Idaho Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Updated January 1, 2016

Highlights indicated change from previous posting.

ALZHEIMER'S DRUGS[CL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Cholinesterase Inhibitors [CL]		
donepezil [CL] – except 23 mg tablet donepezil ODT [CL] EXELON transdermal (rivastigmine) [CL] rivastigmine capsule [CL]	*donepezil 23 mg tablet [CL]* *EXELON (rivastigmine) capsule [CL]* *galantamine [CL]* *galantamine ER [CL]* *rivastigmine transdermal [CL]*	▪ Link to PA Form for Alzheimer's Agents (required for all drugs in class) ▪ Donepezil 5 and 10 mg will be approved for patients with mild to severe Alzheimer's dementia ▪ Other preferred cholinesterase inhibitors will be approved for patients with mild to moderate dementia except for Exelon 13.3mg patches which will only be approved for patients with severe dementia. ▪ The other non-preferred cholinesterase inhibitors will be approved for patients with mild to moderate dementia except for Aricept 23mg which will only be approved for patients with severe Alzheimer's dementia. ▪ Aricept 23 mg will be approved for patients who have received donepezil 10 mg/day for at least three months ▪ Non-preferred agents will be approved for patients who have failed a preferred agent within the last 6 months
NMDA Receptor Antagonist [CL]		
memantine tablet [CL]	*memantine solution [CL]* *NAMENDA XR (memantine) [CL]* *NAMENDA (memantine) solution [CL]*	▪ Link to PA Form for Alzheimer's Agents (required for all drugs in class) ▪ Memantine will be approved for patients with moderate to severe Alzheimer's dementia. ▪ Namenda XR will only be approved for patients who have tried and failed memantine immediate release
Combination Products [CL]		
	NAMZARIC (donepezil/memantine) [CL]	▪ Link to PA Form for Alzheimer's Agents (required for all drugs in class) ▪ Please use prescriptions for individual agents

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[NR] – New drug that has not been reviewed by P & T Committee

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ANALGESICS, NARCOTIC – LONG-ACTING

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria

morphine ER capsules (generic Kadian)
morphine ER tablets
	BELBUCA (buprenorphine) buccal film [CL]
	BUTRANS (buprenorphine transdermal) [CL]
	CONZIP (tramadol ER) [CL]
	EMBEDA (morphine/naloxone) [CL]
	EXALGO (hydromorphone) [CL]
	hydromorphone ER [CL]
	HYSINGLA ER (hydrocodone ER) [CL]
	fentanyl transdermal [CL]
	methadone [CL]
	morphine ER capsules (generic AVINZA) [CL]
	NUCYNTA ER (tapentadol ER) [CL]
	oxycodone ER [CL]
	OXYCONTIN (oxycodone ER)[CL]
	oxymorphone ER [CL]
	tramadol ER [CL]
	XTAMPZA ER (oxycodone) [NR]
	ZOHYDRO ER (hydrocodone ER)[CL]
		▪ Link to PA Form for Methadone, Initial Request
		▪ Link to PA Form for Methadone, Reauthorization
		▪ Link to PA Form for Narcotic Analgesics, Long-Acting (required for Non-Preferred drugs)
		▪ Non-preferred agents will be approved for patients who have received the same non-preferred agent in the last 60 days with a day supply greater than 3 days.
		▪ New prescriptions for non-preferred agents will be approved for patients meeting one of the following criteria:
		  ▪ Documented failure of at least a 30 day trial of a preferred agent within the previous 6 months.
		  ▪ Diagnosis of malignant pain (ICD-9 = 140-208, 99.25 or chemotherapy administration related CPT code).
		▪ Belbuca will be approved for treatment of severe pain for whom alternative treatment options are inadequate (includes non-opioid analgesics and immediate release opioids). Also requires trial and failure of a preferred long acting opioid.
		▪ Link to PA Form for Topical Narcotic Analgesics, Long-Acting
		▪ Butrans will not be approved for patients requiring greater than 80mg morphine equivalents daily. It will only be approved for patients with pain severe enough to require daily, around-the-clock, long-term opioid treatment who have tried and failed or have a contra-indication to a preferred long acting opioid and who have an inability to swallow tablets or capsules (documentation required).
		▪ Fentanyl transdermal will be approved for patients meeting one of the following criteria:
		  ▪ Diagnosis of malignant pain (ICD-9 = 140-208, 99.25 or chemotherapy administration related CPT code)
		  ▪ Inability to swallow tablets or capsules. (Documentation required).
		  ▪ History of 30 days or more of a preferred agent in the last 180 days and fentanyl dose requested

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ANALGESICS, NARCOTIC – LONG-ACTING

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
		is equivalent to the dose of preferred agent tried or documentation supporting an increase or decrease in the morphine equivalent dose provides justification. ▪ Fentanyl transdermal 37.5mcg/hr, 62.5 mcg/hr and 87.5 mcg/hr will not be approved unless adequate documentation is provided that the required pain dose cannot be achieved with a combination of 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr or 100 mcg/hr strength patches. ▪ Link to PA Form for OxyContin (oxycodone ER) ▪ OxyContin (oxycodone ER) will be approved for patients meeting one the following criteria: ▪ Diagnosis of malignant pain (ICD-9 = 140-208, 99.25 or chemotherapy administration related CPT code) ▪ History of 30 days or more of a preferred agent in the last 180 days ▪ Oxycodone dose requested is equivalent or less than the dose of the preferred agent tried or documentation supporting an increase in the morphine equivalent dose provides justification. ▪ Adequate documentation supporting the use over other long-acting opioids ▪ Tramadol ER or ConZip will be approved with adequate documentation providing therapeutic justification for why generic immediate release tramadol cannot be used. ▪ Zohydro ER will only be approved after an adequate trial of at least one preparation of **each** of the available long-acting opioids including morphine, fentanyl, oxycodone, hydromorphone and oxymorphone **plus** either documented failure of **all** of these agents and/or a documented serious adverse effect to **all** of these agents.

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ANALGESICS, NARCOTIC – SHORT-ACTING

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Oral/Rectal/Nasal		
codeine (except solution) codeine/acetaminophen hydrocodone/acetaminophen hydromorphone tablet morphine IR tablet , solution and concentrate solution oxycodone/acetaminophen oxycodone solution and concentrate tramadol IR tramadol/acetaminophen	*butalbital/acetaminophen/caffeine/ codeine* *butalbital/aspirin/caffeine/ codeine* *butorphanol tartrate nasal spray* *carisoprodol compound w/codeine (carisoprodol/aspirin/codeine)* *capital and codeine suspension (codeine/acetaminophen)* *codeine solution* *dihydrocodeine/ acetaminophen/caffeine* *dihydrocodeine/ aspirin/caffeine* *hydrocodone/ibuprofen* *hydromorphone liquid and suppositories* *IBUDONE (hydrocodone/ibuprofen)* *levorphanol* *meperidine* *morphine suppositories* *NUCYNTA (tapentadol)* *oxycodone IR tablets, capsules* *oxycodone/aspirin* *oxycodone/ibuprofen* *oxymorphone* *pentazocine/naloxone* *PRIMLEV (oxycodone/acetaminophen)* *ROXICET solution (oxycodone/acetaminophen)* *XARTEMIS XR (oxycodone/acetaminophen)* *XODOL(hydrocodone/acetaminophen)*	▪ Link to PA Form for Narcotic Analgesics, Short-acting (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of 3 preferred agents with at least a 7 day trial of each in the past 180 days ▪ For carisoprodol: ▪ Use will be limited to no more than 34 days ▪ Additional authorization will not be granted for at least six months following the last day of the previous course of therapy ▪ Approval will not be granted for patients with a history of meprobamate use in the previous two years ▪ Approval will not be granted for patients concurrently using opioids
Buccal/Sublingual/Transmucosal Fentanyl		
	ABSTRAL (fentanyl) [CL] *ACTIQ (fentanyl transmucosal)* [CL] *fentanyl OTFC* [CL] *FENTORA (fentanyl)* [CL] *LAZANDA (fentanyl) nasal spray* [CL] *SUBSYS (fentanyl)* [CL]	▪ Link to PA Form for Fentanyl (transmucosal) (required for all buccal/sublingual/ transmucosal/nasal drugs) ▪ Fentanyl buccal/sublingual /transmucosal/nasal will only be approved for breakthrough cancer pain in patients already receiving, and tolerant to, opioid therapy.

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ANALGESICS, PAIN – OTHER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria

duloxetine 20 mg, 30 mg and 60 mg capsule [CL]
gabapentin capsules, tablets
	duloxetine 40 mg capsule (for Irenka)
	gabapentin solution
	GRALISE (gabapentin) [CL]
	HORIZANT (gabapentin) [CL]
	IRENKA (duloxetine) [CL]
	lidocaine transdermal [CL]
	LYRICA (pregabalin) [CL]
	SAVELLA (milnacipran) [CL]
		▪ Link to Universal PA Form
		▪ Gabapentin capsules and tablets will be approved for a diagnosis of epilepsy or post-herpetic neuralgia.
		▪ Gabapentin solution will be approved for patients unable to swallow capsules or tablets.
		▪ Gralise will be approved for a diagnosis of post-herpetic neuralgia or seizure disorder in patients who have failed use of gabapentin capsules or tablets within the last 60 days.
		▪ Horizant will be approved for a diagnosis of post-herpetic neuralgia who have failed use of gabapentin capsules or tablets or for restless leg syndrome.
		▪ Lyrica will be approved after failure of a preferred agent for the following diagnoses.
		  ▪ Epilepsy
		  ▪ Diabetic peripheral neuropathy
		  ▪ Fibromyalgia
		  ▪ Neuropathic pain – spinal cord injury
		  ▪ Post-herpetic neuralgia
		▪ Link to PA form for Analgesics, Topical
		  ▪ Lidocaine transdermal will be approved for patients with pain associated with postherpetic neuralgia
		▪ Link to PA Form for Fibromyalgia Agents
		  ▪ Duloxetine, Lyrica and Savella will be approved for patients with a diagnosis of fibromyalgia
		  ▪ Dual therapy with duloxetine and Savella will not be authorized for payment

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ANDROGENIC DRUGS (TOPICAL)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANDROGEL (testosterone) [CL]	*ANDRODERM (testosterone)*[CL] *AXIRON (testosterone)*[CL] *FORTESTA (testosterone)*[CL] *NATESTO (testosterone) nasal* [CL] *testosterone gel (generic ANDROGEL, FORTESTA TESTIM, VOXELGO)*[CL] *testosterone gel pump (ANDROGEL, VOXELGO)*[CL]	▪ Link to PA Form for Androgenic Agents (required for all drugs in the class) ▪ Preferred androgenic drugs will be approved for male patients with a documented diagnosis of hypogonadism with ▪ At least one non-sexual dysfunction symptom ▪ Serum testosterone level below the lower limit of normal range for testing laboratory ▪ Non-preferred agents will be approved for male patients meeting the above criteria with documented failure of a preferred agent within the last 6 months

ANGIOTENSIN MODULATORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	ACE Inhibitors	
benazepril captopril enalapril lisinopril ramipril	*EPANED (enalapril powder for solution)* *fosinopril* *moexipril* *perindopril* *QBRELIS (lisinopril solution)*[NR] *quinapril* *trandolapril*	▪ Link to PA Form for ACE Inhibitors (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved if the patient has a history of one preferred agent in the last 6 months ▪ EPANED will only be approved for patients who have documented inability to swallow tablets
	ACE Inhibitor / Diuretic Combinations	
benazepril/hydrochlorothiazide captopril/hydrochlorothiazide enalapril/hydrochlorothiazide lisinopril/hydrochlorothiazide	*fosinopril/hydrochlorothiazide* *moexipril/hydrochlorothiazide* *quinapril/hydrochlorothiazide*	▪ Link to PA Form for ACE Inhibitors (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved if the patient has a history of one preferred agent in the last 6 months
	Angiotensin Receptor Blockers	
irbesartan losartan valsartan	*BENICAR (olmesartan)* *candesartan* *EDARBI (azilsartan)* *eprosartan* *MICARDIS (telmisartan)* *telmisartan*	▪ Link to PA Form for ARB-Angiotensin II Receptor Antagonists (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved if the patient has a history of one preferred agent in the last 6 months
	Angiotensin Receptor Blocker / Diuretic Combinations	
irbesartan/hydrochlorothiazide losartan/hydrochlorothiazide valsartan/hydrochlorothiazide	*BENICAR-HCT (olmesartan/hydrochlorothiazide)* *candesartan/hydrochlorothiazide* *EDARBYCLOR (azilsartan/chlorthalidone)*	▪ Link to PA Form for ARB-Angiotensin II Receptor Antagonists (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved

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ANGIOTENSIN MODULATORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	telmisartan/hydrochlorothiazide *TEVETEN-HCT (eprosartan/hydrochlorothiazide)*	if the patient has a history of one preferred agent in the last 6 months
Angiotensin Modulator / Calcium Channel Blocker and Beta Blocker Combinations		
benazepril/amlodipine EXFORGE HCT (valsartan/amlodipine/hydrochlorothiazide) valsartan/amlodipine	*AZOR (olmesartan/amlodipine)* *BYVALSON (valsartan/nebivolol)*[NR] *PRESTALIA (perindopril/amlodipine)* *telmisartan/amlodipine* *trandolapril/verapamil* *TRIBENZOR (olmesartan/amlodipine/ hydrochlorothiazide)* *valsartan/amlodipine/hydrochlorothiazide*	▪ Link to PA Form for Angiotensin Modulators-Calcium Channel Blockers (required for Non-preferred drugs) ▪ Non-preferred agents will be approved if the patient has a history of one preferred agent in the last 6 months.
Direct Renin Inhibitors		
	TEKTURNA (aliskiren)	▪ Link to PA Form for Direct Renin Inhibitors (required for all drugs in the class) ▪ Tekturna will only be authorized if there is a documented trial and failure of a preferred ACEI or ARB ▪ Tekturna will not be approved for concomitant use with ACEI or ARB in diabetic or kidney disease patients
Direct Renin Inhibitor Combinations		
	AMTURNIDE (aliskiren/amlodipine/hydrochlorothiazide) *TEKAMLO (aliskiren/amlodipine)* *TEKTURNA/HCT (aliskiren/hydrochlorothiazide)*	▪ Link to PA Form for Direct Renin Inhibitors (required for all drugs in the class) ▪ Aliskiren combinations will only be authorized if there is a documented trial and failure of a preferred ACEI or ARB ▪ Aliskiren combinations will not be approved for concomitant use with ACEI or ARB in diabetic or kidney disease patients
Neprilysin Inhibitor Combination		
	ENTRESTO (sacubitril/valsartan) [CL]	▪ Sacubitril-valsartan (Entresto) will be approved for patients with a diagnosis of chronic heart failure (NYHA Class II-IV) with left ventricular ejection fraction < 40%. Sacubitril-valsartan will not be approved for patients currently receiving an ACE-inhibitor or patients on aliskeren with diabetes.

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ANTI-ALLERGENS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	GRASTEK (Timothy grass pollen allergen extract) [CL] *ORALAIR (grass pollen extract – Cocksfoot, Sweet Vernal Grass, Rye Grass, Meadow Grass, Timothy)* [CL] *RAGWITEK (Short Ragweed pollen allergen extract)* [CL]	▪ Link to Universal PA Form ▪ Oral Allergy-Specific Immunotherapy agents will be approved for participants who have had an inadequate response, intolerance or contraindication to intranasal corticosteroids, leukotriene inhibitors and antihistamines. The participant must have a positive test for the specific allergen(s) covered by the specific agent and first dose must be 12 weeks before estimated actual start of the specific pollen season.

ANTIBIOTICS, GI

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ALINIA suspension (nitazoxanide) metronidazole tablet neomycin tinidazole vancomycin capsules	*ALINIA tablet (nitazoxanide)* *DIFICID (fidaxomicin)* [CL] *FLAGYL/FLAGYL ER (metronidazole)* *metronidazole capsule* *paromomycin* *XIFAXAN (rifaximin)* [CL]	▪ Link to Universal PA Form ▪ Dificid will only be approved with documentation of a clostridium difficile infection. Treatment will be limited to 10 days. ▪ Link to PA Form for Xifaxan ▪ Xifaxan 200 mg will only be approved for documented traveler's diarrhea and is limited to one prescription with a 3 day supply. ▪ Xifaxan 550 mg will be approved for patients with irritable bowel syndrome with diarrhea, or documented hepatic encephalopathy who have received lactulose at least 90 ml per day for 72 of the last 90 days and are continuing on lactulose concurrently. ▪ Other non-preferred agents will only be approved after documented failure of a preferred agent.

ANTIBIOTICS, INHALED [CL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BETHKIS (tobramycin) [CL] CAYSTON (aztreonam) [CL] KITABIS PAK (tobramycin) [CL]	*TOBI (tobramycin)* [CL] *TOBI Podhaler* [CL] *tobramycin solution* [CL] *tobramycin pak (KITABIS PAK)* [CL]	▪ Link to PA Form for Inhaled Antibiotics (required for all agents in class) ▪ Preferred agents will be approved for patients with a diagnosis of cystic fibrosis. ▪ Non-preferred agents will only be approved for patients with cystic fibrosis that have a documented failure of a preferred agent

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ANTIBIOTICS, TOPICAL

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mupirocin ointment	*ALTABAX (retapamulin)* *gentamicin ointment and cream* *mupirocin cream*	▪ Link to PA Form for Antibiotics, Topical (required for Non-Preferred drugs) ▪ Non-preferred agents will only be approved after documented failure of a preferred agent

ANTIBIOTICS, VAGINAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CLEOCIN OVULES (clindamycin) metronidazole 0.75% gel	*clindamycin cream* *NUVESSA 1.3% gel (metronidazole)* *VANDAZOLE (metronidazole)*	▪ Link to Universal PA Form ▪ Non-preferred agents will only be approved after documented failure of a preferred agent

ANTICOAGULANTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ELIQUIS (apixaban) [CL] enoxaparin syringe FRAGMIN (dalteparin) vial LOVENOX vial (enoxaparin) warfarin XARELTO (rivaroxaban) [CL]	*enoxaparin vial* *fondaparinux* *FRAGMIN (dalteparin) syringe* *PRADAXA (dabigatran)* [CL] *SAVAYSA (edoxaban)* [CL] *XARELTO (rivaroxaban)* [CL] *Starter Pack*	▪ Link to PA Form for Anticoagulants, Oral ▪ Eliquis and Xarelto will be approved for non-valvular atrial fibrillation, for prophylaxis of DVT or PE following hip or knee replacement surgery, for treatment of DVT or PE or to reduce the risk of recurrence of DVT or PE. ▪ Pradaxa will be approved for non-valvular atrial fibrillation, for treatment of DVT or PE in patients who have been treated with a parenteral anticoagulant for 5-10 days, to reduce the risk or recurrence of DVT or PE, or for the prophylaxis of DVT and PE in patient who have undergone hip replacement surgery. ▪ Savaysa will be approved for non-valvular atrial fibrillation or for treatment of DVT or PE in patients who have been treated with a parenteral anticoagulant for 5-10 days **and if** they have a documented failure of a preferred oral agent other than warfarin within the most recent 30 days. ▪ Link to PA Form for Anticoagulants, Injectable ▪ Enoxaparin and fondaparinux will be approved after a trial and failure of a preferred agent in the last 30 days

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ANTICONVULSANTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Barbiturates		
phenobarbital primidone		▪ Link to PA Form for Anticonvulsants for Seizure Disorder ▪ The non-preferred agents will be approved only after documented failure of a preferred agent.
Benzodiazepines		
clonazepam tablet DIASTAT (diazepam rectal) ONFI tablet (clobazam) [CL]	*clonazepam ODT* [CL] *diazepam rectal* *ONFI suspension (clobazam)* [CL]	▪ Link to PA Form for Anticonvulsants for Seizure Disorder ▪ Non-preferred agents without additional clinical criteria will be approved only after documented failure of a preferred agent. ▪ Onfi will be approved for patients with a diagnosis of seizure disorder (ICD-9 = 345 or ICD-10= G40 or R56) within the previous 2 years. ▪ Onfi suspension will be approved for patients meeting Onfi clinical criteria who have a documented inability to swallow tablets. ▪ Link to PA Form for Clonazepam ODT Form. ▪ Clonazepam orally disintegrating tablets (ODT) will be approved for patients that have a diagnosis of panic disorder with or without agoraphobia whose clonazepam dose is being titrated up or down or who have a documented inability to swallow other oral medication dosage forms.
Hydantoins		
DILANTIN (phenytoin) capsules DILANTIN INFATAB (phenytoin) PEGANONE (ethotoin) phenytoin capsule, chew tab, suspension phenytoin sodium extended (generic PHENYTEK)	*DILANTIN suspension (phenytoin)*	▪ Link to PA Form for Anticonvulsants for Seizure Disorder ▪ The non-preferred agents will be approved only after documented failure of a preferred agent.
Succinimides		
CELONTIN (methsuximide) ethosuximide capsules ethosuximide syrup		▪ Link to PA Form for Anticonvulsants for Seizure Disorder

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ANTICONVULSANTS

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Adjuvants, Epilepsy		
APTIOM (eslicarbazepine) [CL] DEPAKOTE Sprinkle (divalproex) [CL] levetiracetam solution, tablets [CL] oxcarbazepine suspension [CL] oxcarbazepine tablets [CL] QUDEXY XR (topiramate XR) capsules [CL] topiramate ER (generic QUDEXY XR) capsules [CL] topiramate sprinkle [CL] VIMPAT (lacosamide) [CL] zonisamide [CL]	*BANZEL (rufinamide) tablets, suspension* [CL] *BRIVIACT (brivaracetam) tablets, solution* [CL] *divalproex sprinkle* [CL] *felbamate tablet, suspension* [CL] *FYCOMPA (perampanel) tablets, suspension* [CL] *lamotrigine XR* [CL] *levetiracetam ER* [CL] *OXTELLAR XR (oxcarbazepine)* [CL] *POTIGA (ezogabine)* [CL] *SABRIL (vigabatrin)* [CL] *SPRITAM (levetiracetam) suspension* [CL] *tiagabine* [CL] *TROKENDI XR (topiramate ER) capsules* [CL]	▪ Link to PA Form for Anticonvulsants for Seizure Disorder ▪ (required for Non-Preferred drugs) ▪ All agents require a seizure diagnosis (ICD-9=345 or 780.39 or ICD-10= G40 or R56) within the last 2 years. ▪ Preferred agents will be approved within the approved dosage quantities and age limits for eligible participants with a seizure diagnosis. ▪ Non-preferred brand agents will be approved for patients with a diagnosis of seizure disorder who have been receiving the brand drug for 90 days and are compliant with therapy (72 days out of the past 90) or who have documented failure of at least two different generic formulations from different manufacturers. Generic failures must also include a copy of the FDA MedWatch form documenting reason for failure. ▪ Other non-preferred agents will be approved for patients with a documented failure of a preferred agent in the past 180 days.
Adjuvants, Pain and Mood Disorders		
carbamazepine chewable tablet carbamazepine ER (generic for CARBATROL) carbamazepine IR DEPAKOTE ER (divalproex) divalproex ER divalproex tablet lamotrigine tablets [CL] TEGRETOL (carbamazepine) suspension TEGRETOL XR (carbamazepine XR) topiramate tablets [CL] valproate syrup valproic acid	*carbamazepine suspension* *carbamazepine XR (generic for TEGRETOL XR)* *EQUETRO (carbamazepine ER)* *LAMICTAL ODT (lamotrigine)* [CL] *lamotrigine ODT* [CL]	▪ Link to PA Form for Anticonvulsants for Pain and Mood Disorders ▪ Preferred agents with no clinical criteria will be approved for eligible participants within the approved dosage quantities and age limits. ▪ Non-preferred brand agents will be approved for patients with a diagnosis of seizure disorder (ICD-9=345 or 780.39 or ICD-10= G40 or R56) who have been receiving the brand drug for at least 90 days and are compliant with therapy (72 days out of the past 90 days) or who have a documented failure of at least two different generic formulations from different manufacturers. Generic failures must also include a copy of the FDA MedWatch form documenting the reason for failure. ▪ Non-preferred generic agents with no additional clinical criteria will be approved after trial and failure of a preferred agent within the approved dosage quantities and age limits.

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ANTICONVULSANTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
		▪ Lamotrigine or lamotrigine ODT will be approved for patients with one of the following diagnoses within the previous 2 years. ▪ Seizure disorder (ICD-9=345 or 780.39 or ICD-10= G40 or R56) ▪ Bipolar disorder (ICD-9 – 296 or ICD-10 = F31) ▪ Topiramate IR will be approved for patients with one of the following diagnoses within the past 2 years. ▪ Seizure disorder (ICD-9=345 or 780.39 or ICD-10= G40 or R56) ▪ Migraine headache (ICD-9 -346 or ICD-10 = G43) ▪ Non-preferred agents meeting the above clinical criteria will be approved after trial and failure of a preferred agent.

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[CL] – Prior Authorization / Class Criteria apply

[NR] – New drug that has not been reviewed by P & T Committee

Non-preferred brand name drugs with generic equivalents will require failure of a preferred agent plus meet all the requirements of the brand-generic rule (i.e., failure of two generics from different manufacturers and submission of a MedWatch Form).

ANTIDEPRESSANTS, OTHER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria

bupropion HCl IR
bupropion SR
bupropion XL
mirtazapine tablets
trazodone
venlafaxine IR
venlafaxine ER capsules
	APLENZIN (bupropion HBr)
	desvenlafaxine ER
	desvenlafaxine fumarate ER
	duloxetine [CL]
	EMSAM (selegiline transdermal) [CL]
	FETZIMA (levomilnacipran)
	FORFIVO XL (bupropion)
	IRENKA (duloxetine) [CL]
	KHEDEZLA (desvenlafaxine)
	MARPLAN (isocarboxazid)
	mirtazapine ODT
	nefazodone
	OLEPTRO ER (trazodone)
	PARNATE (tranylcypromine)
	phenelzine
	PRISTIQ (desvenlafaxine succinate)
	tranylcypromine
	TRINTELLIX (vortioxetine)
	venlafaxine ER tablets
	VIIBRYD (vilazodone)
		▪ Link to PA Form for Antidepressants, Other (required for Non-Preferred Drugs - except duloxetine and Emsam - see below)
		▪ Trintellix, Fetzima and Viibryd require trial and failure of two preferred antidepressants, including one from the Antidepressants, Other class.
		▪ Other non-preferred agents will be approved for payment only after documented failure of at least one preferred agent
		▪ Link to PA Form for duloxetine
		▪ Duloxetine will be approved for patients meeting one of the following criteria:
		  ▪ Diagnosis of major depressive disorder (MDD) or generalized anxiety disorder (GAD) who have tried and failed treatment with a preferred antidepressant
		  ▪ Diagnosis of diabetic peripheral neuropathy (DPN) who have tried and failed gabapentin therapy in the past 6 months
		  ▪ Diagnosis of fibromyalgia
		  ▪ Diagnosis of chronic musculoskeletal pain.
		▪ Link to PA Form for Emsam
		▪ Emsam will be approved for adult patients meeting all of the following criteria:
		  ▪ Diagnosis of major depressive disorder (MDD)
		  ▪ Failure of trials of an SSRI, an SNRI and at one least one other antidepressant from another therapeutic class
		  ▪ Not currently receiving any contraindicated medications
		  ▪ No diagnosis of pheochromocytoma

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[CL] – Prior Authorization / Class Criteria apply

[NR] – New drug that has not been reviewed by P & T Committee

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ANTIDEPRESSANTS, SSRIS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
citalopram tablet, solution escitalopram tablets fluoxetine capsules, tablets, solution fluvoxamine paroxetine tablet sertraline	*BRISDELLE (paroxetine)* [CL] *escitalopram solution* *fluoxetine weekly* [CL] *fluvoxamine ER* *paroxetine CR* *PAXIL Suspension (paroxetine)* *PEXEVA (paroxetine)* *PROZAC (fluoxetine) weekly* [CL]	▪ Link to PA Form for Antidepressants, SSRIs (required for Non-Preferred drugs – including fluoxetine weekly) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent within the last 6 months. ▪ Fluoxetine weekly will be approved for patients with a diagnosis of depression who are not receiving other medications at least daily. ▪ Brisdelle will be approved for treatment of vasomotor symptoms only and not depression.

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[CL] – Prior Authorization / Class Criteria apply

[NR] – New drug that has not been reviewed by P & T Committee

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ANTIEMETIC/ANTIVERTIGO AGENTS (ORAL/TRANSDERMAL)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Cannabinoids		
	CESAMET (nabilone) [CL] *dronabinol* [CL]	▪ Link to PA Form for Cannabinoids ▪ Dronabinol will be approved for patients who have received chemotherapy in the last 12 months or have a history of HIV associated cachexia.
5HT$_3$ Receptor Blockers[CL]		

ondansetron
ondansetron ODT
	ANZEMET (dolasetron)
	granisetron
	SANCUSO (granisetron)
	SUSTOL (granisetron)[NR]
	ZUPLENZ (ondansetron)
		▪ Link to PA Form for Antiemetics, Oral - 5HT3 Antagonists (required for all drugs)
		▪ A PA is not required for ondansetron for the following situations:
		  ▪ Patients 15 years and younger within the quantity limit of not more than 30 tablets monthly
		  ▪ Adults for a one time fill of 10 tablets or less
		▪ Ondansetron and ondansetron ODT will be approved for patients with:
		  ▪ Chemotherapy or radiation-induced nausea and vomiting OR
		  ▪ Documented clinically significant hyperemesis gravidarum OR
		  ▪ Post-operative nausea/vomiting (limited to one fill only)
		▪ Sancuso will be approved for patients with chemotherapy or radiation-induced nausea and vomiting with documentation that they cannot take oral therapy
		▪ Non-preferred agents will be approved only after documented failure of a preferred agent within the last 6 months

NK1 Receptor Antagonist		
EMEND (aprepitant)	*AKYNZEO (netapitant/palonosetron)* *VARUBI (rolapitant)*	▪ Link to Universal PA Form ▪ Non-preferred agents will be approved after failure of at least one preferred agent in the most recent 60 days
Other		
dimenhydrinate OTC meclizine OTC and RX metoclopramide tablet prochlorperazine (oral) promethazine (oral, rectal 12.5 & 25 mg) trimethobenzamide TRANSDERM-SCOP (scopolamine)	*COMPRO (prochlorperazine) rectal* *DICLEGIS (doxylamine/pyridoxine)* [CL] *metoclopramide ODT* *prochlorperazine (rectal)* *promethazine 50 mg suppositories*	▪ Link to Universal PA Form ▪ A prescription is required for all drugs ▪ Non-preferred agents will be approved after failure of at least one preferred agent in the most recent 60 days.

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[CL] – Prior Authorization / Class Criteria apply

[NR] – New drug that has not been reviewed by P & T Committee

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ANTIFUNGALS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria

clotrimazole
fluconazole
nystatin tablets and suspension
terbinafine
	CRESEMBA (isavuconazonium)
	flucytosine
	griseofulvin suspension
	griseofulvin ultramicrosize tablets
	griseofulvin V tablets
	itraconazole
	ketoconazole [CL]
	LAMISIL (terbinafine) granules
	NOXAFIL (posaconazole)
	nystatin oral powder
	ONMEL (itraconazole)
	ORAVIG (miconazole)
	voriconazole
		▪ Link to PA Form for Antifungals, Oral
		▪ Ketoconazole will be approved for blastomycosis, coccidioidomycosis, histoplasmosis, chromomycosis or paracoccidioidomycosis in patients who have failed or cannot tolerate other oral antifungal agents.
		  ▪ Ketoconazole will not be approved for fungal infections of the skin or nails or for fungal meningitis.
		  ▪ Ketoconazole will not be approved for patients with liver disease, adrenal problems, or those who have undergone recent major surgery, or who are receiving interacting medications. (see product PI for list of interacting medications)
		▪ Non-preferred agents will be approved after failure of at least one preferred agent in the most recent 60 days.

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[CL] – Prior Authorization / Class Criteria apply

[NR] – New drug that has not been reviewed by P & T Committee

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ANTIFUNGALS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Antifungals		
clotrimazole OTC and RX ketoconazole cream, shampoo and gel LAMISIL (terbinafine) cream, gel, spray miconazole cream, powder OTC nystatin cream, ointment, powder terbinafine OTC tolnaftate OTC	*butenafine OTC* *ciclopirox cream, gel, shampoo, suspension* *ciclopirox solution nail lacquer* [CL] *econazole* *ECOZA (econazole)* *ERTACZO (sertaconazole)* *EXELDERM (sulconazole)* *EXTINA (ketoconazole foam)* *JUBLIA (efinaconazole)* *KERYDIN (tavaborole)* *ketoconazole foam* *LAMISIL (terbinafine) granules* *LOPROX (ciclopirox)* [NR] *LUZU (luliconazole)* *miconazole nitrate, ointment, spray OTC* *MENTAX (butenafine)* *naftifine* *NIZORAL shampoo (ketoconazole)* *NIZORAL AD shampoo OTC(ketoconazole)* *oxiconazole* *OXISTAT (oxiconazole)* *VUSION (miconazole/petrolatum/ zinc oxide)* *XOLEGEL(ketoconazole)*	▪ Link to PA Form for Antifungals, Topical (required for Non-Preferred drugs -except antifungal nail lacquers - see below) ▪ Non-preferred agents will be approved only after documented failure of the preferred agents within the previous six months ▪ Link to PA Form for Topical Antifungal Nail Lacquer (required for ciclopirox solution, Jublia (efinaconazole) and Kerydin (tavaborole)) ▪ Antifungal nail preparations will only be approved for patients meeting all of the following criteria: ▪ Diagnosis of onychomycosis within the last year ▪ Contraindication to oral itraconazole and terbinafine as defined by presence of heart failure, hepatic impairment or viral hepatitis ▪ Proof from prescriber that therapy is not for cosmetic purposes
Antifungal/Steroid Combinations		
nystatin/triamcinolone cream, ointment	*clotrimazole/betamethasone* *ketoconazole/hydrocortisone*	▪ Individual prescriptions for clotrimazole, betamethasone, ketoconazole and hydrocortisone should be used for patients requiring the combination product.

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[CL] – Prior Authorization / Class Criteria apply

[NR] – New drug that has not been reviewed by P & T Committee

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ANTIHISTAMINES, MINIMALLY SEDATING

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
cetirizine solution, tablets loratadine solution, tablets loratadine ODT	*cetirizine capsule OTC* *cetirizine chewable* *desloratadine* *desloratadine ODT* *fexofenadine* *levocetirizine*	▪ A prescription is required for all drugs. ▪ Link to PA Form for Antihistamines, Minimally Sedating (required for Non-Preferred drugs) ▪ Non-preferred agents will be authorized if a patient has failed a preferred agent within the most recent six months. ▪ Cetirizine solution is available for patients ≤ 12 years

ANTIHYPERTENSIVES, SYMPATHOLYTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CATAPRES TTS (clonidine transdermal) clonidine guanfacine methyldopa	*clonidine transdermal* *CLORPRES (chlorthalidone/clonidine)* *methyldopa-hydrochlorothiazide* *methyldopate injectable* *reserpine*	▪ Non-preferred agents will be approved only after documented failure of the preferred agent.

ANTIHYPERURICEMICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria

allopurinol
probenecid
probenecid/colchicine
	colchicine [CL]
	ULORIC (febuxostat) [CL]
	ZURAMPIC (lesinurad) [CL]
		▪ Link to PA Form for Antihyperuricemics, Oral (required for Non-Preferred drugs)
		▪ Colchicine:
		  ▪ A prescription for three tablets does not require prior authorization if processed by the pharmacy as an Emergency Override.
		  ▪ For acute gout, colchicine will be approved if there is a failure of or contraindication to NSAIDS or corticosteroids.
		  ▪ For chronic gout, colchicine will be approved for patients on concomitant allopurinol who have failed or have documented intolerance to NSAIDs.
		▪ Uloric will be approved for continuation of gout attacks with serum urate levels >6 mg/dl after at least three months of allopurinol at a therapeutic dose or with documented intolerance to allopurinol.
		▪ Zurampic will be approved for patients with gout who have not achieved target serum uric levels with a xanthine oxidase inhibitor alone at therapeutic doses. It will not be approved for treatment of asymptomatic hyperuricemia or as monotherapy.

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[CL] – Prior Authorization / Class Criteria apply

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ANTIMIGRAINE AGENTS[CL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Oral		
rizatriptan oral tablets, MLT RELPAX (eletriptan) sumatriptan	*almotriptan* *FROVA (frovatriptan)* *naratriptan* *TREXIMET (sumatriptan/naproxen)* [CL] *zolmitriptan*	▪ Link to PA Form for Triptans (required for all drugs) ▪ Triptans will be approved for migraine treatment in patients ≥ 12 years. Exception: Rizatriptan MLT may be approved for patients ≥ 6 years old. ▪ Triptans will only be approved for patients with no history of ischemic heart disease, angina pectoris, silent ischemia, ischemic bowel disease, cerebrovascular disease, peripheral vascular disease or malignant or uncontrolled hypertension ▪ Treximet will be approved if patient has tried and failed therapy with separate prescriptions for sumatriptan and naproxen. ▪ Non-preferred agents will be approved only if the patient has tried and failed therapy with at least two preferred agents (different chemical entities) within the last 6 months.
Nasal		
sumatriptan	*ZOMIG (zolmitriptan)*	▪ Link to PA Form for Triptans (required for all drugs) ▪ Triptans will only be approved for patients with no history of ischemic heart disease, angina pectoris, silent ischemia, ischemic bowel disease, cerebrovascular disease, peripheral vascular disease or malignant or uncontrolled hypertension. ▪ Non-preferred agents will be approved only if patient has tried and failed therapy with a preferred agent within the last 6 months.

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[CL] – Prior Authorization / Class Criteria apply

[NR] – New drug that has not been reviewed by P & T Committee

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ANTIMIGRAINE AGENTS[CL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Injectable		
sumatriptan syringe and vial	*sumatriptan syringe* *SUMAVEL DOSEPRO (sumatriptan)* *ZEMBRACE SYMTOUCH (sumatriptan)* [NR]	▪ Link to PA Form for Triptans (required for all drugs) ▪ Triptans will only be approved for patients with no history of ischemic heart disease, angina pectoris, silent ischemia, ischemic bowel disease, cerebrovascular disease, peripheral vascular disease or malignant or uncontrolled hypertension. ▪ Non-preferred agents will be approved only if patient has tried and failed therapy with a preferred agent within the last 6 months.
Transdermal		
	ZECUITY (sumatriptan)	▪ Link to PA Form for Triptans (required for all drugs) ▪ Non-preferred agents will be approved only if patient has tried and failed therapy with all of the preferred agents within the last 6 months.

ANTIPARASITICS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
NATROBA (spinosad) permethrin OTC and Rx SKLICE (ivermectin) ULESFIA (benzyl alcohol)	*EURAX (crotamiton) lotion & cream* *lindane* *malathion* *NIX COMPLETE (permethrin)* [NR] *piperonyl butoxide and pyrethrins OTC* *spinosad*	▪ Link to PA Form for Antiparasitics, Topical (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

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ANTIPARKINSON'S DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Anticholinergics		
benztropine trihexyphenidyl		▪ Link to PA Form for Antiparkinson Agents ▪ Non-preferred agents will be approved only after documented failure of any preferred antiparkinson agent.
COMT Inhibitors		
	entacapone *TASMAR (tolcapone)* *tolcapone*	▪ Link to PA Form for Antiparkinson Agents ▪ Non-preferred agents will be approved only after documented failure of any preferred antiparkinson agent.
Dopamine Agonists		
bromocriptine pramipexole IR ropinirole IR	*MIRAPEX ER (pramipexole)* *NEUPRO transdermal patch (rotigotine)* *pramipexole ER* *ropinirole ER*	▪ Link to PA Form for Antiparkinson Agents ▪ Link to PA Form for Restless Leg Syndrome ▪ Non-preferred agents will be approved only after documented failure of any preferred antiparkinson agent.
MAO-B Inhibitors		
selegiline	*AZILECT (rasagiline)* *ELDEPRYL (selegiline)* [NR] *ZELAPAR (selegiline disintegrating tablets)*	▪ Link to PA Form for Antiparkinson Agents ▪ Non-preferred agents will be approved only after documented failure of any preferred antiparkinson agent.
Other Antiparkinson's Drugs		
amantadine capsule, syrup carbidopa/levodopa ER carbidopa/levodopa IR tablets carbidopa/levodopa/entacapone	*amantadine tablet* *carbidopa* *carbidopa/levodopa ODT* *RYTARY (carbidopa/levodopa ER)*	▪ Link to PA Form for Antiparkinson Agents ▪ Non-preferred agents will be approved only after documented failure of any preferred antiparkinson agent.

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[CL] – Prior Authorization / Class Criteria apply

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ANTIPSYCHOTICS, FIRST GENERATION

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Oral/Intranasal		
chlorpromazine fluphenazine haloperidol loxapine ORAP (pimozide) perphenazine perphenazine/amitriptyline thiothixene trifluoperazine	*ADASUVE (loxapine)* [CL] *molindone* *pimozide* *thioridazine*	▪ Link to PA Form for Antipsychotics, Oral ▪ A non-preferred agent will be approved only after documented failure of a preferred agent.
Injectable (Acute Treatment)		
haloperidol lactate		
Injectable (Maintenance Treatment)		
fluphenazine decanoate haloperidol decanoate		

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[CL] – Prior Authorization / Class Criteria apply

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ANTIPSYCHOTICS, SECOND GENERATION

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Oral		
aripiprazole tablets clozapine FAZACLO (clozapine ODT) olanzapine olanzapine ODT quetiapine risperidone solution, tablets, ODT SEROQUEL XR (quetiapine) ziprasidone	*aripiprazole disintegrating tablet* *aripiprazole solution* *clozapine ODT* *FANAPT (iloperidone)* *INVEGA (paliperidone ER)* *LATUDA (lurasidone)* *NUPLAZID (pimavanserin)* *olanzapine/fluoxetine (must use individual agents)* *paliperidone ER* *quetiapine XR* [NR] *REXULTI (brexpiprazole)* *SAPHRIS (asenapine)* *VERSACLOZ (clozapine)* *VRAYLAR (cariprazine)*	▪ Link to PA Form for Antipsychotics, Oral ▪ A non-preferred agent will be approved only after documented failure of a preferred agent.
Injectable (Acute Treatment)		
GEODON (ziprasidone) olanzapine		
Injectable (Maintenance Treatment)		
ABILIFY MAINTENA (aripiprazole) [CL] INVEGA SUSTENNA (paliperidone) INVEGA TRINZA (paliperidone) RISPERDAL CONSTA (risperidone)	*ARISTADA (aripiprazole)* [CL] *ZYPREXA RELPREVV (olanzapine)*	▪ Link to PA Form for Injectable Long Acting Antipsychotics 2nd Generation ▪ Preferred injectable antipsychotics will be approved within FDA approved age, dosing, and diagnosis parameters in patients who have failed oral therapy. Non-preferred agents require trial and failure or contra-indication to a preferred injectable antipsychotic. ▪ Zyprexa Relprevv (olanzapine) is reimbursed as a medical benefit only and not dispensed through the outpatient pharmacy program.

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[CL] – Prior Authorization / Class Criteria apply

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ANTIVIRALS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Antiherpetic Drugs		
acyclovir capsules, tablets, suspension valacyclovir ZOVIRAX (acyclovir) suspension	*famciclovir* *SITAVIG (acyclovir) buccal*	▪ Link to PA Form for Non-Preferred drugs ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
Antiinfluenza Drugs		
RELENZA (zanamivir) TAMIFLU (oseltamivir)	*oseltamivir* *rimantadine*	▪ Link to PA Form for Non-Preferred drugs ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

ANTIVIRALS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ZOVIRAX (acyclovir) Cream	*acyclovir ointment* [CL] *DENAVIR (penciclovir)* *XERESE (acyclovir/hydrocortisone)* *Zovirax (acyclovir) ointment* [CL]	▪ Link to PA Form for Antivirals, Topical (required for Non-Preferred Drugs) ▪ Acyclovir ointment will be authorized for patients with a diagnosis of genital herpes. ▪ The CDC discourages the use of topical therapy for the treatment of genital herpes.

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[CL] – Prior Authorization / Class Criteria apply

[NR] – New drug that has not been reviewed by P & T Committee

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BETA BLOCKERS (ORAL)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Beta Blockers		
atenolol metoprolol metoprolol XL propranolol propranolol ER sotalol	*acebutolol* *betaxolol* *bisoprolol* *BYSTOLIC (nebivolol)* *HEMANGEOL(propranolol)* *INDERAL XL (propranolol)* *INNOPRAN XL (propranolol)* *nadolol* *LEVATOL (penbutolol)* *pindolol* *timolol* *SOTYLIZE (sotalol)*	▪ Link to PA Form for Beta Adrenergic Blockers (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved for patients with documented failure to one of the preferred agents within the past 6 months.
Beta Blocker/Diuretic Combinations		
atenolol/chlorthalidone bisoprolol/hydrochlorothiazide propranolol/hydrochlorothiazide	*DUTOPROL (metoprolol succinate/hydrochlorothiazide)* *metoprolol/hydrochlorothiazide* *nadolol/bendroflumethiazide*	▪ Link to PA Form for Beta Adrenergic Blockers (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved for patients with documented failure to one of the preferred agents within the past 6 months.
Beta- and Alpha- Blockers		
carvedilol labetalol	*COREG CR (carvedilol)*	▪ Link to PA Form for Beta Adrenergic Blockers (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved for patients with documented failure to one of the preferred agents within the past 6 months.

BLADDER RELAXANT PREPARATIONS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
oxybutynin ER oxybutynin IR TOVIAZ (fesoterodine) VESICARE (solifenacin)	*ENABLEX (darifenacin)* *darifenacin* *flavoxate* *GELNIQUE (oxybutynin)* *MYRBETRIQ (mirabegron)* *OXYTROL transdermal (oxybutynin)* *tolterodine* *tolterodine ER* *trospium* *trospium ER*	▪ Link to PA Form for Bladder Relaxants (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

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[CL] – Prior Authorization / Class Criteria apply

[NR] – New drug that has not been reviewed by P & T Committee

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BONE RESORPTION SUPPRESSION AND RELATED AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	Bisphosphonates	
alendronate tablets	*ACTONEL (risedronate)* *ACTONEL (risedronate) with calcium* *alendronate solution* *ATELVIA (risedronate)* *BINOSTO (alendronate)* *etidronate* *FOSAMAX Plus D (alendronate/cholecalciferol)* *ibandronate* *risedronate*	▪ Link to PA Form for Bone Resorption Suppression and Related Agents (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent
	Other Bone Resorption Suppression and Related Drugs	
	calcitonin-salmon *FORTEO (teriparatide)* [CL] *FORTICAL (calcitonin)* *MIACALCIN (calcitonin)* *PROLIA (denosumab)*	▪ Link to PA Form for Bone Resorption Suppression and Related Agents for Non-Preferred drugs ▪ Non-preferred agents will be approved only after documented failure of a preferred agent. ▪ Forteo will also be approved for patients that have a diagnosis of glucocorticoid-induced osteoporosis: ICD-9 of 733.xx or 733.09 plus history of glucocorticoid prescription use OR documented failure of a Preferred agent

BOTULINUM TOXINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria

BOTOX [CL] (onabotulinumtoxinA) –(except for cervical dystonia)
DYSPORT [CL] (abobotulinumtoxinA)
MYOBLOC [CL] (rimabotulinumtoxinB)
XEOMIN [CL] (incobotulinumtoxinA)
	BOTOX [CL] (onabotulinumtoxinA) –(for cervical dystonia)	▪ Link to PA Form for Botulinum toxin, Other
		▪ Link to PA Form for Botox for Migraines
		▪ Botox will be approved for the following indications:
		  ▪ Chronic daily headaches defined as > 15 days/month lasting > 4 hours/day for patients who have failed at least two oral prophylactic medications and at least two rescue medications (e.g. triptans).
		  ▪ Spasticity in patients who have failed at least two oral skeletal muscle relaxants.
		  ▪ Overactive bladder in patients who have failed at least two oral anticholinergic agents.
		  ▪ Urinary incontinence due to detrusor overactivity associated with a neurologic condition in patients who have failed at least

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[CL] – Prior Authorization / Class Criteria apply

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BOTULINUM TOXINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
		two oral anticholinergic agents. ▪ Blepharospasm and strabismus. ▪ For cervical dystonia, trial and failure of a preferred botulinum toxin. ■ Dsyport will be approved for the following indications: ▪ Cervical dystonia in patients who have tried and failed at least two oral skeletal muscle relaxants. ▪ Spasticity in patients who have failed at least two oral skeletal muscle relaxants. ■ Myobloc will be approved for the following indications: ▪ Cervical dystonia in patients who have tried and failed at least two oral skeletal muscle relaxants. ■ Xeomin will be approved for the following indications: ▪ Blepharospasm ▪ Cervical dystonia in patients who have tried and failed at least two oral skeletal muscle relaxants. ▪ Spasticity in patients who have failed at least two oral skeletal muscle relaxants.

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BPH TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Alpha Blockers		
alfuzosin doxazosin tamsulosin terazosin	*CARDURA XL (doxazosin)* *RAPAFLO (silodosin)*	▪ Link to Universal PA Form ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
5-Alpha-Reductase (5AR) Inhibitors		
finasteride 5 mg tablet	*dutasteride*	▪ Link to Universal PA Form ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
Combination Agents		
	dutasteride/tamsulosin *JALYN (dutasteride/tamsulosin)*	▪ Link to Universal PA Form ▪ Non-preferred agents will be approved only after documented failure of individual agents.

BRONCHODILATORS, BETA AGONIST

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Inhalers, Short-Acting		
PROAIR HFA (albuterol) PROVENTIL HFA (albuterol)	*MAXAIR (pirbuterol)* *PROAIR RESPICLICK (albuterol)* *VENTOLIN HFA (albuterol)* *XOPENEX HFA (levalbuterol)*	▪ Link to PA Form for Short-Acting Beta-2 Agonists (required for Non-preferred drugs) ▪ The non-preferred agents will be approved only after documented failure of a preferred agent.
Bronchodilators, Beta Agonist Inhalers, Long-Acting		

SEREVENT (salmeterol) [CL]	*ARCAPTA (indacaterol)* [CL]
	STRIVERDI RESPIMAT (olodaterol) [CL]
		▪ Link to PA Form for Long-Acting Beta-2 Agonists (required for Non-Preferred drugs)
		▪ Long-acting beta agonist inhalers will be approved for participants meeting the following criteria
		  ▪ Concurrent (i.e., active therapy on the in-process claim date) use of a short-acting beta-2-agonist MDI or nebulizer in the last 30 days **PLUS**
		  ▪ Age >17 years old **PLUS**
		  ▪ Diagnosis of chronic obstructive pulmonary disease (COPD) ,chronic bronchitis and emphysema (ICD-9 = 491.xx, 492.xx, 493.xx, 496.xx)
		  OR
		  ▪ Concomitant inhaled corticosteroid use

Inhalation Solution		
albuterol	*levalbuterol* *BROVANA (arformoterol)* *PERFOROMIST (formoterol)*	▪ Link to PA Form for Short-Acting Beta-2 Agonists (required for Non-preferred drugs) ▪ Link to PA Form for Long-Acting Beta-2 Agonists (Brovana/Perforomist) (required for

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BRONCHODILATORS, BETA AGONIST

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
		Non-preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent. ▪ Long-acting inhalation solution will be approved for participants meeting the following criteria ▪ Concurrent (i.e., active therapy on the in-process claim date) use of a short-acting beta-2-agonist MDI or nebulizer in the last 30 days **PLUS** ▪ Age >17 years old **PLUS** ▪ Diagnosis of chronic obstructive pulmonary disease (COPD) ,chronic bronchitis and emphysema (ICD-9 = 491.xx, 492.xx, 493.xx, 496.xx) ***OR*** ▪ Concomitant inhaled corticosteroid use
Oral		
terbutaline	*albuterol* *albuterol ER* *metaproterenol*	▪ Link to Universal PA Form (required for Non-Preferred drugs) ▪ Non-preferred agents require medical justification for using an oral beta agonist rather than an inhaled beta agonist.

CALCIUM CHANNEL BLOCKERS (ORAL)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Short-Acting		
diltiazem nifedipine verapamil	*isradipine* *nicardipine*	▪ Link to Universal PA Form ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
Long-Acting		
amlodipine diltiazem ER capsules (generic for Cardizem CD) nifedipine ER nimodipine verapamil ER (except 360 mg caps)	*COVERA-HS (verapamil)* *diltiazem ER tablets (generic for Cardizem LA)* *DYNACIRC CR (isradipine)* *felodipine ER* *nisoldipine* *NYMALIZE (nimodipine)* *TIAZAC (diltiazem) 420 mg* *verapamil ER PM* *verapamil ER 360 mg caps*	▪ Link to Universal PA Form ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

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CEPHALOSPORINS AND RELATED AGENTS (ORAL)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Beta Lactam/Beta-Lactamase Inhibitor Combinations		
amoxicillin/clavulanate IR amoxicillin/clavulanate suspension AUGMENTIN suspension (amoxicillin/clavulanate) 125 mg/5 mL	*amoxicillin/clavulanate XR*	▪ Link to PA Form for Cephalosporins Oral and Related Agents (required for Non-preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
Cephalosporins – First Generation		
cefadroxil capsule, suspension cephalexin	*cefadroxil tablet*	▪ Link to PA Form for Cephalosporins Oral and Related Agents (required for Non-preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
Cephalosporins – Second Generation		
cefprozil cefuroxime	*cefaclor* *cefaclor ER* *CEFTIN SUSPENSION (cefuroxime)*	▪ Link to PA Form for Cephalosporins Oral and Related Agents (required for Non-preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
Cephalosporins – Third Generation		
cefdinir SUPRAX (cefixime) capsule, chew tab, tablet and suspension	*ceftibuten capsule, suspension* *cefixime suspension* *cefditoren* *cefpodoxime*	▪ Link to PA Form for Cephalosporins Oral and Related Agents (required for Non-preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

COLONY STIMULATING FACTORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
GRANIX (tbo-filgrastim) LEUKINE (sargramostim) NEUPOGEN (filgrastim) NEULASTA (pegfilgrastim)	*ZARXIO (filgrastim)*	▪ Link to Universal PA Form ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

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CONTRACEPTIVES, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
All agents are recommended preferred at this time		

COPD AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	Anticholinergics	
ATROVENT HFA (ipratropium) ipratropium nebulizer solution SPIRIVA capsules (tiotropium)	*INCRUSE ELLIPTA (umeclidinium)* *SEEBRI NEOHALER (glycopyrrolate)* *SPIRIVA RESPIMAT (tiotropium)* *TUDORZA PRESSAIR (aclidinium)*	▪ Link to PA Form for COPD Agents ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
	Anticholinergic-Beta Agonist Combinations	
albuterol/ipratropium COMBIVENT RESPIMAT (albuterol/ipratropium)	*ANORO ELLIPTA (umeclidinium /vilanterol)* *BEVESPI AEROSPHERE (glycopyrrolate/formoterol)* *STIOLTO RESPIMAT(tiotropium/olodaterol)* *UTIBRON NEOHALER(glycopyrrolate/indacaterol)*	▪ Link to PA Form for COPD Agents ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
	PDE-4 Inhibitors	
	DALIRESP (roflumilast)[CL]	▪ Link to PA Form for Daliresp ▪ Daliresp will be approved for adults with severe COPD associated with chronic bronchitis and a history of exacerbations

COUGH AND COLD AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
No agents are recommended to be preferred at this time.	*All products are non-preferred*	▪ Link to Universal PA Form ▪ The Idaho Medicaid Pharmacy and Therapeutics Committee has recommended not to approve cough and cold medications due to the absence of evidence establishing clinical efficacy and safety.

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[CL] – Prior Authorization / Class Criteria apply

[NR] – New drug that has not been reviewed by P & T Committee

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CYTOKINE & CAM ANTAGONISTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
COSENTYX (secukinumab) HUMIRA (adalimumab)	*ACTEMRA (tocilizumab)* *ARCALYST (rilonacept)* *CIMZIA (certolizumab)* *ENBREL (etanercept)* *ENTYVIO(vedolizumab)* *ILARIS (canakinumab)* *INFLECTRA (infliximab)* [NR] *KINERET (anakinra)* *ORENCIA (abatacept)* *OTEZLA (apremilast)* *REMICADE (infliximab)* *SIMPONI SQ (golimumab)* *SIMPONI ARIA (golimumab)* *STELARA (ustekinumab)* *TALTZ (ixekizumab)* *XELJANZ (tofacitinib)* *XELJANZ XR (tofacitinib)*	▪ Link to PA Form for Cytokine & CAM Antagonists (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

CYSTIC FIBROSIS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	ORKAMBI (lumacaftor/ivacaftor) [CL] *KALYDECO (ivacaftor)* [CL]	▪ Agents will be approved for cystic fibrosis (CF) patients with documentation of the drug specific FDA approved mutation of the CFTR gene within age and quantity parameters.

EPINEPHRINE, SELF-INJECTED

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
epinephrine (generic ADRENACLICK, EPIPEN, EPIPEN JR) EPIPEN EPIPEN JR	*AUVI-Q (currently unavailable due to recall)*	▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

ERYTHROPOIESIS STIMULATING PROTEINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ARANESP (darbepoetin) PROCRIT (rHuEPO)	*EPOGEN (rHuEPO)* *MIRCERA (PEG-EPO)* [NR]	▪ Link to PA Form for Erythropoiesis Stimulating Proteins ▪ Non-preferred agents will only be authorized if there is documented failure of one preferred agent within the past 180 days.

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[CL] – Prior Authorization / Class Criteria apply

[NR] – New drug that has not been reviewed by P & T Committee

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FLUOROQUINOLONES, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ciprofloxacin tablet CIPRO Suspension (ciprofloxacin) levofloxacin tablets	*ciprofloxacin ER* *ciprofloxacin suspension* *levofloxacin solution* *moxifloxacin* *NOROXIN (norfloxacin)* *ofloxacin*	▪ Link to PA Form for Fluoroquinolones (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

GI MOTILITY, CHRONIC (FORMERLY IRRITABLE BOWEL SYNDROME)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
AMITIZA (lubiprostone) [CL] LINZESS (linaclotide) [CL] MOVANTIK (naloxegol) [CL]	*alosetron* [CL] *LOTRONEX (alosetron)* [CL] *RELISTOR (methylnaltrexone) (oral, syringe, vial)* [CL] *VIBERZI (eluxadoline)* [CL]	▪ Link to PA Form for GI Motility ▪ Linzess will be approved for participants with a diagnosis of constipation or irritable bowel syndrome. ▪ Amitiza 8 mcg capsules will be approved for female participants with irritable bowel syndrome with constipation. ▪ Amitiza 24 mcg capsules will be approved for chronic idiopathic constipation or opioid induced constipation in chronic non-cancer pain. ▪ Lotronex/alosetron will be approved for female participants with severe, diarrhea-predominant irritable bowel syndrome. ▪ Movantik will be approved for participants with chronic constipation that have been on opioids continuously for at least four weeks. ▪ Relistor will be approved for participants with chronic constipation that have been on opioids continuously for at least four weeks and have tried and failed Movantik.

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[CL] – Prior Authorization / Class Criteria apply

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GLUCOCORTICOIDS, INHALED

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Glucocorticoids		
ASMANEX Twisthaler (mometasone) PULMICORT Respules 0.25, 0.5 mg (budesonide) [CL] QVAR (beclomethasone)	*ALVESCO (ciclesonide)* *AEROSPAN (flunisolide)* *ARNUITY ELLIPTA (fluticasone)* *ASMANEX HFA (mometasone)* *budesonide respules 0.25, 0.5 and 1 mg* *FLOVENT (fluticasone)* *PULMICORT FLEXHALER (budesonide)* *PULMICORT Respules 1.0 mg (budesonide)*	▪ Link to PA Form for Inhaled Glucocorticoids (required for Non-Preferred drugs) ▪ Non-preferred agents will only be approved if patient has tried and failed therapy with a preferred agent within the last 6 months. ▪ Pulmicort Respules are only preferred for the treatment of asthma in children 8 years and younger.
Glucocorticoid/Bronchodilator Combinations [CL]		

ADVAIR (fluticasone/salmeterol) [CL]
SYMBICORT (budesonide/formoterol) [CL]
	BREO ELLIPTA (fluticasone/vibanterol) [CL]
	DULERA (mometasone/formoterol) [CL]
		▪ Link to PA Form for Inhaled Glucocorticoid/Bronchodilator Combinations (required for all drugs)
		▪ Asthma:
		  ▪ Advair (fluticasone/salmeterol) and Symbicort (budesonide/formoterol) will be approved for eligible participants with a documented diagnosis of persistent asthma (ICD-10 = J45) who have tried and failed an inhaled glucocorticoid within the last 60 days.
		  ▪ Dulera (mometasone/formoterol) and Breo Ellipta (fluticasone/vibanterol) will be approved for eligible participants with a documented diagnosis of persistent asthma (ICD-10 = J45) who have tried and failed Advair or Symbicort within the last 180 days.
		▪ COPD:
		  ▪ Advair Diskus 250/50 or Symbicort 160/4.5 will be approved for eligible participants with a diagnosis of Stage III or Stage IV COPD (ICD-10 = J44) with repeated exacerbations and a failure of a long acting beta agonist inhaler (Serevent)
		  ▪ Breo Ellipta 100/25 will be approved for eligible participants with a diagnosis of Stage III or Stage IV COPD with related exacerbations, failure of a long acting beta agonist inhaler (Serevent) and trial and failure of Advair Diskus 250/50 or Symbicort 160/4.5

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GROWTH HORMONE[CL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
NORDITROPIN (somatropin) NUTROPIN AQ NUSPIN (somatropin)	*GENOTROPIN (somatropin)* *HUMATROPE (somatropin)* *OMNITROPE (somatropin)* *SAIZEN (somatropin)* *SEROSTIM (somatropin)* *ZOMACTON (somatropin)* *ZORBTIVE (somatropin)*	▪ Link to PA Form for Growth Hormone (required for all drugs) ▪ Growth hormone will be approved for patients with any of the following diagnoses and meeting the criteria defined on the PA Form: ▪ Chronic Renal Impairment awaiting renal transplantation (ICD-10 N18.9) ▪ Growth Hormone Deficiency (ICD-10 E23.0) ▪ Prader-Willi Syndrome (ICD-10 Q87.1) ▪ Turner Syndrome (ICD-10 Q96.0) ▪ HIV plus Cachexia (ICD-10 B20) ▪ Non-preferred agents will only be approved if patient has tried and failed therapy with a preferred agent within the last 6 months.

H. PYLORI TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
PYLERA (bismuth subcitrate potassium, metronidazole, tetracycline)	*lansoprazole, amoxicillin, clarithromycin* *OMECLAMOX-PAK (omeprazole, amoxicillin, clarithromycin)* *PREVPAC (lansoprazole, amoxicillin, clarithromycin)*	▪ Link to PA Form for H. Pylori Treatment ▪ Non-preferred agents will only be approved after documented failure of a preferred agent.

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HEPATITIS C TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Interferon		
PEGASYS (pegylated interferon alfa-2a) PEG-INTRON (pegylated interferon alfa-2b)		▪ Link to PA Form for Hepatitis C - Interferon and Ribavirin (required for Non-preferred drugs) ▪ The non-preferred agent will only be approved if patient has tried and failed therapy with a preferred agent within the last 6 months.
Ribavirin		
ribavirin tablet, capsule	*RIBAPAK (ribavirin)* *RIBASPHERE (ribavirin)* *ribavirin dose pack*	▪ Link to PA Form for Hepatitis C - Interferon and Ribavirin (required for Non-preferred drugs) ▪ The non-preferred agent will only be approved if patient has tried and failed therapy with a preferred agent within the last 6 months.
Direct-Acting Anti-Viral Agents [CL]		
EPCLUSA (sofosbuvir, velpatasvir) [CL] (genotype 2 and 3) HARVONI (ledipasvir, sofosbuvir) [CL] (genotype 1) VIEKIRA PAK (dasabuvir, ombitasvir, paritaprevir, ritonavir) [CL] (genotype 1) VIEKIRA XR (dasabuvir, ombitasvir, paritaprevir, ritonavir) [CL] (genotype 1)	*DAKLINZA (daclatasvir) [CL]* *OLYSIO (simeprevir) [CL]* *SOVALDI (sofosbuvir) [CL]* *TECHNIVIE (ombitasvir, paritaprevir, ritonavir) [CL]* *ZEPATIER (elbasvir/grazoprevir) [CL]*	▪ Link to PA Form for Treatment of Hepatitis C Virus ▪ For complete criteria refer to Hepatitis C Agents Therapeutic Criteria

HEREDITARY ANGIOEDEMA

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CINRYZE (C1- esterase inhibitor) [CL] FIRAZYR (icatibant) [CL] KALBITOR (ecallantide) [CL]	*BERINERT (C1-esterase inhibitor) [CL]* *RUCONEST (recombinant C1 esterase) [CL]*	▪ Link to Universal PA Form ▪ Treatment of Acute Attacks: Preferred agents are Firazyr and Kalbitor. Berinert requires trial and failure of a preferred agent or a contra-indication to a preferred agent. ▪ Prophylaxis: Approved with documentation of 2 or more HAE attacks monthly and trial and failure of oral danazol (which does not require prior authorization).

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[CL] – Prior Authorization / Class Criteria apply

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HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
INCRETIN ENHANCERS		
JANUMET (sitagliptin/metformin) JANUMET XR (sitagliptin/metformin) JANUVIA (sitagliptin) JENTADUETO (linagliptin/metformin) TRADJENTA (linagliptin) [CL]	*alogliptin* [NR] *alogliptin/metformin* [NR] *alogliptin/pioglitazone* [NR] *GLYXAMBI (empagliflozin/linagliptin)* *KAZANO (alogliptin/metformin)* *KOMBIGLYZE XR (saxagliptin/metformin)* *NESINA (alogliptin)* *ONGLYZA (saxagliptin)* *OSENI (alogliptin/pioglitazone)*	▪ Link to PA Form for Hypoglycemics – Incretin Enhancers ▪ Non-preferred agents will only be approved if patient has tried and failed therapy with a preferred agent within the last 6 months.
INCRETIN MIMETICS		
BYDUREON (exenatide ER) [CL] BYETTA (exenatide) [CL] SYMLIN (pramlintide) [CL] TANZEUM (albiglutide) [CL]	*ADLYXIN (lixisenatide)* [NR] *SOLIQUA (Insulin glargine/lixisenatide)* [NR] *TRULICITY (dulaglutide)* [CL] *VICTOZA (liraglutide)* [CL] *XULTOPHY (Insulin degludec/liraglutide)* [NR]	▪ Link to PA Form for Hypoglycemics, Incretin Mimetics (for all products except Symlin) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent. ▪ Link to PA Form for Symlin ▪ Symlin will be approved for patients with diabetes who are currently on insulin therapy. ▪ Symlin will not be approved for pediatric patients <6 years of age or for patients with a diagnosis of gastroparesis or who require the use of medication to stimulate gastric motility.

HYPOGLYCEMICS, INSULIN

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
HUMALOG (insulin lispro) except 200 U/ml HUMALOG MIX (insulin lispro/lispro protamine) HUMULIN (insulin) except 500 U/ml PEN LANTUS (insulin glargine) LEVEMIR (insulin detemir) NOVOLOG (insulin aspart) NOVOLOG MIX (insulin aspart/aspart protamine)	*AFREZZA (insulin, inhaled)* [CL] *APIDRA (insulin glulisine)* *BASAGLAR KWIKPEN (insulin glargine)* [NR] *HUMALOG (insulin lispro) 200 U/ml* *HUMULIN (insulin) 500 U/ml PEN* *NOVOLIN (insulin)* *TOUJEO (insulin glargine)* *TRESIBA FLEXTOUCH (insulin degludec)*	▪ Link to PA Form for Insulin (required for non-preferred drugs) ▪ Apidra will be approved for participants with documented hypoglycemia with Humalog or NovoLog. ▪ Afrezza requires medical necessity documentation for why injectable insulin cannot be used. ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

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[CL] – Prior Authorization / Class Criteria apply

[NR] – New drug that has not been reviewed by P & T Committee

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HYPOGLYCEMICS, METFORMINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
glyburide-metformin metformin metformin ER (GLUCOPHAGE XR)	*FORTAMET (metformin ER)* *glipizide-metformin* *GLUMETZA (metformin ER)* *metformin ER (FORTAMET)* *metformin ER (GLUMETZA)* *RIOMET (metformin) oral solution*	▪ Link to Universal PA Form ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

HYPOGLYCEMICS, SGLT2

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
INVOKANA (canagliflozin) [CL] INVOKAMET (canagliflozin/metformin) [CL]	*FARXIGA (dapagliflozin)* [CL] *GLYXAMBI (empagliflozin/linagliptin)* *INVOKAMET XR (canagliflozin/metformin* [NR] *JARDIANCE (empagliflozin)* [CL] *SYNJARDY (empagliflozin/metformin)* [CL] *XIGDUO XR (dapagliflozin/metformin XR)* [CL]	▪ Link to PA Form for SGLT2 Inhibitors (required for non-preferred drugs) ▪ Sodium Glucose Co-transporter Inhibitors will be approved after a trial of any agent in the following drug classes within the previous 30 days: ▪ Metformins ▪ Incretin mimetic/enhancers ▪ Insulins ▪ Non-preferred agents will be approved after trial and failure of a preferred agent in the Sodium Glucose Co-Transporter Inhibitor Class.

HYPOGLYCEMICS, TZDS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	Thiazolidinediones	
pioglitazone	*AVANDIA (rosiglitazone)*	▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
	Thiazolidinedione Combinations	
	ACTOPLUS MET XR (pioglitazone/metformin) [CL] *AVANDAMET (rosiglitazone/metformin)* [CL] *AVANDARYL (rosiglitazone/glipizide)* [CL] *pioglitazone/glimepiride* [CL] *pioglitazone/metformin* [CL]	▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

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[CL] – Prior Authorization / Class Criteria apply

[NR] – New drug that has not been reviewed by P & T Committee

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IMMUNE GLOBULINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CYTOGAM (cytomegalovirus immune globulin) intravenous solution [CL] FLEBOGAMMA DIF intravenous solution [CL] GAMASTAN S/D intramuscular [CL] GAMMAGARD LIQUID injection solution [CL] GAMMAPLEX intravenous solution [CL] GAMUNEX-C injection solution [CL] HEPAGAM B (hepatitis B immune globulin) intramuscular [CL] HIZENTRA subcutaneous solution [CL] PRIVIGEN intravenous solution [CL] VARIZIG (Varicella-Zoster immune globulin) intramuscular [CL]	*BABYBIG intravenous solution* [NR] *BIVIGAM intravenous solution* [CL] *CARIMUNE NF nano filtered powder for intravenous solution* [CL] *CUVITRU subcutaneous solution* [NR] *GAMMAGARD S/D powder for intravenous solution* [CL] *GAMMAKED injection solution* [CL] *HYQVIA subcutaneous solution* [CL] *OCTAGAM intravenous solution* [CL]	▪ Link to Immune Globulin PA Form ▪ Preferred immune globulin products will be approved for FDA indications or for diagnoses that have evidence-based documentation to support their usage for which there are no therapeutic alternatives. Usual age, dosage, and frequency limitations apply as well as reasonable dosage rounding (+/- 10%) to utilize whole vials to minimize wastage. ▪ Non-preferred agents require either trial and failure of a preferred agent or documentation of medical necessity.

IMMUNOMODULATORS FOR ATOPIC DERMATITIS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ELIDEL (pimecrolimus)	*PROTOPIC (tacrolimus)* *tacrolimus*	▪ Black box warning – Not FDA approved for use in children less than 2 years of age (Elidel 1% and Protopic 0.03%) or <16 years old (Protopic 0.1%). ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

IMMUNOMODULATORS, ASTHMA

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
No agents are recommended to be preferred at this time.	*XOLAIR (omalizumab)* [CL] *CINQUAIR (reslizumab)* [CL] *NUCALA (mepolizumab)* [CL]	▪

IMMUNOSUPPRESSIVES, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
azathioprine cyclosporine capsule cyclosporine softgel cyclosporine, modified mycophenolate mofetil capsules, tablets NEORAL (cyclosporine, modified) tacrolimus	*ASTAGRAF (tacrolimus XL)* *AZASAN (azathioprine)* *ENVARSUS XR (tacrolimus)* *mycophenolate mofetil suspension* *mycophenolic acid* *sirolimus* *ZORTRESS (everolimus)*	▪ Link to PA Form for Immunosuppressives, Oral ▪ Non-preferred agents will be approved for payment only after documented failure of at least one preferred agent within the last 6 months.

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[CL] – Prior Authorization / Class Criteria apply

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INTRANASAL RHINITIS AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	Anticholinergics	
ipratropium		▪ Link to PA Form for Intranasal Rhinitis Agents (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
	Antihistamines	
PATANASE (olopatadine)	*azelastine* *olopatadine*	▪ Link to PA Form for Intranasal Rhinitis Agents (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
	Corticosteroids	
fluticasone	*BECONASE AQ (beclomethasone)* *budesonide* *flunisolide* *mometasone* *OMNARIS (ciclesonide)* *QNASL (beclomethasone)* *TICANASE (fluticasone)* *VERAMYST (fluticasone)* *ZETONNA (ciclesonide)*	▪ Link to PA Form for Intranasal Rhinitis Agents (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
	Antihistamine / Corticosteroid Combinations	
	DYMISTA (azelastine/fluticasone)	▪ Link to PA Form for Intranasal Rhinitis Agents (required for Non-Preferred drugs) ▪ Dymista will be approved only after documented failure of any preferred intranasal rhinitis agent.

LEUKOTRIENE MODIFIERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
montelukast tabs and chew tab	*montelukast granules* *zafirlukast* *ZYFLO CR (zileuton)*	▪ Link to PA Form for Leukotriene Modifiers (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

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Idaho Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Updated January 1, 2016
Highlights indicated change from previous posting.

LIPOTROPICS, OTHER (NON-STATINS)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Apolipoprotein B Synthesis Inhibitors		
	JUXTAPID (lomitapide mesylate) [CL] *KYNAMRO (mipomersen)* [CL]	▪ Link to Universal PA Form ▪ (required for Non-Preferred drugs - except for Zetia - see below)
Bile Acid Sequestrants		
cholestyramine colestipol tablets	*colestipol granules* *WELCHOL (colesevelam)*	▪ Link to PA Form for Non-Statin Lipotropics (required for Non-Preferred drugs - except for Zetia - see below) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
Fibric Acid Derivatives		
fenofibrate 48mg, 145mg (generic for TRICOR) gemfibrozil 600 mg TRILIPIX (fenofibric acid)	*fenofibrate (generic ANTARA , FENOGLIDE, LOFIBRA, LIPOFEN)* *fenofibric acid (generic FIBRICOR and TRILIPIX)* *FENOGLIDE (fenofibrate)* *TRIGLIDE (fenofibrate)*	▪ Link to PA Form for Non-Statin Lipotropics (required for Non-Preferred drugs - except for Zetia - see below) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent
Niacin		
niacin ER	*NIACOR (niacin)*	▪ Link to PA Form for Non-Statin Lipotropics (required for Non-Preferred drugs -except for Zetia - see below) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
Omega-3 Fatty Acids		
	omega-3 fatty ethyl esters (generic for LOVAZA) *VASCEPA (icosapent ethyl)*	▪ Link to PA Form for Non-Statin Lipotropics (required for Non-Preferred drugs - except for Zetia - see below) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
Cholesterol Absorption Inhibitors [CL]		
	ezetimibe [NR] *ZETIA (ezetimibe)*	▪ Link to PA Form for Zetia ▪ Zetia will be approved for patients who have a diagnosis of hypercholesterolemia and have either failed statin monotherapy or have a documented intolerance to statins. ▪ Zetia treatment is only approved as an adjunct to concurrent statin therapy unless there is a documented intolerance to the statins.
PCSK9 Inhibitors		
	PRALUENT (alirocumab) [CL] *REPATHA (evolocumab)* [CL]	▪ Link to Universal PA Form

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LIPOTROPICS, STATINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	STATINS	
atorvastatin lovastatin pravastatin simvastatin (except 80 mg)	*ALTOPREV (lovastatin)* *CRESTOR (rosuvastatin)* *fluvastatin* *fluvastatin ER* *LESCOL XL (fluvastatin)* *LIVALO (pitavastatin)* *rosuvastatin* *simvastatin 80 mg*	▪ Link to PA Form for Statins (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved after documented failure of two preferred agents for a total of ≥150 days in the last six months ▪ Simvastatin 80 mg will only be approved for patients who have been on this dose for more than one year without muscle toxicity.
	Statin Combinations	
	atorvastatin/ amlodipine *LIPTRUZET (atorvastatin/ezetimibe)* *VYTORIN (simvastatin/ezetimibe)*	▪ Link to PA Form for Statins (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved after documented failure of two preferred agents for a total of ≥150 days in the last six months

MACROLIDES (ORAL)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
azithromycin *clarithromycin IR tablets*	*clarithromycin ER* *clarithromycin suspension* *E.E.S. 200 mg suspension (erythromycin ethylsuccinate)* *E.E.S. 400 mg tablets (erythromycin ethylsuccinate)* *ERYPED suspension (erythromycin ethylsuccinate)* *ERY-TAB (erythromycin)* *erythromycin base* *erythromycin stearate* *PCE (erythromycin)* *ZMAX (azithromycin suspension)*	▪ Link to PA Form for Macrolides (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

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MULTIPLE SCLEROSIS DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Injectable Disease Modifying Therapies		
AVONEX (interferon beta-1a) BETASERON (interferon beta-1b) COPAXONE 20 mg syringe (glatiramer) REBIF (interferon beta-1a)	*COPAXONE 40 mg syringe (glatiramer)* *EXTAVIA (interferon beta-1b)* *GLATOPA (glatiramer 20 syringe)* *LEMTRADA (alemtuzamab) IV* *PLEGRIDY (peginterferon beta-1 a) IV* *REBIF REBIDOSE (interferon beta-1a)* *TYSABRI (natalizumab)* *ZINBRYTA (Daclizumab)* [NR]	▪ Non-preferred injectable agents (except Lemtrada) will be approved only after documented failure (e.g. inadequate response, adverse reaction) of a preferred injectable agent. ▪ Copaxone (glatiramer) 40 mg and Glatopa (glatiramer) will be approved after documented inability to use Copaxone 20 mg ▪ Lemtrada (alemtuzumab) will be approved as a clinician administered drug for patients with relapsing forms of multiple sclerosis who have a documented inadequate response to 2 or more previous treatments for MS. Lemtrada is only available through the health care professional who administers the drug. Idaho Medicaid does not pay for this drug to be dispensed through a retail pharmacy. ▪ Tysabri (natalizumab) is a clinician administered infusion drug for treatment of patients with relapsing forms of multiple sclerosis who do not have anti-JCV antibodies. It is also FDA approved for treatment of Crohn's disease. Tysabri is only available through the TOUCH Prescribing Program to prescribers and infusion centers. Idaho Medicaid does not pay for this drug to be dispensed through a retail pharmacy. ▪ All other non-preferred injectable agents will be approved only after documented failure of a preferred agent.
Oral Disease Modifying Therapies		
	AUBAGIO (teriflunomide) [CL] *GILENYA (fingolimod)* [CL] *TECFIDERA (dimethyl fumarate)* [CL]	▪ Aubagio (teriflunomide) will be approved for patients with a relapsing form of multiple sclerosis who have a documented contraindication or history of intolerance to any preferred multiple sclerosis agent. ▪ Tecfidera (dimethyl fumarate) will be approved for patients with a relapsing form of multiple sclerosis who have a documented contraindication or history of intolerance to any preferred multiple sclerosis agent. ▪ Gilenya (fingolimod) will be approved for patients with a relapsing form of multiple sclerosis who have a

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MULTIPLE SCLEROSIS DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
		documented contraindication or history of intolerance to any preferred multiple sclerosis agent and have an EKG within the most recent 3 months that shows no evidence of heart block or bradycardia.
Other		
	AMPYRA (dalfampridine) [CL]	▪ Link to PA form for Ampyra ▪ Ampyra will be approved for patients with multiple sclerosis who are ambulatory, have a creatinine clearance of greater than 50 ml/min and no history of seizure disorder. ▪ Chart note documentation of the medical necessity is required.

NSAIDS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Nonselective		
diclofenac SR flurbiprofen ibuprofen* INDOCIN Suspension (indomethacin) indomethacin IR nabumetone naproxen* naproxen EC sulindac	*diclofenac IR* *diflunisal* *etodolac IR* *etodolac SR* *fenoprofen* *INDOCIN (indomethacin) rectal* *indomethacin ER* *ketoprofen ER* *ketoprofen IR* *ketorolac* *meclofenamate* *mefenamic acid* *NAPRELAN (naproxen CR 750 mg)* *naproxen CR 375 and 500 mg* *naproxen sodium* *oxaprozin* *piroxicam* *SPRIX nasal (ketorolac)* *TIVORBEX (indomethacin)* *tolmetin* *ZIPSOR (diclofenac)* *ZORVOLEX (diclofenac)*	▪ Link to PA Form for NSAIDs (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent. ▪ * Prescription strength only; OTC ibuprofen and OTC naproxen are not covered by Idaho Medicaid.
NSAID/GI Protectant Combinations		
	diclofenac/misoprostol *DUEXIS (ibuprofen/famotidine)* *VIMOVO (naproxen/esomeprazole)*	▪ Please use prescriptions for individual agents.

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NSAIDS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
COX-II Selective		
meloxicam tablets MOBIC Suspension (meloxicam)	*celecoxib* *meloxicam suspension* *VIVLODEX (meloxicam)*	▪ Link to PA Form for NSAIDs ▪ Non-preferred agents will be approved only after documented failure of a preferred agent (non-selective or Cox-II selective NSAID).
NSAIDS, TOPICAL		

VOLTAREN GEL (diclofenac) [CL]	*DERMACINRX LEXITRAL (diclofenac) topical solution* [CL]
	diclofenac gel
	diclofenac solution 1.5% [CL]
	FLECTOR (diclofenac) [CL]
	PENNSAID 2% (diclofenac) [CL]
		▪ Link to PA form for Analgesics, Topical (required for all drugs in class)
		▪ Diclofenac solution 1.5% will be approved for patients meeting the following criteria:
		  ▪ Diagnosis of osteoarthritis of the knee
		  ▪ History of preferred oral NSAID within the past 15 days
		▪ Flector Patch will be approved for one fill of 15 days for patients meeting the following criteria:
		  ▪ Diagnosis of acute pain due to minor strains, sprains, and contusion
		  ▪ History of preferred oral NSAID within the past 15 days
		  ▪ No history of a Flector Patch in the last 90 days
		▪ Pennsaid will be approved for patients meeting the following criteria:
		  ▪ Diagnosis of osteoarthritis of the knee
		  ▪ History of preferred oral NSAID within the past 15 days
		▪ Voltaren Gel will be approved for patients meeting the following criteria:
		  ▪ Diagnosis of osteoarthritis of either the hand or knee
		  ▪ History of preferred oral NSAID within the past 15 days

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Idaho Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Updated January 1, 2016
Highlights indicated change from previous posting.

OPHTHALMIC ANTIBIOTIC-STEROID COMBINATIONS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BLEPHAMIDE suspension (prednisolone/sulfacetamide) neomycin/polymyxin/dexamethasone sulfacetamide/prednisolone TOBRADEX ointment and suspension (tobramycin/dexamethasone)	*BLEPHAMIDE S.O.P. ointment (prednisolone/sulfacetamide)* *neomycin/bacitracin/polymyxin/ hydrocortisone* *neomycin/polymyxin/ hydrocortisone* *PRED-G (gentamicin/prednisolone)* *TOBRADEX ST (tobramycin/dexamethasone)* *tobramycin/dexamethasone* *ZYLET (loteprednol/tobramycin)*	• Link to PA Form for Ophthalmic Antibiotic-Steroid Combinations (required for Non-preferred drugs). • Non-preferred agents will be approved for participants failing to respond to a preferred agent.

OPHTHALMIC ANTIBIOTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
bacitracin/polymyxin CILOXAN Ointment (ciprofloxacin) ciprofloxacin erythromycin gentamicin MOXEZA (moxifloxacin) ofloxacin polymyxin/trimethoprim sulfacetamide solution tobramycin solution TOBREX Ointment (tobramycin) VIGAMOX (moxifloxacin)	*AZASITE (azithromycin)* *bacitracin* *BESIVANCE (besifloxacin)* *CILOXAN Solution (ciprofloxacin)* *gatifloxacin* *levofloxacin* *NATACYN (natamycin)* *neomycin/bacitracin/polymyxin* *neomycin/polymyxin/gramicidin* *sulfacetamide ointment* *ZYMAXID (gatifloxacin)*	▪ Link to PA Form for Ophthalmic Antibiotics (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
cromolyn PATADAY (olopatadine) PAZEO (olopatadine)	*ALOCRIL (nedocromil)* *ALOMIDE (lodoxamide)* *ALREX (loteprednol)* *azelastine* *BEPREVE (bepotastine)* *EMADINE (emedastine)* *epinastine* *LASTACAFT (alcaftadine)* *olopatadine* *PATANOL (olopatadine)*	▪ Link to PA Form for Ophthalmics for Allergic Conjunctivitis (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

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OPHTHALMIC ANTI-INFLAMMATORIES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
dexamethasone diclofenac DUREZOL (difluprednate) fluorometholone flurbiprofen ketorolac 0.5 % ketorolac LS 0.4% LOTEMAX drops (loteprednol) MAXIDEX (dexamethasone) PRED MILD (prednisolone acetate) prednisolone acetate	*ACUVAIL (ketorolac 0.45%)* *bromfenac 0.09%* *BROMSITE (bromfenac)* [NR] *FLAREX (fluorometholone)* *FML FORTE (fluorometholone)* *FML S.O.P. (fluorometholone)* *ILEVRO (nepafenac 0.3%)* *LOTEMAX gel and ointment (loteprednol)* *NEVANAC (nepafenac 0.1%)* *PRED FORTE (prednisolone acetate)* *prednisolone sodium phosphate* *PROLENSA (bromfenac 0.07%)* *VEXOL (rimexolone)*	▪ Link to PA Form for Ophthalmic Anti-Inflammatories (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved for patients failing to respond to a preferred agent.

OPHTHALMICS, ANTI-INFLAMMATORY/IMMUNOMODULATORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
RESTASIS (cyclosporin) [CL]	*XIIDRA (lifitegrast)* [CL]	▪ Link to Universal PA Form

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OPHTHALMICS, GLAUCOMA DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Parasympathomimetics		
PHOSPHOLINE IODIDE (echothiophate) pilocarpine	*PILOPINE-HS (pilocarpine gel)*	▪ Link to PA Form for Ophthalmic Glaucoma Drugs (required for Non-preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
Sympathomimetics		
ALPHAGAN P 0.1% and 0.15% (brimonidine) brimonidine 0.1%	*apraclonidine* *brimonidine P 0.15%*	▪ Link to PA Form for Ophthalmic Glaucoma Drugs (required for Non-preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
Beta Blockers		
BETIMOL (timolol) carteolol ISTALOL (timolol maleate) levobunolol metipranolol timolol	*betaxolol 0.5% solution* *BETOPTIC S (betaxolol 0.25% suspension)*	▪ Link to PA Form for Ophthalmic Glaucoma Drugs (required for Non-preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
Carbonic Anhydrase Inhibitors		
AZOPT (brinzolamide) dorzolamide		▪ Link to PA Form for Ophthalmic Glaucoma Drugs (required for Non-preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
Prostaglandin Analogs		
latanoprost TRAVATAN Z (travoprost)	*bimatoprost* *LUMIGAN (bimatoprost)* *RESCULA (unoprostone)* *travoprost* *ZIOPTAN (tafluprost)*	▪ Link to PA Form for Ophthalmic Glaucoma Drugs (required for Non-preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
Combination Drugs		
COMBIGAN (brimonidine/timolol) dorzolamide/timolol SIMBRINZA (brinzolamide/brimonidine)	*COSOPT PF Droperettes*	▪ Link to PA Form for Ophthalmic Glaucoma Drugs (required for Non-preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

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OPIATE DEPENDENCE TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria

naloxone vial, syringe
naltrexone (oral)
NARCAN (naloxone) nasal
SUBOXONE film (buprenorphine/naloxone)
VIVITROL (naltrexone) injection
	BUNAVAIL(buprenorphine/naloxone) buccal
	buprenorphine
	buprenorphine/naloxone sublingual tablets
	EVZIO (naloxone) injection
	PROBUPHINE (buprenorphine) implant [NR]
	ZUBSOLV (buprenorphine/naloxone tablet)
		▪ Naloxone may be prescribed and dispensed by an authorized pharmacist using the pharmacist's individual NPI (not pharmacy NPI)
		▪ Link to PA Form for Opiate Dependence Treatments
		  ▪ Buprenorphine containing prescriptions must be from an authorized prescriber for treatment of documented opioid dependence or opioid abuse.
		  ▪ Oral buprenorphine/naloxone combination products are preferred except in pregnant women to minimize the possibility of diversion of buprenorphine single entity via the injection route.
		  ▪ Non-preferred agents will be approved after documented failure of preferred agents.
		  ▪ Total daily dose of buprenorphine cannot exceed 24 mg.
		  ▪ Idaho Medicaid participants receiving Suboxone (buprenorphine/naloxone) or buprenorphine will be blocked by Idaho Medicaid for payment of any other opioids.
		  ▪ If an Idaho Medicaid participant currently receiving buprenorphine or buprenorphine/naloxone is identified as paying cash for other opioids, Idaho Medicaid will cease paying for buprenorphine or buprenorphine/naloxone.

OTIC ANTI-INFECTIVES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
acetic acid acetic acid/aluminum	*acetic acid/hydrocortisone*	▪ Link to PA Form for Otic Anti-Infectives (required for Non-Preferred drugs). ▪ Non-preferred agents will be approved only after documented failure of a preferred agent

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OTIC ANTIBIOTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CIPRO HC (ciprofloxacin/hydrocortisone) CIPRODEX (ciprofloxacin/dexamethasone) ciprofloxacin COLY-MYCIN S (colistin/neomycin/ hydrocortisone) CORTISPORIN TC (colistin/neomycin/ hydrocortisone) neomycin/polymyxin/hydrocortisone	*CORTISPORIN SOLUTION (bacitracin/hydrocortisone/neomycin/polymyxin)* *ofloxacin* *OTOVEL (ciprofloxacin/fluocinolone)*	▪ Link to PA Form for Otic Antibiotics (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved for patients failing to respond to a preferred agent.

PANCREATIC ENZYMES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CREON pancrelipase ZENPEP	*PANCREAZE* *PERTZYE* *ULTRESA* *VIOKACE*	▪ Link to PA Form for Pancreatic Enzymes ▪ Non-preferred agents will be approved for patients failing to respond to a preferred agent within the last 6 months

PHOSPHATE BINDERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
calcium acetate capsule (generic for PhosLo) PHOSLYRA (calcium acetate) RENAGEL (sevelamer HCl)	*AURYXIA (ferric citrate)* *calcium acetate tablet (generic for Eliphos)* *FOSRENOL (lanthanum)* *sevelamer carbonate* *VELPHORO (sucroferric oxyhydroxide)*	▪ Link to PA Form for Phosphate Binders (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved for patients failing to respond to a preferred agent.

PLATELET AGGREGATION INHIBITORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BRILINTA (ticagrelor) clopidogrel dipyridamole EFFIENT (prasugrel)	*AGGRENOX (aspirin/ dipyridamole)* *dipyridamole/aspirin* *DURLAZA (aspirin ER)* *ticlopidine* *YOSPRALA (aspirin/esomeprazole)* [NR] *ZONTIVITY (vorapaxar)*	▪ Link to PA Form for Platelet Aggregation Inhibitors (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved for patients failing to respond to a preferred agent.

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[CL] – Prior Authorization / Class Criteria apply

[NR] – New drug that has not been reviewed by P & T Committee

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PROTON PUMP INHIBITORS (ORAL)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
NEXIUM suspension (esomeprazole) omeprazole Rx pantoprazole PROTONIX suspension (pantoprazole)	*ACIPHEX sprinkle (rabeprazole)* *DEXILANT (dexlansoprazole)* *esomeprazole strontium* *lansoprazole* *NEXIUM (esomeprazole) capsule OTC* *omeprazole OTC* *omeprazole/sodium bicarbonate* *omeprazole magnesium OTC* *Prevacid Solutab (lansoprazole)* *Prilosec Suspension (omeprazole)* *rabeprazole*	▪ Link to PA Form for PPIs (required for Non-Preferred drugs) ▪ Prevacid SoluTab will be authorized for patients meeting one of the following criteria: ▪ age <5 years ▪ has a G-tube ▪ has failed or is not a candidate for capsules ▪ Non-preferred agents will only be approved if patient has tried and failed therapy with two preferred agents within the last six months. ▪ Quantity limits of one dose per day apply to this class

PULMONARY ARTERIAL HYPERTENSION AGENTS[CL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Endothelin Receptor Antagonists		
LETAIRIS (ambrisentan) TRACLEER (bosentan)	*OPSUMIT (macitentan)*	• Link to PA Form for Pulmonary Arterial Hypertension Agents (required for Non-Preferred drugs)
Prostacyclin Receptor Agonist		
	UPTRAVI (selexipag)	• Link to PA Form for Pulmonary Arterial Hypertension Agents (required for Non-Preferred drugs)
Prostanoids		
	ORENITRAM ER (treprostinil)) *TYVASO (treprostinil)* *VELETRI (epoprostenol)* [NR] *VENTAVIS (iloprost)*	▪ Link to PA Form for Pulmonary Arterial Hypertension Agents (required for Non-Preferred drugs)
PDE-5 Inhibitors		
sildenafil	*ADCIRCA (tadalafil)* *REVATIO (sildenafil) suspension* [CL]	▪ Adcirca and sildenafil will only be approved for diagnosis of pulmonary artery hypertension (ICD-9 416xx) ▪ Link to PA Form for Pulmonary Arterial Hypertension Agents (required for Non-Preferred drugs)
Soluble Guanylate Cyclase Stimulators		
	ADEMPAS (riociguat)	▪ Link to PA Form for Pulmonary Arterial Hypertension Agents (required for Non-Preferred drugs)

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SEDATIVE HYPNOTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Benzodiazepines		
	DORAL (quazepam) *estazolam* *flurazepam* *temazepam* *triazolam*	▪ Link to PA Form for Sedative Hypnotics (required for Non-Preferred drugs) ▪ Non-preferred agents will only be approved if patient has tried and failed therapy with two preferred agents within the last 6 months.
Others		
ROZEREM (ramelteon) zolpidem IR	*BELSOMRA (suvorexant)* *EDLUAR (zolpidem)* *eszopiclone* *HETLIOZ (tasimelteon)* *INTERMEZZO SL (zolpidem)* *SILENOR (doxepin)* *zaleplon* *zolpidem ER* *zolpidem SL* *ZOLPIMIST (zolpidem)*	▪ Link to PA Form for Sedative Hypnotics (required for Non-Preferred drugs) ▪ Non-preferred agents will only be approved if patient has tried and failed therapy with two preferred agents within the last 6 months.

SKELETAL MUSCLE RELAXANTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria

baclofen
chlorzoxazone
cyclobenzaprine IR 5, 10 mg tablets
dantrolene
methocarbamol
tizanidine tablets
	AMRIX (cyclobenzaprine ER)
	carisoprodol [CL]
	carisoprodol compound [CL]
	cyclobenzaprine ER
	cyclobenzaprine IR 7.5 mg tablets
	LORZONE (chlorzoxazone)
	metaxalone
	orphenadrine
	orphenadrine compound
	tizanidine capsules
		▪ Link to PA Form for Skeletal Muscle Relaxants (required for Non-Preferred drugs)
		▪ The non-preferred agents will be approved for patients with documented failure of at least a one week trial each of two preferred agents.
		▪ For carisoprodol:
		  ▪ Use will be limited to no more than 34 days
		  ▪ Additional authorization will not be granted for at least six months following the last day of the previous course of therapy
		  ▪ Approval will not be granted for patients with a history of meprobamate use in the previous two years
		  ▪ Approval will not be granted for patients concurrently using opioids

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Idaho Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Updated January 1, 2016

Highlights indicated change from previous posting.

STIMULANTS AND RELATED DRUGS[CL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ADDERALL XR [CL] (amphetamine salt combination) amphetamine salt combination IR [CL] FOCALIN (dexmethylphenidate) [CL] FOCALIN XR (dexmethylphenidate) [CL] METADATE CD (methylphenidate) [CL] methylphenidate ER (generic Concerta) [CL] methylphenidate ER (generic Ritalin SR) [CL] methylphenidate IR Tablets QUILLIVANT XR (methylphenidate) solution [CL] VYVANSE (lisdexamfetamine) [CL]	*ADZENYS XR ODT (amphetamine)* [CL] *amphetamine salt combination ER* [CL] *APTENSIO XR (methylphenidate)* [CL] *DAYTRANA (methylphenidate)* [CL] *DYANAVEL XR (amphetamine)* [CL] *dexmethylphenidate* [CL] *dexmethylphenidate XR* [CL] *dextroamphetamine IR, ER* [CL] *dextroamphetamine solution* [CL] *EVEKEO (amphetamine)* [CL] *methylphenidate chewable tablets* [CL] *methylphenidate solution* [CL] *methylphenidate CD (generic Metadate CD)* [CL] *methylphenidate ER (generic Ritalin LA)* [CL] *PROCENTRA (dextroamphetamine sulfate solution)* [CL] *QUILLICHEW ER (methylphenidate)* [CL] *ZENZEDI (dextroamphetamine)* [CL]	▪ Link to PA Form for Stimulants - ADD/ADHD Drugs (required for Non-Preferred drugs) ▪ Stimulants for adults (> or = to 18 years) will be approved for patients with a diagnosis of ADHD (ICD-9 = 314 or ICD-10 F90) in the previous two years without any of the following contraindications: ▪ opiate abuse ▪ drug dependence, including to opioids, cocaine, amphetamine, hallucinogens ▪ hypertension ▪ hyperthyroidism ▪ glaucoma ▪ Amphetamine salt combination products and dextroamphetamine will be approved only for patients ≥3 years of age. ▪ Dexmethylphenidate, methylphenidate, Focalin and Focalin XR will be approved only for patients >6 years of age. ▪ Daytrana will only be approved for patients who are unable to take oral therapy. ▪ Non-preferred agents will be approved for payment only after documented failure of at least one preferred agent.
Non-Stimulants		
clonidine IR guanfacine ER guanfacine IR STRATTERA (atomoxetine) [CL]	*clonidine ER* [CL] *KAPVAY (clonidine ER)* [CL]	▪ Link to PA Form for Non-Stimulant Therapy for ADHD ▪ Guanfacine, clonidine, guanfacine ER will be approved for patients with a diagnosis of ADHD (ICD-9 = 314.xx or ICD-10 = F90) ▪ Kapvay or clonidine ER will be approved for ADHD patients with a documented failure of clonidine immediate release. ▪ Strattera will be approved for patients with a documented diagnosis of ADHD (ICD-9 = 314.xx or ICD-10 = F90)

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STIMULANTS AND RELATED DRUGS[CL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	Narcolepsy-Specific Agents	
	armodafinil [CL] *modafinil* [CL] *NUVIGIL (armodafinil)* [CL]	▪ Link to PA Form for Nuvigil & Provigil ▪ Provigil and Nuvigil will be approved for patient > 16 years of age with documented need in the following diagnoses ▪ Narcolepsy (ICD-9=347) ▪ Obstructive sleep apnea (ICD-9=780.51, 780.53) ▪ Shift work sleep disorder (ICD-9=307.45)

TETRACYCLINES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
doxycycline hyclate IR minocycline capsules tetracycline	*ACTICLATE (doxycycline)* [NR] *ADOXA (doxycycline monohydrate)* *demeclocycline* *DORYX (doxycycline hyclate)* *doxycycline hyclate DR* *doxycycline monohydrate* *minocycline ER* *minocycline tablets* *MORGIDOX (doxycycline)* *ORACEA (doxycycline)* *SOLODYN (minocycline)* *TARGADOX (doxycycline)* [NR] *VIBRAMYCIN Suspension, Syrup (doxycycline)*	▪ Link to PA Form for Oral Antibiotics for Acne ▪ Non-preferred agents will be approved only after documented failure of a preferred agent ▪ An age override is required for patients less than 9 yrs of age

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TOBACCO CESSATION

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
bupropion SR 150 MG CHANTIX (varenicline) [CL] nicotine gum OTC buccal (nicotine polacrilex) nicotine lozenge OTC buccal (nicotine polacrilex) nicotine patch OTC (nicotine)	*NICOTROL inhalation (nicotine)* *NICOTROL NS nasal (nicotine)*	▪ Link to PA Form Tobacco Cessation: Nicotine Replacement or Bupropion SR ▪ Nicotine replacement agents or bupropion SR will be approved for participants over the age of 18 years. Up to two (2) 90 days treatments will be approved over any 12 month period. ▪ Non-preferred agents will be considered if there is failure of an adequate trial of a preferred agent. ▪ Chantix (varenicline) (link to PA for Chantix (varenicline)) will be considered for approval for participants 18 years or older who have been provided with appropriate educational materials and counseling to support quit attempt. Documentation of risk vs benefits must be noted on the prior authorization form and a follow-up appointment scheduled for evaluation for adverse effects.

ULCERATIVE COLITIS DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	Oral	
APRISO (mesalamine) PENTASA (mesalamine) sulfasalazine	*ASACOL HD (mesalamine)* *balsalazide* *DELZICOL (mesalamine)* *DIPENTUM (olsalazine)* *GIAZO (balsalazide)* *LIALDA (mesalamine)* *mesalamine (generic for ASACOL HD)* *UCERIS (budesonide)*	▪ Link to PA Form for Ulcerative Colitis Drugs (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved for patients failing to respond to a preferred agent
	Rectal	
CANASA (mesalamine) mesalamine	*SFROWASA (mesalamine)* *UCERIS (budesonide)*	▪ Link to PA Form for Ulcerative Colitis Drugs (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved for patients failing to respond to a preferred agent

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VASODILATORS, CORONARY

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
isosorbide dinitrate tablets isosorbide mononitrate tablets isosorbide mononitrate SR tablets NITRO-BID (nitroglycerin) ointment nitroglycerin ER oral capsules nitroglycerin transdermal patch NITROLINGUAL spray (nitroglycerin lingual spray) NITROSTAT (nitroglycerin sublingual tablets)	*BIDIL (isosorbide dinitrate/hydralazine)* *GONITRO (nitroglycerin)* [NR] *isosorbide dinitrate sublingual tablets* *isosorbide dinitrate ER tablets, capsules* *isosorbide dinitrate/hydralazine* *NITRO-DUR (nitroglycerin transdermal patch)* *nitroglycerin translingual spray* *NITROMIST (nitroglycerin translingual spray)*	▪ Link to Universal PA Form ▪ Non-preferred agents will be approved for patients failing to respond to a preferred agent. ▪ Individual agents must be used prior to use of isosorbide dinitrate/hydralazine (BiDil).

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