeutic classes are reviewed each year, with approximately one-quarter of the classes reviewed at each meeting:

- The January PDL includes decisions made at the July and October meetings
- The July PDL includes decisions made at the January and April meetings

Education

- Texas Health Steps offers free online continuing education courses and the *Prescriber's Guide to Texas Medicaid Outpatient Pharmacy Prior Authorization* quick course:
  - txhealthsteps.com
  - txvendordrug.com/providers/prescriber-education

Updates

- Both the formulary and PDL are available for free on mobile devices using the Epocrates drug information system:
  - txvendordrug.com/formulary/epocrates
- Texas Medicaid Email Notification Service
  - txvendordrug.com/about/news/notices

Contact

- vdp-formulary@hhsc.state.tx.us

HEALTH AND HUMAN SERVICES COMMISSION
TEXAS MEDICAID PREFERRED DRUG LIST (PDL) and PRIOR AUTHORIZATION (PA) CRITERIA
Effective January 28, 2021

PREFERRED DRUG LIST PUBLICATION LOG	
The PDL is published biannually (January, July). Recent changes to the PDL status are highlighted:	
January 28, 2021:	Published

ACNE AGENTS, ORAL		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
AMNESTEEM (isotretinoin) CLARAVIS (isotretinoin) isotretinoin MYORISAN (isotretinoin) ZENATANE (isotretinoin)	*ABSORICA (isotretinoin)* *ABSORICA LD (isotretinoin)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

ACNE AGENTS, TOPICAL		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Antibiotics		
clindamycin gel (Clindagel) clindamycin pledgets clindamycin solution erythromycin gel, solution	*CLEOCIN-T (clindamycin)* *clindamycin foam* *clindamycin lotion* *erythromycin medicated swab*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions The following Clinical Prior Authorization applies **to all drugs** in the class: ▪ Topical Acne Agents

ACNE AGENTS, TOPICAL *continued*		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Benzoyl Peroxide		
benzoyl peroxide gel (Rx) benzoyl peroxide wash	*BENZEFOAM FOAM OTC (topical)* *benzoyl peroxide cleanser* *benzoyl peroxide cream* *benzoyl peroxide foam* *benzoyl peroxide gel* *benzoyl peroxide kit* *benzoyl peroxide lotion* *benzoyl peroxide towelette*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions The following Clinical Prior Authorization applies **to all drugs** in the class: ▪ Topical Acne Agents

ACNE AGENTS, TOPICAL *continued*		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Retinoids		
tretinoin cream (Avita, Retin-A) tretinoin gel	*AKLIEF (trifarotene)* *adapalene* *ALTRENO (tretinoin)* *ATRALIN (tretinoin)* *AVITA (tretinoin)* *DIFFERIN (adapalene)* *FABIOR (tazarotene)* *tazarotene* *TAZORAC (tazarotene)* *tretinoin gel (Atralin)* *tretinoin microspheres*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions The following Clinical Prior Authorization applies **to all drugs** in the class: ▪ Topical Retinoids

ACNE AGENTS, TOPICAL *continued*			
Preferred Agents	***Non-Preferred Agents***		**PA Criteria** *Client must meet at least one of the listed PA criteria*
Combination and Other Agents			
benzoyl peroxide/clindamycin (Duac)	*ACZONE 7.5% (dapsone)* *AZELEX (azelaic acid)* *BENZACLIN GEL (benzoyl peroxide/clindamycin)* *benzoyl peroxide (Epiduo)* *clindamycin/benzoyl peroxide* *clindamycin/tretinoin* *dapsone* *DUAC (benzoyl peroxide/clindamycin)* *EPIDUO (benzoyl peroxide/adapalene)* *EPIDUO FORTE (benzoyl peroxide/adapalene)*	*erythromycin/benzoyl peroxide* *sulfacetamide* *sulfacetamide sodium* *sulfacetamide sodium/sulfur* *sulfacetamide/sulfur* *sulfacetamide/sulfur/urea* *ZIANA (clindamycin/tretinoin)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions The following Clinical Prior Authorization applies **to all drugs** in the class: ▪ Retinoids ▪ Topical Acne Agents

ALZHEIMER'S AGENTS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Cholinesterase Inhibitors		▪ Stable therapy with a non-preferred agent for 30 days in the past 180 days ▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions ▪ For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization Dose Optimization applies to some strengths where a "*" is noted
donepezil 5, 10 mg tablet* donepezil ODT* EXELON (rivastigmine) transdermal	*ARICEPT (donepezil)** *donepezil 23 mg tablet** *galantamine** *galantamine ER* *RAZADYNE (galantamine) tablet** *RAZADYNE ER (galantamine ER)* *rivastigmine capsules* *rivastigmine transdermal*	
NMDA Receptor Antagonist		
memantine tablets	*memantine solution* *memantine tablet dose pack* *NAMENDA (memantine) tablets* *NAMENDA XR (memantine)*	
Cholinesterase Inhibitor/NMDA Receptor Antagonist Combinations		
	NAMZARIC (donepezil/memantine)	

ANALGESICS, NARCOTIC – LONG ACTING		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
BUTRANS (buprenorphine) EMBEDA (morphine/naloxone) fentanyl patch (12.5, 25, 50, 75, 100 mcg) morphine ER (generic MS Contin) tramadol ER (Ultram ER) XTAMPZA ER (oxycodone)	*BELBUCA (buprenorphine)* *buprenorphine patch* *DURAGESIC (fentanyl)* *EXALGO (hydromorphone)* *fentanyl patch (37.5, 62.5, 87.5 mcg)* *hydromorphone ER* *HYSINGLA ER (hydrocodone)* *KADIAN* (morphine) *methadone* *MORPHABOND ER (morphine)* *morphine ER (generic Avinza, Kadian)* *MS CONTIN (morphine)* *NUCYNTA ER (tapentadol)* *OPANA ER (oxymorphone)* *oxycodone ER* *OXYCONTIN (oxycodone)* *oxymorphone ER* *tramadol ER (generic Conzip, Ryzolt)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions ▪ Methadone oral solution will be authorized for patients less than 24 months of age. The following Clinical Prior Authorization applies **to all drugs** in the class: ▪ Morphine Milligram Equivalent ▪ Opiate Overutilization ▪ Opiate/Benzodiazepine/Muscle Relaxant A drug specific prior authorization applies to drugs with a hyperlink

ANALGESICS, NARCOTIC – SHORT ACTING (NON-PARENTERAL)			
Preferred Agents	***Non-Preferred Agents***		**PA Criteria** *Client must meet at least one of the listed PA criteria*
APAP/codeine hydrocodone/APAP hydrocodone/ibuprofen hydromorphone tablet morphine tablets morphine solution oxycodone solution oxycodone tablet oxycodone/APAP tramadol tramadol/APAP	*ACTIQ (fentanyl)* *APADAZ (benzhydrocodone/APAP)* *butalbital/ASA/caffeine/codeine* *butalbital/APAP/caffeine/codeine* *butorphanol* *carisoprodol/aspirin/codeine* *codeine* *dihydrocodeine/ASA/caffeine* *DILAUDID (hydromorphone)* *fentanyl buccal* *FENTORA (fentanyl)* *FIORINAL W/CODEINE (butalbital/ASA/caffeine/codeine)* *hydromorphone liquid* *hydromorphone suppositories* *IBUDONE (hydrocodone/ibuprofen)* *LAZANDA (fentanyl)* *levorphanol* *meperidine* *morphine concentrated solution*	*NALOCET (oxycodone/APAP)* *NORCO (hydrocodone/APAP)* *NUCYNTA (tapentadol)* *OPANA (oxymorphone)* *oxycodone/ASA* *oxycodone/ibuprofen* *oxycodone capsule* *oxycodone concentratedsolution* *oxymorphone* *pentazocine/naloxone* *PERCOCET (oxycodone/APAP)* *ROXICODONE (oxycodone)* *SUBSYS (fentanyl)* *TYLENOL-CODEINE (codeine/APAP)* *ULTRACET (tramadol/APAP)* *ULTRAM (tramadol)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions The following Clinical Prior Authorization applies **to all drugs** in the class: ▪ Morphine Milligram Equivalent ▪ Opiate Overutilization ▪ Opiate/Benzodiazepine/Muscle Relaxant A drug specific prior authorization applies to drugs with a hyperlink

ANDROGENIC AGENTS, TOPICAL		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
ANDROGEL (testosterone) pump	*ANDRODERM (testosterone)* *ANDROGEL (testosterone) packet* *FORTESTA (testosterone)* *TESTIM (testosterone)* *testosterone gel* *VOGELXO (testosterone)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions The following Clinical Prior Authorization applies **to all drugs** in the class: ▪ Androgenic Agents

ANGIOTENSIN MODULATORS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Ace Inhibitors		▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions ▪ Epaned will be authorized for patients six years of age and under Dose Optimization applies to some strengths where a "*" is noted The following Clinical Prior Authorization applies **to all drugs** in the class: Duplicate Therapy
benazepril enalapril fosinopril* lisinopril quinapril ramipril*	*ACCUPRIL (quinapril)* *ALTACE (ramipril)** *captopril* *EPANED (enalapril)* *moexepril* *perindopril** *PRINIVIL (lisinopril)* *QBRELIS (lisinopril) solution* *trandolapril** *VASOTEC (enalapril)*	
ACE Inhibitor/Diuretic Combinations		
enalapril/HCTZ lisinopril/HCTZ	*ACCURETIC (quiaprilHCTZ)* *benazepril/HCTZ* *captopril/HCTZ* *fosinopril/HCTZ* *moexipril/HCTZ* *quinapril/HCTZ* *VASERETIC (enalapril/HCTZ)* *ZESTORETIC (lisinopril/HCTZ)*	
Angiotensin II Receptor Blockers (ARBs)		
DIOVAN (valsartan)* irbesartan* losartan*	*ATACAND(candesartan** *AVAPRO (irbesartan)** *BENICAR (olmesartan)** *candesartan** *COZAAR (losartan)** *EDARBI (azilsartan)* *eprosartan* *MICARDIS (telmisartan)** *olmesartan* telmisartan** *valsartan**	

ANGIOTENSIN MODULATORS *continued*		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
ARB/Diuretic Combinations		▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions ▪ For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization The following Clinical Prior Authorization applies **to all drugs** in the class: ▪ Duplicate Therapy Dose Optimization applies to some strengths where a "*" is noted A drug specific prior authorization applies to drugs with a hyperlink
irbesartan/HCTZ losartan/HCTZ*	*ATACAND-HCT (candesartan/HCTZ)* *AVALIDE (irbesartan/HCTZ)* *BENICAR-HCT (olmesartan/HCTZ)* *candesartan/HCTZ* *DIOVAN-HCT (valsartan/HCTZ)* *EDARBYCLOR (azilsartan/chlorthalidone)* *HYZAAR (losartan/HCTZ)** *MICARDIS-HCT (telmisartan/HCTZ)* *olmesartan/HCTZ* *telmisartan /HCTZ* *valsartan/HCTZ*	
Direct Renin Inhibitors		
	TEKTURNA (aliskerin)	
Direct Renin Inhibitor/Diuretic Combinations		
	TEKTURNA HCT (aliskerin/HCTZ)	
ARB/Neprilysin Inhibitor Combinations		
ENTRESTO (valsartan/sacubitril)		

ANGIOTENSIN MODULATOR COMBINATIONS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
benazepril /amlodipine valsartan/amlodipine	*AZOR (olmesartan/amlodipine)* *BYVALSON (valsartan/nebivolol)* *EXFORGE (valsartan/amlodipine)* *LOTREL (benazepril/amlodipine)* *olmesartan/amlodipine* *olmesartan/amlodipine/HCTZ* *telmisartan/amlodipine* *trandolapril/verapamil* *valsartan/amlodipine/HCTZ*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions A drug specific prior authorization applies to drugs with a hyperlink

ANTI-ALLERGENS, ORAL		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
	ORALAIR (Sweet Vernal, Orchard, Perennial Rye, Timothy, & Kentucky Blue Grass mixed pollens allergen extract) *PALFORZIA MAINTENANCE SACHET (peanut allergen powder)* *PALFORZIA TITRATION CAPSULE (peanut allergen powder)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions ▪ For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization A drug specific prior authorization applies to drugs with a hyperlink

ANTIBIOTICS, GASTROINTESTINAL		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
FIRVANQ(vancomycin) metronidazole tablet neomycin tinidazole	*DIFICID (fidaxomicin)* *FLAGYL (metronidazole)* *metronidazole capsule* *paromomycin* *TINDAMAX (tinidazole)* *VANCOCIN (vancomycin)* *vancomycin* *XIFAXAN (rifaximin)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions A drug specific prior authorization applies to drugs with a hyperlink

ANTIBIOTICS, INHALED		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
ARIKAYCE (amikacin) BETHKIS (tobramycin) CAYSTON (aztreonam) KITABIS PAK (tobramycin) TOBI PODHALER (tobramycin)	*TOBI (tobramycin) solution* *tobramycin solution*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions The following Clinical Prior Authorization applies **to all drugs** in the class: ▪ Antibiotics, Inhaled

ANTIBIOTICS, TOPICAL		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
bacitracin ointment mupirocin ointment triple antibiotic ointment neomycin/polymyxin/pramoxine	*CENTANY (mupirocin)* *gentamicin* *mupirocin cream* *mupirocin ointment syringe* *XEPI (ozenoxacin)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

ANTIBIOTICS, VAGINAL		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
CLEOCIN (clindamycin) ovules CLINDESSE (clindamycin) NUVESSA (metronidazole)	*CLEOCIN (clindamycin) cream* *clindamycin* *metronidazole* *SOLOSEC (secnidazole)* *VANDAZOLE (metronidazole)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

ANTICOAGULANTS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
ELIQUIS (apixaban) enoxaparin FRAGMIN (dalteparin) syringe PRADAXA (dabigatran) warfarin XARELTO (rivaroxaban)	*ARIXTRA (fondaparinux)* *BEVYXXA (betrixaban)* *COUMADIN (warfarin)* *fondaparinux* *FRAGMIN (dalteparin) vial* *LOVENOX (enoxaparin)* *SAVAYSA (edoxaban)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions The following Clinical Prior Authorization applies **to all drugs** in the class: ▪ Duplicate Therapy

ANTICONVULSANTS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
APTIOM (eslicarbazine) BANZEL (rufinamide) BRIVIACT (brivaracetam) carbamazepine carbamazepine ER, XR CARBATROL (carbamazepine) CELONTIN (methsuximide) clobazam clonazepam DEPAKOTE (divalproex sodium) DEPAKOTE ER (divalproex sodium) DIACOMIT (stiripentol) DIASTAT (diazepam) DIASTAT ACUDIAL (diazepam) diazepam DILANTIN (phenytoin) DILANTIN INFATAB (phenytoin) divalproex divalproex ER EPIDIOLEX (cannabidiol) EQUETRO (carbamazepine) ethosuximide felbamate FELBATOL (felbamate) FINTEPLA (fenfluramine) FYCOMPA (perampanel) GABITRIL (tiagabine) KEPPRA (levetiracetam) KEPPRA XR (levetiracetam) KLONOPIN (clonazepam) LAMICTAL (lamotrigine) tablet, ODT LAMICTAL XR (lamotrigine) lamotrigine tablet, ODT levetiracetam levetiracetam XR		▪ All of the agents in the Anticonvulsants class are preferred

ANTICONVULSANTS *continued*		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
MYSOLINE (primidone) NAYZILAM (midazolam) ONFI (clobazam) oxcarbazepine OXTELLAR XR (oxcarbazepine) PEGANONE (ethotoin) phenobarbital PHENYTEK (phenytoin) phenytoin primidone QUDEXY XR (topiramate) SABRIL (vigabatrin) SPRITAM (levetiracetam) SYMPAZAN (clobazam) TEGRETOL (carbamazepine) TEGRETOL XR (carbamazepine) tiagabine TOPAMAX (topiramate) topiramate topiramate ER TRILEPTAL (oxcarbazepine) TROKENDI XR (topiramate) valproic acid VALTOCO (diazepam) zonisamide vigabatran VIMPAT (lacosamide) XCOPRI (cenobamate) ZARONTIN (ethosuximide)		▪ All of the agents in the Anticonvulsants class are preferred

ANTIDEPRESSANTS, OTHER		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
bupropion bupropion SR bupropion XL* mirtazapine* phenelzine trazodone venlafaxine ER capsules* venlafaxine IR	*APLENZIN (bupropion)* *desvenlafaxine ER* *EFFEXOR XR (venlafaxine)** *EMSAM (selegiline)* *FETZIMA (levomilnacipran)* *FORFIVO XL (bupropion)* *KHEDEZLA (desvenlafaxine)* *MARPLAN (isocarboxazid)* *NARDIL (phenelzine)* *nefazodone* *PRISTIQ (desvenlafaxine)* *REMERON (mirtazapine)** *tranylcypromine* *TRINTELLIX (vortioxetine)* *venlafaxine ER tablets** *VIIBRYD (vilazodone)* *WELLBUTRIN SR (bupropion)* *WELLBUTRIN XL (bupropion)**	▪ Stable therapy with a non-preferred agent for 30 days in the past 180 days ▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions Dose Optimization applies to some strengths where a "*" is noted

ANTIDEPRESSANTS, SSRIs			
Preferred Agents	***Non-Preferred Agents***		**PA Criteria** *Client must meet at least one of the listed PA criteria*
citalopram* escitalopram tablets* fluoxetine IR fluvoxamine paroxetine* sertraline*	*BRISDELLE (paroxetine)* *CELEXA (citalopram)** *escitalopram solution* *fluoxetine capsule DR* *fluoxetine 60mg tablets* *fluvoxamine ER* *LEXAPRO (escitalopram)**	*paroxetine CR** *PAXIL (paroxetine)** *PAXIL CR (paroxetine)** *PROZAC (fluoxetine)* *ZOLOFT (sertraline)**	▪ Stable therapy with a non-preferred agent for 30 days in the past 180 days ▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions Dose Optimization applies to some strengths where a "*" is noted

ANTIDEPRESSANTS, TRICYCLIC			
Preferred Agents	***Non-Preferred Agents***		**PA Criteria** *Client must meet at least one of the listed PA criteria*
amitriptyline doxepin imipramine nortriptyline capsule	*amoxapine* *ANAFRANIL (clomipramine)* *clomipramine* *desipramine* *imipramine pamoate* *maprotiline* *nortriptyline solution* *PAMELOR (nortriptyline)* *protriptyline*	*SURMONTIL (trimipramine)* *TOFRANIL (imipramine)* *trimipramine*	▪ Stable therapy with a non-preferred agent for 30 days in the past 180 days ▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

ANTIEMETIC-ANTIVERTIGO AGENTS (EXCLUDES INJECTABLES)		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Anticholinergics, Antihistamines, Dopamine Antagonists		▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions ▪ For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization The following Clinical Prior Authorization applies **to all drugs** in the class: ▪ Antiemetic-Antivertigo Agents A drug specific prior authorization applies to drugs with a hyperlink
dimenhydrinate meclizine metoclopramide solution, tablets phosphoric acid/dextrose/fructose prochlorperazine tablets promethazine syrup, tablets	*BONJESTA (doxylamine/pyridoxine)* *COMPRO (prochlorperazine)* *DICLEGIS (doxylamine/pyridoxine)* *doxylamine/pyridoxine* *metoclopramide ODT* *prochlorperazine suppositories* *promethazine suppositories* *REGLAN (metoclopramide)* *scopolamine patches* *TRANSDERM-SCOP (scopolamine)* *trimethobenzamide*	
Cannabinoids		
	dronabinol *MARINOL (dronabinol)*	

ANTIEMETIC-ANTIVERTIGO AGENTS (EXCLUDES INJECTABLES) *continued*		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
5-HT3 Receptor Antagonists		▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions ▪ Ondansetron solution will be authorized for patients six years of age and under ▪ For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization A drug specific prior authorization applies to drugs with a hyperlink The following Clinical Prior Authorization applies **to all drugs** in the class: ▪ Antiemetic
ondansetron	*ANZEMET (dolasetron)* *granisetron* *SANCUSO (granisetron)* *ZOFRAN (ondansetron)* *ZUPLENZ (ondansetron)*	
Substance P Antagonists & Combinations		
	aprepitant *AKYNZEO (netupitant/palonosetron)* *EMEND (aprepitant)*	

ANTIFUNGALS, ORAL		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
clotrimazole fluconazole griseofulvin suspension ketoconazole nystatin terbinafine	*ANCOBON (flucytosine)* *CRESEMBA (isavuconazonium sulfate)* *DIFLUCAN (fluconazole)* *flucytosine* *griseofulvin tablets* *itraconazole* *NOXAFIL (posaconazole)* *nystatin powder* *ORAVIG (miconazole)* *posaconazole* *SPORANOX (itraconazole)* *TOLSURA (itraconazole)* *VFEND (voriconazole)* *voriconazole*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

ANTIFUNGALS, TOPICAL		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Antifungals		▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions
clotrimazole ketoconazole shampoo miconazole cream, powder nystatin terbinafine tolnaftate cream, powder	*BENSAL HP (benzoic acid/salicylic acid)* *ciclopirox* *clotrimazole solution RX* *DERMACINRX THERAZOLE PAK (betamethasone/clotrimazole/zinc oxide)* *econazole* *EXTINA (ketoconazole)* *FUNGOID (miconazole)* *JUBLIA (efinaconazole)* *KERYDIN (tavaborole)* *ketoconazole cream, foam* *LOPROX (ciclopirox)* *MENTAX (butenafine)* *miconazole ointment, spray* *naftifine* *oxiconazole* *OXISTAT (oxiconazole)* *VUSION (miconazole/ zinc/petrolatum)*	
Antifungal/Steroid Combinations		
clotrimazole/betamethasone cream	*clotrimazole/betamethasone lotion* *LOTRISONE (clotrimazole/betamethasone)* *nystatin/triamcinolone*	

ANTIHISTAMINES, FIRST GENERATION		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Antihistamines		
carbinoxamine liquid clemastine tablet OTC clorpheniramine IR tablets cyproheptadine syrup, tablet diphenhydramine capsules, liquid, tablet HISTEX (triprolidine) liquid, PD DROPS Hydroxyzine PEDIACLEAR (triprolidine)	*carbinoxamine tablets* *chlorpheniramine ER tablets* *clemastine tablets* *diphenhydramine elixir* *ED CHLORPRED (chlorpheniramine/ phenylephrine)* *KARBINAL ER (carbinoxamine) suspension* *M-HIST (triprolidine) PD DROPS* *MICLARA LQ OTC (triprolidine)* *RYCLORA (dexchlorpheniramine)* *RYVENT (carbinoxamine)* *THERAFLU NIGHTIME (diphenhydramine)* *triprolidine* *VANACLEAR (triprolidine) PD DROPS* *VANAHIST (triprolidine) PD DROPS* *VANAMINE (diphenhydramine) PD DROPS* *VISTARIL (hydroxyzine)*	▪ Treatment failure after no less than a 30-day trial of preferred drugs ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions The following Clinical Prior Authorization applies **to all drugs** in the class: ▪ Duplicate Therapy

ANTIHISTAMINES, MINIMALLY SEDATING		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Antihistamines		
cetirizine solution, tablets* loratadine solution, tablets	*cetirizine chewable* *CLARINEX (desloratadine)* *desloratadine* *fexofenadine* *levocetirizine* *loratadine ODT*	▪ Treatment failure after no less than a 30-day trial of preferred drugs ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions ▪ For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization The following Clinical Prior Authorization applies **to all drugs** in the class: ▪ Duplicate Therapy Dose Optimization applies to some strengths where a "*" is noted
Antihistamine/Decongestant Combinations		
	cetirizine/pseudoephedrine *loratadine/pseudoephedrine* *SEMPREX-D* *(acrivastine/pseudoephedrine)*	

ANTIHYPERTENSIVES, SYMPATHOLYTICS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
CATAPRES-TTS (clonidine) clonidine IR tablets guanfacine IR methyldopa	*CATAPRES (clonidine)* *clonidine transdermal* *methyldopa / HCTZ*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions A drug specific prior authorization applies to drugs with a hyperlink

ANTIHYPERURICEMICS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
allopurinol probenecid probenecid/colchicine	*colchicine* *COLCRYS (colchicine)* *GLOPERBA (colchicine)* *ULORIC (febuxostat)* *ZYLOPRIM (allopurinol)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

ANTIMIGRAINE AGENTS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Triptans		
rizatriptan sumatriptan injection kit sumatriptan syringe sumatriptan tablets sumatriptan vial ZOMIG (zolmitriptan) nasal	*almotriptan* *AMERGE (naratriptan)* *eletriptan* *FROVA (frovatriptan)* *frovatriptan* *IMITREX (sumatriptan) injection kit* *IMITREX (sumatriptan) nasal* *IMITREX (sumatriptan) tablets* *IMITREX (sumatriptan) vial* *MAXALT (rizatriptan)* *naratriptan* *ONZETRA XSAIL (sumatriptan)* *RELPAX (eletriptan)* *sumatriptan injection kit (SUN Pharma Global)* *sumatriptan nasal* *sumatriptan/naproxen* *SUMAVEL DOSEPRO (sumatriptan)* *TOSYMRA (sumatriptan)* *TREXIMET (sumatriptan/naproxen)* *ZEMBRACE SYMTOUCH (sumatriptan)* *zolmitriptan tablets* *ZOMIG (zolmitriptan) tablets*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions A drug specific prior authorization applies to drugs with a hyperlink

ANTIMIGRAINE AGENTS *continued*		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Non-Triptans		
AIMOVIG (erenumab) EMGALITY (galcanezumab-gnlm) UBRELVY (ubrogepant)	*AJOVY (fremanezumab-vfrm)* *CAMBIA (diclofenac)* *D.H.E. 45 (dihydroergotamine)* *dihydroergotamine mesylate* *EMGALITY 100 mg (cluster headache) (galcanezumab-gnlm)* *MIGRANAL (dihydroergotamine mesylate)* *NURTEC ODT (rimegepant)* *REYVOW (lasmiditan)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions A drug specific prior authorization applies to drugs with a hyperlink

ANTIPARASITICS, TOPICAL		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
NATROBA (spinosad) permethrin VANALICE GEL OTC (piperonyl butoxide/pyrethrum)	*CROTAN (crotamiton)* *EURAX (crotamiton)* *lindane* *malathion* *OVIDE (malathion)* *SKLICE (ivermectin)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

ANTIPARKINSON'S AGENTS (ORAL/TRANSDERMAL)		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Anticholinergics		▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions ▪ For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization
benztropine trihexyphenidyl		
COMT Inhibitors		
	COMTAN (entacapone) *entacapone* *TASMAR (tolcapone)* *tolcapone*	
Dopamine Agonists		
pramipexole ropinirole	*bromocriptine* *MIRAPEX (pramipexole)* *MIRAPEX ER (pramipexole)* *NEUPRO transdermal (rotigotine)* *pramipexole ER* *REQUIP (ropinirole)* *REQUIP XL (ropinirole)* *ropinirole ER*	

ANTIPARKINSON'S AGENTS (ORAL/TRANSDERMAL) *continued*		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
MAO-B Inhibitors		▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions ▪ For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization
	AZILECT (rasagiline) *rasagiline* *selegiline* *XADAGO (safinamide)* *ZELAPAR (selegiline)*	
Others		
amantadine carbidopa/levodopa tablets carbidopa/levodopa ER carbidopa/levodopa/entacapone	*carbidopa* *carbidopa/levodopa ODT* *DUOPA (carbidopa/levodopa)* *GOCOVRI (amantadine)* *INBRIJA (levodopa)* *LODOSYN (carbidopa)* *NOURIANZ (istradefylline)* *OSMOLEX ER (amantadine)* *RYTARY (carbidopa/levodopa)* *SINEMET (carbidopa/levodopa)* *SINEMET CR (carbidopa/levodopa)* *STALEVO (levodopa/carbidopa/entacapone)*	

ANTIPSYCHOTICS

Preferred Agents		*Non-Preferred Agents*		PA Criteria *Client must meet at least one of the listed PA criteria*
Antipsychotics				
aripiprazole tablets*	perphenazine	*ABILIFY (aripiprazole) tablets**	*pimozide*	▪ Stable therapy with a non-preferred drug for 30 days within the past 180 days ▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions The following Clinical Prior Authorization applies **to all drugs** in the class: ▪ Antipsychotics A drug specific prior authorization applies to drugs with a hyperlink Dose Optimization applies to some strengths where a "*" is noted
chlorpromazine	quetiapine IR	*ABILIFY MYCITE (aripiprazole)*	*quetiapine ER*	
clozapine	risperidone tablets*, solution	*aripiprazole ODT, solution*	*REXULTI (brexpiprazole)*	
fluphenazine	thioridazine	*clozapine ODT*	*RISPERDAL (risperidone)**	
haloperidol	thiothixene	*CAPLYTA (lumateperone)*	*risperidone ODT**	
haloperidol decanoate inj.	trifluoperazine	*CLOZARIL (clozapine)*	*SAPHRIS (asenapine)*	
LATUDA (lurasidone)	ziprasidone	*FANAPT (iloperidone)*	*SECUADO (asenapine)*	
olanzapine*		*FAZACLO (clozapine)*	*SEROQUEL (quetiapine)*	
olanzapine ODT*		*fluphenazine decanoate*	*SEROQUEL XR (quetiapine)*	
		GEODON (ziprasidone) capsule, IM	*VERSACLOZ (clozapine)*	
		HALDOL (haloperidol) decanoate	*VRAYLAR (cariprazine)*	
		haloperidol lactate injection	*ZYPREXA (olanzapine)**	
		INVEGA (paliperidone)	*ZYPREXA ZYDIS (olanzapine)**	
		loxapine		
		NUPLAZID (pimavanserin)		
		olanzapine IM		
		ORAP (pimozide)		
		paliperidone		
Antipsychotic/SSRI Combinations				
amitriptyline/perphenazine		*olanzapine/fluoxetine* *SYMBYAX (olanzapine/fluoxetine*		

ANTIPSYCHOTICS *Continued*		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Long-Acting Injectables		
ABILIFY MAINTENA (aripiprazole) ARISTADA (aripiprazole) ARISTADA INITIO (aripiprazole) INVEGA SUSTENNA (paliperidone) INVEGA TRINZA (paliperidone) RISPERDAL CONSTA (risperidone)	*PERSERIS (risperidone)* *ZYPREXA RELPREVV (olanzapine)*	▪ Stable therapy with a non-preferred drug for 30 days in the last 180 days ▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions The following Clinical Prior Authorization applies **to all drugs** in the class: ▪ Antipsychotics A drug specific prior authorization applies to drugs with a hyperlink

ANTIVIRALS (ORAL/NASAL)		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Antiherpetic		▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions
acyclovir famciclovir valacyclovir	*VALTREX (valacyclovir)* *ZOVIRAX (acyclovir)*	
Anti-influenza		
oseltamivir RELENZA (zanamivir)	*rimantadine* *TAMIFLU (oseltamivir)* *XOFLUZA (baloxavir)*	
Anti-CMV		
VALCYTE (valganciclovir) tablets, solution	*valganciclovir tablets, solution*	

ANTIVIRALS, TOPICAL		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
acyclovir ointment DENAVIR (penciclovir)	*XERESE (acyclovir/hydrocortisone)* *ZOVIRAX (acyclovir)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

ANXIOLYTICS				
Preferred Agents		***Non-Preferred Agents***		**PA Criteria** *Client must meet at least one of the listed PA criteria*
alprazolam tablet	diazepam solution	*alprazolam ER*	*TRANXENE T-TAB (clorazepate)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions The following Clinical Prior Authorization applies **to all drugs** in the class: ▪ Anxiolytics ▪ Opiate/Benzodiazepine/Muscle Relaxant
buspirone	diazepam tablet	*alprazolam intensol*	*XANAX XR (alprazolam)*	
chlordiazepoxide	lorazepam intensol	*alprazolam ODT*	*XANAX (alprazolam) tablet*	
clorazepate	lorazepam tablet	*diazepam intensol*		
		meprobamate		
		oxazepam		

BETA BLOCKERS (ORAL)		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Beta Blockers		▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions A drug specific prior authorization applies to drugs with a hyperlink Dose Optimization applies to some strengths where a "*" is noted
acebutolol atenolol bisoprolol HEMANGEOL (propranolol) metoprolol IR metoprolol XL propranolol IR sotalol	*betaxolol* *BYSTOLIC (nebivolol)* *INDERAL LA (propranolol)* *INNOPRAN XL (propranolol)* *KAPSPARGO (metoprolol succinate)* *nadolol* *pindolol* *propranolol ER* *SOTYLIZE (sotalol)* *TENORMIN (atenolol)* *timolol* *TOPROL XL (metoprolol succinate)*	
Beta Blocker Combinations		
atenolol/chlorthalidone bisoprolol/HCTZ	*CORZIDE (nadolol/bendroflumethiazide)* *DUTOPROL (metoprolol succinate ER/HCTZ)* *metoprolol/HCTZ* *nadolol/bendroflumethiazide* *propranolol/HCTZ* *TENORETIC (atenolol/HCTZ)* *ZIAC (bisoprolol/HCTZ)*	
Beta- and Alpha-Blockers		
carvedilol labetalol	*carvedilol ER** *COREG (carvedilol)* *COREG CR (carvedilol)**	

BILE SALTS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
ursodiol tablet	*ACTIGALL (ursodiol)* *CHENODAL (chenodiol)* *CHOLBAM (cholic acid)* *OCALIVA (obeticholic acid)* *URSO (ursodiol)* *URSO FORTE (urosodiol)* *ursodiol capsule*	▪ Treatment failure with preferred drug ▪ Contraindication to preferred drug ▪ Allergic reaction to preferred drug ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

BLADDER RELAXANT PREPARATIONS			
Preferred Agents	***Non-Preferred Agents***		**PA Criteria** *Client must meet at least one of the listed PA criteria*
oxybutynin IR oxybutynin ER* TOVIAZ (fesoterodine) VESICARE (solifenacin)*	*darifenacin* *DETROL (tolterodine)* *DETROL LA (tolterodine)** *DITROPAN XL (oxybutynin)** *ENABLEX (darifenacin)* *flavoxate* *GELNIQUE (oxybutynin)* *MYRBETRIQ (mirabegron)*	*OXYTROL (oxybutynin)* *tolterodine* *tolterodine ER** *trospium* *trospium ER*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions Dose Optimization applies to some strengths where a "*" is noted

BONE RESORPTION SUPPRESSION AND RELATED AGENTS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Bisphosphonates		▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions ▪ For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization A drug specific prior authorization applies to drugs with a hyperlink
alendronate tablets	*ACTONEL (risedronate)* *alendronate solution* *ATELVIA (risedronate)* *BINOSTO (alendronate)* *BONIVA (ibandronate) etidronate* *EVENITY (romosozumab-aqqg)* *FOSAMAX (alendronate)* *FOSAMAX PLUS D (alendronate/vitamin D)* *ibandronate risedronate*	
Other Bone Resorption Suppression and Related Agents		
	calcitonin nasal *EVISTA (raloxifene)* *FORTEO (teriparatide)* *raloxifene* *teriparatide* *TYMLOS (abaloparatide)*	

BPH AGENTS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Alpha Blockers		▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions ▪ For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization Dose Optimization applies to some strengths where a "*" is noted
alfuzosin doxazosin* tamsulosin terazosin*	*CARDURA (doxazosin)** *FLOMAX (tamsulosin)** *RAPAFLO (silodosin)*	
5-Alpha-Reductase (5AR) Inhibitors		
finasteride	*AVODART (dutasteride)* *dutasteride* *PROSCAR (finasteride)*	
Alpha Blocker/5AR Inhibitor Combinations		
	dutasteride/tamsulosin *JALYN (dutasteride/tamsulosin)*	
Phosphodiesterase 5 Inhibitors		
	tadalafil	

BRONCHODILATORS, BETA AGONIST		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Inhalers, Short-Acting		▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions ▪ For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization The following Clinical Prior Authorization applies **to all drugs** in the class: ▪ Duplicate Therapy
PROAIR HFA (albuterol) PROVENTIL HFA (albuterol)	*levalbuterol* *PROAIR DIGIHALER (albuterol)* *PROAIR RESPICLICK (albuterol)* *VENTOLIN HFA (albuterol)* *XOPENEX HFA (levalbuterol)*	
Inhalers, Long-Acting		
	ARCAPTA (indacaterol) *SEREVENT (salmeterol)* *STRIVERDI RESPIMAT (olodaterol)*	

BRONCHODILATORS, BETA AGONIST *continued*		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Inhalation Solution		▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions The following Clinical Prior Authorization applies **to all drugs** in the class: ▪ Duplicate Therapy
albuterol	*BROVANA (arformoterol)* *levalbuterol* *PERFOROMIST (formoterol)* *XOPENEX (levalbuterol)*	
Oral		
albuterol syrup	*albuterol tablet* *albuterol ER* *metaproterenol* *terbutaline*	

CALCIUM CHANNEL BLOCKERS (ORAL)		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Short-Acting		
diltiazem verapamil	*CALAN (verapamil)* *CARDIZEM (diltiazem)* *Isradipine* *nicardipine* *nifedipine* *nimodipine* *NYMALIZE (nimodipine)* *PROCARDIA (nifedipine)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions Dose Optimization applies to some strengths where a "*" is noted
Long-Acting		
amlodipine* diltiazem ER felodipine ER* nifedipine ER* verapamil ER capsules, tablets*	*ADALAT CC (nifedipine)** *CALAN SR (verapamil)* *CARDIZEM CD (diltiazem)* *CARDIZEM LA (diltiazem)* *diltiazem LA* *KATERZIA (amlodipine)* *MATZIM LA (diltiazem)* *nisoldipine** *NORVASC (amlodipine)** *PROCARDIA XL (nifedipine)** *TIAZAC (diltiazem)* *verapamil 360 mg capsules* *verapamil ER PM** *VERELAN (verapamil)* *VERELAN PM (verapamil)*	

CEPHALOSPORINS AND RELATED ANTIBIOTICS (ORAL)		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Beta Lactam/Beta-Lactamase Inhibitor Combinations		▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions
amoxicillin/clavulanate tablets, suspension	*amoxicillin/clavulanate chewable,* XR tablets *AUGMENTIN suspension (amoxicillin/clavulanate)* *AUGMENTIN XR (amoxicillin/clavulanate)*	
Cephalosporins – First Generation		
cefadroxil capsules, suspension cephalexin capsules, suspension	*cefadroxil tablets cephalexin tablets*	

CEPHALOSPORINS AND RELATED ANTIBIOTICS (ORAL) *continued*		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Cephalosporins – Second Generation		▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions
cefprozil suspension cefprozil tablets cefuroxime tablets	cefaclor ER cefaclor IR capsules, suspension	
Cephalosporins – Third Generation		
cefdinir	*cefixime* *cefpodoxime* *ceftibuten* *SUPRAX (cefixime)*	

COLONY STIMULATING FACTORS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
NEUPOGEN (filgrastim) vial, syringe UDENYCA (pegfilgrastim-cbqv)	FULPHILA (pegfilgrastim - jmdb) GRANIX (tbo-filgrastim) *LEUKINE (sargramostim)* *NEULASTA (pegfilgrastim)* *NIVESTYM (filgrastim-aafi)* *ZARXIO (filgrastim-sndz)* *ZIEXTENZO SYRINGE (pegfilgrastim-bmez)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

COPD AGENTS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Anticholinergics		▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions ▪ For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization The following Clinical Prior Authorization applies **to all drugs** in the class: ▪ Duplicate Therapy
ATROVENT HFA (ipratropium) ipratropium inhalation solution SPIRIVA HANDIHALER (tiotropium)	*INCRUSE ELLIPTA (umeclidinium)* *LONHALA MAGNAIR (glycopyrrolate)* *SEEBRI NEOHALER (glycopyrrolate)* *SPIRIVA RESPIMAT (tiotropium)* *TUDORZA (aclidinium)*	
Anticholinergic-Beta Agonist Combinations		
albuterol/ipratropium BEVESPI AEROSPHERE (glycopyrrolate/formoterol) COMBIVENT RESPIMAT (albuterol/ipratropium) STIOLTO RESPIMAT (tiotropium/olodaterol)	*ANORO ELLIPITA (umeclidinium/vilanterol)* *DUAKLIR PRESSAIR (aclidinium/formoterol)* *UTIBRON NEOHALER (glycopyrrolate/indacaterol)* *YUPELRI (revefenacin)*	
Phosphodiesterase Inhibitors		
	DALIRESP (roflumilast)	

COUGH AND COLD AGENTS	
See Separate Preferred Cough and ColdAgent Listing.	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions The following Clinical Prior Authorization applies **to all drugs** in the class: ▪ Cough & cold PA criteria

CYTOKINE AND CAM ANTAGONISTS

Preferred Agents	*Non-Preferred Agents*	PA Criteria *Client must meet at least one of the listed PA criteria*
ENBREL (etanercept) HUMIRA (adalimumab) OTEZLA (apremilast)	*ACTEMRA (tocilizumab)* *CIMZIA (certolizumab)* *COSENTYX (secukinumab)* *ILARIS (canakinumab)* *ILUMYA (tildrakizumab-asmn)* *KEVZARA (sarilumab)* *KINERET (anakinra)* *OLUMIANT (baricitinib)* *ORENCIA (abatacept)* *RINVOQ ER (upadacitinib)* *SILIQ (brodalumab)* *SIMPONI (golimumab)* *SKYRIZI (risankizumab-rzaa)* *STELARA (ustekinumab)* *TALTZ (ixekizumab)* *TREMFYA (guselkumab)* *XELJANZ (tofacitinib)* *XELJANZ XR (tofacitinib)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions The following Clinical Prior Authorization applies **to all drugs** in the class: ▪ Cytokine and CAM Antagonists

EPINEPHRINE, SELF-INJECTED

Preferred Agents	*Non-Preferred Agents*	PA Criteria *Client must meet at least one of the listed PA criteria*
epinephrine (Mylan authorized generic EPIPEN and EPIPEN JR)	*epinephrine (generic ADRENACLICK)* epinephrine (generic EPIPEN and EPIPEN JR) *EPIPEN (epinephrine)* *EPIPEN JR (epinephrine)* *SYMJEPI (epinephrine)*	▪ Treatment failure with preferred products ▪ Contraindication to preferred products ▪ Allergic reaction to preferred products ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

ERYTHROPOIESIS STIMULATING PROTEINS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
ARANESP (darbepoetin) EPOGEN (RhUEPO) RETACRIT (RhUEPO)	*MIRCERA (PEG-EPO)* *PROCRIT (RhUEPO)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions The following Clinical Prior Authorization applies **to all drugs** in the class: ▪ Erythropoiesis-Stimulating Agents

FLUOROQUINOLONES, ORAL		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
ciprofloxacin IR ciprofloxacin suspension levofloxacin tablets	*AVELOX (moxifloxacin)* *BAXDELA (delafloxacin)* *CIPRO (ciprofloxacin) tablets* *CIPRO (ciprofloxacin) suspension* *ciprofloxacin ER* *LEVAQUIN (levofloxacin)* *levofloxacin solution* *moxifloxacin* *ofloxacin*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

GI MOTILITY, CHRONIC		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
AMITIZA (lubiprostone) LINZESS (linaclotide) MOVANTIK (naloxegol)	*alosetron* *LOTRONEX (alosetron)* *MOTEGRITY (prucalopride)* *RELISTOR (methylnaltrexone) injection* *RELISTOR (methylnaltrexone) oral* *SYMPROIC (naldemedine)* *TRULANCE (plecanatide)* *VIBERZI (eluxadoline)*	▪ Treatment failure with preferred drugs within any subclass (including OTC products) ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions The following Clinical Prior Authorization applies **to all drugs** in the class: ▪ GI Motility

GLUCOCORTICOIDS, INHALED		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Glucocorticoids		
ASMANEX (mometasone) FLOVENT HFA (fluticasone) PULMICORT 0.25, 0.5 MG RESPULES (budesonide) PULMICORT 1 MG RESPULES (budesonide)	*ALVESCO (ciclesonide)* *ARMONAIR RESPICLICK (fluticasone)* *ARNUITY ELLIPTA (fluticasone)* *ASMANEX HFA (mometasone)* *budesonide respules* *FLOVENT DISKUS (fluticasone)* *PULMICORT FLEXHALER (budesonide)* *QVAR (beclomethasone)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions The following Clinical Prior Authorization applies **to all drugs** in the class: ▪ Duplicate Therapy
Glucocorticoid/Bronchodilator Combinations		
ADVAIR (fluticasone/salmeterol) DULERA (mometasone/formoterol) SYMBICORT (budesonide/formoterol)	*BREO ELLIPTA (fluticasone/vilanterol)* *fluticasone/salmeterol (Air Duo)* *TRELEGY ELLIPTA (fluticasone/umeclidinium/vilanterol)*	

GLUCOCORTICOIDS, ORAL			
Preferred Agents	***Non-Preferred Agents***		**PA Criteria** *Client must meet at least one of the listed PA criteria*
budesonide EC dexamethasone elixir, solution, tablets hydrocortisone methylprednisolone tablet dose pack prednisolone sodium phosphate prednisolone prednisone solution, tablets	*CORTEF (hydrocortisone)* *dexamethasone intensol* *DEXPAK (dexamethasone)* *DXEVO (dexamethasone)* *EMFLAZA (deflazacort)* *ENTOCORT EC (budesonide)* *MEDROL (methylprednisolone)* *methylprednisolone tablets* *MILLIPRED (prednisolone)*	*prednisolone sodium phosphate ODT, solution* *prednisone intensol* *prednisone tablet dose pack* *TAPERDEX (dexamethasone)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions The following Clinical Prior Authorization applies **to all drugs** in the class: ▪ Duplicate Therapy A drug specific prior authorization applies to drugs with a hyperlink

GLUCAGON AGENTS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
BAQSIMI (glucagon) glucagon injection glucagon emergency kit (Lilly) PROGLYCEM (diazoxide)	*glucagon emergency kit (Fresenius)* *GVOKE (glucagon)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

GROWTH HORMONE		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
GENOTROPIN NORDITROPIN	*HUMATROPE* *NUTROPIN AQ* *OMNITROPE* *SAIZEN* *SEROSTIM* *ZORBTIVE*	▪ Stable therapy with a non-referred agent for 30 days in the past 180 days ▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions The following Clinical Prior Authorization applies **to all drugs** in the class: ▪ Growth Hormone

H. PYLORI TREATMENT		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
PYLERA (bismuth subcitrate/metronidazole/tetracycline)	*lansoprazole/amoxicillin/clarithromycin* *OMECLAMOX PAK (omeprazole/amoxicillin/clarithromycin)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

HEMOPHILIA TREATMENT

Preferred Agents	*Non-Preferred Agents*	PA Criteria *Client must meet at least one of the listed PA criteria*
Factor VIII		▪ All of the agents in the Hemophilia Treatment class are preferred
ADVATE ADYNOVATE AFSTYLA ELOCTATE ESPEROCT HEMOFIL M HUMATE P JIVI KOATE DVI KOGENATE FS KOVALTRY NOVOEIGHT NUWIQ OBIZUR RECOMBINATE XYNTHA		
Factor IX		
ALPHANINE SD ALPROLIX BENEFIX IDELVION IXINITY MONONINE PROFILNINE REBINYN RIXUBIS		
Other		
ALPHANATE (von Willebrand factor/Factor VIII) COAGADEX (Factor X) CORIFACT (Factor XIII) FEIBA NF (activated prothrombin complex) HEMLIBRA (emicizumab-kxwh) NOVOSEVEN RT (Factor VIIa) TRETTEN (Factor XIII) VOVENDI (von Willebrand factor) WILATE (von Willebrand factor/Factor VIII)		

HEPATITIS C AGENTS

Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Pegylated Interferons		
	PEGASYS (pegylated IFN alfa-2a)	▪ Stable therapy with a non-preferred agent for 30 days in the past 180 days ▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions ▪ For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization ▪ The following Clinical Prior Authorization applies to this class: ▪ Manual Prior Authorization
Polymerase/Protease Inhibitors		
EPCLUSA (sofosbuvir/velpatasvir) MAVYRET (glecaprevir/pibrentasvir) VOSEVI (sofosbuvir, velpatasvir, voxilaprevir)	*DAKLINZA (daclatasvir)* *HARVONI (ledipasvir/sofosbuvir) tablets, pellet pack* *ledipasvir/sofosbuvir* *sofosbuvir/velpatasvir* *SOVALDI (sofosbuvir) tablets, pellet pack* *TECHNIVIE (ombitasvir/paritaprevir/ritonavir)* *VIEKIRA PAK (dasabuvir/ombitasvir/paritaprevir/ritonavir)* *VIEKIRA XR (dasabuvir/ombitasvir/paritaprevir/ritonavir)* *ZEPATIER (elbasvir/grazoprevir)*	
Ribavirin		
ribavirin capsule ribavirin tablet	*REBETOL solution* *RIBASPHERE 400, 600 mg* *ribavirin dose pack*	

HEREDITARY ANGIOEDEMA (HAE) TREATMENTS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
BERINERT (C1 esterase inhibitor) CINRYZE (C1 esterase inhibitor) FIRAZYR (icatibant) HAEGARDA (C1 esterase inhibitor) KALBITOR (ecallantide)	*RUCONEST (C1 esterase inhibitor)* *TAKHZYRO (lanadelumab-flyo)*	▪ Stable therapy with a non-preferred agent for 30 days in the past 180 days. ▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions The following Clinical Prior Authorization applies **to all drugs** in the class: ▪ Hereditary Angioedema

HIV/AIDS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Antiretroviral Single Agent Products		▪ All of the agents in the HIV/AIDS class are preferred
abacavir APTIVUS (tipranavir) atazanavir CRIXIVAN (indinavir) didanosine EDURANT (rilpivirine) efavirenz EMTRIVA (emtricitabine) EPIVIR (lamivudine) fosamprenavir FUZEON (enfuvirtide) INTELENCE (etravirine) INVIRASE (saquinavir) ISENTRESS (raltegravir) lamivudine LEXIVA (fosamprenavir) Nevirapine NORVIR (ritonavir) PIFELTRO (doravirine) PREZCOBIX (darunavir/cobicistat) PREZISTA (darunavir) RETROVIR (zidovudine) REYATAZ (atazanavir) ritonavir RUKOBIA (fostemsavir) SELZENTRY (maraviroc) stavudine SUSTIVA (efavirenz) tenofovir disoproxil fumarate TIVICAY (dolutegravir) TROGARZO (ibalizumab-uiyk) TYBOST (cobicistat) VIDEX (didanosine) VIRACEPT (nelfinavir) VIRAMUNE (nevirapine) VIRAMUNE XR (nevirapine) VIREAD (tenofovir disoproxil fumurate) ZIAGEN (abacavir) zidovudine		

HIV/AIDS *continued*		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Antiretroviral Combinations		▪ All of the agents in the HIV/AIDS class are preferred
abacavir/lamivudine abacavir/lamivudine/zidovudine ATRIPLA (efavirenz/emtricitabine/tenofovir) BIKTARVY (bictegravir/emtricitabine/tenofovir) CIMDUO (lamivudine/tenofovir DF) COMBIVIR (lamivudine/zidovudine) COMPLERA (emtricitabine/rilpivirine/tenfovir DF) DELSTRIGO (doravirine/lamivudine/ tenofovir DF) DESCOVY (emtricitabine/tenofovir alafenamide) DOVATO (dolutegravir/lamivudine) EPZICOM (abacavir/lamivudine) EVOTAZ (atazanavir/cobicistat) GENVOYA (elvitegravir/cobicistat/ emtricitabine/tenofovir alafenamide) JULUCA (dolutegravir/rilpivirine) KALETRA (lopinavir/ritonavir) lamivudine/zidovudine lopinavir/ritonavir ODEFSEY (emtricitabine/rilpivirine/ tenofovir alafenamide) STRIBILD (elvitegravir/cobicistat/ emtricitabine/tenofovir DF) SYMFI (efavirenz/lamivudine/ tenofovir DF) SYMFI LO (efavirenz/lamivudine/ tenofovir DF) SYMTUZA (darunavir/cobicistat/ emtricitabine/tenofovir DF) TEMIXYS (lamivudine/tenofovir DF) TRIUMEQ (abacavir/dolutegravir/ lamivudine) TRIZIVIR (abacavir/lamivudine/ zidovudine) TRUVADA (emtricitabine/ tenofovir DF)		

HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Amylin Analogs		
SYMLIN (pramlintide)		▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions The following Clinical Prior Authorization applies **to all drugs** in the class except for Amylin Analogs: ▪ DPP4 Inhibitor A drug specific prior authorization applies to drugs with a hyperlink
Incretin Enhancers		
JANUVIA (sitagliptin) JENTADUETO (linagliptin/metformin) KOMBIGLYZE XR (saxagliptin/metformin) ONGLYZA (saxagliptin) TRADJENTA (linagliptin)	*alogliptin* *alogilptin/metformin* *alogliptin/pioglitazone* *JANUMET (sitagliptin/metformin)* *JANUMET XR (sitagliptin/metformin)* *JENTADUETO XR (linagliptin/metformin)* *KAZANO (alogliptin /metformin)* *NESINA (alogliptin)* *OSENI (alogliptin /pioglitazone)* *TRIJARDY XR (empagliflozin/linagliptin/metformin)*	

HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS *continued*		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Incretin Mimetics		
BYDUREON (exenatide ER) pens, vials BYETTA (exenatide) VICTOZA (liraglutide)	*ADLYXIN (lixisenatide)* *BYDUREON BCISE (exenatide ER)* *OZEMPIC (semaglutide)* *RYBELSUS (semaglutide)* *TRULICITY (dulaglutide)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions The following Clinical Prior Authorization applies **to all drugs** in the class: ▪ GLP-1 Receptor Antagonists

HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS *continued*		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Incretin Enhancers/SGLT2 Inhibitor Combinations		■ Treatment failure with preferred drugs within any subclass ■ Contraindication to preferred drugs ■ Allergic reaction to preferred drugs ■ Treatment of stage-four advanced, metastatic cancer and associated conditions The following Clinical Prior Authorization applies **to all drugs** in the class: ■ DPP4 Inhibitor The following Clinical Prior Authorization applies **to all drugs** in the class: ■ GLP-1 Receptor Antagonists
GLYXAMBI (empagliflozin/linagliptin)	*QTERN (dapagliflozin/saxagliptin)* *STEGLUJAN (ertugliflozin/sitagliptin)*	
Incretin Mimetic/Insulin Combinations		
	SOLIQUA (lixisenatide/insulin glargine) *XULTOPHY (liraglutide/insulin degludec)*	

HYPOGLYCEMICS, INSULIN		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
HUMALOG (insulin lispro) pens, vials HUMALOG JUNIOR KWIKPEN (insulin lispro) HUMALOG MIX (insulin lispro/lispro protamine) pens, vials HUMULIN (insulin) pens, vials HUMULIN 500 UNITS/ML (insulin) vial HUMULIN 70/30 (insulin) pens, vials LANTUS (insulin glargine) LEVEMIR (insulin detemir) NOVOLIN (insulin) vials NOVOLOG (insulin aspart) NOVOLOG MIX (insulin aspart/aspart protamine)	*ADMELOG (insulin lispro)* *AFREZZA (insulin)* *APIDRA (insulin glulisine)* *BASAGLAR (insulin glargine)* *FIASP (insulin aspart)* *HUMALOG 200 UNITS/ML* *HUMULIN (insulin) pens* *insulin lispro* *LYUMJEV (insulin lispro)* *NOVOLIN (insulin) pens* *NOVOLIN 70/30 (insulin)* *TOUJEO (insulin glargine)* *TRESIBA (insulin degludec)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

HYPOGLYCEMICS, MEGLITINIDES		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
nateglinide repaglinide	*repaglinide/metformin* *STARLIX (nateglinide)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions The following Clinical Prior Authorization applies **to all drugs** in the class: ▪ Duplicate Therapy

HYPOGLYCEMICS, METFORMIN		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
glyburide/metformin metformin metformin ER (GLUCOPHAGE XR)	FORTAMET (metformin ER) glipizide/metformin GLUCOPHAGE (metformin) GLUCOPHAGE XR (metformin ER) GLUMETZA (metformin ER) metformin ER (FORTAMET) metformin ER (GLUMETZA) RIOMET (metformin) RIOMET ER (metformin)	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

HYPOGLYCEMICS, SGLT2		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
FARXIGA (dapagliflozin) INVOKANA (canaglifozin) JARDIANCE (empagliflozin)	*STEGLATRO (ertugliflozin)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions The following Clinical Prior Authorization applies **to all drugs** in the class: ▪ SGLT2 Inhibitor

HYPOGLYCEMICS, SGLT2 *continued*		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
SGLT2 Combinations		
SYNJARDY (empagliflozin/metformin) XIGDUO XR (dapagliflozin/metformin)	*INVOKAMET (canagliflozin/metformin)* *INVOKAMET XR (canagliflozin/metformin)* *SEGLUROMET (ertugliflozin/metformin)* *SYNJARDY XR (empagliflozin/metformin)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions The following Clinical Prior Authorization applies **to all drugs** in the class: ▪ SGLT2 Combinations

HYPOGLYCEMICS, TZD		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Thiazolidinediones		
pioglitazone	*AVANDIA (rosiglitazone)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions ▪ Separate prescriptions for the individual components should be used instead of the combination drugs ▪ For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization The following Clinical Prior Authorization applies **to all drugs** in the class: ▪ Thiazolidinediones
TZD Combinations		
	ACTOPLUS MET XR (pioglitazone/metformin) *DUETACT (pioglitazone/glimepiride)* *pioglitazone/metformin* *pioglitazone/glimepiride*	

IMMUNE GLOBULINS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
CYTOGAM (CMV immune globulin) GAMMAGARD (immune globulin) GAMMAKED (immune globulin) GAMUNEX-C (immune globulin) HIZENTRA (immune globulin) vial	*ASCENIV (immune globulin)* *BIVIGAM (immune globulin)* *CARIMUNE NF (immune globulin)* *CUTAQUIG (immune globulin)* *CUVITRU (immune globulin)* *FLEBOGAMMA DIF (immune globulin)* *HYQVIA (immune globulin)* *HIZENTRA (immune globulin) syringe* *OCTAGAM (immune globulin)* *PANZYGA (immune globulin)* *PRIVIGEN (immune globulin)* *XEMBIFY (immune globulin)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

IMMUNOMODULATORS, ASTHMA		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
FASENRA PEN (benralizumab)	*NUCALA (mepolizumab)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions ▪ The PA criteria above apply to Dupixent for Asthma The following Clinical Prior Authorization applies **to all drugs** in the class: Immunomodulators, Asthma

IMMUNOMODULATORS, ATOPIC DERMATITIS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
EUCRISA (crisaborole)	*DUPIXENT (dupilumab)* *ELIDEL (pimecrolimus)* *tacrolimus*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions ▪ Dupixent, in this therapeutic PDL class, is for Atopic Dermatitis indication. The clinical prior authorization linked here includes the product's other indications. A drug specific prior authorization applies to drugs with a hyperlink

IMMUNOSUPPRESSIVES, ORAL			
Preferred Agents	***Non-Preferred Agents***		**PA Criteria** *Client must meet at least one of the listed PA criteria*
azathioprine cyclosporine, modified mycophenolate mofetil capsules, tablets NEORAL (cyclosporine, modified) capsules RAPAMUNE (sirolimus) solution sirolimus tablets tacrolimus	*ASTAGRAF XL (tacrolimus)* *CELLCEPT (mycophenolate mofetil)* *cyclosporine* *ENVARSUS XR (tacrolimus)* *mycophenolate mofetil suspension* *mycophenolic acid* *MYFORTIC (mycophenolic acid)* *NEORAL (cyclosporine, modified) solution*	*PROGRAF (tacrolimus)* *RAPAMUNE (sirolimus) tablets* *SANDIMMUNE (cyclosporine)* *sirolimus solution* *ZORTRESS (everolimus)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

INTRANASAL RHINITIS AGENTS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Glucocorticoids		▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions ▪ The PA criteria above apply to Dupixent for Chronic Rhinosinusitis ▪ For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization
fluticasone	*BECONASE AQ (beclomethasone)* *budesonide* *fluticasone OTC* *flunisolide* *mometasone* *NASONEX (mometasone)* *OMNARIS (ciclesonide)* *QNASL (beclomethasone dipropionate)* *triamcinolone* *XHANCE (fluticasone)*	
Others		
azelastine (generic ASTELIN)	*ASTEPRO (azelastine)* *azelastine (generic ASTEPRO)* *ipratropium nasal spray* *olopatadine* *PATANASE (olopatadine)*	
Combinations		
	DYMISTA (azelastine/fluticasone)	

IRON, ORAL	
See Separate Listing of Preferred Oral Iron Drugs.	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

LEUKOTRIENE MODIFIERS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
montelukast chewable tablets, tablets	montelukast granules *SINGULAIR (montelukast)* *zafirlukast* *zileuton* *ZYFLO CR (zileuton)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions The following Clinical Prior Authorization applies **to all drugs** in the class: ▪ Leukotriene Modifiers

LINCOSAMIDES/OXAZOLIDINONES/STREPTOGRAMINS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
clindamycin capsules clindamycin solution linezolid	*CLEOCIN (clindamycin)* *LINCOCIN (lincomycin)* *SIVEXTRO (tedizolid)* *ZYVOX (linezolid)*	▪ 14-day treatment trial with a preferred drug within the past 180 days ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

LIPOTROPICS, OTHER		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Adenosine Triphosphate-Citrate Lyase Inhibitor		▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Trial and failure of atorvastatin, rosuvastatin, and ezetimibe. ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions ▪ For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization
	NEXLETOL (bempedoic acid) *NEXLIZET (bempedoic acid/ezetimibe)*	
Bile Acid Sequestrants		
cholestyramine colestipol tablets	*colesevalam* *COLESTID (colestipol)* *colestipol granules* *QUESTRAN (cholestyramine)* *QUESTRAN LIGHT (cholestyramine)* *WELCHOL (colesevalam)*	
Cholesterol Absorption Inhibitors		
ZETIA (ezetimibe)	*ezetimibe*	
Fibric Acid Derivatives		
fenofibrate (generic Lofibra, Tricor) gemfibrozil	*fenofibrate (generic Antara, Fenoglide, Lipofen)* *fenofibric acid (generic Fibricor, Trilipix)* *FENOGLIDE (fenofibrate)* *LIPOFEN (fenofibrate)* *LOPID (gemfibrozil)* *TRICOR (fenofibrate)* *TRIGLIDE (fenofibrate)* *TRILIPIX (fenofibric acid)*	

LIPOTROPICS, OTHER *continued*		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Homozygous Familial Hypercholesterolemia Treatments		▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions ▪ For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization A drug specific prior authorization applies to drugs with a hyperlink For PCSK9 Inhibitors ▪ Trial of atorvastatin, rosuvastatin, and ezetimibe ▪ Concurrent therapy of atorvastatin or rosuvastatin ▪ PCSK9 Inhibitors clinical prior authorization
	JUXTAPID (lomitapide) *KYNAMRO (mipomersen)*	
Niacin		
niacin OTC	*niacin ER* *NIASPAN (niacin)*	
Omega-3 Fatty Acids		
	LOVAZA (omega-3 fatty acids) *omega-3 fatty acids* *VASCEPA (icosapent ethyl)*	
PCSK9 Inhibitors		
	PRALUENT (alirocumab) *REPATHA (evolocumab)*	

<table>
<tr><th colspan="3">LIPOTROPICS, STATINS</th></tr>
<tr><th>Preferred Agents</th><th colspan="2">Non-Preferred Agents</th><th>PA Criteria
Client must meet at least one of the listed PA criteria</th></tr>
<tr><td colspan="3">Statins</td><td rowspan="4">■ Treatment failure with at least two preferred drugs accounting for no less than 120 days of therapy combined
■ Contraindication to preferred drugs
■ Allergic reaction to preferred drugs
■ Treatment of stage-four advanced, metastatic cancer and associated conditions
■ For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization

The following Clinical Prior Authorization applies to all drugs in the class:
■ Duplicate Therapy

Dose Optimization applies to some strengths where a “*” is noted</td></tr>
<tr><td>atorvastatin*
lovastatin*
pravastatin*
rosuvastatin*
simvastatin*</td><td>CRESTOR (rosuvastatin)*
EZALLOR SPRINKLE (rosuvastatin)
fluvastatin*
fluvastatin ER
LESCOL XL (fluvastatin)
LIPITOR (atorvastatin)*</td><td>LIVALO (pitavastatin)
PRAVACHOL (pravastatin)*
ZOCOR (simvastatin)*
ZYPITAMAG (pitavastatin)</td></tr>
<tr><td colspan="3">Statin Combinations</td></tr>
<tr><td></td><td colspan="2">atorvastatin/amlodipine
CADUET (atorvastatin/amlodipine)
simvastatin/ezetimibe
VYTORIN (simvastatin/ezetimibe)</td></tr>
</table>

MACROLIDES (ORAL)			
Preferred Agents	***Non-Preferred Agents***		**PA Criteria** *Client must meet at least one of the listed PA criteria*
azithromycin clarithromycin tablets ERYPED (erythromycin) erythromycin base	*clarithromycin suspension* *clarithromycin ER* *E.E.S. (erythromycin)* *ERY-TAB (erythromycin)* *ERYTHROCIN (erythromycin)*	*erythromycin base filmtab* *erythromycin ethylsuccinate suspension* *ZITHROMAX (azithromycin)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions ▪ For clients with diagnosis of Gastroparesis, Cerebral Palsy Gastroparesis, and GERD associated with Gastrostomy complications, a 90-day PA duration will be approved

MOVEMENT DISORDERS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
AUSTEDO (deutetrabenazine) INGREZZA (valbenazine)	*tetrabenazine* *XENAZINE (tetrabenazine)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions The following Clinical Prior Authorization applies **to all drugs** in the class: ▪ VMAT2 Inhibitors

MULTIPLE SCLEROSIS AGENTS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
AMPYRA (dalfampridine) AUBAGIO (teriflunomide) AVONEX (interferon beta-1a) BAFIERTAM (monomethyl fumarate) BETASERON (interferon beta-1b) COPAXONE (glatiramer) dalfampridine dimethyl fumarate EXTAVIA (interferon beta-1b) GILENYA (fingolimod) glatiramer KESIMPTA (ofatumumab) MAVENCLAD (cladribine) MAYZENT (siponimod) PLEGRIDY (peginterferon beta-1a) REBIF (interferon beta-1a) TECFIDERA (dimethyl fumarate) TYSABRI (natalizumab) VUMERITY (diroximel fumarate) ZEPOSIA (ozanimod)		▪ All of the agents in the Multiple Sclerosis class are preferred

NEUROPATHIC PAIN		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Oral Agents		▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions A drug specific prior authorization applies to drugs with a hyperlink
duloxetine (Cymbalta) gabapentin pregabalin capsule	*CYMBALTA (duloxetine)* *RIZALMA SPRINKLE (duloxetine)* *duloxetine (Irenka)* *GABACAINE KIT (gabapentin/lidocaine)* *GRALISE (gabapentin)* *HORIZANT (gabapentin enacarbil ER)* *LYRICA (pregabalin)* *LYRICA CR (pregabalin)* *SAVELLA (milnacipran)*	
Topical Agents		
capsaicin OTC	*lidocaine patch* *LIDODERM (lidocaine)* *LIDOPURE (lidocaine)* *ZILACAINEPATCH (lidocaine)* *ZTLIDO (lidocaine)*	

NSAIDS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Nonspecific		
diclofenac potassium ibuprofen indomethacin capsules naproxen EC naproxen sodium OTC naproxen tablets	*ADVIL (ibuprofen)* *ALEVE (naproxen)* *ANAPROX(naproxen)* *CHILDREN'S MOTRIN (ibuprofen)* *DAYPRO (oxaprozin)* *diclofenac sodium* *diclofenac SR* *diflunisal* *etodolac* *etodolac SR* *FELDENE (piroxicam)* *fenoprofen* *flurbiprofen* *INDOCIN (indomethacin) capsules, suspension* *indomethacin ER capsules* *ketoprofen* *ketoprofen ER* *ketorolac* *meclofenamate* *mefenamic acid* *nabumetone* *NALFON(fenoprofen)* *NAPROSYN (naproxen)* *naproxen CR* *naproxen sodium (Rx)* *naproxen suspension* *oxaprozin* *piroxicam* *RELAFEN DS (nabumetone)* *sulindac* *tolmetin* *ZORVOLEX (diclofenac)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions ▪ For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization The following Clinical Prior Authorization applies **to all drugs** in the class: ▪ Duplicate Therapy A drug specific prior authorization applies to drugs with a hyperlink

NSAIDS *continued*		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
NSAID/GI Protectant Combinations		
	ARTHROTEC (diclofenac/misoprostol) *diclofenac/misoprostol* *DUEXIS (ibuprofen/famotidine)* *VIMOVO (naproxen/ esomeprazole)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions ▪ For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization The following Clinical Prior Authorization applies **to all drugs** in the class: ▪ Duplicate Therapy

NSAIDS *continued*		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
COX-II Selective		
meloxicam tablets*	*CELEBREX (celecoxib)* *celecoxib* *MOBIC (meloxicam)** *QMIIZ ODT (meloxicam)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions The following Clinical Prior Authorization applies the **COX II Selective** Subclass: ▪ Cox II Inhibitors The following Clinical Prior Authorization applies **to all drugs** in the class: ▪ Duplicate Therapy Dose Optimization applies to some strengths where a "*" is noted
Topical NSAIDs		
diclofenac gel 1% *VOLTAREN gel (diclofenac)*	*FLECTOR (diclofenac)* *INDOCIN (indomethacin) suppositories* *PENNSAID (diclofenac)*	

ONCOLOGY, ORAL - BREAST		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
anastrozole ARIMIDEX (anastrozole) AROMASIN (exemestane) capecitabine cyclophosphamide exemestane FARESTON (toremifene) FEMARA (letrozole) IBRANCE (palbociclib) KISQALI (ribociclib) KISQALI/FEMARA KIT (ribociclib/letrozole) letrozole NERLYNX (neratinib) PIQRAY (alpelisib) SOLTAMOX (tamoxifen) TALZENNA (talazoparib) tamoxifen toremifene TUKYSA (tucatinib) TYKERB (lapatinib) VERZENIO (abemaciclib) XELODA (capecitabine)		All of the agents in the Oncology, Oral - Breast class are preferred

ONCOLOGY, ORAL - HEMATOLOGIC			
Preferred Agents		***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
ALKERAN (melphalan)	mercaptopurine		All of the agents in the Oncology, Oral - Hematologic class are preferred
BOSULIF (bosutinib)	MYLERAN (busulfan)		
BRUKINSA (zanubrutinib)	NINLARO (ixazomib)		
CALQUENCE (acalabrutinib)	POMALYST (pomalidomide)		
COPIKTRA (duvelisib)	PURIXAN (mercaptopurine)		
DAURISMO (glasdegib)	REVLIMID (lenalidomide)		
FARYDAK (panobinostat)	RYDAPT (midostaurin)		
GLEEVEC (imatinib)	SPRYCEL (dasatinib)		
ICLUSIG (ponatinib)	TABLOID (thioguanine)		
IDHIFA (enasidenib)	TASIGNA (nilotinib)		
imatinib	THALOMID (thalidomide)		
IMBRUVICA (ibrutinib)	TIBSOVO (ivosidenib)		
INQOVI (decitabine/cedazuridine)	tretinoin		
INREBIC (fedratinib)	VENCLEXTA (venetoclax)		
JAKAFI (ruxolitinib)	XOSPATA (gilteritinib)		
LEUKERAN (chlorambucil)	XPOVIO (selinexor)		
MATULANE (procarbazine)	ZOLINZA (vorinostat)		
melphalan	ZYDELIG (idelalisib)		

ONCOLOGY, ORAL - LUNG		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
ALECENSA (alectinib) ALUNBRIG (brigatinib) erlotinib GILOTRIF (afatinib) HYCAMTIN (topotecan) IRESSA (gefitinib) LORBRENA (lorlatinib) RETEVMO (selpercatinib) ROZLYTREK (entrectinib) TABRECTA (capmatinib) TAGRISSO (osimertinib) TARCEVA (erlotinib) VIZIMPRO (dacomitinib) XALKORI (crizotinib) ZYKADIA (ceritinib)		All of the agents in the Oncology, Oral - Lung class are preferred

ONCOLOGY, ORAL - OTHER		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
AYVAKIT (avapritinib) BALVERSA (erdafitinib) CAPRELSA (vandetanib) COMETRIQ (cabozantinib) KOSELUGO (selumetinib) LONSURF (trifluridine/tipiracil) LYNPARZA (olaparib) PEMAZYRE (pemigatinib) QINLOCK (ripretinib) RUBRACA (rucaparib) STIVARGA (regorafenib) TAZVERIK (tazemetostat) TEMODAR (temozolomide) temozolomide TURALIO (pexidartinib) VITRAKVI (larotrectinib) ZEJULA (niraparib)		All of the agents in the Oncology, Oral - Other class are preferred

ONCOLOGY, ORAL - PROSTATE		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
abiraterone bicalutamide EMCYT (estramustine) ERLEADA (apalutamide) flutamide nilutamide NUBEQA (darolutamide) XTANDI (enzalutamide) YONSA (abiraterone) ZYTIGA (abiraterone)		All of the agents in the Oncology, Oral - Prostate class are preferred

ONCOLOGY, ORAL – RENAL CELL		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
AFINITOR (everolimus) CABOMETYX (cabozantinib) everolimus INLYTA (axitinib) NAXAVAR (sorafenib) SUTENT (sunitinib) VOTRIENT (pazopanib)		All of the agents in the Oncology, Oral – Renal Cell class are preferred

ONCOLOGY, ORAL – SKIN		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
BRAFTOVI (encorafenib) COTELLIC (cobimetinib) ERIVEDGE (vismodegib) MEKINIST (trametinib) MEKTOVI (binimetinib) ODOMZO (sonidegib) TAFINLAR (dabrafenib) ZELBORAF (vemurafenib)		All of the agents in the Oncology, Oral – Skin class are preferred

OPHTHALMICS, ANTIBIOTIC – STEROID COMBINATIONS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
BLEPHAMIDE (sulfacetamide/prednisolone) neomycin/polymyxin/dexamethasone sulfacetamide/prednisolone TOBRADEX (tobramycin/dexamethasone) ointment	*BLEPHAMIDE S.O.P. (sulfacetamide/prednisolone)* *MAXITROL (neomycin/polymyxin/ dexamethasone)* *neomycin/bacitracin/polymyxin/hydrocortisone* *neomycin/polymyxin/hydrocortisone* *PRED-G (gentamicin/prednisolone)* *TOBRADEX (tobramycin/dexamethasone) suspension* *TOBRADEX ST (tobramycin/dexamethasone)* *tobramycin/dexamethasone* *ZYLET (tobramycin/loteprednol)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

OPHTHALMIC ANTIBIOTICS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Aminoglycosides		▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions
GENTAK (gentamicin) gentamicin tobramycin TOBREX (tobramycin) ointment	*TOBREX (tobramycin) solution*	
Quinolones		
ciprofloxacin ofloxacin	*BESIVANCE (besifloxacin)* *CILOXAN (ciprofloxacin)* *gatifloxacin* *levofloxacin* *MOXEZA (moxifloxacin)* *moxifloxacin* *OCUFLOX (ofloxacin)* *VIGAMOX (moxifloxacin)*	
Macrolides		
erythromycin	*AZASITE (azithromycin)*	

OPHTHALMIC ANTIBIOTICS *Continued*		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Other		
bacitracin/polymyxin polymyxin/trimethoprim	*bacitracin* *BLEPH-10 (sulfacetamide)* *NATACYN (natamycin)* *neomycin/bacitracin/polymyxin* *neomycin/polymyxin/gramicidin* *POLYTRIM (polymyxin/trimethoprim)* *sulfacetamide ointment, solution*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS			
Preferred Agents	***Non-Preferred Agents***		**PA Criteria** *Client must meet at least one of the listed PA criteria*
cromolyn PAZEO (olopatadine)	*ALOCRIL (nedocromil)* *ALOMIDE (lodoxamide)* *ALREX (loteprednol)* *azelastine* *BEPREVE (bepotastine)* *ELESTAT (epinastine)* *EMADINE (emedastine)* *epinastine*	*ketotifen* *LASTACAFT (alcaftadine)* *olopatadine* *PATADAY (olopatadine)* *PATADAY OTC (olopatadine)* *PATANOL (olopatadine)* *ZERVIATE (cetirizine)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

OPHTHALMICS, ANTI-INFLAMMATORIES		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
NSAIDS		
diclofenac ketorolac	*ACULAR (ketorolac)* *ACULAR LS (ketorolac)* *ACUVAIL (ketorolac)* *bromfenac* *flurbiprofen* *ILEVRO (nepafenac)* *ketorolac LS* *NEVANAC (nepafenac)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

OPHTHALMICS, ANTI-INFLAMMATORIES *continued*		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Steroids		
DUREZOL (difluprednate) LOTEMAX (loteprednol) ointment prednisolone acetate	*dexamethasone* *FLAREX (fluorometholone)* *fluorometholone* *FML (fluorometholone)* *FML FORTE (fluorometholone)* *ML S.O.P. (fluorometholone)* *INVELTYS (loteprednol)* *LOTEMAX (loteprednol) gel, suspension* *loteprednol* *MAXIDEX (dexamethasone)* *OMNIPRED (prednisolone)* *PRED FORTE (prednisolone)* *PRED MILD (prednisolone)* *prednisolone sodium phosphate*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

OPHTHALMICS, ANTI-INFLAMMATORY IMMUNOMODULATORS

Preferred Agents	*Non-Preferred Agents*	PA Criteria *Client must meet at least one of the listed PA criteria*
RESTASIS (cyclosporine)	*RESTASIS MULTIDOSE (cyclosporine)* *CEQUA (cyclosporine)* *XIIDRA (lifitegrast)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

OPHTHALMICS, GLAUCOMA AGENTS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Sympathomimetics		▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions ▪ For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization
brimonidine pilocarpine	*ALPHAGAN P (brimonidine)* *apraclonidine* *brimonidine P* *IOPIDINE (apraclonidine)*	
Beta Blockers		
carteolol levobunolol timolol	*betaxolol* *BETOPTIC S (betaxolol)* *ISTALOL (timolol)* *timolol (Istalol)* *TIMOPTIC (timolol)* *TIMOPTIC XE (timolol)*	

OPHTHALMICS, GLAUCOMA AGENTS
continued

Preferred Agents	*Non-Preferred Agents*	PA Criteria *Client must meet at least one of the listed PA criteria*
Carbonic Anhydrase Inhibitors		
AZOPT (brinzolamide) dorzolamide	*TRUSOPT (dorzolamide)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions ▪ For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization

OPHTHALMICS, GLAUCOMA AGENTS *continued*		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Rho Kinase Inhibitor		▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions ▪ For drugs in a therapeutic class or subclass with no preferred option, the provider must obtain a PDL prior authorization
RHOPRESSA (netarsudil) ROCKLATAN (netarsudil/latanoprost)		
Prostaglandin Analogs		
latanoprost TRAVATAN-Z (travoprost)	*bimatoprost* *LUMIGAN (bimatoprost)* *VYZULTA (latanoprostene bunod)* *XALATAN (latanoprost)* *XELPROS (latanoprost)* *ZIOPTAN (tafluprost)*	
Combination Agents		
COMBIGAN (brimonidine/timolol) dorzolamide/timolol SIMBRINZA (brinzolamide/brimonidine)	*COSOPT (dorzolamide/timolol)* *COSOPT PF (dorzolamide/timolol)* *dorzolamide/timolol*	
Miscellaneous		
	phospholine iodide	
OPIATE DEPENDENCE TREATMENTS		

Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
BUNAVAIL (buprenorphine/naloxone)* buprenorphine* buprenorphine/naloxone* LUCEMYRA (lofexidine) naloxone syringe, vial naltrexone NARCAN (naloxone) nasal SUBOXONE (buprenorphine/naloxone) film* VIVITROL (naltrexone) ZUBSOLV (buprenorphine/naloxone)*		▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions The following Clinical Prior Authorization applies to drugs with an "*" in the class: ▪ Duplicate Therapy ▪ Opiate/Benzodiazepine/Muscle Relaxant

OTIC ANTIBIOTICS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
CIPRODEX (ciprofloxacin/dexamethasone) neomycin/polymyxin/hydrocortisone ofloxacin	*CIPRO HC (ciprofloxacin/hydrocortisone)* *COLY-MYCIN S (colistin/neomycin/hydrocortisone)* *ciprofloxacin* *OTOVEL (ciprofloxacin/fluocinolone)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

OTIC ANTI-INFECTIVES/ANESTHETICS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
acetic acid	*acetic acid/hydrocortisone* *PINNACAINE (benzocaine)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

PAH AGENTS (ORAL, INHALATION)		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
ADCIRCA (tadalafil) ambrisentan REVATIO (sildenafil) suspension sildenafil tablet (generic Revatio) TRACLEER (bosentan) tablet	*ADEMPAS (riociguat)* *LETAIRIS (ambrisentan)* *OPSUMIT (macitentan)* *ORENITRAM ER (treprostinil)* *REVATIO (sildenafil)* *sildenafil suspension (generic Revatio)* *tadalafil (generic Adcirca)* *TRACLEER (bosentan) suspension* *TYVASO Inhalation (treprostinil)* *UPTRAVI (selexipag)* *VENTAVIS Inhalation (iloprost)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions A drug specific prior authorization applies to drugs with a hyperlink

PANCREATIC ENZYMES		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
CREON (pancrelipase) ZENPEP (pancrelipase)	*PANCREAZE (pancrelipase)* *PERTZYE (pancrelipase)* *VIOKACE (pancrelipase)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

PEDIATRIC VITAMIN PREPARATIONS	
See Separate Listing Of Preferred Pediatric Vitamin Preparations.	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

PENICILLINS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
amoxicillin ampicillin dicloxacillin penicillin VK		▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

PHOSPHATE BINDERS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
calcium acetate RENAGEL (sevelamer HCl)	*AURYXIA (ferric citrate)* *ELIPHOS (calcium acetate)* *FOSRENOL (lanthanum)* *lanthanum* *PHOSLYRA (calcium acetate)* *RENVELA (sevelamer carbonate)* *sevelamer* *VELPHORO (sucroferric oxyhydroxide)*	▪ Allergic reaction to preferred drug ▪ Treatment failure with preferred drug ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions ▪ Diagnosis of ESRD, hyperphosphatemia AND at least one of the following: o Hypercalcemia (corrected serum calcium >10.2 mg/dL) o Plasma PTH levels <150 pg/mL on two consecutive measurements o Dialysis patients with severe vascular and/or soft tissue calcifications ▪ Dialysis patients with severe vascular and/or soft tissue calcifications A drug specific prior authorization applies to drugs with a hyperlink

PLATELET AGGREGATION INHIBITORS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
AGGRENOX (dipyridamole/aspirin) BRILINTA (ticagrelor) clopidogrel prasugrel	*dipyridamole* *dipyridamole/aspirin* *EFFIENT (prasugrel)* *PLAVIX (clopidogrel)* *ZONTIVITY (vorapaxar)*	▪ Treatment failure with preferred drug ▪ Contraindication to preferred drug ▪ Allergic reaction to preferred drug ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions A drug specific prior authorization applies to drugs with a hyperlink

PRENATAL VITAMINS	
See Separate Preferred Prenatal Vitamin Listing.	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions ▪ Prenatal vitamins are covered only for females less than 50 years of age.

PROGESTATIONAL AGENTS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
MAKENA AUTO INJECTOR (hydroxyprogesterone) MAKENA (hydroxyprogesterone)	*hydroxyprogesterone*	▪ Treatment failure with preferred drug ▪ Contraindication to preferred drug ▪ Allergic reaction to preferred drug ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions The following Clinical Prior Authorization applies **to all drugs** in the class: ▪ Makena

PROGESTINS FOR CACHEXIA		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
megestrol suspension, tablets	*megestrol ES suspension (generic Megace ES)*	▪ Treatment failure with preferred drug ▪ Contraindication to preferred drug ▪ Allergic reaction to preferred drug ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

PROTON PUMP INHIBITORS (ORAL)			
Preferred Agents	***Non-Preferred Agents***		**PA Criteria** *Client must meet at least one of the listed PA criteria*
omeprazole Rx* pantoprazole* NEXIUM suspension (esomeprazole) PROTONIX (pantoprazole) suspension	*ACIPHEX (rabeprazole)* *DEXILANT (dexlansoprazole)* *esomeprazole** *lansoprazole** *NEXIUM capsules (esomeprazole)** *NEXIUM OTC (esomeprazole)** *omeprazole OTC** *omeprazole/sodium bicarbonate* *PREVACID (lansoprazole)** *PROTONIX tablets (pantoprazole)**	*rabeprazole* *ZEGERID (omeprazole/sodium bicarbonate)*	▪ Treatment failure after no less than a 30-day trial of each preferred drug ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions ▪ Prevacid Solutabs will be approved for children 10 years of age and under The following Clinical Prior Authorization applies **to all drugs** in the class: ▪ Proton Pump Inhibitor Dose Optimization applies to some strengths where a "*" is noted

ROSACEA AGENTS, TOPICAL		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
metronidazole cream, gel	*azelaic acid* *FINACEA (azelaic acid)* *ivermectin* *METROCREAM (metronidazole)* *METROGEL (metronidazole)* *metronidazole lotion* *MIRVASO (brimonidine)* *NORITATE (metronidazole)* *RHOFADE (oxymetazoline)* *ROSADAN KIT (metronidazole)* *SOOLANTRA (ivermectin)*	▪ Treatment failure after no less than a 30-day trial of every preferred drug ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions The following Clinical Prior Authorization applies **to all drugs** in the class: ▪ Rosacea Agents, Topical Dose Optimization applies to some strengths where a "*" is noted

SEDATIVE HYPNOTICS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Benzodiazepines		
flurazepam temazepam 15, 30 mg triazolam	*DAYVIGO (lemborexant)* *Estazolam* *RESTORIL (temazepam)* *temazepam 7.5, 22.5 mg*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions The following Clinical Prior Authorization applies **to all drugs** in the class: ▪ Anxiolytics and Sedatives/Hypnotics ▪ Opiate/Benzodiazepine/Muscle Relaxant

SEDATIVE HYPNOTICS *continued*			
Preferred Agents	***Non-Preferred Agents***		**PA Criteria** *Client must meet at least one of the listed PA criteria*
Others			
eszopiclone zaleplon zolpidem	*AMBIEN (zolpidem)* *AMBIEN CR (zolpidem)* *BELSOMRA (suvorexant)* *EDLUAR (zolpidem)* *HETLIOZ (tasimelteon)* *INTERMEZZO (zolpidem)*	*LUNESTA (eszopiclone)* *ROZEREM (ramelteon)* *SILENOR (doxepin)* *SONATA (zaleplon)* *zolpidem ER*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions A drug specific prior authorization applies to drugs with a hyperlink

SICKLE CELL ANEMIA TREATMENTS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
DROXIA (hydroxyurea) hydroxyurea	*ENDARI (glutamine)* *OXBRYTA (voxelotor)** *SIKLOS (hydroxyurea)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions The following Clinical Prior Authorization applies to drugs with an "*" in the class: ▪ Sickle Cell Anemia Treatments

SKELETAL MUSCLE RELAXANTS			
Preferred Agents	***Non-Preferred Agents***		**PA Criteria** *Client must meet at least one of the listed PA criteria*
baclofen carisoprodol (except 250 mg)* cyclobenzaprine* methocarbamol* tizanidine tablets	*AMRIX (cyclobenzaprine ER)** *carisoprodol 250 mg** *carisoprodol compound* *chlorzoxazone** *DANTRIUM (dantrolene)* *dantrolene* *FEXMID (carisoprodol)**	*LORZONE (chlorzoxazone)** *metaxolone** *NORGESIC FORTE (orphenadrine/aspririn/caffeine)* *orphenadrine** *ROBAXIN (methocarbamol)** *SKELAXIN (metaxolone)** *SOMA (carisoprodol)** *tizanidine capsules* *ZANAFLEX (tizanidine)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions The following Clinical Prior Authorization applies to drugs with an "*" in the class: ▪ Opiate/Benzodiazepine/Muscle Relaxant

SMOKING CESSATION		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
bupropion SR CHANTIX (varenicline) nicotine gum nicotine lozenge nicotine patch	*NICODERM CQ (nicotine)* *NICORETTE (nicotine) gum* *NICORETTE (nicotine) lozenge* *NICOTROL (nicotine)* *NICOTROL NS (nicotine)* *ZYBAN (bupropion)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

STEROIDS, TOPICAL			
Preferred Agents	***Non-Preferred Agents***		**PA Criteria** *Client must meet at least one of the listed PA criteria*
Low Potency			▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions
DERMA-SMOOTHE/FS (fluocinolone) hydrocortisone cream, ointment hydrocortisone/aloe cream PROCTOSOL-HC (hydrocortisone)	*alclometasone* *DESONATE (desonide)* *desonide* *fluocinolone oil* *hydrocortisone lotion (Rx)*	*MICORT-HC (hydrocortisone)* *TEXACORT (hydrocortisone) solution*	
Medium Potency			
fluticasone propionate cream, ointment mometasone cream, ointment, solution	*beclomethasone valerate foam* *BESER KIT (fluticasone)* *clocortolone cream* *CLODERM (clocortolone)* *CORDRAN (flurandrenolide)* *CUTIVATE (fluticasone)* *ELOCON (mometasone)* *fluocinolone acetonide* *flurandrenolide*	*fluticasone propionate lotion* *hydrocortisone butyrate* *hydrocortisone valerate* *LUXIQ (betamethasone)* *PANDEL (hydrocortisone probutate)* *prednicarbate*	

STEROIDS, TOPICAL *continued*			
Preferred Agents	***Non-Preferred Agents***		**PA Criteria** *Client must meet at least one of the listed PA criteria*
High Potency			▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions
betamethasone dipropionate lotion betamethasone dipropionate/propylene glycol cream betamethasone valerate cream, ointment triamcinolone acetonide cream, lotion, ointment	*Amcinonide* *betamethasone dipropionate cream, gel, ointment* *betamethasone dipropionate/ propylene glycol lotion, ointment* *betamethasone valerate lotion,* *desoximetasone* *diflorasone* *DIPROLENE (betamethasone dipropionate)*	*fluocinonide* *HALOG (halcinonide)* *KENALOG aerosol (triamcinolone)* *SERNIVO (betamethasone dipropionate)* *TOPICORT (desoximetasone)* *triamcinolone acetonide aerosol,* *TRIANEX (triamcinolone)* *VANOS (fluocinonide)*	
Very High Potency			
clobetasol emollient clobetasol propionate cream, gel, ointment, solution halobetasol cream, ointment	*APEXICON E (diflorasone)* *BRYHALI (halobetasol propionate)* *clobetasol lotion, shampoo* *clobetasol propionate foam, spray* *CLOBEX (clobetasol)* *halobetasol foam* *LEXETTE (halobetasol propionate)* *OLUX (clobetasol)*	*TEMOVATE (clobetasol)* *ULTRAVATE (halobetasol propionate)* *ULTRAVATE X PAC (halobetasol/lactic acid)*	

STIMULANTS AND RELATED AGENTS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
Stimulants		▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions A drug specific prior authorization applies to drugs with a hyperlink Dose Optimization applies to some strengths where a "*" is noted The following Clinical Prior Authorization also applies to **Non-Stimulats drugs** in the class: ▪ ADHD Agents
amphetamine salt combination IR amphetamine salt combination ER* APTENSIO XR (methylphenidate) DAYTRANA (methylphenidate)* dexmethylphenidate IR dexmethylphenidate ER* dextroamphetamine IR DYANAVEL XR (amphetamine) METHYLIN (methylphenidate) solution methylphenidate IR methylphenidate ER (authorized generic Concerta)* QUILLICHEW ER (methylphenidate) QUILLIVANT XR (methylphenidate) VYVANSE (lisdexamfetamine) VYVANSE (lisdexamfetamine) chewable tablets	*ADDERALL XR (amphetamine salt combination)** *ADHANSIA XR (methylphenidate)* *ADZENYS XR ODT (amphetamine)* *ADZENYS ER (amphetamine) suspension* *amphetamine salt combination ER** *amphetamine sulfate* *armodafinil* *CONCERTA (methylphenidate)** *COTEMPLA XR ODT (methylphenidate)* *DESOXYN (methamphetamine)* *DEXEDRINE (dextroamphetamine)* *dextroamphetamine ER* *dextroamphetamine solution* *EVEKEO (amphetamine)* *FOCALIN (dexmethylphenidate)* *FOCALIN XR (dexmethylphenidate)** *JORNAY PM (methylphenidate ER)** *methamphetamine* *methylphenidate CD** *methylphenidate chewable tablets* *methylphenidate ER** *methylphenidate solution* *modafinil* *MYDAYIS (amphetamine salt combination ER)* *NUVIGIL (armodafinil)* *PROCENTRA (dextroamphetamine)* *PROVIGIL (modafinil)* *RITALIN (methylphenidate)* *RITALIN LA (methylphenidate ER)** *SUNOSI (solriamfetol)* *ZENZEDI (dextroamphetamine)*	
Non-Stimulants		
atomoxetine guanfacine ER	*clonidine ER* *INTUNIV (guanfacine ER)* *STRATTERA (atomoxetine)*	

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TETRACYCLINES			
Preferred Agents	***Non-Preferred Agents***		**PA Criteria** *Client must meet at least one of the listed PA criteria*
doxycycline hyclate capsule doxycycline monohydrate 50, 100 mg capsules minocycline capsules VIBRAMYCIN (doxycycline) suspension	*demeclocycline* *doxycycline hyclate IR* *doxycycline hyclate DR* *doxycycline monohydrate 40, 75, 150 mg capsules* *doxycycline monohydrate suspension, tablets* *minocycline tablets* *minocycline ER*	*MINOLIRA ER (minocycline)* *NUZYRA tablet (omadacycline)* *ORACEA (doxycycline)* *SOLODYN (minocycline)* *tetracycline* *VIBRAMYCIN (doxycycline) capsule, syrup*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

THROMBOPOIESIS STIMULATING PROTEINS		
Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
NPLATE (romiplostim) PROMACTA (eltrombopag)	*DOPTELET (avatrombopag)* *MULPLETA (lusutrombopag)* *TAVALISSE (fostamatinib)*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

ULCERATIVE COLITIS

Preferred Agents	*Non-Preferred Agents*	PA Criteria *Client must meet at least one of the listed PA criteria*
Oral		
DELZICOL (mesalamine) LIALDA (mesalamine) sulfasalazine sulfasalazine DR	*APRISO (mesalamine)* *ASACOL HD (mesalamine)* *AZULFIDINE (sulfasalazine)* *balsalazide* *budesonide DR* *COLAZAL (balsalazide)* *DIPENTUM (olsalazine)* *GIAZO (balsalazide)* *mesalamine* *PENTASA (mesalamine)* UCERIS (budesonide)	▪ Treatment failure with preferred drugs ▪ Contraindication to preferred drugs of same route ▪ Allergic reaction to preferred drugs of same route ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

THROMBOPOIESIS STIMULATING PROTEINS

Preferred Agents	*Non-Preferred Agents*	PA Criteria *Client must meet at least one of the listed PA criteria*
Rectal		
mesalamine	*CANASA (mesalamine)* *UCERIS (budesonide)*	▪ Treatment failure with preferred drugs ▪ Contraindication to preferred drugs of same route ▪ Allergic reaction to preferred drugs of same route ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions

UREA CYCLE DISORDERS

Preferred Agents	***Non-Preferred Agents***	**PA Criteria** *Client must meet at least one of the listed PA criteria*
BUPHENYL (sodium phenylbutyrate) CARBAGLU (carglumic acid)	*RAVICTI (glycerol phenylbutyrate)* *sodium phenylbutyrate powder*	▪ Treatment failure with preferred drugs within any subclass ▪ Contraindication to preferred drugs ▪ Allergic reaction to preferred drugs ▪ Treatment of stage-four advanced, metastatic cancer and associated conditions The following Clinical Prior Authorization applies **to all drugs** in the class: ▪ Urea Cycle Disorders

PDL Review and Implementation Schedule

2020 Review	CLASS	Date of Most Recent PDL Change	Date of Next PDL Change (Tentative)	2021 Review (Tentative)
JAN	ACNE AGENTS, ORAL	7/1/2020	7/1/2021	JAN
JAN	ACNE AGENTS, TOPICAL	7/1/2020	7/1/2021	JAN
JAN	ANALGESICS, NARCOTICS LONG	7/1/2020	7/1/2021	JAN
JAN	ANALGESICS, NARCOTICS SHORT	7/1/2020	7/1/2021	JAN
JAN	ANGIOTENSIN MODULATOR COMBINATIONS	7/1/2020	7/1/2021	JAN
JAN	ANGIOTENSIN MODULATORS	7/1/2020	7/1/2021	JAN
APR	ANTIPARKINSONS AGENTS	7/1/2020	7/1/2021	JAN
JAN	ANTIMIGRAINE AGENTS, OTHER	7/1/2020	7/1/2021	JAN
JAN	ANTIMIGRAINE AGENTS, TRIPTANS	7/1/2020	7/1/2021	JAN
JAN	BLADDER RELAXANT PREPARATIONS	7/1/2020	7/1/2021	JAN
JAN	GLUCAGON AGENTS	7/1/2020	7/1/2021	JAN
JAN	H. PYLORI TREATMENT	7/1/2020	7/1/2021	JAN
JAN	IMMUNOMODULATORS, ATOPIC DERMATITIS	7/1/2020	7/1/2021	JAN
JAN	INTRANASAL RHINITIS AGENTS	7/1/2020	7/1/2021	JAN
JAN	MOVEMENT DISORDERS	7/1/2020	7/1/2021	JAN
JAN	NEUROPATHIC PAIN	7/1/2020	7/1/2021	JAN
OCT	ONCOLOGY, ORAL - BREAST	1/1/2021	7/1/2021	JAN
OCT	ONCOLOGY, ORAL - HEMATOLOGIC	1/1/2021	7/1/2021	JAN
OCT	ONCOLOGY, ORAL - LUNG	1/1/2021	7/1/2021	JAN
OCT	ONCOLOGY, ORAL - OTHER	1/1/2021	7/1/2021	JAN
OCT	ONCOLOGY, ORAL - PROSTATE	1/1/2021	7/1/2021	JAN
OCT	ONCOLOGY, ORAL - RENAL CELL	1/1/2021	7/1/2021	JAN
OCT	ONCOLOGY, ORAL - SKIN	1/1/2021	7/1/2021	JAN
JAN	PHOSPHATE BINDERS	7/1/2020	7/1/2021	JAN
JAN	PLATELET AGGREGATION INHIBITORS	7/1/2020	7/1/2021	JAN
JAN	PROGESTINS FOR CACHEXIA	7/1/2020	7/1/2021	JAN
JAN	PROTON PUMP INHIBITORS	7/1/2020	7/1/2021	JAN
JAN	SMOKING CESSATION	7/1/2020	7/1/2021	JAN

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2020 Review	CLASS	Date of Most Recent PDL Change	Date of Next PDL Change (Tentative)	2021 Review (Tentative)
JAN	STIMULANTS AND RELATED AGENTS	7/1/2020	7/1/2021	JAN
APR	ANTI-ALLERGENS, ORAL	7/1/2020	7/1/2021	APR
APR	ANTIBIOTICS, INHALED	7/1/2020	7/1/2021	APR
APR	ANTICOAGULANTS	7/1/2020	7/1/2021	APR
APR	ANTIDEPRESSANTS, OTHER	7/1/2020	7/1/2021	APR
APR	ANTIDEPRESSANTS, SSRIs	7/1/2020	7/1/2021	APR
APR	ANTIDEPRESSANTS, TRICYCLIC	7/1/2020	7/1/2021	APR
APR	ANTIHYPERURICEMICS	7/1/2020	7/1/2021	APR
APR	ANTIVIRALS, ORAL/NASAL	7/1/2020	7/1/2021	APR
APR	ANXIOLYTICS	7/1/2020	7/1/2021	APR
APR	BETA-BLOCKERS	7/1/2020	7/1/2021	APR
APR	BILE SALTS	7/1/2020	7/1/2021	APR
APR	BPH TREATMENTS	7/1/2020	7/1/2021	APR
APR	BRONCHODILATORS, BETA AGONIST	7/1/2020	7/1/2021	APR
APR	COPD AGENTS	7/1/2020	7/1/2021	APR
APR	COUGH AND COLD	7/1/2020	7/1/2021	APR
APR	ERYTHROPOIESIS STIMULATING PROTEINS	7/1/2020	7/1/2021	APR
APR	GLUCOCORTICOIDS, INHALED	7/1/2020	7/1/2021	APR
APR	HAE TREATMENTS	7/1/2020	7/1/2021	APR
OCT	HEMOPHILIA TREATMENTS	1/1/2021	7/1/2021	APR
OCT	HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS	1/1/2021	7/1/2021	APR
APR	IMMUNE GLOBULINS, IV	7/1/2020	7/1/2021	APR
APR	IMMUNOMODULATORS, ASTHMA	7/1/2020	7/1/2021	APR
APR	LINCOSAMIDES/OXAZOLIDINONES/STREPTOGRAMINS	7/1/2020	7/1/2021	APR
APR	LIPOTROPICS, OTHER	7/1/2020	7/1/2021	APR
APR	LIPOTROPICS, STATINS	7/1/2020	7/1/2021	APR
APR	PAH AGENTS, ORAL AND INHALED	7/1/2020	7/1/2021	APR
APR	PANCREATIC ENZYMES	7/1/2020	7/1/2021	APR

2020 Review	CLASS	Date of Most Recent PDL Change	Date of Next PDL Change (Tentative)	2021 Review (Tentative)
APR	PEDIATRIC VITAMIN PREPARATIONS	7/1/2020	7/1/2021	APR
APR	PRENATAL VITAMINS	7/1/2020	7/1/2021	APR
APR	SEDATIVE HYPNOTICS	7/1/2020	7/1/2021	APR
APR	SICKLE CELL ANEMIA TREATMENTS	7/1/2020	7/1/2021	APR
APR	THROMBOPOIESIS STIMULATING PROTEINS	7/1/2020	7/1/2021	APR
APR	UREA CYCLE DISORDER, ORAL	7/1/2020	7/1/2021	APR
JUL	ALZHEIMERS AGENTS	1/1/2021	1/1/2022	JUL
JUL	ANTIHISTAMINES, MINIMALLY SEDATING	1/1/2021	1/1/2022	JUL
JUL	ANTIHYPERTENSIVES, SYMPATHOLYTIC	1/1/2021	1/1/2022	JUL
JUL	CALCIUM CHANNEL BLOCKERS	1/1/2021	1/1/2022	JUL
JUL	CEPHALOSPORINS AND RELATED ANTIBIOTICS	1/1/2021	1/1/2022	JUL
JUL	CYTOKINE AND CAM ANTAGONISTS	1/1/2021	1/1/2022	JUL
JUL	FLUOROQUINOLONES, ORAL	1/1/2021	1/1/2022	JUL
JUL	GLUCOCORTICOIDS, ORAL	1/1/2021	1/1/2022	JUL
JUL	IMMUNOSUPPRESSIVES, ORAL	1/1/2021	1/1/2022	JUL
JUL	IRON, ORAL	1/1/2021	1/1/2022	JUL
JUL	LEUKOTRIENE MODIFIERS	1/1/2021	1/1/2022	JUL
JUL	NSAIDS	1/1/2021	1/1/2022	JUL
JUL	OPHTHALMIC ANTIBIOTICS	1/1/2021	1/1/2022	JUL
JUL	OPHTHALMIC ANTIBIOTIC-STEROID COMBINATIONS	1/1/2021	1/1/2022	JUL
JUL	OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS	1/1/2021	1/1/2022	JUL
JUL	OPHTHALMICS, ANTI-INFLAMMATORY	1/1/2021	1/1/2022	JUL
JUL	OPHTHALMIC ANTI-INFLAMMATORY/IMMUNOMODULATORS	1/1/2021	1/1/2022	JUL
JUL	OPHTHALMICS, GLAUCOMA AGENTS	1/1/2021	1/1/2022	JUL
JUL	OTIC ANTIBIOTICS	1/1/2021	1/1/2022	JUL
JUL	OTIC ANTI-INFECTIVES & ANESTHETICS	1/1/2021	1/1/2022	JUL
JUL	PENICILLINS	1/1/2021	1/1/2022	JUL
JUL	PROGESTATIONAL AGENTS	1/1/2021	1/1/2022	JUL

2020 Review	CLASS	Date of Most Recent PDL Change	Date of Next PDL Change (Tentative)	2021 Review (Tentative)
JUL	ROSACEA AGENTS, TOPICAL	1/1/2021	1/1/2022	JUL
JUL	SKELETAL MUSCLE RELAXANTS	1/1/2021	1/1/2022	JUL
JUL	STEROIDS, TOPICAL	1/1/2021	1/1/2022	JUL
JUL	ULCERATIVE COLITIS	1/1/2021	1/1/2022	JUL
OCT	ANDROGENIC AGENTS	1/1/2021	1/1/2022	OCT
OCT	ANTIBIOTICS, GI	1/1/2021	1/1/2022	OCT
OCT	ANTIBIOTICS, TOPICAL	1/1/2021	1/1/2022	OCT
OCT	ANTIBIOTICS, VAGINAL	1/1/2021	1/1/2022	OCT
OCT	ANTIEMETICS/ANTIVERTIGO AGENTS	1/1/2021	1/1/2022	OCT
OCT	ANTIFUNGALS, ORAL	1/1/2021	1/1/2022	OCT
OCT	ANTIFUNGALS, TOPICAL	1/1/2021	1/1/2022	OCT
OCT	ANTIHISTAMINES, FIRST GENERATION	1/1/2021	1/1/2022	OCT
OCT	ANTIPARASITICS, TOPICAL	1/1/2021	1/1/2022	OCT
OCT	ANTIPSYCHOTICS	1/1/2021	1/1/2022	OCT
OCT	ANTIVIRALS, TOPICAL	1/1/2021	1/1/2022	OCT
OCT	BONE RESORPTION SUPPRESSION AND RELATED	1/1/2021	1/1/2022	OCT
OCT	COLONY STIMULATING FACTORS	1/1/2021	1/1/2022	OCT
OCT	EPINEPHRINE, SELF-INJECTED	1/1/2021	1/1/2022	OCT
OCT	GI MOTILITY, CHRONIC	1/1/2021	1/1/2022	OCT
OCT	GROWTH HORMONE	1/1/2021	1/1/2022	OCT
OCT	HEPATITIS C AGENTS	1/1/2021	1/1/2022	OCT
OCT	HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS	1/1/2021	1/1/2022	OCT
OCT	HYPOGLYCEMICS, INSULIN AND RELATED	1/1/2021	1/1/2022	OCT
OCT	HYPOGLYCEMICS, MEGLITINIDES	1/1/2021	1/1/2022	OCT
OCT	HYPOGLYCEMICS, METFORMIN	1/1/2021	1/1/2022	OCT
OCT	HYPOGLYCEMICS, SLGT2	1/1/2021	1/1/2022	OCT
OCT	HYPOGLYCEMICS, TZD	1/1/2021	1/1/2022	OCT
OCT	MACROLIDES-KETOLIDES	1/1/2021	1/1/2022	OCT
OCT	OPIATE DEPENDENCE TREATMENTS	1/1/2021	1/1/2022	OCT

Search the Medicaid Formulary to verify formulary coverage for any drug listed on PDL: txvendordrug.com/formulary/formulary-search

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

2020 Review	CLASS	Date of Most Recent PDL Change	Date of Next PDL Change (Tentative)	2021 Review (Tentative)
OCT	TETRACYCLINES	1/1/2021	1/1/2022	OCT

For all classes listed below the standard PA criteria apply:
■ Treatment failure with preferred drugs within any subclass
■ Contraindication to preferred drugs
■ Allergic reaction to preferred drugs
■ Treatment of stage-four advanced, metastatic cancer and associated conditions

COUGH AND COLD ORAL

Preferred Agents		Non-Preferred Agents	
Agent	Ingredients	Agent	Ingredients
ALA-HIST IR TABLET OTC (ORAL)	dexbrompheniramine maleate	DEXBROMPHENIRAMINE/PHENYLEPHRINE OTC (ORAL)	dexbrompheniramin/phenylephrin
ALA-HIST PE TABLET OTC (ORAL)	dexbrompheniramin/phenylephrin	DIPHENHYDRAMINE/PHENYLEPHRINE/APAP POWDER PACK OTC (ORAL)	diphenhyd/phenyleph/acetaminop
CHILDREN'S MUCINEX LIQUID OTC (C) (ORAL)	diphenhyd/phenyleph/acetaminop	DOXYLAMINE/PHENYLEPHRINE OTC (ORAL)	doxylamine/phenylephrine HCl
DECONEX IR TABLET OTC (ORAL)	guaifenesin/phenylephrine HCl	ED A-HIST LIQUID OTC (ORAL)	chlorpheniramine/phenylephrine
ED A-HIST TABLET OTC (ORAL)	chlorpheniramine/phenylephrine	GUAIFENESIN/PHENYLEPHRINE TABLET OTC (ORAL)	guaifenesin/phenylephrine HCl
ED BRON GP LIQUID OTC (ORAL)	guaifenesin/phenylephrine HCl	GUAIFENESIN/PHENYLEPHRINE TABLET OTC (ORAL)	guaifenesin/pseudoephedrne HCl
GUAIFENESIN 200 MG TABLET OTC (ORAL)	guaifenesin	GUAIFENESIN/PHENYLEPHRINE/APAP TABLET OTC (ORAL)	guaifen/phenyleph/acetaminophn
GUAIFENESIN 400 MG TABLET OTC (ORAL)	guaifenesin	GUAIFENESIN/PSEUDOEPHEDRNE TABLET OTC (ORAL)	guaifenesin/pseudoephedrne HCl
GUAIFENESIN LIQUID OTC (ORAL)	guaifenesin	LOHIST-D LIQUID OTC (ORAL)	chlorpheniramine/pseudoephed
GUAIFENESIN TABLET ER OTC (ORAL)	guaifenesin	LORTUSS LQ LIQUID OTC (ORAL)	doxylamine/pseudoephedrine HCl
GUAIFENESIN/PSE TABLET ER OTC (ORAL)	guaifenesin/pseudoephedrne HCl	MUCINEX FAST-MAX NITE COLD-FLU LIQUID OTC (ORAL)	diphenhyd/phenyleph/acetaminop
HISTEX-PE LIQUID OTC (ORAL)	phenylephrine HCl/triprolidine	PHENYLEPHRINE/APAP TABLET OTC (ORAL)	phenylephrine HCl/acetaminophn
MUCINEX D TABLET ER 12H OTC (ORAL)	guaifenesin/pseudoephedrne HCl	PHENYLEPHRINE/APAP/CHLORPHENIRAMINE TABLET OTC (ORAL)	phenylephrine/acetaminophn/cpm
MUCINEX ER TABLET OTC (ORAL)	guaifenesin	PHENYLEPHRINE/BROMPHENIRAMINE TABLET OTC (ORAL)	brompheniramine/phenylephrine
MUCINEX FAST-MAX COLD-SINUS TABLET OTC (ORAL)	guaifen/phenyleph/acetaminophn	POLY-VENT IR TABLET OTC (ORAL)	guaifenesin/pseudoephedrne HCl
MUCINEX GRAN PACK OTC (ORAL)	guaifenesin	RESCON TABLET OTC (ORAL)	dexchlorpheniramin/pseudoephed
MUCUS-CHEST CONGESTION LIQUID OTC (ORAL)	guaifenesin	RESCON-GG LIQUID OTC (ORAL)	guaifenesin/phenylephrine HCl
NASOPEN PE LIQUID OTC (ORAL)	thonzylamine/phenylephrine	RYMED TABLET OTC (ORAL)	dexchlorpheniram/phenylephrine
NOHIST-LQ LIQUID OTC (ORAL)	chlorpheniramine/phenylephrine	STAHIST AD TABLET OTC (ORAL)	chlorcyclizine/pseudoephedrine
POLY HIST FORTE TABLET OTC (ORAL)	doxylamine/phenylephrine HCl		
PSE/CHLORPHENIRAMINE TABLET OTC (ORAL)	chlorpheniramine/pseudoephed		
PSE/TRIPROLIDINE TABLET OTC (ORAL)	triprolidine/pseudoephedrine		
RYNEX PE SOLUTION OTC (ORAL)	brompheniramine/phenylephrine		
RYNEX PSE LIQUID OTC (ORAL)	brompheniramin/pseudoephedrine		

COUGH AND COLD NASAL

Preferred Agents		Non-Preferred Agents	
Agent	Ingredients	Agent	Ingredients
OXYMETAZOLINE 12 HR NASAL SPRAY OTC (NASAL)	oxymetazoline HCl		

COUGH AND COLD, NARCOTIC

Preferred Agents		Non-Preferred Agents	
Agent	Ingredients	Agent	Ingredients
GUAIFENESIN/CODEINE LIQUID OTC (ORAL)	codeine phosphate/guaifenesin	GUAIFENESIN/PSE/CODEINE SYRUP OTC (ORAL)	pseudoephed/codeine/guaifen
PROMETHAZINE/CODEINE SYRUP (ORAL)	promethazine HCl/codeine	HYDROCODONE/CHLORPHENIRAMINE SUSPENSION ER 12H (ORAL)	hydrocodone/chlorphen p-stirex
		HYDROCODONE/HOMATROPINE SYRUP (ORAL)	hydrocodone bit/homatrop me-br
		HYDROCODONE/HOMATROPINE TABLET (ORAL)	hydrocodone bit/homatrop me-br
		NINJACOF-XG LIQUID OTC (ORAL)	codeine phosphate/guaifenesin

COUGH AND COLD, NON-NARCOTIC

Preferred Agents		Non-Preferred Agents	
Agent	Ingredients	Agent	Ingredients
ALA-HIST DM LIQUID OTC (ORAL)	d-methorphan/pe/dexbromphenir	CHILDREN'S DAYCLEAR ALLERGY CHEWABLE OTC (ORAL)	pyrilamine/chlophedianol
ALAHIST CF TABLET OTC (ORAL)	d-methorphan/pe/dexbromphenir	CHLO TUSS LIQUID OTC (ORAL)	dexbromphen/pseudoeph/chlophed
BENZONATATE CAPSULE (ORAL)	benzonatate	DM/APAP/DOXYLAMINE CAPSULE OTC (ORAL)	DM/acetaminophen/doxylamine
BROM-PSE-DM SYRUP (ORAL)	brompheniramine/pseudoephed/DM	DM/APAP/DOXYLAMINE LIQUID OTC (ORAL)	DM/acetaminophen/doxylamine
BROMPHENIRAMINE/PHENYLEPHRINE/DM SOLUTION OTC (ORAL)	brompheniram/phenylephrine/DM	DM/CHLORPHENIRAMINE TABLET OTC (ORAL)	chlorpheniramine/dextromethorp
BROTAPP DM ELIXIR OTC (ORAL)	brompheniramine/pseudoephed/DM	DM/PHENYLEPHRINE/APAP CAPSULE OTC (ORAL)	d-methorphan/PE/acetaminophen
CHILD MUCINEX M-S COLD DAY-NTE LIQUID SEQUELES OTC (ORAL)	diphenhydram/PE/DM/acetamin/GG	DM/PHENYLEPHRINE/APAP LIQUID OTC (ORAL)	d-methorphan/PE/acetaminophen
CHILDREN'S MUCINEX LIQUID OTC (NN) (ORAL)	guaifen/dextromethorphan/PE	DM/PHENYLEPHRINE/APAP POWDER PACK OTC (ORAL)	d-methorphan/PE/acetaminophen
CHILDREN'S MUCINEX LIQUID OTC (NN) (ORAL)	phenylephrine/DM/acetaminop/GG	DM/PHENYLEPHRINE/APAP TABLET OTC (ORAL)	d-methorphan/PE/acetaminophen
DECONEX DMX TABLET OTC (ORAL)	guaifen/dextromethorphan/PE	DM/PHENYLEPHRINE/APAP/DOXYLAMINE LIQUID OTC (ORAL)	DM/PE/acetaminophen/doxylamine
DELSYM SUSPENSION ER 12H OTC (ORAL)	dextromethorphan polistirex	DURAFLU TABLET OTC (ORAL)	pseudoeph/DM/guaifen/acetamin
DEXTROMETHORPHAN CAPSULE OTC (ORAL)	dextromethorphan HBr	ED A-HIST DM TABLET OTC (ORAL)	chlorpheniramine/phenyleph/DM
DEXTROMETHORPHAN SUSPENSION ER 12H OTC (ORAL)	dextromethorphan polistirex	GUAIFENESIN/DM TABLET OTC (ORAL)	guaifenesin/dextromethorphan
DM/PSE/CHLORPHENIRAMINE LIQUID OTC (ORAL)	chlorpheniramin/pseudoephed/DM	M-END DMX LIQUID OTC (ORAL)	dexbromphen/pseudoephedrine/DM
ED-A-HIST DM LIQUID OTC (ORAL)	chlorpheniramine/phenyleph/DM	MUCINEX FAST-MAX DAY-NITE COLD LIQUID SEQ OTC (ORAL)	diphenhydram/PE/DM/acetamin/GG
GUAIFEN/DEXTROMETHORPHAN/PE OTC (ORAL)	guaifen/dextromethorphan/PE	MUCINEX FAST-MAX DAY-NITE CONG TABLET OTC (ORAL)	diphenhydram/PE/DM/acetamin/GG
GUAIFENESIN/DM LIQUID OTC (ORAL)	guaifenesin/dextromethorphan	MUCINEX FAST-MAX SEVERE COLD LIQUID OTC (ORAL)	phenylephrine/DM/acetaminop/GG
GUAIFENESIN/DM TABLET ER 12H OTC (ORAL)	guaifenesin/dextromethorphan	MUCUS DM MAX TABLET ER 12H OTC (ORAL)	guaifenesin/dextromethorphan
GUAIFENESIN/DM/PHENYLEPHRINE LIQUID OTC (ORAL)	guaifen/dextromethorphan/PE	NINJACOF LIQUID OTC (ORAL)	pyrilamine/chlophedianol
GUAIFENESIN/DM/PHENYLEPHRINE SYRUP OTC (ORAL)	guaifen/dextromethorphan/PE	PHENYLEPHRINE/DM/APAP/GUAIFENESIN CAPLET OTC (ORAL)	phenylephrine/DM/acetaminop/GG
HISTEX-DM SYRUP OTC (ORAL)	triprolidine/phenylephrine/DM	POLY-HIST PD DROPS OTC (ORAL)	thonzylamine/chlophedianol
LOHIST-DM LIQUID OTC (ORAL)	brompheniram/phenylephrine/DM	POLYTUSSIN DM OTC (ORAL)	dexchlorphen/phenylephrine/DM
MUCINEX COLD-FLU & SORE THROAT LIQUID OTC (ORAL)	phenylephrine/DM/acetaminop/GG	RESCON-DM LIQUID OTC (ORAL)	chlorpheniramin/pseudoephed/DM
MUCINEX COUGH GRAN PACK OTC (ORAL)	guaifenesin/dextromethorphan	VANACOF DMX LIQUID OTC (ORAL)	guaifen/dextromethorphan/PE
MUCINEX DM TABLET ER 12H OTC (ORAL)	guaifenesin/dextromethorphan		
MUCINEX FAST-MAX CONGEST-COUGH TABLET OTC (ORAL)	guaifen/dextromethorphan/PE		
MUCINEX FAST-MAX DM MAX LIQUID OTC (ORAL)	guaifenesin/dextromethorphan		
NOHIST-DM LIQUID OTC (ORAL)	chlorpheniramine/phenyleph/DM		
POLY-HIST DM LIQUID OTC (ORAL)	thonzylamine/phenylephrine/DM		
POLY-VENT DM TABLET OTC (ORAL)	guaifenesin/DM/pseudoephedrine		
PROMETHAZINE/DM SYRUP (ORAL)	promethazine/dextromethorphan		
RYNEX DM SOLUTION OTC (ORAL)	brompheniram/phenylephrine/DM		
VANACOF DM LIQUID OTC (ORAL)	guaifen/dextromethorphan/PE		
VANACOF LIQUID OTC (ORAL)	dexchlorphenir/pse/chlophedian		
VANATAB DM TABLET OTC (ORAL)	guaifen/dextromethorphan/PE		

IRON, ORAL

Preferred Agents

Agent	Ingredients
FERROUS FUMARATE TABLET OTC (ORAL)	ferrous fumarate
FERROUS FUMARATE/FA/MULTIVITAMIN & MINERALS CAPSULE (ORAL)	iron fum/folic acid/mv,min 15
FERROUS FUMARATE/IRON POLYSACCHARIDES/FA/MULTIVITAMIN CAPSULE (ORAL)	iron fm,ps no.1/folic/mv no.18
FERROUS GLUCONATE TABLET OTC (ORAL)	ferrous gluconate
FERROUS SULFATE DROPS OTC (ORAL)	ferrous sulfate
FERROUS SULFATE SOLUTION OTC (ORAL)	ferrous sulfate
FERROUS SULFATE TABLET ER OTC (ORAL)	ferrous sulfate
FERROUS SULFATE TABLET OTC (ORAL)	ferrous sulfate
FERROUS SULFATE, DRIED TABLET ER OTC (ORAL)	ferrous sulfate, dried
HEMOCYTE PLUS CAPSULE (ORAL)	iron fum/folic acid/mv,min 15
HEMOCYTE-F TABLET (ORAL)	ferrous fumarate/folic acid
INTEGRA F CAPSULE (ORAL)	iron fum,ps/folic acid/vitC/B3
INTEGRA PLUS CAPSULE (ORAL)	iron fum,ps/folic/Bcomp,C no.9
IRON CARBONYL/ASCORBIC ACID TABLET OTC (ORAL)	iron,carbonyl/ascorbic acid
IRON POLYSACCHARIDES CAPSULE OTC (ORAL)	iron polysaccharide complex
IRON POLYSACCHARIDES/B12/FA CAPSULE (ORAL)	iron ps complex/B12/folic acid
TANDEM PLUS CAPSULE (ORAL)	iron fm,ps no.1/folic/mv no.18

Non-Preferred Agents

Agent	Ingredients
CITRANATAL BLOOM (ORAL)	iron carb,gl/FA/B12/C/docusate
CORVITE 150 TABLET (ORAL)	iron,carb/folate6/mv,min no.41
CORVITE FE TABLET (ORAL)	iron/folate no.6/mv,mins no.40
FEOSOL TABLET OTC (ORAL)	iron polysacch/iron heme polyp
FER-IN-SOL DROPS OTC (ORAL)	ferrous sulfate
FERGON TABLET OTC (ORAL)	ferrous gluconate
FERIVA 21-7 (ORAL)	iron/C/folate/B12/zinc/succin
FERIVA FA CAPSULE (ORAL)	iron/C/folate/B12/biot/cupric
FERRIMIN 150 TABLET OTC (ORAL)	ferrous fumarate
FERROUS SULFATE/ASCORBIC ACID/FA TABLET ER OTC (ORAL)	ferrous sulfate/vit C/folic ac
FUSION PLUS CAPSULE (ORAL)	iron,fm,ps/folic/B,C18/L.casei
HEMOCYTE TABLET OTC (ORAL)	ferrous fumarate
IROSPAN TABLET (ORAL)	iron bg,ps/folic/B,C no.12/suc
NEPHRON FA TABLET (ORAL)	vit B comp C no.24/iron/folic
TARON FORTE CAPSULE (ORAL)	iron bg,ps/vitC/B12/FA/calcium

PEDIATRIC VITAMIN PREPARATIONS

Preferred Agents

Agent	Ingredients
MULTIVITAMINS WITH FLUORIDE DROPS (ORAL)	pedi multivit no.2 w-fluoride
MULTIVITS WITH IRON & FLUORIDE DROPS (ORAL)	pedi multivit 45/fluoride/iron
PEDI MVI NO.16 WITH FLUORIDE TAB CHEW (ORAL)	pedi multivit no.16 w-fluoride

Non-Preferred Agents

Agent	Ingredients
FLORIVA CHEW (ORAL)	pedi multivit no.85/fluoride
FLORIVA PLUS DROPS OTC (ORAL)	pedi multivit no.161/fluoride
FLUORIDE/VITAMINS A,C,AND D DROPS (ORAL)	ped mvit A,C,D3 no.21/fluoride
POLY-VI-FLOR CHEW (ORAL)	pedi multivit no.33/fluoride
POLY-VI-FLOR DROPS (ORAL)	pedi multivit no.37 w-fluoride
POLY-VI-FLOR WITH IRON CHEW (ORAL)	pedi multivit 33/fluoride/iron
POLY-VI-FLOR WITH IRON DROPS (ORAL)	pedi multivit 37/fluoride/iron
QUFLORA (ORAL)	pedi multivit 84 with fluoride
QUFLORA (ORAL)	pedi multivit no.63 w-fluoride
QUFLORA (ORAL)	pedi multivit no.83 w-fluoride
QUFLORA FE (ORAL)	ped multivit 142/iron/fluoride
QUFLORA FE (ORAL)	ped multivit 151/iron/fluoride
QUFLORA OTC (ORAL)	pedi multivit no.157/fluoride
TRI-VI-FLORO DROPS (ORAL)	ped mvit A,C,D3 no.38/fluoride
TRI-VITAMIN WITH FLUORIDE (ORAL)	ped mvit A,C,D3 no.21/fluoride

PRENATAL VITAMINS

Preferred Agents

Agent	Ingredients
CITRANATAL 90 DHA (ORAL)	PNV72/iron,gluc/folic/dss/dha
CITRANATAL ASSURE (ORAL)	PNV73/iron,gluc/folic/dss/dha
CITRANATAL B-CALM (ORAL)	prenatal 48/iron/folic acid/B6
CITRANATAL HARMONY (ORAL)	PNV59/iron,carb,fum/FA/dss/dha
CITRANATAL RX (ORAL)	prenatal81/iron/folic/docusate
PNV2/IRON B-G SUC-P/FA/OMEGA-3 (ORAL)	PNV cmb 52/iron/FA/omega-3/dha
PROVIDA OB (ORAL)	prenatal vit 65/iron fum,ps/FA
SELECT-OB + DHA (ORAL)	prenatal vit 33/iron/folic/dha
TRICARE (ORAL)	prenatal vit103/iron fum/folic
TRINATAL RX 1 (ORAL)	prenatal vit27,calcium/iron/FA
VITAFOL NANO (ORAL)	prenatal no.75/iron/folate no1
VITAFOL ULTRA (ORAL)	PNV 67/iron ps/folate no.1/dha
VITAFOL-OB (ORAL)	prenatal vit 10/iron fum/folic
VITAFOL-OB+DHA (ORAL)	prenatal vit 10/iron/folic/dha
VITAFOL-ONE (ORAL)	prenatal 26/iron ps/folic/dha

Non-Preferred Agents

Agent	Ingredients
CITRANATAL DHA (ORAL)	PNV 76/iron,gluc/folic/dss/dha
COMPLETENATE CHEW TABLET (ORAL)	prenatal vit 14/iron fum/folic
CONCEPT DHA (ORAL)	mvn-min75/iron/iron ps/om3/dha
CONCEPT OB (ORAL)	mvn-min 74/iron fum/iron/FA
FE C/FA (ORAL)	multivit-min69/iron/folic acid
NESTABS (ORAL)	prenatal vit86/iron/folic acid
NESTABS DHA (ORAL)	prenatal 87/iron bis/folic/dha
OB COMPLETE ONE (ORAL)	PNV 85/iron/folic/dha/fish oil
OB COMPLETE PETITE (ORAL)	prenatal56/iron/folic acid/dha
OB COMPLETE PREMIER (ORAL)	PNV83/iron,carb,asp/folic acid
OB COMPLETE TABLET (ORAL)	multivit-min69/iron/folic acid
PNV COMBO#47/IRON/FA #1/DHA (ORAL)	multivit 47/iron/folate 1/dha
PNV NO.118/IRON FUMARATE/FA CHEW TABLET (ORAL)	PNV no.118/iron fumarate/FA
PNV NO.15/IRON FUM & PS CMP/FA (ORAL)	mvn-min 74/iron fum/iron/FA
PNV W-CA NO.40/IRON FUM/FA CMB NO.1 (ORAL)	prenatal,calc.40/iron/folate 1
PNV WITH CA NO.68/IRON/FA NO.1/DHA (ORAL)	mv-mins 71/iron/folic no.1/dha
PNV#16/IRON FUM & PS/FA/OM-3 (ORAL)	mvn-min75/iron/iron ps/om3/dha
PRENATAL VIT #76/IRON,CARB/FA (ORAL)	prenatal vit,calc76/iron/folic
PRENATE AM (ORAL)	multivit 38/folate no.6/ginger
PRENATE CHEWABLE TABLET (ORAL)	multivitamin no.36/folate no.6
PRENATE DHA (ORAL)	prenatal 78/iron/folate 1/dha
PRENATE ELITE (ORAL)	prenatal 114/iron a-g/folate 1
PRENATE ENHANCE (ORAL)	prenatal vit68/iron/FA no6/dha
PRENATE ESSENTIAL (ORAL)	multivit no.40/iron/folat1/dha
PRENATE MINI (ORAL)	prenatal vit 87/iron/folic/dha
PRENATE PIXIE (ORAL)	prenatal vit 85/iron/FA 1/dha
PRENATE RESTORE (ORAL)	prenatal vit69/iron/folate6/dh
PRENATE STAR (ORAL)	prenatal no.77/iron asp gly/FA
SELECT-OB TAB CHEW (ORAL)	prenatal vit128/iron/folic acd
TRISTART DHA (ORAL)	prenatal 93/iron/folate 9/dha
VITAFOL TAB CHEW (ORAL)	PNV 112/iron/folic/om3/dha/epa
VP-PNV-DHA (ORAL)	prenatal no.52/iron/FA/dha