CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
PDL Effective January 1, 2025								
*PLEASE NOTE: For a search box hit Ctrl F								
*** PLEASE NOTE: All cost effective generics applicable to DEL are considered PREFERRED Drugs. "BASIC" Covered Drugs are bolded with the Coverage Indicator of "MC / DEL".**								
General Criteria for all PDL categories- For more information or help using the PDL, providers may call 1-888-445-0497; members should call 1-866-796-2463. To access PDL and PA materials via the internet: www.mainecarepdl.org								
A: Preferred Drugs- Unless otherwise specified, preferred drugs are available without prior authorization. Step order may apply for preferred drugs in some drug categories as indicated on the PDL. (See item "D" below for explanation of step order.)								
B: Requests for Non-preferred Drugs- Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.								
C: Adequate Drug Trials- 1. The minimum trial period for each preferred and step order drug is two weeks, unless otherwise stated within specific PDL drug categories; trials with less than a two week duration will be reviewed on a case-by-case basis; 2. A trial will not be considered valid if preferred or non-preferred products were readily available (by override, individual purchase, samples, etc.); 3. Certain drug trials, such as with controlled substances, may require evidence that the preferred drugs were actually tried (example: with random pill counts and with random urine drug tests, using the methods of GC/MS with no lower threshold); 4. Adequate trials require documentation of attempts to titrate dose of preferred agents toward desired clinical response. 5. Adequate trials include prevention/treatment of common adverse effects associated with preferred agents (example: antinausea, antipruritics, etc.)								
D: Step Order- When numbers appear in the "step order" column, it means drugs in this category must be used in the order specified, with the lower numbers having preference over the higher numbers. Chart notes should be provided to confirm drug trials that do not appear in the member's MaineCare drug profile.								
E. The Department will institute strategies to ensure cost effectiveness through the use of an enhanced Drug Benefit Preferred brand drugs will no longer be preferred in any PDL drug category where preferred generic drugs are also available. It is expected that preferred generics will be used prior to any preferred brands. This will be operated as a form of step care. Preferred brands in these categories will require prior authorization for these high utilization / high cost members.								
F: Brand Name Medication Requests- (Must be submitted on the Brand Name PA request form)- According to MaineCare Benefits Manual Chapter II (80.07-5), when medically necessary covered brand-name drugs have an A-rated generic equivalent available, the most cost effective medically necessary version will be approved and reimbursed, since the brand-name and A-rated generic drugs have been determined by the FDA to be chemically and therapeutically equivalent. The Bureau does not make determinations as to whether or not a generic drug is clinically inferior or inequivalent to its brand version. This is the proper role of the FDA. Physicians should submit their reports of generic inequivalence directly to the FDA via the MEDWATCH.								
G: PA requests for non- FDA Approved Indications- Decisions will be made on a case-by-case basis until the DUR committee is able to review the evidence and make a recommendation. Interim approvals and DUR recommendations for approval of a drug for a non- FDA approved indication will require a minimum of two published, peer reviewed, non contradicted, double- blind, placebo-controlled randomized clinical studies establishing both safety and efficacy.								
H: Dose Consolidation Requirements- Some drugs may also be affected by dose consolidation requirements. Please see Dose Consolidation List and/or Splitting Tables provided in the PDL.								
I. Trials from Multiple Drug Classes - Trial/failure/intolerance to preferred agents from multiple classes within the same category or other catagories of drugs may be required prior to the approval of non-preferred agents (e.g., Cymbalta, Zofran, Elidel and others).								
J. Drug-specific PA Forms- Drug-specific PA forms contain medical necessity documentation requirements and/or criteria that may not be repeated in the PDL. Drug-specific PA forms may be obtained on the web at ***www.mainecarepdl.org*** .								
K. PA Exemptions for Prescribers- According to MaineCare Benefits Manual Chapter II (80.07-4), providers may receive a three (3) month exemption from prior authorization requirement for certain categories of drugs when they demonstrate high compliance with the Department's PDL. The Department will notify providers in writing which drug categories are included and what dates apply to the exemption. If a provider loses his/ her exemption, members who previously were not required to obtain a PA while the prescriber was exempt will be required to do so, and criteria for approval of that medication will need to be met.								
L: Drug-Drug Interactions (DDI)- The DUR Committee has implemented new drug-drug interation edits requiring prior authorization. Several drug-drug combinations and PDL drug catagories are affected by new PA requirements. These will be indicated in the PDL with DDI notation. Please see the DDI document provided in the PDL.								
ASSORTED ANTIBIOTICS								
BETA-LACTAMS / CLAVULANATE COMBO'S	MC/DEL		AMOXICILLIN	MC/DEL		AUGMENTIN[3]	3. Chewable 125mg & 250mg and Solution 125mg/5ml and 250mg/5ml available without PA.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		AMOXICILLIN/POTASSIUM CLA CHEW	MC/DEL		AUGMENTIN XR TB12[4]		
	MC/DEL		AMOXICILLIN/POTASSIUM CLA SUSR					
	MC/DEL		AMOXICILLIN/POTASSIUM CLA TABS					
	MC/DEL		AMPICILLIN				4. Use preferred generic amoxicillin/clavulanate potassium alternatives. Use PA Form# 20420	**DDI:** Ampicillin will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, pantoprazole, Prilosec, or any currently non preferred PPI.
	MC		BICILLIN L-A SUSP					
	MC/DEL		DICLOXACILLIN SODIUM CAPS					
	MC		OXACILLIN SODIUM SOLR					
	MC/DEL		PENICILLIN V POTASSIUM					
	MC		TIMENTIN SOLR					
	MC		UNASYN SOLR					
	MC/DEL		ZOSYN					
CEPHALOSPORINS	MC/DEL		CEFADROXIL HEMIHYDRATE	MC		CEDAX	1. Both brand and generic are clinically non-preferred.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		CEFAZOLIN SODIUM SOLR	MC/DEL		CEFACLOR[1]		
	MC/DEL		CEFDINIR	MC/DEL		CEFADROXIL MONOHYDRATE TABS		
	MC/DEL		CEFEPIME	MC/DEL		**CEFIXIME SUS**	2. Dosing limits apply, please see Dosage Consolidation List.	
	MC/DEL		CEFPODOXIME	MC/DEL		CEPHALEXIN TABS		
	MC/DEL		**CEFPODOXIME PROXETIL SUS**	MC		CEPHALEXIN 750MG CAPS		
	MC/DEL		**CEFPODOXIME PROXETIL TAB**	MC/DEL		CEFTIN	3. Approvals will only be considered for patients 18 years of age or older who have limited or no alternative	**DDI:** Vantin will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, pantoprazole, Prilosec, or any currently non
	MC/DEL		CEFIXIME 400MG[2] CAP	MC		DAXBIA		
	MC/DEL		CEFPROZIL	MC		FETROJA[3]		

	MC/DEL		CEPHALEXIN 250MG & 500MG CAPS	MC/DEL		FORTAZ	treatment options for the treatment of complicated urinary tract infections (cUTIs)	preferred PPI.
	MC		CEFTAZIDIME 6MG	MC/DEL		FORTAZ SOLN		
	MC/DEL		CEFTIN SUSP	MC		KEFLEX CAPS		As outlined in the US CDC Guidance on the Use of Expedited Partner Therapy (EPT) in the Treatment of Gonorrhea, MaineCare will cover a single 800 mg dose of cefixime for the treatment of gonorrhea as part of EPT.
	MC/DEL		CEFTRIAXONE	MC		OMNICEF		
	MC/DEL		CEFUROXIME AXETIL TABS	MC/DEL		ROCEPHIN		
	MC/DEL		CEPHALEXIN MONOHYDRATE	MC/DEL		SUPRAX[2]		
	MC		FORTAZ SOLR	MC		TAZICEF SOLR		
	MC/DEL		SUPRAX CHEWABLE	MC/DEL		TEFLARO		
	MC		TAZICEF 6GM				Use PA Form# 20420	
MACROLIDES / ERYTHROMYCIN'S	MC/DEL		AZITHROMYCIN TABS	MC/DEL		AZITHROMYCIN POW	1. 7- Day supply per month without PA.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		AZITHROMYCIN SUSP	MC/DEL		CLARITHROMYCIN SUSP		
	MC		E.E.S.	MC/DEL		CLARITHROMYCIN TABS		**DDI:** Preferred erythromycin will now be non-preferred and require prior authorization if it is currently being used in combination with either Carbamazepine, Enablex 15mg or Vesicare 10mg. Any non preferred formulation of erythromycin will require prior authorization and the member's drug profile will also be monitored for concurrent use with either Carbamazepine, Enablex 15mg or Vesicare 10mg.
	MC		ERYPED 200 SUSR	MC		DIFICID		
	MC		ERYPED 400 SUSR	MC		PCE TBEC		
	MC		ERY-TAB TBEC	MC/DEL		ZITHROMAX TABS		
	MC		ERYTHROCIN STEARATE TABS	MC/DEL		ZITHROMAX 1GM PAK	Use PA Form# 20420	
	MC/DEL		ERYTHROMYCIN	MC/DEL		ZITHROMAX TRI-PAK		**DDI:** Preferred clarithromycin formulations (clarithromycin tablets) will now be non-preferred and require prior authorization if they are currently being used in combination with either Carbamazepine, Onglyza 5mg, Enablex 15mg or Vesicare 10mg. Any non preferred formulation of clarithromycin will require prior authorization and the member's drug profile will also be monitored for concurrent use with either Carbamazepine, Onglyza 5mg, Enablex 15mg or Vesicare 10mg.
				MC/DEL		ZITHROMAX SUSP		
				MC/DEL		ZMAX		
				MC/DEL		ZINPLAVA		Zinplava® will be non-preferred and require clinical prior authorization to verify it is prescribed or consulted by GI or ID specialist, diagnosis, and concurrent use of an antibacterial agent as well as limiting its use to those who have recurrent C. diff disease that has recurred despite use of guideline recommended vancomycin taper or for whom this would be contraindicated.
TETRACYCLINES	MC/DEL		DOXYCYCLINE MONOHYDRATE 100mg & 50mg CAPS	MC		DECLOMYCIN TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		MINOCYCLINE HCL CAPS	MC/DEL		DORYX CPEP		
	MC/DEL		TETRACYCLINE HCL CAPS	MC/DEL		DOXYCYCLINE HYCLATE	1. For the treatment of patients ≥ 8 years of age.	
				MC/DEL		DOXYCYCLINE MONOHYDRATE 150mg & 75mg CAPS		
				MC/DEL		DYNACIN CAPS	2. For the treatment of patients ≥ 9 years of age.	
				MC/DEL		MINOLIRA ER		
				MC/DEL		NUZYRA[1]		
				MC		ORACEA		
				MC/DEL		PERIOSTAT		
				MC		SEYSARA[2]		
				MC/DEL		SOLODYN ER		
				MC		XIMINO		
FLUOROQUINOLONES	MC/DEL		CIPROFLOXACIN	MC		AVELOX SOLN		Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		LEVOFLOXACIN	MC		AVELOX ABC PACK TABS	Use PA Form# 20420	
	MC/DEL		OFLOXACIN	MC		BAXDELA	1. Dosing limits apply, see Dosage Consolidation List.	**DDI:** Preferred ofloxacin will now be non-preferred and require prior authorization if they are currently being used in combination with amiodarone.
				MC		CIPRO		**DDI:** Preferred levofloxacin will now be non-preferred and require prior authorization if they are currently being used in combination with amiodarone.
				MC		FACTIVE		**DDI:** Preferred Avelox will now be non-preferred and require prior authorization if they are currently being used in combination with amiodarone.
				MC		LEVAQUIN TABS SOLN/INJ		**DDI:** All preferred fluoroquinolones will require clinical PA for patients over 60 that are currently on immunosuppressants or steroid therapy.
				MC		LEVAQUIN TABS[1]		
				MC		NOROXIN TABS		**DDI:** Factive is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for concurrent use with amiodarone.
				MC		PROQUIN XR		
AMINO GLYCOSIDES	MC		GENTAMICIN	MC/DEL		ARIKAYCE[1,2]	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		KITABIS PAK	MC		BETHKIS[1]	1. Clinial PA to verify appropriate diag	
	MC/DEL		NEOMYCIN SULFATE TABS	MC/DEL		TOBI PODHALER[1]	2. See criteria section	TOBI Podhaler is limited to patients with significant impairment from using nebulized version of medication
	MC/DEL		**TOBRAMYCIN AMPUL-NEB**	MC		TOBI NEBU[2]		
				MC/DEL		TOBRAMYCIN SULFATE SOLN[2]		Current users of Tobi Nebu and Tobramycin Soln will be allowed a grace period until 10/1/15 to transition to preferred Kitabis.
				MC/DEL		ZEMDRI[2]		

								Arikayce will require clinical PA to confirm MAC lung disease and for use in adults who have limited or no alternative treatment options. Zemdri will be reserved for patients with limited or no alternative treatment of care.
ANTI-MYCOBACTERIALS / ANTI-TUBERCULOSIS	MC/DEL MC/DEL MC/DEL MC/DEL		ETHAMBUTOL HCL TABS MYAMBUTOL TABS **RIFABUTIN CAPS** RIFAMPIN	MC/DEL MC/DEL MC		MYCOBUTIN CAPS **PRETOMANID** RIFADIN CAPS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Pretomanid is indicated as part of a combination regimen with bedaquiline and linezolid for the treatment of adults with pulmonary extensively drug resistant (XDR) or treatment-intolerant or non-responsive multidrug-resistant (MDR) tuberculosis (TB). Approval of this indication is based in limited clinical safety and efficacy data. This drug is indicated for use in a limited and specific population of patients. **DDI:** Preferred rifampin will be non-preferred and require prior authorization if it is currently being used in combination with either Pradaxa or Latuda.
ANTIMALARIAL AGENTS	MC/DEL MC MC/DEL MC/DEL		**DARAPRIM TABS** **KRINTAFEL**[2] **MEFLOQUINE HCL TABS** **QUININE SULFATE**	MC MC/DEL MC/DEL MC MC MC/DEL		ARALEN TABS **CHLOROQUINE PHOSPHATE TABS**[3] **HYDROXYCHLOROQUINE TABS**[3] ISONARIF[1] MALARONE TABS **PLAQUENIL TABS**	Use PA Form# 20420 1. Ingredients available as preferred without PA. 2. Krintafel is preferred for ≥ 16 years of age. 3. Established users will be grandfathered	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Avoid coadministration of Krintafel® with Organic Cation Transporter 2 (OCT2) and Multidrug and Toxin Extrusion (MATE) substrates (e.g. dofetilide, metformin).
ANTHELMINTICS	MC/DEL MC/DEL MC/DEL		**ALBENDAZOLE** **PRAZIQUANTEL TAB** STROMECTOL TABS	MC MC MC/DEL		ALBENZA TABS EMVERM BILTRICIDE TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIBIOTICS - MISC.	MC MC MC MC/DEL MC MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC		AZACTAM SOLR COLY-MYCIN-M SOLR COLISTIMETHATE SODIUM SOLR FIRVANQ[4] FUROXONE TABS METRONIDAZOLE[1] PENTAMIDINE ISETHIONATE SOLR SOLOSEC TRIMETHOPRIM TABS VANCOMYCIN 5GM INJ. VANCOMYCIN CAPS XIFAXAN 200mg	MC MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC MC MC/DEL MC/DEL MC MC		AEMCOLO COLISTIMETHATE SODIUM SOLR CAYSTON[3] FLAGYL CAPS FLAGYL TABS FLAGYL ER TBCR KETEK LIKMEZ METRONIDAZOLE 375MG CAPS[1] METRONIDAZOLE 750MG TABS[1] NEBUPENT SOLR REBYOTA[5] TINDAMAX VANCOMYCIN 10GM INJ.[2] XENLETA XIFAXAN VOWST[5]	1. 375mg caps and 750mg tabs are non-preferred. Please use available preferred strengths(250mg & 500mg tabs) to obtain required dose without PA. 2. Please use multiple 5gm which are preferred to obtain dose without PA. 3. Clinical PA is required to establish CF diagnosis and medical necessity. Prior trail and failure of preferred Tobi before approval will be granted. 4. Quantity limit of one per 150ml bottle. 5. For the treatment of patients 18 years of age and older. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. 1. For macrolide resistant infections when quinolones inappropriate **DDI:** Ketek is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for concurrent use with either Enablex 15mg or Vesicare 10mg or carbamazepine. Cayston is only indicated to improve respiratory symptoms in CF patients with Pseudomonas aeruginosa. Dosing limits, as should be given TID X28 days (followed by 28 days OFF Cayston therapy). A bronshodilator should be used before administration of Cayston. Xenleta will be considered for the treatment of adults with community-acquired bacterial pneumonia (CABP) caused by the following susceptible microorganisms: Streptococcus pneumoniae, Staphylococcus aureus (methicillin-susceptible isolates), Hemophilus influenzae, Legionella pneumophila, Mycoplasma pneumoniae, and Chlamydophila pneumoniae. Vowst: To prevent the recurrence of Clostridioides difficile infection (CDI) in individuals 18 years of age and older following antibacterial treatment for recurrent CDI (rCDI). Likmez: patient has a medical necessity for a non-solid oral dosage form. Rebyota: For the prevention of recurrence of Clostridioides difficile infection (CDI) in individuals 18 years of age and older following antibiotic treatment for recurrent CDI. The limitation of use is that Rebyota® is not indicated for treatment of CDI.
CARBAPENEMS				MC MC MC/DEL MC/DEL		INVANZ SOLR MERREM SOLR PRIMAXIN RECARBRIO	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

LINCOSAMIDES / OXAZOLIDINONES / LEPROSTATICS	MC/DEL		CLEOCIN SOLN	MC/DEL	8	CLEOCIN CAPS	1. Use multiple 150's for Clindamycin instead of 300's. 2. Quantity limit of 14 days supply within a 60day period. Use PA Form# 30820 for Zyvox & Vibativ Use PA Form# 20420 for all others	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. For Zyvox or Vibativ, please see the criteria listed in the Antibacterial Antibiotics PA form.
	MC/DEL		CLEOCIN SUSR	MC/DEL	8	CLINDAMYCIN HCL 300CAPS[1]		
	MC/DEL		CLINDAMYCIN HCL 150CAPS	MC	8	SIVEXTRO		
	MC		DAPSONE TABS	MC/DEL	8	VIBATIV		
	MC/DEL		**LINEZOLID 600mg TABS[2]**	MC/DEL	9	ZYVOX SUSR		
				MC/DEL	9	ZYVOX TABS		
ANTI INFECTIVE COMBO'S - MISC.	MC/DEL		ERYTHROMYCIN/SULF SUSR	MC		BACTRIM DS TABS	Use PA Form# 20420 1. For the treatment of patients ≥ 18 years of age.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		SEPTRA/DS TABS	MC		VABOMERE[1]		
	MC/DEL		SULFAMETHOXAZOLE/TRIMETH					
	MC/DEL		TRIMETHOPRIM/SULFAMETHOXA					
ANTIPROTOZOALS	MC/DEL		**BENZNIDAZOLE[2]**	MC		ALINIA[1]	1. Alina is preferred for children less than 12 years of age. 2. Clinical PA required for appropriate diagnosis. Use PA Form# 20420	Benznidazole is indicated for pediatric patients 2 to 12 years of age for the treatment of Chagas disease (American trypanosomiasis) caused by Trypanosoma cruzi.
	MC/DEL		LAMPIT[2]					
ANTI - FUNGALS								
ANTIFUNGALS - ASSORTED	MC		ANCOBON CAPS	MC/DEL	6	LAMISIL TABS[4]	See quantity limit table. Non-preferred products must be used in specified step order. Continue to use Anti-Fungal PA form for non-preferred products. 1. QL--1/every 7-day period (150mg only). 2. Sporanox QL 300cc/month with PA. See quantity limit table. 3. Sporanox QL 30/month with PA. 4. Quantity limit of one tablet daily. Please see dosage consolidation list. 5. Approved if immuno suppressed/ HIV or if the member has failed a 7 day trial of a preferred antifungal therapy. 6. Eraxis will be approved if submitting with documentation that it was initiated during a hospitalization and this request is to finish the hospital course. 7. Quantity limits allowing 30 day supply without PA. PA will be required if using > 30	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. The other criteria are listed on the Antifungal PA form including the required proof of a non-cosmetic fungal infection. **DDI:** Any Griseofulvin will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, pantoprazole, Prilosec, or any currently non preferred PPI. **DDI:** Sporanox is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for current use with Enablex 15mg, Vesicare 10mg, Prandin, Prevacid, pantoprazole, Prilosec, or any currently non preferred PPI, due to a significant drug-drug interaction. **DDI:** Vfend is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for concurrent use with Warfarin. **DDI:** Fluconazole (except 150mg strength) will now be non-preferred and require prior authorization if it is currently being used with glimepiride (Amaryl), Enablex 15mg, or Vesicare 10mg. Diflucan is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for concurrent use with either glimepiride (Amaryl), Enablex [illegible] **DDI:** Fluconazole will require prior authorization if being used in combination with Plavix or Warfarin. **DDI:** Ketoconazole will now be non-preferred and require prior authorization if they are currently being used in combination with any of the following medications: Prevacid, Pantoprazole, Plavix, Onglyza, Enablex 15mg, Vesicare 10mg, Latuda, Cometriq, Tafinlar or Omeprazole. Rezzayo: In patients 18 years of age or older who have limited or no alternative options for the treatment of candidemia and invasive candidiasis.
	MC/DEL		FLUCONAZOLE[1]	MC/DEL	6	ITRACONAZOLE		
	MC/DEL		KETOCONAZOLE TABS[7]	MC	8	BREXAFEMME		
	MC/DEL		NYSTATIN	MC/DEL	8	CRESEMBA[9]		
	MC/DEL		TERBINAFINE TABS[4]	MC/DEL	8	GRIFULVIN V TABS		
	MC/DEL		**VORICONAZOLE TABS**	MC	8	GRISEOFULVIN SUSP		
				MC	8	GRISEOFULVIN ULTRAMICROSI TABS		
				MC	8	GRIS-PEG TABS		
				MC	8	REZZAYO[9]		
				MC/DEL	8	SPORANOX SOLN[2]		
				MC/DEL	8	SPORANOX PULSEPAK CAPS[3]		
				MC/DEL	8	SPORANOX CAPS[3]		
				MC/DEL	8	DIFLUCAN		
				MC/DEL	8	ERAXIS INJ[6]		
				MC	8	GRIFULVIN SUSP		
				MC/DEL	8	ONMEL		
				MC/DEL	8	NOXAFIL[5]		
				MC/DEL	8	TOLSURA		
				MC/DEL	8	VFEND TABS		
				MC	8	VIVJOA		

							days. 8. For children < 18, quantity limits allows 8 weeks supply without PA. PA will be required if using > than 8 weeks. If 18 and older PA will be required for any quantity. Not approving for Onychomycosis indication. 9. For patients ≥ 18years of age Use PA Form# 10120	
ANTI - VIRALS								
ANTIRETROVIRALS	MC/DEL		**ABACAVIR TABS**	MC/DEL	8	**ABACAVIR SOL**		
	MC		APRETUDE	MC/DEL	8	APTIVUS	Use PA Form# 20420	
	MC/DEL		**ATAZANAVIR**	MC	8	ATRIPLA[1]	1. Quantity limit of one per day	Fuzeon: Prescriber is either an HIV specialist provider or has consulted with one. Documentation of genotype testing issupplied and shows that there is no other potent, appropriate two or three drug oral regimen available, AND patient has a positive HIV viral load within past 6 months while on his/her current antiretroviral regimen AND the drug will be prescribed with at least two other drugs that are likely to be active based on the genotype testing.
	MC		BIKTARVY	MC/DEL	8	CIMDUO		
	MC		CABENUVA	MC/DEL	8	COMBIVIR TABS	2. Only preferred if Norvir script is in member's profile within the past 30 days of filling Prezista	
	MC		COMPLERA[1]	MC/DEL	8	EDURANT		**DDI:** Reyataz requires prior authorization if it is currently being used in combination with either Prevacid, pantoprazole, Prilosec, or any currently non preferred PPI .
	MC/DEL		DELSTRIGO	MC/DEL	8	EPZICOM[1]		
	MC		DESCOVY[1]	MC/DEL	8	FUZEON		
	MC		DIDANOSINE	MC/DEL	8	INTELENCE	3.Isentress Chewable will only be approved if between the age of 2-12 years old	**DDI:** Norvir requires prior authorization if it is currently being used in combination with either Enablex 15mg or Vesicare 10mg.
	MC/DEL		DOVATO	MC/DEL	8	ISENTRESS[3]		
	MC		EFAVIRENZ TAB	MC/DEL	8	ISENTRESS HD		
	MC/DEL		**EFAVIRENZ CAP**	MC	8	JULUCA	4. Clinical PA required.	**DDI:** Preferred Crixivan caps requires prior authorization if it is currently being used in combination with either Enablex 15mg or Vesicare 10mg.
	MC		EFAVIRENZ-EMTRICITABINE-TENOFOVIR DF TAB	MC	8	KALETRA	5. Only preferred for post-exposure prophylaxis.	
	MC		EMTRICITABINE-TENOFOVIR	MC/DEL	8	**LAMIVUDINE SOLN**		DDI: The concomitant use of the following drugs with **Descovy®** is not recommended: tipranavir/ritonavir, St. John's wort, and the antimycobacterials rifabutin, rifampin, or rifapentine.
	MC		EMTRIVA[1]	MC/DEL	8	LEXIVA		
	MC		EPIVIR SOL	MC/DEL	8	NEVIRAPINE		
	MC/DEL		EVOTAZ[1]	MC	8	NORVIR		DDI: Administration with the following drugs: the anticonvulsants carbamazepine, oxcarbazepine, phenobarbital, and phenytoin; the antimycobacterials rifampin and rifapentine; proton pump inhibitors such as dexlansoprazole, esomeprazole, lansoprazole, omeprazole, pantoprazole, rabeprazole; systemic dexamethasone (more than a single dose); and St. John's wort with **Odefsey** is contraindicated.
	MC		GENVOYA[1,4]	MC/DEL	8	PIFELTRO		
	MC/DEL		ISENTRESS 400MG[5]	MC	8	RETROVIR		
	MC/DEL		ISENTRESS CHEW[3]	MC	8	REYATAZ		Stribild: PA required; must provider rationale as to why the member's medical need cannot be met with preferred agents, particularly Genvoya or combinations of preferred and agents AND must be antiretroviral treatment-naïve or virologically controlled on current therapy (HIV-1RNA < copies/ml) AND be HBV negative AND not be combined with other anti-retroviral agents.
	MC/DEL		ISENTRESS POWDER	MC/DEL	8	SELZENTRY		
	MC/DEL		**LAMIVUDINE TABS**	MC	8	STAVUDINE		
	MC/DEL		**LAMIVUDINE/ZIDOVUDINE**	MC	8	STRIBILD[1]		
	MC/DEL		**LOPINAVIR-RITONAVIR SOL**	MC/DEL	8	SYMFI[4]		DDI: Tivicay will require prior authorization is used with nevirapine, oxcarbazepine, phenytion, phenobarbital, carbamazepine, and St. John's wort.
	MC		LOPINAVIR-RITONAVIR TAB	MC/DEL	8	SYMFI LO[4]		
	MC		ODEFSEY[1]	MC/DEL	8	SYMTUZA		
	MC/DEL		PREZCOBIX	MC/DEL	8	TRIZIVIR TABS		
	MC		PREZISTA[2]	MC	8	TRUVADA[1]		
	MC/DEL		**RITONAVIR TAB 100MG**	MC/DEL	8	VIRACEPT TABS		DDI:Aatazanavir or darunavir and the following drugs are contraindicated (due to potential for serious and/or life-threatening events or loss of therapeutic effect): alfuzosin, dronedarone, rifampin, irinotecan, dihydroergotamine, ergotamine, methylergonovine, cisapride, St. John's wort, lovastatin, simvastatin, pimozide, nevirapine, sildenafil (when given as Revatio® for treatment of PAH), indinavir, triazolam, or PO midazolam will be non-preferred and require prior authorization if it is currently being used in combination with Tybost.
	MC		RUKOBIA[4]	MC	8	VITEKTA		
	MC		SUNLENCA	MC	8	ZERIT		
	MC		SUSTIVA[1]	MC	8	VIDEX EC		
	MC		TIVICAY	MC	8	VIREAD TABS[1]		DDI: Combined P-gp, UGT1A1 and strong CYP3A inhibitors may significantly increase plasma concentrations of Sunlenca®. Concomitant administration of Sunlenca® with these inhibitors is not recommended.
	MC		TIVICAY PD	MC/DEL	8	ZIAGEN TABS		
	MC		TRIUMEQ[1]	MC/DEL	8	ZIAGEN SOL		
	MC		TROGARZO[4]	MC/DEL	9	VIRAMUNE XR		Sunlenca: In combination with other antiretroviral(s) for the treatment of HIV-1 infection in heavily treatment-experienced adults with multidrug resistant HIV-1 infection failing their current antiretroviral regimen due to resistance, intolerance, or safety considerations.
	MC		TYBOST					
	MC		VIREAD POW					
	MC/DEL		**ZIDOVUDINE**					
CYTO-MEGALOVIRUS AGENTS	MC		CIDOFOVIR	MC		VALCYTE TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered

	MC		FOSCARNET SODIUM	MC/DEL		FOSCAVIR		on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		GANCICLOVIR	MC/DEL		LIVTENCITY[1]		
	MC/DEL		VALGANCICLOVIR	MC/DEL		PREVYMIS	1. Must show failure or contraindication to all the following ganciclovir, valganciclovir, cidofovir and foscarnet before Livtencity will be approved.	Prevymis: Documentation that member is high-risk for CMV reactivation as defined by transplant guidelines or that there has been significant myelosuppression by one of the preferred agents. DDI: Livtencity is a substrate of CYP3A4. Coadministration of Livtencity® with strong inducers of CYP3A4 is not recommended, except for selected anticonvulsants.
HERPES AGENTS	MC/DEL		ACYCLOVIR	MC/DEL	8	FAMCICLOVIR[1]	1. Must fail Acyclovir and Valacyclovir before non-preferred products in step order. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		VALACYCLOVIR HCL	MC	8	SITAVIG		
				MC/DEL	8	ZOVIRAX[1]		
				MC	8	VALTREX TABS[1]		
				MC/DEL	9	FAMVIR TABS[1]		
INFLUENZA AGENTS	MC		AMANTADINE CAPS	MC		AMANTADINE TABS	1. Tamiflu and Oseltamivir 10 caps or 60cc's per month. Will be audited for presence of positive influenza tests in patient or family member. Use PA Form# 20420 for all others	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		RELENZA DISKHALER AEPB	MC		FLUMADINE TABS		
	MC/DEL		**OSELTAMIVIR[1]**	MC		FLUMIST		
				MC/DEL		RIMANTADINE HCL TABS		
				MC/DEL		TAMIFLU[1]		
				MC/DEL		TAMIFLU SUS		
				MC/DEL		XOFLUZA		
IMMUNE SERUMS								
IMMUNE SERUMS	MC		HYPERRHO INJ					
HEPATITIS AGENTS								
HEPATITIS C AGENTS			SOFOSBUVIR/VELPATASVIR[2] (Authorized generic labeler 72626 Asegua Therapeutics)	MC/DEL		COPEGUS TABS	1. Dosing limits apply, please see dosage consolidation list. 2. Approvals will require clinical PA. Please see the Hepatitis PA form for criteria Use PA Form #10700	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Olysio will require a prior authorization if it is currently being used in combination with drugs known to be significant CYP3A4 inhibitors (ketoconazole, itraconazole, clarithromycin, indinavir, nefazodone, nelfinavir, ritonavir, atazanavir, saquinavir and telithromycin).
	MC		MAVYRET[2]	MC/DEL		DAKLINZA		
	MC/DEL		PEGASYS KIT[1]	MC		EPCLUSA[2]		
	MC/DEL		PEGASYS SOLN	MC		HARVONI[2]		
	MC/DEL		PEG-INTRON KIT[1]	MC/DEL		REBETOL CAPS		
	MC		RIBAVIRIN	MC		RIBAPAK		
	MC/DEL		**RIBASPHERE**	MC		SOVALDI[2]		
				MC		VIEKIRA PAK[2]		
				MC		VIEKIRA XR[2]		
				MC		VOSEVI		
				MC/DEL		ZEPATIER[2]		
HEPATITIS AGENTS - MISC.				MC		ACTIMMUNE	Use PA Form# 20420	Approved for chronic granulomatous disease, osteopetrosis and idiopathic pulmonary fibrosis.
HEPATITIS B ONLY	MC/DEL		**ENTECAVIR**	MC		BARACLUDE	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Baraclude is indicated for treatment of chronic Hep B virus (HBV) in adults with: evidence of active viral replication AND either evidence of persistent elevation in serum aminotransferases (ALT or AST) or histologically active disease, Patient is 16 years of age or older. Boxed warning: Use not recommended for those co-infected with HIV and HBV who are not also receiving highly active antiretroviral therapy (HAART). Vemlidy® remain non-preferred and require prior authorization and be available to those who have evidence of bone loss or renal insufficiency or who are unable to tolerate or who have failed on preferred medications.
	MC		TENOFOVIR	MC		HEPSERA TABS		
				MC		TYZEKA		
				MC		VEMLIDY		
RSV PROPHYLAXIS								
RSV PROPHYLAXIS				MC		SYNAGIS[1]	Use PA Form# 30120 1. MaineCare will approve Synagis PA's for start date of	Please see the criteria listed on the Synagis PA form.

							November 29, 2021 for infants who meet the guidelines. PA will be approved for max of 5 doses. Maximum 1 dose/30 days. MaineCare will start accepting PAs November 1, 2021."	
MS TREATMENTS								
MULTIPLE SCLEROSIS - INTERFERONS	MC MC/DEL MC		AVONEX KIT[1] **BETASERON SOLR**[1] REBIF SOLN[1]	MC MC/DEL		PLEGRIDY[1] EXTAVIA	1.Clinical PA is required to establish diagnosis and medical necessity. Use PA Form# 20430	Non-Preferred drugs must be tried in step-order and failed due to lack of efficacy or intolerable side effects before lower ranked non-preferred drugs will be approved , unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
MULTIPLE SCLEROSIS - NON-INTERFERONS	MC MC/DEL MC/DEL MC/DEL MC MC MC		COPAXONE **DALFAMPRIDINE ER** **DIMETHYL FUMARATE CAP** **FINGOLIMOD CAP**[2] KESIMPTA[2,5] TERIFLUNOMIDE TAB[2] TYSABRI[1,2]	MC MC MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC MC MC MC MC	8 8 8 8 8 8 8 8 8 8 8 8 8	AMPYRA AUBAGIO BAFIERTAM BRIUMVI GILENYA **GLATOPA** **MAVENCLAD**[3] **MAYZENT** OCREVUS[2] **PONVORY**[2] TASCENSO ODT[2,4] TECFIDERA VUMERITY ZEPOSIA	1. Providers must be enrolled in the TOUCH Prescribing program, a restricted distribution program. Clinical PA is required to establish diagnosis and medical necessity. 2. Clinical PA is required to establish diagnosis and medical necessity. 3. Due to safety profile, use of Mavenclad® is generally recommended for patients who have had an inadequate response to, or are unable to tolerate, an alternate drug indicated for the treatment of MS 4. For the treatment of patients 10 years of age and older. 5. Approved after single step through preferred drugs. Use PA Form# 20430	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Mavenclad** will require multiple trials of preferred agents including Mayzent for secondary progressive disease. **DDI:** Due to significant increases in exposure to siponimod, concomitant use of Mayzent® and drugs that cause moderate CYP2C9 and moderate or strong CYP3A4 inhibition is not recommended. Ponvory: Before initiation of Ponvory® treatment, assess the following: •Complete Blood Count (CBC)- Obtain a recent (i.e. within the last 6 months) CBC, including lymphocyte count. •Cardiac Evaluation- oObtain an electrocardiogram (ECG) to determine whether pre-existing conduction abnormalities are present. In patients with certain pre-existing conditions, advice from a cardiologist should be sought and first-dose monitoring is recommended. oDetermine whether patients are taking drugs that could slow heart rate of atrioventricular (AV) conduction. •Liver Function Tests- Obtain recent (i.e. within the last 6 months) transaminase and bilirubin levels. •Ophthalmic Evaluation- Obtain an evaluation of the fundus, including the macula. •Current or prior medications with immune system effects- If patients are taking anti-neoplastic, immunosuppressive, or immune-modulating therapies, or if there is a history of prior use of these drugs, consider possible unintended additive immunosuppressive effects before starting treatment with Ponvory®.•Vaccinations- Test for antibodies to varicella zoster virus (VZV) before starting Ponvory®; VZV vaccination of antibody-negative patients is recommended prior to commencing treatment with Ponvory®. If live attenuated vaccine immunizations are required, administer at least 1 month prior to initiation of Ponvory®. •Vaccinations- Test for antibodies to varicella zoster virus (VZV) before starting Ponvory®; VZV vaccination of antibody-negative patients is recommended prior to commencing treatment with Ponvory®. If live attenuated vaccine immunizations are required, administer at least 1 month prior to initiation of Ponvory® **Mayzent for Relapsing forms of MS**: multiple trials of preferred agents, including an intravenous MS product. **Mayzent for Active secondary progressive disease**: prior trials of two preferred agents are required.
MULTIPLE SCLEROSIS - MISC				MC		ZINBRYTA[1]	1. The safety and efficacy of use in children under the age of 17 years have not been established. Use PA Form #20430	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists
ASSORTED NEUROLOGICS								
NEUROLOGICS - MISC.	MC MC		BOTOX[2,4] DYSPORT[4]	MC/DEL MC MC/DEL		FIRDAPSE MYOBLOC[1] RUZURGI[3]	1. Approval will be limited to Cervical dystonia.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

				MC MC/DEL		SKYSONA[4,6] XEOMIN[2]	2. Please see botulinum PA form for additional criteria 3. For the treatment of patients between ages 6-16 years of age. 4. Clinical PA required. 5. For adult patients who are anti-acetylcholine receptor (AChR) antibody positive. 6. For the treatment of patients between ages 4-17 years of age. Use PA Form# 10210	Failed/did not tolerate therapeutic trials fo muscle relaxants, unless contraindicated, including but not limited to baclofen, cyclobenzaprine, orphenadrine, Skelaxin, and tizanidine. **Migraine:** Consideration for Botox approvals will only be made after failures of required trials of the following preferred medications: tricyclic or venlafaxine,beta blocker,valproic acid ,topiramate. **Firdapse** is recommended for the treatment of Lambert-Eaton myasthenic syndrome (LEMS) in adults. Ruzurgi is recommended for the treatment of Lambert-Eaton myasthenic syndrome (LEMS) in patients 6 years to less than 17 years of age.
NEUROLOGICS- hATTR AGENTS				MC MC/DEL MC/DEL MC/DEL MC/DEL		AMVUTTRA[1] ONPATTRO[1] TEGSEDI[1] **VYNDAMAX[1]** **VYNDAQEL[1]** WAINUA[1]	1. PA required for appropriate diagnosis. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Certain drugs require specific diagnoses for approval. Tegsedi® should be non-preferred and approved for patients for whom other treatments, including Onpattro®, have been ineffective. Vyndamax will be considered for the treatment of the cardiomyopathy of wild type or hereditary transthyretin-mediated amyloidosis (ATTR-CM) in adults to reduce cardiovascular mortality and cardiovascular-related hospitalization
NEUROLOGICS- SMA	MC MC MC		GENE ZOLGENSMA[1] NON-GENE EVRYSDI[1,2] SPINRAZA[1]			GENE NON-GENE	1. Clinical PA is required to establish diagnosis and medical necessity 2. For patients 2 months of age and older. Use PA Form# 20420	Zolgensma: The patient is less than 2 years of age AND The diagnosis is spinal muscular atrophy (SMA) AND The patient has bi-allelic mutations of the SMN1 gene AND The patient does not have advanced SMA (e.g. complete paralysis of limbs or permanent ventilator dependence) AND Medication is prescribed per the dosing Spinraza: The diagnosis is spinal muscular atrophy (SMA) type 1, 2, or 3 (results of genetic testing must be submitted) AND The patient has at least 2 copies of the SMN2 gene AND The prescriber is a neurologist, pulmonologist, or other physician with expertise in treating SMA AND Baseline motor ability has been established using one of the following exams: Hammersmith Infant Neurological Exam (HINE) Hammersmith Functional Motor Scale Expanded (HFMSE) Upper Limb Module Test (non-ambulatory) Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND) AND Prior to starting therapy, and prior to each dose, the following laboratory tests will be conducted: Treating provider attests the member has a platelet count > 50,000/ml or greater Treating provider agrees to do platelet count and coagulation test before each dose Treating provider agrees to do a quantitative spot urine protein test before each dose Concomitant use of Spinraza and Zolgensma is investigational and will not be approved AND Use of Spinraza after gene replacement therapy, including Zolgensma is investigational and will not be approved Note: Initial approval will be granted for 4 loading doses (the first 3 loading doses should be administered at 14-day intervals; the 4th loading dose should be administered 30 days after the 3rd dose). Renewal may be granted for up to 12 months with a maximum of 3 doses approved per year (12mg (5ml) every 4 months). For therapy continuation, clinical documentation must be submitted documenting improvement or maintenance of motor ability OR slower progression of disease than would otherwise be expected.
NEUROLOGICS- RETT SUNDROME				MC		DAYBUE[1,2]	1.Clinical PA required for appropriate diagnosis 2. For the treatment of patients 2 years of age and older. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

ALS DRUGS	**MC/DEL**		**RILUZOLE**	**MC**		EXSERVAN	1. Clinical PA for indication required Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Qalsody: For the treatment of amyotrophic lateral sclerosis (ALS) in adults who have a mutation in the superoxide dismutase 1 (SOD1) gene. Continued approval for this indication may be contingent upon verification of clinical benefit in confirmatory trial(s).
				MC		QALSODY		
				MC		RILUTEK TABS		
				MC		RADICAVA[1]		
				MC		RELYVRIO[1]		
				MC		TIGLUTIK		
MOVEMENT DISORDERS	**MC**		AUSTEDO[1]	**MC/DEL**		XENAZINE	1. Clinical PA required for appropriate diagnosis Use PA Form# 20420 Use PA Form# 20710 for Xenazine	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. DDI: Avoid concomitant use of Ingrezza® with MAO inhibitors (e.g. isocarboxazid, phenelzine, or selegiline). Concomitant use with strong CYP3A4 inducers (e.g. rifampin, carbamazepine, phenytoin, St. John's wort) is not recommended
	MC		AUSTEDO XR[1]					
	MC		INGREZZA[1]					
	MC		TETRABENAZINE[1]					
MUSCULAR DYSTROPHY AGENTS	**MC**		EMFLAZA[2]	**MC**		AGAMREE[4]	1. Clinical prior authorization to verify diagnosis and use of stable dose of corticosteroid for at least 6 months. 2. Clinical prior authorization to verify diagnosis for the treatment of Duchenne muscular dystrophy (DMD) in patients 2 years of age and older and a documented intolerance of oral corticosteroid. 3. Clinical prior authorization to verify diagnosis and use of stable dose of corticosteroid 4. For the treatment of Duchenne muscular dystrophy (DMD) in patients 2 years of age and older Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Amondy 45, Exondys 51 and Vyondys 53: • The prescriber is, or has consulted with, a neuromuscular disorder specialist AND • The dose does not exceed 30mg/kg once weekly AND • The patient is currently on a stable corticosteroid dose for at least 6 months (at least 3 months for Elevidy). Amondy 45, Exondys 51, Vyondys 53 Note: Initial approval will be granted for 6 months. For re-approval after 6 months, the patient must demonstrate a response to therapy Elevidys and Viltepso: The prescriber is, or has consulted with, a neuromuscular disorder specialist AND • The dose does not exceed dosing AND • The patient is currently on a stable corticosteroid dose for at least 3 months. Viltepso: For Duchenne muscular dystrophy (DMD) in patients who have a confirmed mutation of the DMD gene that is amenable to exon 53 skipping. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial.
				MC		AMONDYS 45[1]		
				MC		DEFLAZACORT		
				MC		ELEVIDYS[3]		
				MC		EXONDYS 51[1]		
				MC		VILTEPSO[3]		
				MC		VYONDYS 53		
MYASTHENIA GRAVIS	**MC**		PYRIDOSTIGMINE	**MC**		MESTINON	1. For the treatment of generalized myasthenia gravis (gMG) in adult patients who are anti-acetylcholine receptor (AChR) antibody positive Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Zilbrysq recommended to vaccinate patients for meningococcal infection per current Advisory Committee on Immunization Practices (ACIP) recommendations at least 2 weeks prior to administering the first dose.
				MC		VYVGART[1]		
				MC		VYVGART HYTRULO[1]		
				MC		ZILBRYSQ[1]		
FRIEDREICH'S ATAXIA AGENTS				**MC**		SKYCLARYS[1,2]	1.Clinical PA required for appropriate diagnosis 2. For the treatment of patients 16 years of age and older. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

STEROIDS								
GLUCOCORTICOIDS/ MINERALOCORTICOIDS	MC/DEL		BUDESONIDE EC 3mg DR CAPS	MC		ALKINDI SPRINKLE	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		CELESTONE SUSP	MC		CORTEF 10 and 20 TABS		
	MC/DEL		CORTEF 5	MC/DEL		FLORINEF TABS		
	MC/DEL		CORTISONE ACETATE TABS	MC		HEMADY		
	MC/DEL		DELTASONE TABS	MC/DEL		**MEDROL TABS**		
	MC/DEL		DEPO-MEDROL SUSP	MC		MEDROL DOSEPAK TABS		
	MC/DEL		DEXAMETHASONE	MC		MILLIPRED		
	MC		DEXPAK	MC		ORTIKOS		
	MC/DEL		FLUDROCORTISONE ACETATE TABS	MC		ORAPRED SOLN		
	MC/DEL		HYDROCORTISONE	MC		PEDIAPRED LIQD		
	MC		KENALOG	MC		PREDNISONE INTENSOL CONC		
	MC/DEL		METHYLPREDNISOLONE TABS	MC		STERAPRED TABS		**DDI:** All preferred steroids will require clinical PA for patients over 60 that are currently on fluoroquinolone therapy.
	MC/DEL		PREDNISOLONE	MC		ZILRETTA		
	MC/DEL		**PREDNISONE**					
	MC/DEL		SOLU-CORTEF SOLR					
	MC/DEL		SOLU-MEDROL SOLR					
HORMONE REPLACEMENT THERAPIES								
ANDROGENS / ANABOLICS	MC/DEL		ANDRODERM PT24	MC		ANADROL-50	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Additionally, laboratory evidence of a testosterone deficiency must be supplied. One of each dosage form should be tried (tablet, injection, and topical)
	MC/DEL		ANDROGEL 1%	MC		ANDRO LA 200 OIL		
	MC/DEL		ANDROGEL PUMP 1.62%	MC/DEL		ANDROGEL PACKETS 1.62%		
	MC/DEL		DANAZOL CAPS	MC		ANDROID CAPS		
	MC/DEL		TESTOSTERONE CYP	MC		AXIRON		
				MC		DELATESTRYL OIL		Oxandrolone: Weight gain (adjunctive therapy): Adjunctive therapy to promote weight gain after weight loss following extensive surgery, chronic infections, or severe trauma, and in some patients who, without definite pathophysiologic reasons, fail to gain or to maintain normal weight. Other indications included in manufacturer labeling: Adjunctive therapy to offset protein catabolism with prolonged corticosteroid administration. Requirement for documentation of weight loss over two readings- Patient has involuntary weight loss of more than 10% of total body weight in less than four months) and, BMI < 18.5 (Normal BMI = 18.5 to 24.9)
				MC/DEL		DEPO-TESTOSTERONE OIL		
				MC		FORTESTA		
				MC		HALOTESTIN TABS		
				MC/DEL		JATENZO		
				MC/DEL		METHITEST TAB		
				MC/DEL		**METHYLTESTOSTERONE CAP**		
				MC/DEL		**OXANDROLONE**		
				MC/DEL		STRIANT MUC ER		
				MC		TESTIM		
				MC/DEL		**TESTOSTERONE GEL PACKETS**		
				MC/DEL		**TESTOSTERONE SOL**		
				MC		TESTRED CAPS		
				MC		TLANDO		
				MC/DEL		VOGELXO		
				MC/DEL		XYOSTED		
ESTROGENS - PATCHES / TOPICAL	MC		**EVAMIST**	MC/DEL	5	**ESTRADIOL PTWK**	1. Step order drugs must be used in specified step order.	Approved for failures on multiple oral estrogen agents after 90 day trials or if unable to swallow any oral medication.
	MC/DEL		**MINIVELLE PATCH**	MC/DEL	8	**DIVIGEL**[1]		
				MC/DEL	8	**CLIMARA PTWK**		
				MC/DEL	8	**ELESTRIN**[1]		
				MC/DEL	8	**MENOSTAR PATCH**		
				MC/DEL	8	**VIVELLE-DOT PTTW**		
							Use PA Form# 20420	
ESTROGENS - TABS	MC/DEL		**ESTRADIOL**	MC/DEL		ENJUVIA	Must fail preferred products before non-preferred products.	Preferred drugs must be tried for at least 90 days and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**PREMARIN TABS**	MC/DEL		**ESTRADIOL-NORETHINDRONE**		
				MC/DEL		**ESTRACE TABS**		
				MC		ESTRATAB TABS		
				MC/DEL		**MENEST TABS**		
				MC/DEL		**NORETHINDRON-ETHINYL**		
				MC		ORTHO-EST TABS		
							Use PA Form# 20420	

ESTROGEN COMBO'S	MC/DEL MC/DEL MC/DEL MC/DEL		**ANGELIQ** **COMBIPATCH PTTW** **PREMPHASE TABS** **PREMPRO TABS**	MC/DEL MC/DEL MC MC/DEL MC/DEL		**FEMHRT 1/5 TABS**[1] **FYAVOLV** LOPREEZA TAB **ORTHO-PREFEST TABS**[1] SYNTEST H.S. TABS[1]	1. Must fail Premphase and Prempro products before non preferred products. Use PA Form# 20420	Preferred drugs must be tried for at least 90 days and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
PROGESTINS	MC/DEL MC/DEL MC MC		MEDROXYPROGESTERONE ACETA [1] NORETHINDRONE ACETATE TABS[1] 17-ALPH HYDROXYPROGESTERONE PWDR PROGESTERONE CAPS	MC/DEL MC MC MC/DEL MC/DEL		AYGESTIN TABS CYCRIN TABS PROGESTERONE POWD PROMETRIUM CAPS PROVERA TABS	1. Must fail Medroxyprogesterone and Norethindrone products before non-preferred Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ENDOMETROSIS								
CENTRAL PRECOCIOUS PUBERTY AGENTS	MC		FENSOLVI[1]				1. For pediatric patients 2 years of age and older with central precocious puberty (CPP).	
ENDOMETROSIS- NASAL	MC/DEL		SYNAREL (NASAL) SPRAY				Use PA Form# 20420	Synarel is also indicated for central precocious puberty
ENDOMETROSIS/ UTERINE FIBROIDS- ORAL	MC/DEL MC		ORILISSA[1] MYFEMBREE[1,2]	MC		ORIAHNN[1]	1. Prior treatment of NSAID and hormonal contraceptives required 2. Limited to 24 months due to the risk of continued bone loss, which may not be reversible. Use PA Form# 20420	
ENDOMETROSIS- INJECTABLE	MC/DEL		DEPO-SUBQ PROVERA 104				Use PA Form# 20420	
CONTRACEPTIVES								
CONTRACEPTIVES - PROGESTIN ONLY	MC/DEL MC/DEL MC MC MC/DEL MC/DEL		CAMILA TABS ERRIN INCASSIA TAB HEATHER TAB NORETHINDRONE ACETATE 0.35MG TABS SLYND	MC/DEL MC/DEL MC		JOLIVETTE NORA-BE TABS ORTHO MICRONOR TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. If member experienced adverse reactions, consider using Oral Contraceptives from other groups. **DDI:** Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer.
CONTRACEPTIVES - INJECTABLE	MC/DEL		MEDROXYPROGESTERONE ACETATE 150mg IM	MC/DEL		DEPO-PROVERA 150 mg SUSP	Use PA Form# 20420	The preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
CONTRACEPTIVE - EMERGENCY	MC/DEL MC MC MC		ELLA ENCONTRA ONE STEP ECONTRA EZ NEW DAY				1. Allowed 2 tablets per 30 days without PA	Due to the extensive list of products, any covered emergency contraceptive product preferred is and available without a PA.

	MC		OPCION					
	MC/DEL		OPTION 2					
	MC		MY CHOICE					
	MC/DEL		**MY WAY**					
	MC		LEVONORGESTREL					
	MC/DEL		NEXT CHOICE[1]				Use PA Form# 20420	
CONTRACEPTIVES - PATCHES/ VAGINAL PRODUCTS	MC		ELURYNG[1]	MC		ANNOVERA	Use PA Form# 20420 1. Quantity limit allowing 1 every 28 days with out PA. 2. Dose limits apply allowing 3 patches per 28 days supply.	Approved if adequate clinical reason given why patient unable to comply with other preferred agents including long acting injectable.
	MC		NUVARING RING[1]	MC		PHEXXI		
	MC		TWIRLA	MC		ZAFEMY		
	MC/DEL		**XULANE[2]**					
CONTRACEPTIVES- LONG ACTING REVERSIBLE	MC/DEL		MIRENA	MC/DEL		KYLEENA		
				MC		LILETTA		
				MC		NEXPLANON		
				MC/DEL		PARAGARD		
				MC/DEL		SKYLA		
CONTRACEPTIVES - MONOPHASIC COMBINATION O/C'S	MC/DEL		APRI TABS	MC/DEL		BEYAZ	Use PA Form# 20420 If member experienced adverse reactions, consider using Oral Contraceptives from other groups.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		AVIANE TABS	MC/DEL		BREVICON-28 TABS		
	MC/DEL		BALZIVA	MC/DEL		LESSINA-28 TABS		
	MC/DEL		CRYSELLE-28 TABS	MC/DEL		LEVORA		
	MC		DESOGEN TABS	MC/DEL		LOESTRIN FE 1/20 TABS		
	MC/DEL		ESTARYLLA TAB	MC/DEL		LOESTRIN 1.5/30-21 TABS		
	MC		HAILEY FE TAB					
	MC/DEL		ISIBLOOM TAB	MC/DEL		MICROGESTIN FE TABS		If member experienced adverse reactions, consider using Oral Contraceptives from other groups.
	MC/DEL		**JUNEL FE TAB**	MC/DEL		LOESTRIN 1/20-21 TABS		
	MC		LARIN FE TAB					
	MC/DEL		**LESSINA TAB**	MC		LO/OVRAL 21 TABS		
	MC		LEVORA-28 TAB	MC/DEL		LO/OVRAL 28 TABS		
	MC		MILI TAB	MC		NEXTSTELLIS		
						NORDETTE-28 TABS		
	MC/DEL		NORGESTIMATE-ETHINYL ESTRADIOL TAB	MC/DEL				
	MC/DEL		**MIBELAS 24 FE TAB**	MC/DEL		NORTREL		**DDI:** Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer.
	MC/DEL		MICROGESTIN FE TAB	MC/DEL		OCELLA		
	MC/DEL		RECLIPSEN	MC/DEL		OVRAL		
	MC/DEL		SAFYRAL TAB	MC/DEL		PORTIA-28 TABS		
	MC/DEL		SPRINTEC 28 TABS	MC/DEL		SAFYRAL		
	MC/DEL		YASMIN 28 TABS	MC/DEL		ZOVIA		
	MC/DEL		YAZ					
CONTRACEPTIVES - BI-PHASIC COMBINATIONS	MC/DEL		AZURETTE TAB	MC/DEL		LOSEASONIQUE	If member experienced adverse reactions, consider using Oral Contraceptives from other groups.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. If member experienced adverse reactions, consider using Oral Contraceptives from other groups.
	MC/DEL		**CAMRESE**					
	MC/DEL		**CAMRESE LO**					
	MC		DESOGESTREL/ ETH/ ESTRAD 0.15/30mcg					
	MC/DEL		KARIVA TABS					
	MC/DEL		LO LOESTRIN FE					
	MC/DEL		PIMTREA TAB					
	MC		NORETHINDRONE-ETH ESTRADIOL TAB 0.5-35/1-35					
	MC		SIMPESSE TBDSPK 3MO					**DDI:** Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer.
	MC/DEL		VIORELE TAB				Use PA Form# 20420	
CONTRACEPTIVES - TRI-PHASIC COMBINATIONS	MC/DEL		ENPRESSE	MC/DEL		NORTREL 7/7/7	If member experienced adverse reactions, consider using Oral Contraceptives from other groups.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**NORGESTIMATE-ETHINYL ESTRADIOL TAB**	MC		ORTHO TRI-CYCLEN LO TABS		
	MC/DEL		TRIPHASIL 28 TABS					
	MC		TRI-LO-MILI TAB					

	MC MC MC/DEL MC/DEL MC		TRI-LO-ESTARYLLA TAB TRI-ESTARYLLA TRI-SPRINTEC TAB **TRI-LO-SPRINTEC** TRINESSA				Use PA Form# 20420	If member experienced adverse reactions, consider using Oral Contraceptives from other groups. **DDI:** Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer.
CONTRACEPTIVES - MULTI-PHASIC COMBINATIONS				MC		NATAZIA	Use PA Form# 20420	
VASOMOTOR SYMPTOMS AGENTS								
VASOMOTOR SYMPTOMS AGENTS				MC/DEL		VEOZAH	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. DDI: Avoid concomitant use of Veozah with drugs that are weak, moderate or strong CYP1A2 inhibitors. Veozah: Approval requires at least one preferred Hormone Replacement Therapy (HRT) and two preferred non-hormonal therapies (i.e., SSRIs, SNRIs, gabapentin, pregabalin, clonidine).
DIABETES SUPPLIES								
DIABETIC- SUPPLIES			CONTINUOUS GLUCOSE MONITORING[1,2] DIABETIC- LANCETS DIABETIC- LANCING DEVICES DIABETIC- LANCING DEVICES DIABETIC- PEN NEEDLES DIABETIC- SYRINGES DIABETIC- TEST STRIPS DIABETIC- METERS				1. Clinical PA is required to establish diagnosis and medical necessity. 2. Dosing limits apply. Please refer to Dose consolidation list. Use PA Form#20420	Please refer to the MaineCare Preferred Diabetic Supply List available at www.mainecarepdl.org **Continuous Glucose Monitoring Criteria**: Patient has a diagnosis of Diabetes Mellitus AND Practitioner feels patient has sufficient training to use CGM • 2 years of age or older for Dexcom G6 and Dexcom G7, ≥ 14 years for Medtronic Guardian, or ≥ 4 years for Freestyle Libre 2. • At least one of the following are documented: o Hypoglycemic unawareness o Treated with insulin (at least 1X day) o Has history of problematic hypoglycemia with documentation of at least one recurrent level 2 hypoglycemic events, or 1 level 3 hypoglycemic event • Approval of non-preferred products will be limited to cases where the CGM is directly integrated with the patient's insulin pump. The make and model of pump must be documented on the prior authorization.
DIABETES THERAPIES								
DIABETIC - INSULIN	MC/DEL MC MC MC MC MC MC MC MC MC/DEL MC/DEL		**FIASP** HUMALOG KWIKPEN INJ 100/ML HUMALOG JUNIOR KWIKPEN 100/ML HUMALOG MIX 75/25 HUMALOG 50/50 VIAL HUMULIN INJ 70/30 KWIKPEN HUMULIN INJ 70/30 HUMULIN R INJ U-500 INSULIN ASPART PROT MIX 70-30 INSULIN ASPART INSULIN LISPRO LANTUS SOLN LEVEMIR	MC/DEL MC/DEL MC/DEL MC MC MC MC MC MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC		APIDRA **ADMELOG** **AFREZZA**[1] BASAGLAR HUMALOG KWIKPEN U-200 HUMULIN INJ 50/50 HUMULIN N INJ U-100 HUMULIN R U-100 INSULIN DEGLUDEC LYUMJEV **NOVOLIN** **NOVOLOG** **NOVOLOG MIX** NOVOLOG MIX 70/30 FLEXPEN RELION	Use PA Form# 20420 1. Not to be as a monotherapy. Obtain lab values of pulmonary function and recent smoking history 2. For the treatment of patients ≥3 years of age	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
DIABETIC - PENFILLS	MC MC		HUMALOG MIX KWIK 50/50 HUMALOG MIX INJ 75/25 KWP	MC MC/DEL		APIDRA OPTICLIK PEN **NOVOLIN 70/30 PEN**		Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

	MC		HUMALOG KWIK INJ 100/ML	MC/DEL		NOVOLOG MIX PENFILL		another drug and the preferred drug(s) exists.
	MC		HUMALOG KWIK INJ 200/ML	MC/DEL		**NOVOLOG PENFILL SOLN**		
	MC/DEL		**HUMULIN R U-500 KWP**	MC/DEL		NOVOLOG FLEXPEN		
	MC		INSULIN ASPART PROT MIX 70-30 PEN	MC/DEL		NOVOLOG MIX 70/30 VIAL		
	MC		INSULIN ASPART PEN	MC		REZVOGLAR KWIKPEN		
	MC		INSULIN LISPRO KWIKPEN U-100	MC/DEL		**TRESIBA**		
	MC/DEL		LANTUS SOLOSTAR					
	MC/DEL		LEVEMIR FLEXTOUCH					
	MC/DEL		LEVEMIR FLEXPEN				Use PA Form# 20420	
	MC/DEL		**TOUJEO MAX SOLOSTAR**					
	MC/DEL		**TOUJEO SOLOSTAR**					
DIABETIC - DPP- 4 ENZYME INHIBITOR	MC/DEL		JANUVIA[1,2]	MC/DEL		**NESINA**	1. Preferred if therapeutic doses of metformin are seen in members drug profile for at least 60 days within the past 18 months or if phosphate binder is currently seen in the members drug profile.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Onglyza 5mg will require a prior authorization if it is currently being used in combination with drugs known to be significant CYP3A4 inhibitors (ketoconazole, itraconazole, clarithromycin, indinavir, nefazodone, nelfinavir, ritonavir, atazanavir, saquinavir and telithromycin).
	MC/DEL		TRADJENTA[2]	MC/DEL		**ONGLYZA[2]**		
				MC/DEL		QTERN		
				MC		ZITUVIO	2. Dosing limits apply. Please refer to Dose consolidation list.	
							Use PA Form# 20420	
DIABETIC - DPP- 4 ENZYME INHIBITOR-COMBO	MC/DEL		JANUMET[1,2]	MC/DEL		**JENTADUETO XR**	1. Preferred if therapeutic doses of metformin are seen in members drug profile for at least 60 days within the past 18 months or if phosphate binder is currently seen in the members drug profile.	
	MC/DEL		**JANUMET XR[1,2]**	MC/DEL		**KAZANO**		
	MC/DEL		**JENTADUETO[1]**	MC		KOMBIGLYZE XR		
				MC/DEL		**OSENI**	2. Dosing limits apply. Please refer to Dose consolidation list.	
							Use PA Form# 20420	
DIABETIC - LANCET-LANCET DEVICE							Use PA Form# 20420	Please refer to the MaineCare Preferred Diabetic Supply List available at www.mainecarepdl.org
DIABETIC - SYRINGES-NEEDLES							Use PA Form# 20420	Please refer to the MaineCare Preferred Diabetic Supply List available at www.mainecarepdl.org
DIABETIC - OTHER				MC/DEL		CYCLOSET		
				MC		SYMLIN	Use PA Form #20420 for all others	
SGLT 2 INHIBITORS	MC/DEL		**FARXIGA**	MC/DEL		**INVOKANA[1]**	1.Dosing limits apply please refer to Dose Consolidation List	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**JARDIANCE**	MC/DEL		**STEGLATRO**		
							Use PA Form# 20420	

SGLT 2 INHIBITOR COMBINATIONS	MC/DEL		**SYNJARDY**	MC/DEL		**GLYXAMBI**		Preferred drugs must be tried for at least 3 months at full therapeutic doses and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**SYNJARDY XR**	MC/DEL		**INVOKAMET**		
	MC/DEL		**XIGDOU XR**	MC/DEL		**INVOKAMET XR**		Glyxambi /Xigduo XR- Verify prior trials and failures or intolerance of preferred treatments from other diabetic categories
				MC/DEL		**SEGLUROMET**		Synjardy® XR is not recommended for patients with type 1 DM or for the treatment of diabetic ketoacidosis.
				MC/DEL		**STEGLUJAN**		
				MC/DEL		**TRIJARDY XR**	Use PA Form# 20420	
DIABETIC MONITOR	MC		ONE TOUCH ULTRA 2 KIT	MC		ACCUCHECK	Use PA Form# 20420	Effective October 25th 2007, approvals for all non preferred meters/ test strips will require medical necessity documenting clinically significant features that are not available on any of the preferred meters.
	MC		ONE TOUCH ULTRA MINI KIT	MC		ASCENSIA		
	MC		TRUE METRIX	MC		ASSURE		
	MC		TRUETRACK	MC		CONTOUR BREEZE Z		
				MC		EXACTECH		
				MC		FREESTYLE INSULINX		
				MC		FREESTYLE LITE SYSTEM KIT		
				MC		ONE TOUCH ULTRA SMART KIT		
				MC		PRECISION XTRA METER		
				MC		PRODIGY		
DIABETIC TEST STRIPS	MC		ONE TOUCH ULTRA[1]	MC		ACCUCHECK	1. Only 50 ct & 100 ct package size.	Effective October 25th 2007, approvals for all non preferred meters/ test strips will require medical necessity documenting clinically significant features that are not available on any of the preferred meters.
	MC		TRUE METRIX	MC		ASCENSIA		
	MC		TRUETRACK	MC		ASSURE	Use PA Form# 20420	
				MC		CONTOUR BREEZE Z		
				MC		EXACTECH		
				MC		FREESTYLE		
				MC		FREESTYLE		
				MC		FREESTYLE LITE		
				MC		FREESTYLE INSULINX		
				MC		ONE TOUCH DELICA		
				MC		PRECISION XTRA		
				MC		PRODIGY		
INCRETIN MIMETIC	MC/DEL		**RYBELSUS**	MC/DEL	5	**OZEMPIC**		Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		TRULICITY	MC/DEL	8	**ADLYXIN**		
	MC/DEL		VICTOZA	MC/DEL	8	BYDUREON BCISE		
				MC	8	MOUNJARO		
				MC/DEL	8	**SOLIQUA**		Soliqua must try both insulin and a preferred incretin mimetic and have a medical necessity for use that is not based on convenience or simply due to the fact that one injection is needed instead of two.
				MC/DEL	8	**XULTOPHY**		
							Use PA Form# 20420	
DIABETIC - ORAL SULFONYLUREAS	MC/DEL		**CHLORPROPAMIDE TABS**	MC/DEL		**AMARYL TABS**	Use PA Form# 20420	Preferred drugs must be tried for at least 3 months at full therapeutic doses and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		GLIMEPIRIDE	MC/DEL		**DIABETA TABS**	1. Pa required for members ≥65. Glyburide has a greater risk of severe prolonged hypoglycemia in older adults.	
	MC/DEL		**GLIPIZIDE TABS**	MC		**GLUCOTROL TABS**		**DDI:** All sulfonylureas (except glyburide) will now be non-preferred and require prior authorization if it is currently being used with either ranitidine or cimetidine.
	MC/DEL		**GLIPIZIDE ER TABS**	MC/DEL		**GLUCOTROL XL TBCR**		
	MC/DEL		**GLYBURIDE MICRONIZED TABS**	MC/DEL		**GLYNASE TABS**		**DDI:** Glimepiride will now be non-preferred and require prior authorization if it is currently being used with either fluconazole (except 150mg strength) or fluvoxamine. Amaryl is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for concurrent use with either fluconazole or fluvoxamine.
	MC/DEL		**GLYBURIDE TABS**[1]	MC/DEL		**MICRONASE TABS**		
	MC/DEL		**TOLAZAMIDE TABS**					
	MC/DEL		**TOLBUTAMIDE TABS**					
DIABETIC -ORAL BIGUANIDES	MC/DEL		**METFORMIN HCL TABS**	MC		GLUCOPHAGE TABS	Use PA Form# 20420	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered

	MC/DEL		METFORMIN ER	MC MC MC/DEL		GLUCOPHAGE XR TB24 FORTAMET METFORMIN ER OSMOTIC		on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
DIABETIC - THIAZOL / BIGUANIDE COMBO				MC/DEL MC/DEL MC MC		ACTOPLUS MET[1] ACTOPLUS MET XR AVANDARYL[1] **AVANDAMET TABS**[1]	Use PA Form# 20420 1. Requires use of Actos, Metformin, or other preferred anti-diabetics.	**DDI:** Actos, Avandia, or any combination product with Actos or Avandia will now be non-preferred and require prior authorization if it is currently being used with gemfibrozil.
DIABETIC - / THIAZOL	MC/DEL		**PIOGLITAZONE HCL**[1]	MC/DEL MC		**ACTOS TABS**[3] **AVANDIA TABS**[2]	1. Pioglitazone HCL is non-preferred as monotherapy. Pioglitazone HCL is preferred if therapeutic doses of metformin, sulfonylurea or insulin are seen in members drug profile for at least 60 days within the past 18 months. 2. Current users of Avandia who have tried Actos will be able to continue use of Avandia. 3. Dosing limits apply please refer to Dose Consolidation List Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Actos, Avandia, or any combination product with Actos or Avandia will now be non-preferred and require prior authorization if it is currently being used with gemfibrozil.
DIABETIC - ALPHAGLUCOSIDASE	MC/DEL			MC		**PRECOSE TABS**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
DIABETIC - SULFONYLUREA / BIGUANIDE	MC/DEL		GLYBURIDE/METFORMIN	MC MC MC/DEL		**GLUCOVANCE TABS**[1] METAGLIP TABS[1] DUETACT[2]	1. Use individual ingredients. 2. Use Actos with generic glimepiride. Use PA Form# 20420	Approved for patients failing to achieve good diabetic control with maximal doses of individual components.
DIABETIC - MEGLITINIDES	MC		**NATEGLINIDE**	MC/DEL MC/DEL		**PRANDIN TABS** **STARLIX TABS**	Use PA Form# 20420	Preferred drugs from other diabetic sub-categories must be tried and failed due to lack of inadequate diabetic control or intolerable side effects before non-preferred drug will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI**: Prandin is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for current use with both Sporanox and gemfibrozil, due to a significant drug-drug interaction.
GLUCOSE ELEVATING AGENTS								
GLUCOSE ELEVATING AGENTS	MC/DEL MC/DEL	1 2	GLUCAGEN INJ. HYPOKIT[1] BAQSIMI[2,4]	MC MC MC/DEL MC		GLUCAGON DIAGNOSTIC KIT GLUCAGEN DIAGNOSTIC KIT **GVOKE**[3] ZEGALOGUE[5]	Use PA Form# 20420 1. Dosing limits apply, please see dose consolidation list. 2. For the treatment of patients ≥ 4 years of age. 3. For the treatment of patients ≥ 2 years of age. 4. Baqsimi will reguire a step through Glucagen. 5. For the treatment of patients ≥ 6 years of age.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

THYROID								
THYROID EYE DISEASE				MC		**TEPEZZA**	Use PA Form# 20420	
THYROID HORMONES	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		**ARMOUR THYROID TABS** **CYTOMEL TABS** **ERMEZA**[1] **LEVOTHROID TABS** **LEVOTHYROXINE SODIUM TABS** **LEVOXYL TABS** **UNITHROID TABS**	MC MC/DEL MC MC/DEL		LEVOTHYROXINE SODIUM SOLR LIOTHYRONINE SYNTHROID TABS THYQUIDITY	Use PA Form# 20420 1.Clinical PA is required to confirm diagnosis of dysphagia.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTITHYROID THERAPIES	MC/DEL MC/DEL		**METHIMAZOLE TABS** **PROPYLTHIOURACIL TABS**	MC/DEL		**TAPAZOLE TABS**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
CUSHING DISEASE AGENTS								
CUSHING DISEASE AGENTS				MC MC		ISTURISA[1] RECORLEV	1. For the treatment of adult patients with Cushing's disease for whom pituitary surgery is not an option or has not been curative. Use PA Form #20420	Recorlev® is associated with dose-related QT interval prolongation. QT interval prolongation may lead to life-threatening ventricular dysrhythmias such as Torsades de pointes.
OSTEOPOROSIS / BONE AGENTS								
OSTEOPOROSIS	MC/DEL		ALENDRONATE	MC/DEL MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC/DEL MC MC MC MC MC MC/DEL		**ACTONEL TABS** AREDIA SOLR BINOSTO BONIVA INJECTION KIT BONIVA TABS[2,4] CALCITONIN NS **DUAVEE** **DIDRONEL TABS** EVISTA TABS[1] **EVENITY**[2] FORTEO FORTICAL **FOSAMAX TABS AND PLUS D**[3] PROLIA SOHONOS[6] STRENSIQ[5] TYMLOS XGEVA ZOMETA	Use PA Form# 20420 1. Approval only requires failure of Alendronate. 2. Quantity limits apply, please see dosage consolidation list. 3. Please use Alendronate and Vitamin D. 4. Please use other preferred agents. 5. Obtain baseline ophthalmology exams and renal ultrasounds and then periodically during treatment 6. Clinical PA ffor indication required.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Binosto** use preferred generic alendronate tablets Evenity® should be limited to 12 monthly doses Sohonos: For the reduction in volume of new heterotopic ossification in adults and pediatric patients aged 8 years and older for females and 10 years and older for males with fibrodysplasia ossificans progressiva (FOP).
FIBROBLAST GROWTH FACTOR 23 INHIBITORS	MC		CRYSVITA[1]				1.Preferred for patients <21 years for the treatment of X-linked hypophosphatemia. Use PA Form #20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
CALCIMIMETIC AGENTS								
CALCIMIMETIC AGENTS				MC MC		PARSABIV SENSIPAR	Use PA Form# 30115	For Sensipar baseline PTH, Ca, and phosphorous levels are required and initial approvals will be limited to 3 months. Subsequent approvals will require additional levels being done to assess changes. Will not approve if baseline Ca is less than 8.4.

								Parsabiv is for the treatment of secondary hyperparathyroidism (HPT) in adults with chronic kidney disease (CKD) on hemodialysis. Parsabiv® has not been studied in adults with parathyroid carcinoma, primary hyperparathyroidism, or with chronic kidney disease who are not on hemodialysis and is not recommended for use in these populations.
GROWTH HORMONE								
GROWTH HORMONE	MC/DEL		GENOTROPIN[1]	MC	8	HUMATROPE SOLR	Use PA Form# 10710	See Growth Hormone PA form for criteria. Step-order will still apply unless clinical contraindication supplied.
	MC/DEL		NORDITROPIN SOLN[1]	MC	8	INCRELEX	1.Clinical PA is required to establish diagnosis and medical necessity. 2. Preferred after single step therapy of short acting growth hormone.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		SKYTROFA[1,2]	MC/DEL	8	NUTROPIN		
				MC/DEL	8	NGENLA		
				MC	8	OMNITROPE		
				MC	8	SAIZEN SOLR		
				MC/DEL	8	SOGROYA		
				MC/DEL	8	TEV-TROPIN		
ACHONDROPLASIA TREATMENT				MC		VOXZOGO[1]	1. Pediatric patients with achondroplasia who are 5 years of age and older with open epiphyses. Use PA Form# 20420	Voxzogo: To increase linear growth in pediatric patients with achondroplasia who are 5 years of age and older with open epiphyses. This indication is approved under accelerated approval based on an improvement in annualized growth velocity. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trial(s).
SOMATOSTATIC AGENTS				MC/DEL	7	OCTREOTIDE INJ[1]	Use PA Form# 10710 1. Non-preferred products must be used in specified step order.	
				MC	8	BYNFEZIA[1]		
				MC	8	MYCAPSSA[1]		
				MC/DEL	8	SANDOSTATIN[1]		
				MC	8	SOMATULINE[1]		
GROWTH HORMONE ANTAGONISTS								
GH ANTAGONISTS				MC		SOMAVERT	Use PA Form# 10710	Approved for acromegaly patients failing surgery/radiation/drug therapy including bromocriptine and sandostatin.
VASOPRESSIN RECEPTOR ANTAGONIST								
VASOPRESSIN RECEPTOR ANTAGONIST				MC		JYNARQUE[1]	Use PA Form# 20420 1. Clinical PA required for appropriate diagnosis	**Samsca Drug Warning**- Avoid use in patients with underlying liver disease, including cirrhosis, because the ability to recover from liver injury may be impaired. Limit duration of therapy to 30 days to minimize the risk of liver injury. DDI: Jynarque- Concomitant use with strong CYP3A inhibitors is contraindicated. Avoid concomitant use of Jynarque® with OATP1B1/B3 and OAT3 substrates (e.g. statins, bosentan, glyburide, nateglinide, repaglinide, methotrexate, furosemide).
				MC/DEL		SAMSCA		
URINARY INCONTINENCE								
VASOPRESSINS	MC/DEL		**DESMOPRESSIN TABS**	MC/DEL	5	DDAVP TABS	1. Products must be used in specified step order. Nocturnal enuresis patients will be encouraged to periodically attempt stopping DDAVP. 2. Patients with a diagnosis of hemophilia or Von Willebrands disease will be exempt from prior authorization. Use PA Form# 20420	Approved for central diabetes insipidus and for nocturnal enuresis. For nocturnal enuresis- must be over 6 years old, must fail an adequate trial of alarm training (higher success rate, lower relapse rate) and must periodically attempt weaning (at 6 month intervals).
	MC/DEL		DDAVP SOLN	MC/DEL	6	**DESMOPRESSIN SPRAY[1]**		
				MC	8	DESMOPRESSIN ACETATE SOLN[1]		
				MC/DEL	8	NOCDURNA[1]		
				MC	8	NOCTIVA[1]		
				MC/DEL	8	STIMATE SOLN[1,2]		
ANTISPASMODICS	MC/DEL		**DETROL TABS**	MC/DEL	8	**DARIFENACIN ER TAB**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**DETROL LA CAPS**	MC/DEL	8	**DITROPAN**		
	MC/DEL		**OXYBUTYNIN**	MC/DEL	8	**FLAVOXATE HCL TAB**		
				MC/DEL	8	**TOLTERODINE**		
ANTISPASMODICS - LONG ACTING	MC		FESOTERODINE	MC	8	**DITROPAN XL TBCR**	Use PA Form# 20420 1. See Criteria Section. 2. Use a preferred long	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**GELNIQUE GEL PACKET**	MC/DEL	8	ENABLEX[1,2]		
	MC/DEL		**MYRBETRIQ**	MC	8	GEMTESA[2]		

	MC/DEL		**OXYBUTYNIN ER TABS**	MC/DEL	8	**TOLTERODINE TAB**	acting antispasmodic.	1. Vesicare 5mg and Enablex 7.5mg maximum doses if given with drugs known to be significant CYP3A4 inhibitors.(Ketoconazole, Sporanox, Erythromycin, Fluconazole, Nefazodone, Nelfinavir, and Ritonavir)
	MC/DEL		**OXYTROL**	MC/DEL	8	TOVIAZ	3. For the treatment of patients ≥ 2 years of age.	**DDI:** Enablex 15mg and Vesicare 10mg will now be non-preferred and require prior authorization if they are currently being used in combination with any of the following medications: clarithromycin, erythromycin, Ketek, Crixivan, Norvir, ketoconazole, fluconazole (except 150mg strength), Sporanox. nefazodone, or diltiazem.
	MC/DEL		SOLIFENACIN SUCCINATE TAB	MC	8	VESICARE[1]		
	MC/DEL		TROSPIUM	MC	8	VESICARE[3] LS		
CHOLINERGIC	MC/DEL		**BETHANECHOL**	MC/DEL		**URECHOLINE**	Use PA Form# 20420	
HYPERAMMONIA TREATMENTS	MC		CARGLUMIC ACID TABS	MC		CARBAGLU TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
UREA CYCLE DISORDER	MC		BUPHENYL TABLET	MC		BUPHENYL POWDER	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Olpruva: As adjunctive therapy to standard of care, which includes dietary management, for the chronic management of adult and pediatric patients weighing 20kg or greater and with a body surface area (BSA) of 1.2m2 or greater, with urea cycle disorders (UCDs) involving deficiencies of carbamylphosphate synthetase (CPS), ornithine transcarbamylase (OTC), or argininosuccinic acid synthetase (AS).
	MC		PHEBURANE GRANULES	MC		RAVICTI LIQUID		
				MC		OLPRUVA		
				MC/DEL		**SODIUM PHENYLBUTYRATE POWDER**		
				MC/DEL		**SODIUM PHENYLBUTYRATE TAB**		
METABOLIC MODIFIER								
HERED. TYROSINEMIA				MC		ORFADIN	Use PA Form# 20420	Approved for Type 1 hereditary tyrosinemia patients. Must include laboratory evidence of dx at first PA.
FABRY DISEASE AGENTS				MC		ELFABRIO[1]	1.Clinical PA to verify appropriate diagnosis. 2.For the treatment of patients 2 years of age and older.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC		FABRAZYME[2]		
				MC/DEL		GALAFOLD[1]		Elfabrio and Galfold: For the treatment of adults with confirmed Fabry disease.
							Use PA Form# 20420	
ANTIHYPERTENSIVES / CARDIAC								
CARDIAC GLYCOSIDES	MC/DEL		**DIGITEK TABS**				Use PA Form# 20420	
	MC/DEL		**DIGOXIN**					
	MC/DEL		**LANOXIN**					
CARDIAC MYOSIN INHIBITORS				MC		CAMZYOS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Camzyos: For the treatment of adults with symptomatic New York Heart Association (NYHA) class II-III obstructive hypertrophic cardiomyopathy (HCM) to improve functional capacity and symptoms. **DDI:** Concomitant use of Camzyos® with a moderate to strong CYP2C19 inhibitor or a strong CYP3A4 inhibitor is contraindicated.
CARDIAC - SINUS NODE INHIBITORS				MC		CORLANOR	Use PA Form#20420	In patients with stable, symptomatic chronic heart failure with left ventricular ejection fraction ≤35%, who are in sinus rhythm with resting heart rate ≥70 beats per minute (bpm) and
CARDIAC- SOLUBLE GUANYLATE CYCLASE STIMULATORS				MC/DEL		**VERQUVO**	Use PA Form# 20420	

CARDIAC RISK REDUCTION- SGLT2/GLP-1				MC		INPEFA[1]	1. To reduce the risk of cardiovascular death, hospitalization for heart failure, and urgent heart failure visit in adults with: Heart failure or Type 2 diabetes mellitus, chronic kidney disease, and other cardiovascular risk factors. Use PA Form#23976	Other Preferred SGLT inhibitors must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Wegovy:** Patient has BMI > 27 kg/m2, and is not being used for weight loss only Patient has history of at least one of the following: o Stroke o Myocardial Infarction o Symptomatic peripheral arterial disease Patient does not have diagnosis of diabetes, end stage renal disease/dialysis, or NYHA class IV heart failure
				MC/DEL		WEGOVY		
ANTIANGINALS--Isosorbide Di-nitrate/ Mono-Nitrates	MC/DEL		**ISOSORBIDE MONONITRATE TABS**	MC		DILATRATE SR CPCR	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**ISOSORBIDE MONONITRATE ER**	MC		ISORDIL TABS		
				MC		ISORDIL TITRADOSE TABS		
				MC		ISOSORBIDE DINITRATE SUBL		
				MC/DEL		**ISOSORBIDE DINITRATE TABS**		
				MC/DEL		ISOSORBIDE DINITRATE CR TBCR		
				MC/DEL		**ISOSORBIDE DINITRATE ER TBCR**		
				MC/DEL		ISOSORBIDE DINITRATE TD TBCR		
				MC/DEL		**IMDUR TB24**		
				MC/DEL		ISMO TABS		
				MC		MONOKET TABS		
NITRO - OINTMENT/CAP/CR	MC/DEL		**NITROBID OINT**				Use PA Form# 20420	
	MC/DEL		**NITROGLYCERIN CPCR**					
	MC		NITROL OINT					
	MC		NITRO-TIME CPCR					
NITRO - PATCHES	MC/DEL	1	**NITROGLYCERIN PT24[1]**	MC		NITRODISC PT24	1. At least 2 step 1's and step 3 of the preferred products must be used in specified order or PA will be required. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	1	**NITRO-DUR PT 24 0.8MG[1]**	MC/DEL		**NITRO-DUR PT24**		
NITRO - SUBLINGUAL/ SPRAY	MC/DEL		**NITROSTAT SUBL**	MC/DEL		**NITROQUICK SUBL**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC		**NITROLINGUAL SOLN**		
				MC		NITROLINGUAL TABS		
BETA BLOCKERS - NON SELECTIVE	MC/DEL		**CARVEDILOL**	MC		ASPRUZYO	1. Recommend using BID since its effects do not last 24 hours. 2. Please use other strengths in combination to obtain this dose. 3. Dosing limits still apply. Please see dose consolidation list Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. DDI: Concomitant use of Ranolazine products with strong CYP3A inhibitors, including ketoconazole, itraconazole, clarithromycin, nefazodone, nelfinavir, ritonavir, indinavir, and saquinavir, is contraindicated.
	MC		LEVATOL TABS	MC/DEL		**BETAPACE TABS**		
	MC/DEL		**NADOLOL TABS**	MC		**BETAPACE AF TABS**		
	MC/DEL		**PINDOLOL TABS**	MC		**COREG CR[3]**		
	MC/DEL		**PROPRANOLOL HCL SOLN[1]**	MC		**COREG TABS**		
	MC/DEL		**PROPRANOLOL HCL TABS[1]**	MC/DEL		**CORGARD TABS**		
	MC/DEL		**PROPRANOLOL HCL 60MG TABS**	MC/DEL		**INDERAL TABS**		
	MC/DEL		**PROPRANOLOL LA CAPS**	MC/DEL		**HEMANGEOL SOL**		
	MC		RANOLAZINE ER TABS	MC		INDERAL XL CAP		
	MC/DEL		SOTALOL AF	MC		INDERAL LA CPCR		
	MC/DEL		SOTALOL HCL TABS	MC		INNOPRAN XL		
	MC/DEL		**TIMOLOL MALEATE TABS**	MC		RANEXA		
BETA BLOCKERS - CARDIO SELECTIVE	MC/DEL		**ACEBUTOLOL HCL CAPS**	MC		KERLONE TABS	1. Recommend using Atenolol (and metoprolol) BID since its effects do not last 24 hours. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**ATENOLOL TABS[1]**	MC/DEL		**LOPRESSOR TABS**		
	MC/DEL		**BETAXOLOL HCL TABS**	MC		SECTRAL CAPS		
	MC/DEL		**BISOPROLOL FUMARATE TABS**	MC/DEL		**TENORMIN TABS**		
	MC/DEL		BYSTOLIC	MC/DEL		**TOPROL XL TB24**		

	MC/DEL		METOPROLOL TARTRATE TABS[1]	MC/DEL		ZEBETA TABS		
	MC/DEL		METOPROLOL ER					
	MC/DEL		NEBIVOLOL HCL TAB					
BETA BLOCKERS - ALPHA / BETA	MC/DEL		LABETALOL HCL TABS	MC		TRANDATE TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
BETA BLOCKERS & DURECTIC COMBOS	MC/DEL		METOPROLOL-HYDROCHLOROTHIAZIDE TAB	MC/DEL		DUTOPROL	Use PA Form# 20420	
CALCIUM CHANNEL BLOCKERS--Amlodipines, Bepridil, Diltiazems, Felodipines, Isradipines, Nifedipines, Nisoldipine, and Verapamils	MC/DEL		AMLODIPINE[1]				1. Dosing limits apply, please see dose consolidation list.	
				MC/DEL		KATERZIA		
				MC		NORLIQVA		
				MC/DEL		NORVASC TABS[1]	Use PA Form# 20420	
	MC		DILTIA XT CP24	MC/DEL	5	DILACOR XR CP24[1]	1. Products must be used in specified order or PA will be required. Just write "Diltiazem 24-hour"and the pharmacy will use a preferred long acting diltiazem that does not require PA.	Preferred drugs must be tried and failed (in step-order) due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** All preferred diltiazems will now be non-preferred and require prior authorization if they are currently being used in combination with either Enablex 15mg or Vesicare 10mg. All non-preferred diltiazems require prior authorization, but with any prior authorization request, the member's drug profile will also be monitored for current use with Enablex 15mg or Vesicare 10mg.
	MC/DEL		DILTIAZEM HCL ER CP24	MC/DEL	6	TAZTIA[1]		
	MC/DEL		DILTIAZEM HCL XR CP24	MC	8	CARDIZEM TABS[1]		
	MC/DEL		DILTIAZEM CD 300MG CP24	MC	8	CARDIZEM CD CP24[1]		
	MC/DEL		DILTIAZEM CD 360MG CP24	MC	8	CARDIZEM LA TB24[1]		
	MC		CARTIA XT CP24[1]	MC	8	CARDIZEM SR CP12[1]		
	MC/DEL		DILTIAZEM CD CP24[1]	MC/DEL	8	DILTIAZEM HCL TABS[1]		
	MC/DEL		DILTIAZEM HCL ER CP24[1]	MC/DEL	8	DILTIAZEM HCL ER CP12[1]		
	MC/DEL		DILTIAZEM XR CP24[1]	MC/DEL	8	DILTIAZEM HCL ER CP12[1]		
	MC/DEL		TIAZAC CP24[1]				Use PA Form# 20420	
				MC/DEL		PLENDIL TB24	Use PA Form# 20420	Other Preferred calcium channel blockers must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC/DEL		FELODIPINE		
				MC		DYNACIRC CAPS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC		DYNACIRC CR TBCR[1]	1. Established users will be grandfathered	
				MC		CARDENE SR CPCR	Use PA Form# 20420	Other Preferred calcium channel blockers must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC		NICARDIPINE HCL CAPS		
	MC/DEL		AFEDITAB CR	MC/DEL		ADALAT CC TBCR[1]	1. Established users of Adalat CC are grandfathered.	Preferred drug must be tried and failed in step order due to lack of efficacy or intolerable side effects before non-preferred drugs in step order will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		NIFEDIAC CC	MC/DEL		NIFEDIPINE CAPS		
	MC/DEL		NIFEDICAL XL TBCR	MC/DEL		PROCARDIA CAPS		
	MC/DEL		NIFEDIPINE TBCR	MC/DEL		PROCARDIA XL TBCR	Use PA Form# 20420	
	MC/DEL		NIFEDIPINE ER TBCR					
				MC		SULAR TB24	1. Established users of 10MG and 20MG strengths are grandfathered.	
				MC		SULAR CR[1]		
							Use PA Form# 20420	
	MC/DEL	1	VERAPAMIL HCL CR TBCR	MC/DEL		CALAN TABS	Products must be used in specified order or PA will be required. Just write "Verapamil 24-hour" and the pharmacy will use a preferred long acting generic that does not require PA.	Preferred drugs must be tried and failed (in step-order) due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	1	VERAPAMIL HCL ER TBCR	MC/DEL		CALAN SR TBCR		
	MC/DEL	1	VERAPAMIL HCL SR TBCR	MC/DEL		COVERA-HS TBCR		
				MC		ISOPTIN-SR		
				MC/DEL		VERAPAMIL HCL ER CP24		
				MC/DEL		VERAPAMIL HCL SR CP24		
				MC/DEL		VERAPAMIL HCL TABS		
				MC/DEL		VERELAN CP24		
				MC/DEL		VERELAN PM CP24	Use PA Form# 20420	
ANTIARRHYTHMICS	MC/DEL		AMIODARONE HCL	MC/DEL		CORDARONE	1. Prescription must be written by Cardiologist.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Amiodarone will now be non-preferred and require prior authorization if it is currently being used in combination with either Lovastatin (doses greater than 40mg/day) or Lipitor (doses greater than 20mg/day) or Levofloxacin or Gemifloxacin, or Moxifloxacin, or Ofloxacin.
	MC/DEL		DISOPYRAMIDE	MC/DEL		DISOPYRAMIDE		
	MC/DEL		FLECAINIDE	MC/DEL		MULTAQ		
	MC/DEL		MEXILETINE HCL	MC/DEL		NORPACE		
	MC/DEL		PROCAINAMIDE	MC/DEL		PACERONE		
	MC/DEL		PROPAFENONE	MC		QUINIDEX	Use PA Form# 20420	

	MC		QUINAGLUTE	MC/DEL		TAMBOCOR		
	MC/DEL		**QUINIDINE GLUCONATE**	MC/DEL		TIKOSYN[1]		**DDI:** Multaq will be preferred unless the following medications are seen in the member's drug profile within the last 35 days for brand name medications or 90 days for generic medications: Erythromycin, Amiodarone and other antiarrhythmics, TCA's, Phenothiazine, Ketoconazole, Itraconazole, Voriconazole, Cyclosporine, Telithromycin, Clarithromycin, Nefazodone, Ritonavir.
	MC/DEL		**QUINIDINE SULFATE**	MC		**RYTHMOL SR**		
				MC/DEL		**RYTHMOL**		
ACE INHIBITORS	MC/DEL		**BENAZEPRIL HCL**	MC	5	MAVIK TABS	1. Non-preferred products must be used in specified order. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Non-preferred products are subject to step-order requirements unless clinical circumstances warrant exception.
	MC/DEL		**CAPTOPRIL TABS**	MC/DEL	5	**ACCUPRIL TABS**		
	MC/DEL		**ENALAPRIL MALEATE TABS**	MC/DEL	8	**ACEON TABS[1]**		
	MC/DEL		**FOSINOPRIL SODIUM**	MC/DEL	8	**ALTACE CAPS[1]**		
	MC/DEL		**LISINOPRIL TABS**	MC	8	EPANED		
	MC/DEL		**RAMIPRIL**	MC/DEL	8	**LOTENSIN TABS[1]**		
	MC/DEL		**QUINAPRIL HCL**	MC/DEL	8	**MOEXIPRIL HCL[1]**		
				MC	8	**MONOPRIL HCT TABS[1]**		
				MC/DEL	8	**PRINIVIL TABS[1]**		
				MC	8	QBRELIS		
				MC/DEL	8	**UNIVASC[1]**		
				MC	8	VASOTEC TABS[1]		
				MC/DEL	8	**ZESTRIL TABS[1]**		
ANGIOTENSIN RECEPTOR BLOCKER	MC/DEL		**AMLODIPINE-OLMESARTAN TAB[3]**	MC/DEL	8	**ATACAND TABS**	Use PA Form# 20420 1. Dosing limits apply, please see dose consolidation list. 2. Use preferred active ingredients which are available without PA. 3. Preferred without a PA only if patient on a diabetic therapy or prior ACE therapy.	Per best practices patient should have trialed prior therapy of ACE inhibitor or currently on a diabetic therapy
	MC/DEL		**IRBESARTAN[1]**	MC/DEL	8	**AVAPRO**		
	MC/DEL		LOSARTAN[1]	MC/DEL	8	**BENICAR TABS**		
	MC/DEL		**MICARDIS TABS[3]**	MC/DEL	8	**COZAAR**		
	MC/DEL		**OLMESARTAN[1]**	MC/DEL	8	**DIOVAN**		
	MC/DEL		**TELMISARTAN[1]**	MC/DEL	8	EDARBI		
				MC	8	TEVETEN TABS		
DIRECT RENIN INHIBITOR				MC/DEL		AMTURNIDE	1. Must show failure of single and combination therapy from all preferred antihypertensive categories. Use PA Form# 20420	
				MC/DEL		TEKTURNA[1]		
				MC/DEL		TEKAMLO		
ANTIHYPERTENSIVES - CENTRAL	MC/DEL		**CLONIDINE HCL TABS**	MC/DEL		**CLONIDINE PATCH**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**GUANFACINE HCL TABS**	MC/DEL		CLONIDINE TTS		
	MC/DEL		**HYDRALAZINE HCL TABS**	MC		GUANABENZ ACETATE TABS		
	MC		HYLOREL TABS	MC		ISMELIN TABS		
	MC/DEL		**METHYLDOPA TABS**	MC/DEL		**MINIPRESS CAPS**		
	MC/DEL		**MINOXIDIL TABS**	MC		**NEXICLON**		
	MC/DEL		**PRAZOSIN HCL CAPS**	MC/DEL		**TENEX TABS**		
	MC/DEL		**RESERPINE TABS**					
ACE INHIBITORS AND CA CHANNEL BLOCKERS				MC/DEL	8	**AMLODIPINE/BENAZEPRIL**	1. Prestalia will only be approved for patients ≥ 18 years of age. Use individual preferred generic medications. Use PA Form# 20420	
				MC	8	PRESTALIA[1]		
				MC	8	TARKA TBCR		
				MC/DEL	9	**LOTREL CAPS**		
ACE AND THIAZIDE COMBO'S	MC/DEL		**BENAZEPRIL HCL/HYDROCHLOR**	MC/DEL		**ACCURETIC TABS**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**CAPTOPRIL/HYDROCHLOROTHIA**	MC		MONOPRIL HCT TABS		
	MC/DEL		**ENALAPRIL MALEATE/HCTZ TABS**	MC/DEL		**PRINZIDE TABS**		
	MC/DEL		**LISINOPRIL-HCTZ TABS**	MC/DEL		**UNIRETIC TABS**		
	MC/DEL		**LOTENSIN HCT TABS**	MC		VASERETIC TABS		
				MC/DEL		**ZESTORETIC TABS**		
BETA BLOCKERS AND DIURETIC COMBO'S	MC/DEL		**ATENOLOL/CHLORTHALIDONE**	MC/DEL		**CORZIDE TABS**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**BISOPROLOL FUMARATE/HCTZ**	MC/DEL		**LOPRESSOR HCT TABS**		

	MC/DEL		PROPRANOLOL/HCTZ	MC		TENORETIC		preferred drug(s) exists.
				MC		TIMOLIDE 10/25 TABS		
				MC/DEL		ZIAC TABS		
ARB'S AND CA CHANNEL BLOCKERS	MC/DEL		AMLODIPINE/VALSARTAN	MC/DEL		AZOR		DDI: Byvalson will be non-preferred and require a prior authorization if it is currently being used in combination with drugs known to be significant CYP2D6 inhibitors (e.g. quinidine, propafenone, fluoxetine, paroxetine).
	MC/DEL		AMLODIPINE/VALSARTAN HCT	MC		BYVALSON		
	MC/DEL		TRIBENZOR	MC/DEL		EXFORGE		
				MC/DEL		EXFORGE HCT	Use PA Form# 20420	Per best practices patient should have trialed prior therapy of ACE inhibitor or currently on a diabetic therapy
ARB'S AND DIURETICS	MC/DEL		BENICAR HCT[1]	MC/DEL	7	IRBESARTAN HYDROCHLOROTHIAZIDE	1. Dosing limits apply, please see dose consolidation list.	Per best practices patient should have trialed prior therapy of ACE inhibitor or currently on a diabetic therapy
	MC/DEL		LOSARTAN HCT[1]	MC/DEL	8	ATACAND HCT TABS		
	MC/DEL		MICARDIS HCT TABS[1]	MC	8	AVALIDE TABS[1]		
	MC/DEL		VALSARTAN-HCT[1]	MC/DEL	8	DIOVAN HCT TABS[1]		
				MC/DEL	8	HYZAAR TABS		
				MC	8	TEVETEN HCT TABS	Use PA Form# 20420	
ANGIOTENSIN MODULATORS-ARB COMBINATION	MC		ENTRESTO	MC/DEL		EDARBYCLOR		
				MC		ENTRESTO SPRINKLES	Use PA Form# 20420	
ARB'S AND DIRECT RENIN INHIBITOR COMBINATION				MC/DEL		VALTURNA	Use PA Form# 20420	
DIURETICS	MC/DEL		ACETAZOLAMIDE TABS	MC/DEL		ALDACTAZIDE TABS		Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		BUMETANIDE	MC/DEL		ALDACTONE TABS		
	MC/DEL		CHLOROTHIAZIDE TABS	MC/DEL		AMILORIDE HCL		
	MC/DEL		CHLORTHALIDONE TABS	MC/DEL		BUMEX TABS		
	MC		EDECRIN TABS	MC/DEL		DEMADEX TABS		Furoscix: The indication for use is the treatment of congestion due to fluid overload in adults with NYHA Class II or Class III chronic heart failure AND the medication is being prescribed by or in consultation with a cardiologist AND the patient is experiencing symptoms despite compliance with oral loop diuretic therapy AND oral loop diuretic therapy will be resumed as soon as practical AND medical reasoning beyond convenience is provided for not pursuing therapy in an outpatient infusion setting. PA approval will be authorized for 1 month.
	MC/DEL		EDECRIN TABS	MC/DEL		DIAMOX		
	MC/DEL		HYDROCHLOROTHIAZIDE	MC		DIURIL		
	MC/DEL		INDAPAMIDE TABS	MC		DYAZIDE CAPS		
	MC/DEL		METHAZOLAMIDE TABS	MC		CAROSPIR		
	MC/DEL		METHYCLOTHIAZIDE TABS	MC		ENDURON TABS		
	MC/DEL		SPIRONOLACTONE	MC		FUROSCIX		
	MC/DEL		SPIRONOLACTONE/HYDRO	MC/DEL		INSPRA		DDI: The concomitant use of Keveyis® with high dose aspirin is contraindicated.
	MC/DEL		TORSEMIDE TABS	MC/DEL		KERENDIA		
	MC/DEL		TRIAMTERENE/HCTZ	MC/DEL		KEVEYIS		Kerendia: Patient must be on max tolerated preferred ACE-I/ARB and SGLT-2
	MC		ZAROXOLYN TABS	MC/DEL		LASIX TABS		
				MC/DEL		MAXZIDE		
				MC/DEL		MICROZIDE CAPS		
				MC/DEL		MIDAMOR TABS	Use PA Form# 20420	
				MC		NAQUA TABS		
CCB / LIPID				MC/DEL		CADUET	Use PA Form# 20420	
NEUROGENIC ORTHOSTATIC HYPOTENSION								
NEUROGENIC ORTHOSTATIC HYPOTENSION				MC		NORTHERA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
LIPID DRUGS								
CHOLESTEROL - BILE SEQUESTRANTS	MC/DEL		CHOLESTYRAMINE	MC/DEL		COLESTID	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		COLESTIPOL HCl	MC/DEL		PREVALITE		
				MC		QUESTRAN		
				MC/DEL		WELCHOL TABS		
CHOLESTEROL - FIBRIC ACID DERIVATIVES	MC/DEL		FENOFIBRATE TAB	MC		ANTARA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		GEMFIBROZIL TABS	MC/DEL		LOPID		
	MC/DEL		NIACIN ER	MC/DEL		FENOFIBRATE 120mg TAB		
				MC/DEL		FENOFIBRATE CAP		
				MC/DEL		FIBRICOR		DDI: Fenofibrate is preferred but will require a prior authorization requests if used concurrent with Warfarin.
				MC		LIPOFEN		
				MC/DEL		LOFIBRA		DDI: Gemfibrozil will now be non-preferred and require prior authorization if it is currently being used with any of the following medications: Prandin, Actos, Avandia, any Avandia/Actos

				MC/DEL		**NIASPAN ER**		combination product, any HMG-COA Reductase Inhibitors (statins), or Warfarin.
				MC		TRICOR		
				MC		TRIGLIDE		
CHOLESTEROL - HMG COA + ABSORB INHIBITORS MORE POTENT DRUGS/COMBINATIONS	MC/DEL		**ATORVASTATIN**	MC		ATORVALIQ	1. Dosing limits apply, please see dosage consolidation list.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**EZETIM/SIMVA TAB**	MC/DEL		**CRESTOR**		
	MC		ROSUVASTATIN	MC/DEL		**EZALLOR SPRINKLES**[3]		
	MC/DEL		**SIMVASTATIN**[1]	MC/DEL		**LIPITOR**	2. Current users grandfathered.	**DDI:** Lipitor (doses greater than 20mg/day) will now be non-preferred and require prior authorization if they are currently being used in combination cyclosporine.
				MC		LIPTRUZET		
				MC/DEL		**ZOCOR**	3. For the treatment of patients ≥ 18 years of age.	**DDI:** Lipitor (doses greater than 20mg/day) will now be non-preferred and require prior authorization if it is currently being used in combination with Amiodarone.
				MC/DEL		**SIMVASTATIN 80MG**[1,2]		
				MC		**VYTORIN**	Use PA Form# 20420	**DDI:** All preferred statins will now be non-preferred and require prior authorization if it is currently being used in combination with Gemfibrozil.
CHOLESTEROL - HMG COA + ABSORB INHIBITORS LESS POTENT DRUGS/COMBINATIONS	MC/DEL		**EZETIMIBE TABS**	MC	8	ALTOPREV TB24	2. Dosing limits apply, please see dosage consolidation list.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Zetia will be approved for patients unable to tolerate all other therapies or unable to achieve cholesterol goal with maximally tolerated dose of most potent statins.
	MC/DEL		LOVASTATIN TABS[2]	MC/DEL	8	**FLUVASTATIN TAB ER**		
	MC/DEL		PRAVASTATIN[2]	MC/DEL	8	LESCOL XL TB24		
				MC	8	LIVALO		
				MC/DEL	8	MEVACOR TABS		**DDI:** Lescol will now be non-preferred and require prior authorization if it is currently being used in combination with diclofenac.
				MC	8	NEXLETOL		**DDI:** Lovastatin (doses greater than 40mg/day) will now be non-preferred and require prior authorization if it is currently being used in combination with Amiodarone.
				MC	8	NEXLIZET		
				MC/DEL	8	**PRAVACHOL TABS**		
				MC/DEL	8	PRAVIGARD		**DDI:** Lovastatin (doses greater than 20mg per day) will now be non-preferred and require prior authorization if it is currently being used in combination cyclosporine.
				MC	8	ZETIA TABS	Use PA Form# 20420	**DDI:** All preferred statins will now be non-preferred and require prior authorization if it is currently being used in combination with Gemfibrozil.
CHOLESTEROL - HMG COA + ABSORB INHIBITORS STATIN/ NIACIN COMBO	MC		SIMCOR	MC		ADVICOR TBCR	Use PA Form# 20420	
FAMILIAL HYPERCHOLESTEROLEMIA	MC		**PRALUENT (LABLER 72733) PEN**[1,2,3,5]	MC		EVKEEZA[1,4]	1. Clinical PA required for appropriate diagnosis 2. Quantity limits apply 3. Documented adherence to lipid lowering medications and abstinence from tobacco for previous 90 days 4. For the treatment of patients ≥ 12 years of age. 5.Approval of Praluent NDC's with labeler code 00024 will be considered only if labeler code 72733 NDC's are on a long-term backorder and unavailable from the manufacturer.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists Juxtapid is contraindicated with strong CYP3A4 inhibitors. Juxtapid dosage should not exceed 30mg daily when it is used concomitantly with weak CYP3A4 inhibtors. Kynamro requires an appropriate lab testing prior to starting (ALT<AST), Alkaline phosphatase and total billrubin, monthly liver-related tests for the first year, then every three months. **Repatha and Praluent Criteria for approval:** The patients's age is FDA approved for the given indication AND • Concurrent use with statin therapy AND • Documented adherence to prescribed lipid lowering medications for the previous 90 days AND • Recommended or prescribed by a lipidologist or cardiologist AND • Inability to reach goal LDL-C despite a trial of 2 or more maximum tolerated dose of statins (one of which must be atorvastatin or rosuvastatin) and ezetimibe 10mg daily **Additional criteria for the diagnosis of heterozygous familial hypercholesterolemia (HeFH): (both are required):** Total cholesterol > 290 mg/dL OR LDL-C > 190 mg/dL AND one of the following • Presence of tendon xanthomas OR • In 1st or 2nd degree relative-documented tendon xanthomas, MI at age ≤ 60 years or TC > 290 mg/dL . **Additional criteria for the diagnosis of clinical atherosclerotic cardiovascular disease:** History of MI, angina, coronary or other arterial revascularization, stroke, TIA, or PVD of atherosclerotic origin. **Additional criteria for the diagnosis of homozygous familial hypercholesterolemia (Repatha only):** Total cholesterol levels > 290mg/dL or LDL-C > 190mg/dL (adults) OR Total
	MC		REPATHA[1,2,3]	MC		JUXTAPID		
				MC		KYNAMRO[1]		
				MC		LEQVIO		

							Use PA Form# 20420	cholesterol levels > 260mg/dL or LDL-C > 155mg/dL (children < 16 years) and TG within reference range OR Confirmation of diagnosis by gene testing.
PULMONARY ANTI-HYPERTENSIVES								
PULMONARY ANTI-HYPERTENSIVES	MC MC/DEL MC/DEL MC		EPOPROSTENOL INJ[3,6] SILDENAFIL TADALAFIL VENTAVIS[3]	MC/DEL MC MC/DEL MC MC MC MC MC MC MC/DEL MC MC MC MC MC/DEL		ADEMPAS[1,3] ADCIRCA[4] **ALYQ TAB** FLOLAN[3] LIQREV OPSUMIT[1,2] OPSYNVI[4] ORENITRAM REMODULIN[3] REVATIO[4] TADLIQ[4] TYVASO UPTRAVI VELVETRI[3] **WINREVAIR[4]**	1. Requires previous trials/failure of multiple preferred medications. 2. Dosing limits apply, please see the dose consolidation list. 3.Require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 3 or 4. 4.Require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA (WHO) functional class 2 or 3. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significat potential drug interation between another drug and the preferred drug(s) exists. Sildenafil will be preferred with clinical PA for treatment of pulmonary arterial hypotenion (WHO Group 1) in adults to improve exercise ability and delay clinical worsening. Avoid concomitant use of Sildenafil with moderate or strong Cyp3A inhibitors **DDI:** Uptravi will require a prior authorization if it is currently being used in combination with strong inhibitors of CYP2C8 (gemfibrozil) **DDI:** Opsumit will require a prior authorization if it is currently being used in combination with drugs known to be significant CYP3A inhibitors (ketoconazole, itraconazole, clarithromycin, indinavir, nefazodone, nelfinavir, ritonavir, atazanavir, saquinavir and telithromycin). **DDI:** Adempas will require a prior authorization if it is currently being used in combination with drugs known to be PDE inhibitors should be avoided (including dypyridamole, adcira and tadalafil) with adempas Liqrev: treatment of pulmonary arterial hypertension (WHO Group 1) in adults to improve exercise ability and delay clinical worsening.Avoid concomitant use of Liqrev with moderate or strong CYP3A inhibitors.
ERA / ENDOTHELIN RECEPTOR ANTAGONIST	MC MC		LETAIRIS[1,2] TRACLEER				1. Providers must be registered with LEAP Prescribing program, a restricted distribution program. 2. Clinical PA is required to establish diagnosis and medical necessity. Use PA Form# 20420	Tracleer approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 2 thru 4. **DDI:** Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer. Letairis approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and functional class 2 or 3 symptoms.
IMPOTENCE AGENTS								
IMPOTENCE AGENTS							As of January 1, 2006, per CMS (federal govt.), impotence agents are no longer covered.	As of January 1, 2006, per CMS (federal govt.), impotence agents are no longer covered.
ANTI-EMETOGENICS								
ANTIEMETIC - ANTICHOLINERGIC / DOPAMINERGIC	MC MC/DEL MC MC/DEL MC		DOXYLAMINE SUCC-PYRIDOXINE HCL MECLIZINE HCL TABS PROMETHAZINE SUPP PROMETHAZINE TRANSDERM-SCOP PT72	MC MC MC MC MC MC MC MC		ANTIVERT TABS BARHEMSYS BONJESTA DICLEGIS PHENERGAN SOLN PROMETHAZINE 50MG SUPP PROMETHEGAN SUPP TORECAN TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. DDI: Concomitant use of MAOIs and Bonjesta® is contraindicated.
ANTIEMETIC - 5-HT3 RECEPTOR ANTAGONISTS/ SUBSTANCE P NEUROKININ	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		**DRONABINOL CAPS** GRANISETRON TAB **ONDANSETRON TAB** **ONDANSETRON ODT TBDP** **ONDANSETRON SOL**	MC MC MC MC MC MC MC MC	8 8 8 8 8 8 8 8	AKYNZEO[1] APREPITANT ALOXI ANZEMET TABS APONVIE[4] CESAMET[1] CINVANTI[4] EMEND[2]	1. Approvals will require diagnosis of chemo-induced nausea/vomiting and failed trials of all preferred anti-emetics, including 5-HT3 class (Ondansetron) and Marinol.	Preferred drugs and step therapy must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. * Ondansetron limits still apply as listed on the Ondansetron PA form for covered indications including chemotherapy, radiotherapy, post operative nausea & vomiting and hyperemesis gravidarum. Other medical indications will be approved or denied on a case by case basis. Hyperemesis and other medical indications approved are still subject to failure of multiple preferred antiemesis drugs. Akynzeo- Concomitant use should be avoided in patients who are chronically using a strong CYP3A inducer such as rifampin.

				MC	8	FOCINVEZ[1,2]		
				MC/DEL	8	KYTRIL	2. Clinical PA is required for members on highly emetic anti-neoplastic agents.	Varubi – Available to the few who are unable to tolerate or who have failed on preferred medications
				MC/DEL	8	MARINOL CAPS		
				MC	8	SANCUSO		Aponvie is for the prevention of postoperative nausea and vomiting (PONV) in adults.
				MC	8	SUSTOL		
				MC	8	SYNDROS	3. Dosing limits apply, please see Dosage Consolidation List	
				MC	8	TRIMETHOBENZAMIDE CAP		
				MC	8	VARUBI		
				MC/DEL	8	ZOFRAN ODT TBDP[3]	4. Clinical PA required for appropriate diagnosis	
				MC/DEL	8	ZOFRAN TABS[3]		
				MC/DEL	8	ZOFRAN INJ[3]		
				MC	8	ZUPLENZ		
							Use PA Form# 20420	
NON-SEDATING ANTIHISTAMINES / DECONGESTANTS								
ANTIHISTIMINES - NON-SEDATING	MC		ALAVERT TABS	MC	5	CLARINEX TABS[1,5]	1. Must fail preferred drugs, OTC loratidine and cetirizine before moving to non-preferred step order drugs.	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. No combination product with decongestant will be approved since pseudoephedrine available without PA.
	MC/DEL		CETIRIZINE TABS	MC	5	CLARINEX SYR[1,2]		
	MC/DEL		LORATADINE	MC/DEL	5	FEXOFENADINE[1]		
	MC		TAVIST ND (OTC)	MC/DEL	5	ZYRTEC[1]		
				MC/DEL	5	ZYRTEC SYR[1,2]		
				MC/DEL	8	ALLEGRA[3]	2. Clarinex and Zyrtec syrp <6 yr w/o PA.	Pseudoephedrine is available with prescription.
				MC	8	CLARITIN[3]		
				MC/DEL	8	DESLORATADIN	3. Must fail all step 5 drugs (Clarinex, Fexofenadine and Zyrtec) before moving to next step product.	
				MC/DEL	8	LORATADINE ODT[4]		
				MC/DEL	8	LEVOCETIRIZINE[4]		
				MC/DEL	9	XYZAL[3]		
							4. All OTC versions of loratadine ODT are now non-preferred.	
							5. Pa's for Clarinex RediTabs will only be approved if between the ages of 6-11 years old.	
							Use PA Form# 20530	
ANTIHISTIMINES - OTHER	MC/DEL		CLEMASTINE				Use PA Form# 20530	
	MC/DEL		CHLORPHENIRAMINE					
	MC/DEL		DIPHENHYDRAMINE					
ALLERGY / ASTHMA THERAPIES								
ANAPHYLACTIC DEVICES	MC/DEL		**EPINEPHRINE**	MC		TWINJECT		Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**EPIPEN**	MC/DEL		**SYMJEPI**		
	MC/DEL		**EPIPEN JR**					
							Use PA Form# 20420	
ALLERGEN IMMUNOTHERAPY				MC		ODACTRA	Use PA Form# 20420	Prescriber must provide the testing to show that the patient is allergic to the components in the prescribed therapy and must provide a clinically valid rationale why single agent sublingual therapy is being chosen over subcutaneous therapy
				MC		ORALAIR[1]		
				MC		PALFORZIA	1. See criteria section	Palforzia® is approved for use in patients with a confirmed diagnosis of peanut allergy. Initial dose escalation may be administered to patients aged 4 through 17 years. Up-dosing and maintenance may be continued in patients 4 years of age and older.
				MC		RAGWITEK		
				MC		GRASTEK		Odactra® is approved for use in persons 12 through 65 years of age. Note that Odactra® is not indicated for the immediate relief of allergic symptoms.
								Treatment must start 12 weeks before expected onset of pollen season and only after confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for any of the 5 grass species contained in Oralair

								Oralair: Patient age ≥10 years and ≤65 years Have an auto-injectable epinephrine on-hand
ANTIASTHMATIC - ANTICHOLINERGICS - INHALER	**MC** **MC/DEL** **MC/DEL**		**INCRUSE ELLIPTA**[3] SPIRIVA HANDIHALER[1,2] **SPIRIVA RESPIMAT**	**MC** **MC/DEL**		LONHALA MAGNAIR **TUDORZA**	Use PA Form# 20420 1. Quantity limit of 1 inhalation daily (1 capsule for inhalation daily) Spiriva 2. We ask physicians to write "asthma" on the prescription whenever Spiriva is primarily being used for that condition. 3. Quantity limit of 1 inhalation daily	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIASTHMATIC - PHOSPHODIESTERASE 4 INHIBITORS	**MC/DEL**		ROFLUMILAST	**MC/DEL** **MC**		DALIRESP OHTUVAYRE[1]	Use PA Form# 20420 1. For the maintenance treatment of chronic obstructive pulmonary disease (COPD) in adult patients	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIASTHMATIC - ANTICHOLINERGICS - NEBULIZER	**MC/DEL**		**IPRATROPIUM BROMIDE SOLN**	**MC** **MC/DEL**		ATROVENT SOLN **YUPELRI**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIASTHMATIC - ANTIINFLAMMATORY AGENTS	**MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL**		CROMOLYN SODIUM NEBU DUPIXENT[2,4] **FASENRA**[2] **FASENRA**[2] **AUTO INJCT** XOLAIR[1]	**MC** **MC** **MC**		CINQAIR[3] **NUCALA**[2] TEZSPIRE[5]	1. Need max inhaled steroids and written by pulmonary or allergy specialist. Must have elevated IgE and ≥ to age 6. 2. For patients with severe asthma aged 12 years or older and eosinophilia. 3. For patients ≥ 18 years of age with eosinophilia. 4. Clinical PA required. 5. For adult and pediatric patients aged 12 years and older with severe asthma. Use PA Form# 20420	All will require suboptimal response to maximal doses of inhaled steroid as evidenced by asthmatic ER/Hospital admissions and Allergy/Pulmonary specialist management. Dupixent limited to patient with asthma not controlled on high dose ICS-LABA who have eosinophil greater than or equal to 150 cells or the patient is depend on an oral corticosteroid Fasenra, Nucala and Cinqair are not indicated for treatment of other eosinophilic conditions and are not indicated for the relief of acute bronchospasm or status asthmaticus.
ANTIASTHMATIC - NASAL STEROIDS	**MC/DEL** **MC/DEL** **MC** **MC/DEL** **MC/DEL** **MC**		BUDESONIDE SPRAY **FLUTICASONE SPR**[3] OLOPATADINE SPRAY OMNARIS SPR[3] TRIAMCINOLONE NS QNASL	**MC** **MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL** **MC** **MC/DEL**	5 8 8 8 8 8 8	BECONASE AQ INHA[1,3] DYMISTA FLONASE SUSP[2,3] FLUNISOLIDE SOLN[1,3] NASONEX SUSP RHINOCORT AERO[2,3] RHINOCORT AQUA SUSP[2,3]	Use PA Form# 20420 1. All preferred drugs must be tried before moving to non preferred steps. 2. All step 5 medications need to be tried before	Preferred drugs and step therapy must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Xhance** will be considered for the treatment of nasal polyps in patients 18 years of age or older. The patient has had a documented side effect, allergy, or treatment failure of two

				MC	8	RYALTRIS[4]	moving to step 8 s. 3. Dosing limits apply to whole category, please see dosage consolidation list. 4. Use of individual ingredients or other preferred agents.	preferred nasal glucocorticoids, one of which must be fluticasone.
				MC	8	TRI-NASAL SOLN[2,3]		
				MC	8	VANCENASE POCKETHALER AERS[2,3]		
				MC/DEL	8	VERAMYST[2,3]		
				MC	8	XHANCE[2]		
				MC/DEL	8	ZETONNA[3]		
ANTIASTHMATIC - NASAL MISC.	MC/DEL		AZELASTINE	MC/DEL	8	ASTEPRO[2]	Use PA Form# 20420 1. Ipratropium will be approved if submitted with documentation supporting use of CPAP machine. 2. Utilize Multiple preferred, as well as step therapy Azelastine.	Approved if patient fails on nonsedating antihistamines and steroid nasal sprays. Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		CROMOLYN NASAL 4%	MC/DEL	8	PATANASE		
	MC		IPRATROPIUM NASAL SOL[1]					
ANTIASTHMATIC - BETA - ADRENERGICS	MC/DEL		**ALBUTEROL NEB**	MC/DEL		**ACCUNEB NEBU**	1. Xopenex users w/ prior asthma hospitalization due to albuterol nebulizer failure will be grandfathered. 2. Quantity Limit: 12 cc/day. 3. Dosing limits apply, please see dosage consolidation list. 4. For the treatment of patients ≥ 4 years of age. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**ALBUTEROL HFA (Teva labeler 00093 AND Sandoz 00781)**	MC/DEL		**ALBUTEROL HFA**		
	MC		LEVALBUTEROL TARTRATE	MC/DEL		**BRETHINE**		
	MC/DEL		**METAPROTERENOL**	MC/DEL		**PROAIR DIGIHALER[4]**		
	MC		PROAIR RESPICLICK	MC		VOLMAX TBCR		
	MC/DEL		**PROVENTIL HFA**	MC		VOSPIRE ER TB12		
	MC		**SEREVENT**	MC		**XOPENEX HFA[3]**		
	MC/DEL		**STRIVERDI**	MC		**XOPENEX NEBU[1,2]**		
	MC/DEL		**TERBUTALINE SULFATE TABS**					
	MC/DEL		**ALBUTEROL 0.63mg/3ml**					
	MC		**VENTOLIN HFA AERS**					
ANTIASTHMATIC - ADRENERGIC COMBINATIONS	MC		**ADVAIR DISKUS[1]**	MC		AIRDUO DIGIHALER[2]	1. Dosing limits apply, please see dosage consolidation list. 2. For patients ≥ 12 years and older. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. AirDuo® Respiclick be non-preferred and require prior authorization and be available to those who are unable to tolerate or who have failed on preferred medications DDI: Avoid concomitant use of strong CYP3A4 inhibitors (e.g. ritonavir, atazanavir, clarithromycin, indinavir, itraconazole, nefazodone, nelfinavir, saquinavir, ketoconazole, telithromycin) with **AirDuo® Respiclick** is not recommended due to increased systemic corticosteroid and increased cardiovascular adverse effects
	MC		**ADVAIR HFA[1]**	MC/DEL		**AIRSUPRA**		
	MC		AIRDUO RESPICLICK[2]	MC/DEL		**BREZTRI AEROSPHERE**		
	MC		**BREO ELLIPTA[1]**	MC		**TRELEGY ELLIPTA[1]**		
	MC/DEL		DULERA					
	MC/DEL		FLUTICASONE-SALMETEROL					
	MC/DEL		SYMBICORT					
ANTIASTHMATIC - ADRENERGIC ANTICHOLINERGIC	MC/DEL		**ALBUTEROL/IPRATROPIUM NEB. SOLN**	MC/DEL		**BEVESPI AEROSPHERE[2,3]**	1. Please use preferred individual ingredients Albuterol and Ipratropium. 2. Dosing limits apply, please see dosing consolidation list.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Duoneb components are available separately without PA. DDI: Avoid concomitant use of Bevespi with other anticholinergic-containing drugs, due to an increased risk of anticholinergic adverse events. Bevespi® should be used with extreme caution in patients being treated with MAO inhibitors, TCAs, or other drugs known to prolong the QTc interval.
	MC		**ANORO ELLIPTA**	MC/DEL		**DUAKLIR PRESSAIR**		
	MC/DEL		**COMBIVENT RESPIMAT**	MC/DEL		DUONEB SOLN[1]		
	MC/DEL		**STIOLTO**					

							3. The safety and efficacy of use in children under the age of 18 years have not been established. Use PA Form# 20420	Bevespi should be used with extreme caution in patients being treated with MAO inhibitors, TCAs, or other drugs known to prolong the QTc interval.
ANTIASTHMATIC - XANTHINES	**MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL** **MC** **MC/DEL** **MC/DEL** **MC/DEL**		**AMINOPHYLLINE TABS** THEOCHRON TB12 THEOLAIR-SR TB12 **THEOPHYLLINE CR TB12** THEOPHYLLINE ELIX THEOPHYLLINE SOLN **THEOPHYLLINE ER CP12** **THEOPHYLLINE ER TB12**	**MC/DEL** **MC** **MC/DEL**		**THEO-24 CP24** THEOLAIR TABS **UNIPHYL TBCR**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIASTHMATIC - STEROID INHALANTS	**MC** **MC/DEL** **MC/DEL** **MC/DEL** **MC** **MC/DEL** **MC**		**ARNUITY ELLIPTA** **ASMANEX TWISTHALER** [3,4] ASMANEX HFA[5] **BUDESONIDE NEB 0.25MG & 0.5MG**[1] **FLOVENT DISKUS**[3] **PULMICORT FLEXHALER**[3] QVAR AERS[3]	**MC** **MC/DEL** **MC** **MC/DEL** **MC/DEL** **MC**	8 8 8 **8** 8 8	AEROSPAN ALVESCO[3] ARMONAIR DIGIHALER **BUDESONIDE NEB 1MG** **PULMICORT SUSP** **FLOVENT HFA**[3]	1. Budesonide Neb 0.25mg & 0.5mg will be preferred for members under the age of 8 years old. PA will be required for members 8 years of age and older, please consider other preferred options. 2. All preferreds must be	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

							tried before moving to non preferred steps. 3. Dosing limits apply, please see dosage consolidation list. 4. Asmanex 110mcg will be limited to member between the ages of 4-11years old. 5. Asmanex HFA will be preferred for members under the age of 6 years old. PA will be required for members 6 years of age and older, please consider other preferred options. Use PA Form# 20420	
ANTIASTHMATIC - 5-Lipoxygenase Inhibitors				MC		**ZYFLO CR TABS**	Use PA Form# 20420	Other Preferred asthma controller drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIASTHMATIC - LEUKOTRIENE RECEPTOR ANTAGONISTS	MC/DEL		MONTELUKAST GRANULE[1]	MC/DEL	8	**ACCOLATE TABS**	Use PA Form# 20420 1.Montelukast Granules will only be approved if between ages of 6months-24 months. 2.Singulair Chewables 4mg from 2years-5years and Singulair Chewables 5mgs from 6years-14years old.	
	MC/DEL		**MONTELUKAST SODIUM TAB**	MC/DEL	8	**SINGULAIR**[2]		
	MC/DEL		**MONTELUKAST SODIUM CHEW TAB**	MC/DEL	8	**SINGULAIR GRANULES**		
ANTIASTHMATIC - ALPHA-PROTEINASE INHIBITOR				MC	8	ARALAST	Use PA Form# 20420	Prolastin and Azemaira will be approved for members with A1AT deficiency and clinically demonstrable panacinar emphysema.
				MC/DEL	8	**ZEMAIRA**		
				MC	8	GLASSIA		
				MC	8	PROLASTIN SUSR		
ANTIASTHMATIC - HYDRO-LYTIC ENZYMES				MC/DEL		PULMOZYME SOLN	Use PA Form# 20420	Will be approved for cystic fibrosis patients.
ANTIASTHMATIC - MUCOLYTICS	MC/DEL		ACETYLCYSTEINE[1]	MC		MUCOMYST	1. Acetylcysteine is covered with diagnosis of CF. Use PA Form# 20420	
ANTIASTHMATIC-CFTR POTENTIATOR AND COMBINATIONS				MC		BRONCHITOL[1]	1. For the treatment of patients ≥18 years of age with CF.	Kalydeco will be considered for patients with cystic fibrosis (CF) aged 1 month and older who have at least one mutation in the CFTR gene that is responsive to ivacaftor potentiation based on clinical and/or in vitro assay data. If the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of a CFTR mutation followed by verification with bi-directional sequencing when recommended by the mutation test instructions for use. Symdeko will be considered for patients with cystic fibrosis (CF) aged 6 years and older who are homozygous for the *F508de* l mutation or who have at least one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to tezacaftor/ivacaftor based on in vitro data and/or clinical evidence. If the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of a CFTR mutation followed by verification with bi-directional sequencing when recommended by the mutation test instructions for use. Bronchitol will be considered as add-on maintenance therapy to improve pulmonary function in adult patients 18 years and older with cystic fibrosis (CF). Use Bronchitol® only for adults
				MC		ORKAMBI		
				MC		KALYDECO		
				MC		SYMDEKO		
				MC/DEL		**TRIKAFTA**		

										Use PA Form# 20420	who have passed the Bronchitol® Tolerance Test (BTT). (see Recommended Dosage section for further information Trikafta will be considered for the treatment of cystic fibrosis (CF) in patients aged 2 years and older who have at least one F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene or mutation in the CFTE gene that is responsive based on in vitro data. If the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to confirm the presence of at least one F508del mutation or a mutation that is responsive based on in vitro data. Orkambi will be considered for patients with cystic fibrosis (CF) aged 1 year and older who are homozygous for the F508del mutation in the CFTR gene. If the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of the F508del mutation on both alleles of the CFTR gene. The efficacy and safety of Orkambi have not been established in patients with CF other than those homozygous for the F508del mutation.

IDIOPATHIC PULMONARY FIBROSIS	MC/DEL		**OFEV**[1]	MC		ESBRIET[1]	1. Diagnosis required Use PA Form# 20420	Ofev- Avoid concomitant use with P-gp and CYPA4 inducers (e.g. carbamazepine, phenytoin, and St. John's wort Esbriet- The concomitant use with strong CYP1A2 inhibitors (e.g. fluvoxamine, enoxacin) is not recommended
	MC/DEL			MC		PIRFENIDONE		
COUGH/COLD								
COUGH/COLD	MC/DEL		**DEXTROMETHORPHAN CAPS**[1]				1. All of cough cold preparations are not covered except these preferred products. Use PA Form# 20420	All non-preferred products are not covered as permitted by Federal Medicaid regulations and MaineCare Policy.
	MC/DEL		DEXTRO-GUAIF SYRP[1]					
	MC/DEL		GUAIFENESIN SYRP[1]					
	MC/DEL		PSEUDOEPHEDRINE[1]					
	MC		ROBITUSSIN DM SYRP[1]					
	MC		ROBITUSSIN SUGAR FREE SYRP[1]					
DIGESTIVE AIDS / ASSORTED GI								
GI - ANTIPERISTALTIC AGENTS	MC/DEL		DIPHENOXYLATE	MC/DEL		LOFENE TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Certain drugs require specific diagnoses for approval.
	MC/DEL		DIPHENOXYLATE/ATROPINE	MC		LONOX TABS		
	MC/DEL		LOPERAMIDE HCL CAPS/LIQ	MC		MOTOFEN TABS		
	MC/DEL		OPIUM TINCTURE TINC					
	MC		PAREGORIC TINC					
GI - ANTI-DIARRHEAL/ ANTACID - MISC.	MC		**ATROPINE SULFATE SOLN**	MC/DEL		**BELLADONNA ALKALOIDS & OP**	Use PA Form# 20420 1.Dosing limits apply please refer to Dose Consolidation List 2. It is not indicated as monotherapy for treatment of peptic ulcer because effectiveness in peptic ulcer healing has not been established.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Certain drugs require specific diagnoses for approval. Preferred products that used to require diag codes still require diag codes unless indicated otherwise. **Mytesi** requires a diagnosis of non-infectious diarrhea in patients with HIV/AIDS on anti-retroviral therapy, prior trials of preferred, more cost effective anti-diarrheals.
	MC/DEL		BISMATROL	MC/DEL		BENTYL TABS		
	MC/DEL		BISMUTH SUBSALICYLATE	MC/DEL		BENTYL SYRP		
	MC/DEL		CALCIUM CARBONATE (ANTACID) CHEW	MC		CUVPOSA		
	MC/DEL		DICYCLOMINE HCL	MC		DARTISLA ODT[2]		
	MC/DEL		GLYCOPYRROLATE TABS	MC		ED-SPAZ		
	MC/DEL		HYOSCYAMINE CAPS & TABS	MC		MYTESI[1]		
	MC/DEL		HYOSCYAMINE SULFATE	MC/DEL		GLYCOPYRROLATE INJ		
	MC/DEL		KAOPECTATE	MC		LEVSIN TABS		
	MC/DEL		MAGNESIUM OXIDE TABS	MC		LEVSIN/SL SUBL		
	MC/DEL		**MAG-OX 400 TABS**	MC		NULEV TBDP		
	MC/DEL		PAMINE TABS	MC		OSCIMIN		
	MC/DEL		PROPANTHELINE BROMIDE TABS	MC		ROBINUL INJ		
	MC/DEL		SODIUM BICARBONATE TABS	MC		ROBINUL TABS		
	MC/DEL		TUMS					
GI- BILE ACID				MC		CHOLBAM	Use PA Form# 20420	Indication of bile acid synthesis disorders due to single enzyme defects (SEDs) AND for adjunctive treatment of peroxisomal disorders (PDs)
GI- EOSINOPHILIC ESOPHAGITIS	MC		EOHILIA[1]				Use PA Form# 20420 1. Approvals will not be longer than 12 weeks of treatment in adult and pediatric patients 11 years of age and older	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Eohilia: Dietary modification, PPIs, and topical glucocorticoids are required as initial therapy.
GI - H2-ANTAGONISTS	MC		ACID REDUCER TABS	MC		AXID CAPS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. DDI: Cimetidine will now be non-preferred and require prior authorization if it is currently being used with any sulfonylurea (except for glyburide). **DDI:** Cimetidine will require prior authorization if being used in combination with Plavix.
	MC/DEL		CIMETIDINE	MC		AXID AR TABS		
	MC/DEL		FAMOTIDINE	MC/DEL		NIZATIDINE CAPS		
				MC/DEL		PEPCID		
				MC		PEPCID AC		

GI- IBAT INHIBITORS				MC MC		BYLVAY[1,2] LIVMARLI[1,2]	Use PA Form# 20420 1. For the treatment of patients ≥ 3months of age 2. Clinical PA required for appropriate diagnosis	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Certain drugs require specific diagnoses for approval.
GI - PROTON PUMP INHIBITOR	MC/DEL MC/DEL MC/DEL		OMEPRAZOLE CAPS[2] PANTOPRAZOLE[2] LANSOPRAZOLE CAPS [2]	MC/DEL MC/DEL MC MC MC/DEL MC MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	6 6 7 7 8 8 8 8 8 8 8 8 8 8	NEXIUM CPDR[3] NEXIUM SUS[5] PRILOSEC OTC[3] ACIPHEX TBEC[3] DEXILANT (KAPIDEX)[2] KONVOMEP[2] OMEPRAZOLE-SODIUM BICARBONATE CAPS OMEPRAZOLE MAGNESIUM PREVACID CPDR[3] PREVACID SOLUTABS[1,4] PRILOSEC CPDR PROTONIX INJ PROTONIX[2] VOQUEZNA TABS	1. Prevacid Solutabs available without PA for children less than 9 years old. 2. Dosing limits apply, please see dosage consolidation list. 3. All preferreds and step therapy must be tried and failed 4. Payment for Prevacid SoluTabs for patients 9 and older will be considered for those patients who cannot tolerate a preferred solid oral dosage form. 5.Nexium sus available without PA if member is < 12 yrs of age and ≤ 1 pack per day Use PA Form# 20720	All preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Please refer to the PPI PA form for additional criteria on Non-Preferred PPIs **DDI:** Omeprazole will require prior authorization if being used in combination with Plavix. **DDI:** Lansoprazole will require prior authorization if being used in combination with Plavix. **DDI:** Prevacid, Omeprazole and pantoprazole will now be non-preferred and require prior authorization if they are currently being used in combination with any of the following medications: Ampicillin, B-12, Fe salts, Griseofulvin, Sporanox, Ketoconazole, Reyataz, or Vantin. **DDI:** All non-preferred PPIs require prior authorization, but with any prior authorization request, the member's drug profile will also be monitored for current use with ampicillin, B-12, Fe salts, griseofulvin, itraconazole, ketoconazole, Reyataz or Vantin due to a significant drug-drug interaction.
GI - ULCER ANTI-INFECTIVE	MC MC		PYLERA TALICIA			VOQUEZNA DUAL PAK VOQUEZNA TRIPLE PAK	Use PA Form# 20420	
GI - PROSTAGLANDINS	MC		MISOPROSTOL TABS	MC/DEL		CYTOTEC TABS	Use PA Form# 20420	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drug will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
GI - DIGESTIVE ENZYMES	MC/DEL MC		CREON[1] ZENPEP[1]	MC/DEL MC/DEL MC/DEL		PERTZYE ULTRESA VIOKACE	Use PA Form# 20420 1. Clinical PA is required to establish CF diagnosis and medical necessity. In all cases except cystic fibrosis patients, objective evidence of pancreatic insufficiency (fat malabsorption test etc...) must be supplied.	Non -Preferred drugs must be tried and failed in step-order due to lack of efficacy or intolerable side effects before other non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
GI - ANTI - FLATULENTS / GI STIMULANTS	MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL		AMITIZA CALULOSE SYRP CONSTULOSE SYRP ENULOSE SYRP GASTROCROM CONC GENERLAC SYRP LACTULOSE SYRP METOCLOPRAMIDE HCL	MC MC/DEL MC MC/DEL		CEPHULAC SYRP INFANTS GAS RELIEF SUSP GIMOTI SPRAY REGLAN TABS		Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Certain drugs require specific diagnoses for approval.

							Use PA Form# 20420	
GI - INFLAMMATORY BOWEL AGENTS	MC		APRISO	MC/DEL		ASACOL 800MG HD	Use PA Form# 20420 1. Current users grandfathered. 2. Diagnosis required	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Giazo is only indicated for males, as the safety.efficacy for use in females has not been established.Prior trials of preferred products. Uceris Rectal Foam or Tab- Concomitant use with CYP3A inhibitors (e.g. ketoconazole, itraconazole, ritonavir, indinavir, saquinavir, erythromycin, cyclosporine, and grapefruit juice) should be avoided. Verify prior trials and failures or intolerance of preferred treatments
	MC/DEL		BALSALAZIDE	MC/DEL		AZULFIDINE EN-TABS TBEC		
	MC		MESALAMINE ENMA KIT	MC		AZULFIDINE TABS		
	MC		PENTASA	MC		COLAZAL CAPS		
	MC/DEL		**SULFAZINE EC TBEC**	MC/DEL		DELZICOL		
	MC/DEL		**SULFASALAZINE TABS**	MC		DIPENTUM CAPS		
				MC		GIAZO		
				MC/DEL		LIALDA TABS[1]		
				MC/DEL		**MESALAMINE TAB**		
				MC/DEL		ROWASA ENEM		
				MC		SFROWASA		
				MC		UCERIS RECTAL FOAM[2]		
				MC		UCERIS TABS[2]		
GI - IRRITABLE BOWEL SYNDROME AGENTS	MC/DEL		LOTRONEX TABS	MC		VIBERZI	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
GI- SHORT BOWL SYNDROME				MC		GATTEX	Use PA Form #20420	Gattex requires a diagnosis of adult SBS who are dependent on parenteral support. Appropriate colonoscopy and lab assessments 6months prior to starting
GI- NASH				MC		REZDIFFRA	Use PA Form #20420	Rezdiffra: The patient must have a diagnosis of NASH with fibrosis Stage 2 or 3 and utilizing imaging and scanning test such as fibro scan, MRI or ultra sound AND the patient does not have evidence of decompensated cirrhosis
MISCELLANEOUS GI								
GI - MISC.	MC/DEL		BISAC-EVAC SUPP	MC/DEL		ACTIGALL CAPS	1. PA required to confirm FDA approved indication. 2. For the treatment of carcinoid syndrome diarrhea in combination with somatostatin analog (SSA) therapy in adults inadequately controlled by SSA therapy 3. For the treatment of Opioid Induced Constipation(OIC) 4. Established users will be grandfathered	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Certain drugs require specific diagnoses for approval. **Linzess** is preferred for adults as treatment of IBS-Constipation AND treatment of chronic idiopathic constipation in adults. Trulance should be avoided in pediatric patients less than 18 years of age. **Iqirvo:** For the treatment of primary biliary cholangitis (PBC) in combination with ursodeoxycholic acid (UDCA) in adults who have had an inadequate response to UDCA, or as monotherapy in patients unable to tolerate UDCA. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trial(s).
	MC/DEL		BISACODYL	MC		BENEFIBER		
	MC		BISCOLAX SUPP	MC/DEL		CARAFATE		
	MC		CINOBAC CAPS	MC/DEL		CLEARLAX POW		
	MC/DEL		CITRATE OF MAGNESIA SOLN	MC/DEL		COLACE CAPS		
	MC/DEL		CITRUCEL	MC		DIOCTO-C SYRP		
	MC/DEL		CLENPIQ SOL	MC		DOC SOD /CAS CAP		
	MC/DEL		COLYTE	MC		DOC-Q-LAX CAPS		
	MC/DEL		DIOCTO SYRP	MC/DEL		DOCUSATE SODIUM/CAS CAPS		
	MC		DOCUSATE CALCIUM CAPS	MC/DEL		DOK PLUS		
	MC/DEL		DOCUSATE SODIUM	MC/DEL		DULCOLAX SUPP		
	MC/DEL		FIBER LAXATIVE TABS	MC		ENEMEEZ		
	MC		FLEET	MC		FIBER CON TABS		
	MC/DEL		GENFIBER POWD	MC/DEL		FIBER-LAX TABS		
	MC/DEL		GLYCERIN	MC/DEL		GAVILYTE-H		
	MC		HIPREX TABS	MC		GOLYTELY SOLR		
	MC/DEL		KRISTALOSE PACK	MC		IBSRELA		
	MC/DEL		LINZESS	MC		IQIRVO		
	MC		MAALOX	MC/DEL		LINZESS 72mcg[4]		
	MC/DEL		MILK OF MAGNESIA SUSP	MC		MALTSUPEX		
	MC		MINERAL OIL OIL	MC		MIRALAX PACKETS		
	MC		MIRALAX BULK POWD (BRAND)	MC/DEL		MOTEGRITY		
	MC/DEL		MOVANTIK	MC		OCALIVA[1]		
	MC/DEL		MOVIPREP POWD PACK	MC		PEG-ELECTROLYTES SOLR		
	MC		NULYTELY SOLR	MC		PEG 3350 PACKETS		
	MC		PEG 3350- ELECTROLYTE SOL	MC		PREPOPIK PAK		
	MC		PEG 3350 POWDER	MC		RELISTOR TABS		
	MC/DEL		SENNA	MC/DEL		SENEXON TABS		

	MC/DEL		SENOKOT GRAN	MC/DEL		SENOKOT TABS		
	MC/DEL		SENOKOT SYRP	MC		SENOKOT S TABS		
	MC/DEL		SENOKOT CHILDRENS SYRP	MC/DEL		SORBITOL		
	MC		SENOKOT XTRA TABS	MC		STOOL SOFTENER PLUS CAPS		
	MC/DEL		STOOL SOFTENER CAPS	MC		SUFLAVE		
	MC/DEL		SUCRALFATE TABS	MC		SUTAB	Use PA Form# 20420	
	MC/DEL		SUPREP SOL	MC/DEL		SYMPROIC[3]		
	MC		TRULANCE[2]	MC/DEL		UNI-CENNA TABS		
	MC		UNI-EASE CAPS	MC		UNI-EASE PLUS CAPS		
	MC		URSO FORTE	MC		V-R NATURAL SENNA LAXATIV TABS		
	MC/DEL		URSODIOL	MC		URSO 250		
				MC		XERMELO[2]		
MISC. UROLOGICAL								
UROLOGICAL - MISC.	MC		ACETIC ACID 0.25% SOLN	MC		CITRIC ACID/SODIUM CITRAT SOLN	1. Elmiron requires adequate proof of Dx with supportive testing. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		CYTRA-K SOLN	MC/DEL		CYTRA-2 SOLN		
	MC		FOSFOMYCIN (NDC 82036427401 ONLY)	MC/DEL		ELMIRON CAPS[1]		
	MC		K-PHOS MF TABS	MC		FURADANTIN SUSP		
	MC/DEL		METHENAMINE MANDELATE TABS	MC/DEL		MACROBID CAPS		
	MC/DEL		NEOSPORIN GU IRRIGANT SOLN	MC/DEL		MACRODANTIN CAPS		
	MC/DEL		NITROFURANTOIN MONO CAPS	MC/DEL		NITROFURANTOIN MACR SUSP		
	MC/DEL		PHENAZOPYRIDINE HCL TABS	MC		POTASSIUM CITRATE/CITRIC SOLN		
	MC/DEL		PHENAZOPYRIDINE PLUS	MC/DEL		PYRIDIUM PLUS TABS		
	MC		POT CITRATE TAB	MC		PYRIDIUM TABS		
	MC/DEL		PROSED/DS TABS	MC/DEL		RENACIDIN SOLN		
	MC		TRICITRATES SYRP	MC		UROCIT-K		
	MC/DEL		URELIEF PLUS					
	MC		UREX TABS					
	MC/DEL		URISED TABS					
	MC/DEL		UROQID #2 TABS					
PHOSPHATE BINDERS								
PHOSPHATE BINDERS	MC/DEL		CALCIUM ACETATE CAP[1]	MC		AURYXIA[1]	Use PA Form# 20420 1. Diag required.	Preferred drugs must be tried and failed in step-order due to lack of efficacy or intolerable side effects before less preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Xphozah to reduce serum phosphorus in adults with chronic kidney disease (CKD) on dialysis as add-on therapy in patients who have an inadequate response to phosphate binders or who are intolerant of any dose of phosphate binder therapy.
	MC/DEL		FOSRENOL CHEW[1]	MC/DEL		CALCIUM ACETATE TAB[1]		
	MC/DEL		MAGNEBIND - 400[1]	MC/DEL		ELIPHOS[1]		
	MC		PHOSLYRA[1]	MC/DEL		FOSRENOL PWDR[1]		
	MC/DEL		RENVELA[1]	MC		VELPHORO[1]		
				MC		XPHOZAH		
INTRA-VAGINALS								
VAGINAL - ANTIBACTERIALS	MC/DEL		CLEOCIN CREA	MC/DEL		METROGEL VAGINAL GEL[1]	1. Dosing limits apply, please see Dosage Consolidation List. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before less preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		CLEOCIN SUPP	MC/DEL		VANDAZOLE		
	MC		CLINDESSE CREA	MC		XACIATO		
	MC/DEL		METRONIDAZOLE VAGINAL GEL[1]					
	MC/DEL		NUVESSA					
VAGINAL - ANTI FUNGALS	MC/DEL		CLOTRIMAZOLE CREA	MC		AVC CREA	1. Quantity limit: 1/script/2 weeks Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Miconazole will require prior authorization if being used in combination with Warfarin.
	MC/DEL		CLOTRIMAZOLE-3 CREA	MC		CLOTRIMAZOLE 3 DAY CREA		
	MC/DEL		GYNE-LOTRIMIN CREA	MC		GYNAZOLE-1 CREA		
	MC		MICONAZOLE CREA	MC		GYNE-LOTRIMIN 3 TABS		
	MC		MICONAZOLE 3 KIT CREA OTC	MC/DEL		MICONAZOLE 3 COMBO PACK KIT[1]		
	MC/DEL		MICONAZOLE 7 CREA	MC/DEL		MICONAZOLE 3 SUPP		
	MC/DEL		MICONAZOLE NITRATE CREA	MC		TERAZOL 3 CREA		
	MC		NYSTATIN TABS	MC		TERAZOL 7 CREA		
	MC/DEL		TERCONAZOLE CREAM	MC/DEL		TERCONAZOLE SUPP		
	MC		VAGITROL					

	MC		V-R MICONAZOLE-7 CREA					
VAGINAL - CONTRACEPTIVES							Use PA Form# 20420	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drug will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
VAGINAL - ESTROGENS	MC/DEL MC/DEL		**ESTRING RING** **PREMARIN CREA**	MC/DEL MC/DEL		ESTRACE CREA[1] VAGIFEM TABS[1]	1. Must fail all preferred products before non-preferred. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
VAGINAL - OTHER	MC/DEL MC MC		ACID JELLY GEL ACI-JEL GEL CERVICAL AMINO ACID CREA	MC		AMINO ACID CERVICAL CREA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
BENIGN PROSTATIC HYPERPLASIA (BPH)								
BPH	MC/DEL MC/DEL MC/DEL MC/DEL		**DOXAZOSIN MESYLATE TABS** FINASTERIDE[1] 5mg TERAZOSIN HCL CAPS **TAMSULOSIN HCL**	MC/DEL MC/DEL MC MC/DEL MC MC MC/DEL MC/DEL MC/DEL	5 8 8 8 8 8 8 8 8	**FLOMAX CP24** ALFUZOSIN AVODART[2,4] **CARDURA TABS**[4] ENTADFI[5,6] JALYN[3,4] PROSCAR TABS[4] RAPAFLO[4] UROXATRAL[4]	1. There will be dosing limits of 1 tab per day with out PA. 2. Prior use of preferred agent prior to any approvals. 3. Use of preferred (tamsulosin and finasteride) and (tamsulosin and non-preferred Avodart). 4. Non-preferred products must be used in specified order. 5. Use of individual ingredients preferred (Finasteride and tadalafil). 6. Entadfi® is not recommended for more than 26 weeks Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Approval of a non-preferred 5-alpha reductase inhibitor requires objective clinical evidence of a very enlarged prostate rather than just the presence of obstructive urinary outflow symptoms along with adequate trial of preferred Proscar.
ANXIOLYTICS								
ANXIOLYTICS - BENZODIAZEPINES	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		ALPRAZOLAM TABS CHLORDIAZEPOXIDE HCL CAPS CLORAZEPATE DIPOTASSIUM TABS DIAZEPAM LORAZEPAM OXAZEPAM CAPS	MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	8 8 8 8 8 8 8 9	ALPRAZOLAM ER ATIVAN LOREEV XR NIRAVAM SERAX TRANXENE XANAX TABS XANAX XR	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANXIOLYTICS - MISC.	MC/DEL MC MC MC/DEL MC/DEL MC/DEL		BUSPIRONE HCL TABS HYDROXYZINE HCL SOLN HYDROXYZINE HCL SYRP HYDROXYZINE HCL TABS[1] HYDROXYZINE PAMOATE CAPS MEPROBAMATE TABS	MC MC MC/DEL MC/DEL		BUSPAR TABS DROPERIDOL SOLN DROPERIDOL SOLN DROPERIDOL SOLN	Use PA Form# 20420 1. Dosing limits apply, please refer to Dose consolidation list.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTI-DEPRESSANTS								
ANTIDEPRESSANTS - MAO INHIBITORS	MC/DEL		NARDIL TABS	MC/DEL		**TRANYLCYPROMIINE**	Use PA Form# 20420	

ANTIDEPRESSANTS - MAO INHIBITORS TOPICAL				MC/DEL		EMSAM[1]	1. Dosing limits apply, please refer to Dose consolidation list. Use PA Form# 20420	Preferred drugs (including a preferred SSRI, a non-SSRI, and Venlafaxine ER) must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIDEPRESSANTS - SELECTED SSRI's AND OTHERS	MC/DEL		BUPROPION HCL TABS	MC/DEL	8	APLENZIN[4]	1. Strong caution with pediatric population. 2. Max daily dose allowed is 120mg, Combination of multiple strengths require PA 4. Dosing limits allowing 2 tabs/day and a max daily limit of 200mg / day applies. Please see dose consolidation list. 5. Dosing limits apply, please refer to Dose consolidation list and max daily dose applies. Max daily dose allowed is 375mg. 6. Non-preferred products must be used in specified step order. 7. Requires previous trials/failure of multiple preferred medications. Dosing limits apply, please see the dose consolidation list. Max daily dose of 80mg if used concomitantly with strong CYP3A4 inhibitor. 8. Psychiatry recommended. Please see criteria section. 9. Please use multiples of the 20mg, the 40mg is still non-preferred. 10. For the treatment of patients ≥ 18 years of age. 11. Use individual ingredients separtely. 12. Approval will be limited to a 14-day treatment course. Use PA Form# 20420	Preferred drugs (including failure of at least one preferred SSRI, one SNRI and one non-SSRI/SNRI) must be tried for at least 4 weeks each and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **CYMBALTA:** Fibromyalgia diagnosis- prior use and failure of preferred generics (amitriptyline or cyclobenzaprine) and gabapentin prior to approval. **DDI:** Fluvoxamine will now be non-preferred and require prior authorization if it is currently being used with glimepiride (Amaryl). **DDI:** Preferred nefazodone will now be non-preferred and require prior authorization if it is currently being used in combination with either Onglyza 5mg, Enablex 15mg or Vesicare 10mg. **DDI:** Fluoxetine will require prior authorization if being used in combination with Plavix. **DDI:** Fluvoxamine will require prior authorization if being used in combination with Plavix. **SAVELLA:** Fibromyalgia diagnosis and trial of a preferred generic amitriptyline, cyclobenzaprine, duloxetine and gabapentin prior to approval. DDI: Drizalma Sprinkle avoid the concomitant use of duloxetine with potent CYP1A2 inhibitors (e.g. fluvoxamine, cimetidine, ciprofloxacin, enoxacin). Zulresso® is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS) called the Zulresso® REMS. **Spravato:** Treatment Resistant Depression • Must be 18 years of age or older; and medication must be administered under the direct, on site, supervision of a licensed healthcare provider with post-administration observation of a minimum of least 2-hours. The medication must be prescribed by or in consultation with a psychiatrist and prescriber must be enrolled in the REMS program. • Approval is based upon failure of at least two antidepressants and failure of an antidepressant used adjunctively with one recognized augmentation strategy such as lithium, an atypical antipsychotic, thyroid hormone, etc • Ongoing use of Spravato beyond 3 months is based upon a positive response as evidenced by at least a 30 % reduction from baseline as measured by a standardized rating scale **Spravato:** MDD with Suicidal Ideation Approval for this indication only if it is started in an inpatient unit, given adjunctively with an optimized antidepressant regimen, and with an 8-12 week initial approval with ongoing use dependent upon documentation of ongoing benefit. DDI: Reduce the Zurzuvae® dosage when used with a strong CYP3A4 inhibitor.
	MC/DEL		BUPROPION SR	MC	8	AUVELITY[11]		
	MC/DEL		BUPROPION XL 150mg and 300mg	MC/DEL	8	BUPROPION XL 450mg		
	MC/DEL		CITALOPRAM	MC/DEL	8	CELEXA		
	MC/DEL		DULOXETINE[2,9]	MC	8	CYMBALTA[2]		
	MC/DEL		ESCITALOPRAM	MC/DEL	8	DRIZALMA SPRINKLES		
	MC/DEL		FLUOXETINE 10mg AND 20mg AND 40mg CAPS	MC/DEL	8	EFFEXOR TABS		
	MC/DEL		FLUOXETINE HCL LIQD	MC/DEL	8	EFFEXOR XR CP24		
	MC/DEL		FLUVOXAMINE MALEATE TABS	MC/DEL	8	FETZIMA[7]		
	MC/DEL		MIRTAZAPINE	MC/DEL	8	FLUOXETINE 10mg AND 20mg AND 60mg TABS		
	MC/DEL		NEFAZODONE	MC	8	FORFIVO XL		
	MC/DEL		PAROXETINE[1]	MC/DEL	8	IRENKA		
	MC/DEL		SERTRALINE HCL	MC/DEL	8	KHEDEZLA		
	MC/DEL		TRAZODONE HCL TABS	MC/DEL	8	LEXAPRO TABS		
	MC/DEL		VENLAFAXINE ER CAPS[5]	MC	8	LUVOX TABS		
	MC/DEL		VENLAFAXINE TABS[5]	MC	8	MAPROTILINE HCL TABS		
				MC/DEL	8	MIRTAZAPINE ODT		
				MC	8	OLEPTRO		
				MC/DEL	8	PAROXETINE CR[1]		
				MC/DEL	8	PAXIL[1]		
				MC/DEL	8	PAXIL CR[1]		
				MC/DEL	8	PRISTIQ		
				MC	8	PROZAC		
				MC	8	PROZAC CAPS		
				MC	8	PROZAC WEEKLY CPDR		
				MC/DEL	8	REMERON TABS		
				MC/DEL	8	SARAFEM CAPS		
				MC/DEL	8	SPRAVATO[8]		
				MC/DEL	8	TRAZODONE HCL 300MG TABS		
				MC/DEL	8	TRINTELLIX		
				MC	8	WELLBUTRIN TABS		
				MC	8	WELLBUTRIN SR TBCR		
				MC	8	WELLBUTRIN XL		
				MC/DEL	8	REMERON SOLTAB TBDP		
				MC/DEL	8	SAVELLA[4]		
				MC/DEL	8	ZOLOFT		
				MC/DEL	8	ZULRESSO[10]		
				MC	8	ZURZUVAE[12]		
				MC/DEL	8	VENLAFAXINE ER TABS[5]		
				MC/DEL	9	VIIBRYD[6]		
				MC/DEL	9	FLUOXETINE 90mg TABS[6]		
ANTIDEPRESSANTS - TRI-CYCLICS	MC/DEL		**AMITRIPTYLINE HCL TABS[1]**	MC/DEL		**AMOXAPINE TABS**	1. Users over the age of 65 require a pa. 2. Use multiples of 50mg. Use PA Form# 20420 Use PA Form# 10220 for Brand Name requests	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**CLOMIPRAMINE HCL CAPS[1]**	MC/DEL		**ANAFRANIL CAPS**		
	MC/DEL		**DESIPRAMINE HCL TABS[1]**	MC/DEL		**DOXEPIN HCL 150 MG[2]**		
	MC/DEL		**DOXEPIN HCL[1] (not generic Silenor)**	MC/DEL		**DOXEPIN (generic Silenor)**		
	MC/DEL		**IMIPRAMINE HCL TABS[1]**	MC/DEL		**NORPRAMIN TABS**		
	MC/DEL		**NORTRIPTYLINE HCL[1]**	MC/DEL		**PAMELOR**		
	MC		PROTRIPTYLINE HCL TABS[1]	MC		TOFRANIL		
	MC		SURMONTIL CAPS[1]	MC		VIVACTIL TABS		

SEDATIVE / HYPNOTICS								
SEDATIVE/HYPNOTICS - BARBITURATE	MC		BUTISOL SODIUM TABS[1]	MC		LUMINAL SOLN	1. PA required for new users of preferred products if over 65 years. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		CHLORAL HYDRATE SYRP[1]	MC/DEL		SOMNOTE CAPS		
	MC		MEBARAL TABS[1]					
	MC/DEL		PHENOBARBITAL[1]					
SEDATIVE/HYPNOTICS - BENZODIAZEPINES	MC/DEL		DORAL TABS[1]	MC		HALCION TABS[1]	1. Dosing limits apply, please see dosing consolidation list. Use PA Form# 30110	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Benzodiazepines do cause dependence with continued use and usage should be limited to 7-10 days at a time. Chronic intermittent use (2-3 Days per week max) is the standard of care
	MC/DEL		ESTAZOLAM TABS[1]	MC		MIDAZOLAM HCL SYRP		
	MC/DEL		FLURAZEPAM HCL CAPS[1]	MC/DEL		RESTORIL CAPS[1]		
	MC/DEL		TEMAZEPAM CAPS 15 & 30MG[1]	MC/DEL		TEMAZEPAM 7.5MG[1]		
	MC/DEL		TRIAZOLAM TABS[1]					
SEDATIVE/HYPNOTICS - Non-Benzodiazepines	MC/DEL	1	MIRTAZAPINE	MC/DEL	7	AMBIEN[1]	1. Quantity Limit of 12 per 34 days. 2. Quantity limits will be allowed up to 30/30, but intermittent therapy is recommended. 3. Only zolpidem trial/failure will be required to obtain Zaleplon. 4. Must fail all preferred products before non-preferred Use PA Form# 30110	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Ambien, Ambien CR, Lunesta, Sonata, Zaleplon and Zolpidem may cause dependence with continued use and as with benzodiazepines, usage should be limited to 7-10 days at a time. Chronic intermittent use (2-3 days per week max) is the standard of care. Please refer to Sedative/Hypnotic PA form. DDI: Belsomra® with strong CYP3A inhibitors (e.g. ketoconazole, itraconazole, posaconazole, clarithromycin, nefazodone, ritonavir, saquinavir, nelfinavir, indinavir, boceprevir, telaprevir, telithromycin, and conivaptan) is not recommended
	MC	1	TRAZODONE	MC/DEL	7	**ESZOPICLONE**		
	MC/DEL	1	ZOLPIDEM [2]					
				MC/DEL	7	**ZOLPIDEM ER**		
	MC/DEL	2	ZALEPLON [2,3]	MC/DEL	8	AMBIEN CR[1]		
				MC/DEL	8	BELSOMRA[1]		
				MC	8	DAYVIGO[1]		
				MCDEL	8	EDLUAR		
				MC	8	HETLIOZ		
				MC/DEL	8	INTERMEZZO		
				MC/DEL	8	LUNESTA[1]		
				MC/DEL	8	SONATA CAPS[1]		
				MC/DEL	8	ROZEREM		
				MC	8	QUVIVIQ		
				MC/DEL	8	ZOLPIMIST		
ANTI-PSYCHOTICS								
ANTIPSYCHOTICS - ATYPICALS	MC		ABILIFY ASIMTUFII	MC/DEL	8	ABILIFY DISC TAB, INJ and SOL[1]	If prescribing 2 or more antipsychotics, PA will be required for both drugs, except if one is Clozapine.This also includes combination of Seroquel with Seroquel XR. Use PA form# 20440 for Multiple Antipsychotic requests Use PA form# 10130 for non-preferred single therapy atypical requests 1. Established users of single therapy atypicals were grandfathered. 2. Prior Authorization will be required for preferred medications for members under the age of 5	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Non preferred atypicals will be approved for patients with FDA-approved indications, and for specific conditions supported by at least two published peer-reviewed double-blinded, placebo-controlled randomized trials that are not contradicted by other studies of similar quality and as long as all first line preferred therapies have been tried and failed at full therapeutic doses for adequate durations (at least two weeks). Prescriptions for quetiapine are limited to a maximum daily dose of 800mg. Uzedy: Establish tolerability with oral risperidone prior to initiating Uzedy **Atypicals:** Prior Authorization will be required for preferred medication to assure indication is in accordance with FDA approved or literature supported evidence-based best practices. The approved indications are: • **schizophrenia** • **bipolar disorder** • **agitation related to autism** • **adjunct in major depressice disorder** If prescribing 2 or more antipsychotics, PA will be required for both drugs, except if one is Clozapine.This also includes combination of Seroquel with Seroquel XR. DDI: It is recommended to reduce the Vraylar® dose if it is used concomitantly with a strong CYP3A inhibitor (such as itraconazole, ketoconazole). The concomitant use of Vraylar® with a CYP3A4 inducer (such as rifampin, carbamazepine) is not recommended.
	MC/DEL		ARIPIPRAZOLE TAB[3]	MC/DEL	8	**ARIPIPRAZOLE SOL**		
	MC		ARISTADA	MC/DEL	8	ARIPIPRAZOLE ODT		
	MC		ARISTADA INITIO	MC	8	CAPLYTA		
	MC/DEL		**OLANZAPINE[2,3]**	MC	8	FANAPT		
	MC/DEL		**OLANZAPINE[2,3] ODT**	MC/DEL	8	GEODON		
	MC/DEL		INVEGA HAFYERA	MC	8	INVEGA		
	MC		INVEGA SUSTENNA	MC	8	IGALMI		
	MC/DEL		INVEGA TRINZA INJ	MC	8	LATUDA		
	MC/DEL		**LURASIDONE TAB**	MC	8	LYBALVI		
	MC/DEL		**PALIPERIDONE ER**	MC	8	NUPLAZID		
	MC/DEL		PERSERIS	MC	8	REXULTI		
	MC		RISPERDAL CONSTA	MC	8	RISPERDAL TAB		
	MC/DEL		RISPERIDONE ODT	MC	8	RISPERDAL M TAB[1]		
	MC/DEL		RISPERIDONE TAB[2,3]	MC	8	RISPERDAL SOLN		
	MC/DEL		RISPERIDONE SOLN[2]	MC/DEL	8	SAPHRIS[1]		
	MC		RYKINDO	MC	8	SECUADO		
	MC/DEL		QUETIAPINE[2,3]	MC/DEL	8	SEROQUEL TABS		
	MC/DEL		QUETIAPINE XR	MC	8	UZEDY		
	MC		VRAYLAR[4]	MC	8	ZYPREXA TABS		
	MC/DEL		**ZIPRASIDONE[2,3]**	MC		ZYPREXA RELPREVV		
				MC	8	ZYPREXA ZYDIS TBDP [1]		

				MC/DEL	9	SEROQUEL XR	under the age of 6. 3. Dosing limits apply please refer to the dose consolidation list. 4.Requires step through 1 preferred drug for all indications except AMDD. AMDD requires insufficient response from two antidepressants	DDI: The concomitant use of Nuplazid with other drugs known to prolong the QT interval (e.g. Class IA antiarrhythmics, Class 3 antiarrhythmics, antipsychotics, and antibiotics such as gatifloxacin and moxifloxacin). Lybalvi: Step through aripiprazole and Latuda. If criteria is met then initial approval for 3 months. Subsequent approvals will be based on evidence of not gaining >= 10 % baseline body weight for ongoing approval. If weight gain >= 10 % of initial body weight, then criteria for ongoing use not met. Invega Hafyera: The patient is started and stabilized on the medication OR The patient has been adequately treated with Invega Sustenna (paliperidone palmitate 1-month) for at least four months or Invega Trinza (paliperidone palmitate 3- month) following at least one 3-month injection cycle.
ANTIPSYCHOTICS - SPECIAL ATYPICALS	MC/DEL		CLOZAPINE TABS	MC/DEL MC/DEL MC/DEL		CLOZAPINE ODT CLOZARIL TABS VERSACLOZ SUSP	Use PA Form# 20420	Preferred generic drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred brand will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Patients previously stabilized on brand name drug will be approved.
ANTIPSYCHOTICS - TYPICAL	MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL		CHLORPROMAZINE HCL FLUPHENAZINE DECANOATE FLUPHENAZINE HCL HALDOL HALOPERIDOL HALOPERIDOL DECANOATE SOLN HALOPERIDOL LACTATE SOLN LOXAPINE SUCCINATE CAPS LOXITANE-C CONC MOBAN TABS PERPHENAZINE PROCHLORPERAZINE SERENTIL THIORIDAZINE HCL THIOTHIXENE TRIFLUOPERAZINE HCL TABS	MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC MC		COMPAZINE COMPRO SUPP FLUPHENAZINE HCL CONC HALDOL DECANOATE LOXITANE CAPS MELLARIL NAVANE CAPS PROLIXIN STELAZINE TABS	Use PA Form# 20420 If prescribing 2 or more antipsychotics, PA will be required for both drugs, except if one is Clozapine.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. If prescribing 2 or more antipsychotics, PA will be required for both drugs, except if one is Clozapine.
LITHIUM								
LITHIUM	MC/DEL MC/DEL		LITHIUM CARBONATE LITHIUM CITRATE SYRP	MC/DEL MC/DEL		ESKALITH CAPS ESKALITH CR TBCR	Use PA Form# 20420	
COMBINATION - PSYCHOTHERAPEUTIC								
PSYCHOTHERPEUTIC COMBINATION				MC/DEL MC/DEL		CHLORDIAZEPOXIDE/AMITRIPT PERPHENAZINE/AMITRIPTYLIN	Use PA Form# 20420	
STIMULANTS								
STIMULANT - AMPHETAMINES -SHORT ACTING	MC/DEL MC/DEL MC		AMPHETAMINE SALT COMBO[1,4] DEXTROAMPHET SULF TABS PROCENTRA	MC/DEL MC MC/DEL MC		ADDERALL TABS EVEKEO METHAMPHETAMINE HCL ZENZEDI	1. Preferred stimulants will be available without PA if diagnosis of ADHD or Narcolepsy. 2. As per recent FDA alert, Adderal & Dexedrinel should not be used in patients with underlying heart defects since they may be at increased risk for sudden death.	

							3. Dosing limits apply, please see dosing consolidation list. 4. Max daily dose of 50mg. Use PA Form# 20420	
STIMULANT - LONG ACTING AMPHETAMINES SALT	**MC/DEL** **MC** **MC**		AMPHETAMINE/DEXTROAMPHET ER[3,4,7] ADDERALL XR CP24[1,3,4,7] VYVANSE[2,3,4]	**MC** **MC** **MC**		MYDAYIS[5] VYVANSE CHEW[4,6] XELSTRYM[8]	Use PA Form# 20420 1. As per recent FDA alert, Adderall should not be used in patients with underlying heart defects since they may be at increased risk for sudden death. 2. FDA approval is currently for adults and children 6 or older. Will be available without PA for this age group if within dosing limits. Limit of one capsule daily. Max dose of 70MG daily. 3. Preferred stimulants will be available without PA if diagnosis of ADHD. 4. Dosing limits applly, please see dosing consolidation list. 5. For the treatment of Attention Deficit Hyperactivity Disorder (ADHD) in patients 13 years and older 6. Vyvanse chew grace period for current user through June 2022. 7. FDA approval is currently for adults and children 6 or older. Will be available without PA for this age group if within dosing limits. Max dose of 50MG daily without a PA. 8. For the treatment of patients 6 years of age and older.	**DDI**: The concomitant use of Mydayis® is contraindicated with monoamine oxidase inhibitors (MAOIs) or within 14 days after discontinuing MAOI treatment, as concomitant use can increase hypertensive crisis.
LONG ACTING AMPHETAMINES	**MC** **MC/DEL**		DEXTROAMPHET SULF CPSR[1,3] **DEXTROAMPHETAMINE ER**	**MC/DEL** **MC**		ADZENYS ER[3] ADZENYS XR- ODT	1. Preferred stimulants will be available without PA if diagnosis of ADHD.	

							2. As per recent FDA alert, Adderall & Dexedrine should not be used in patients with underlying heart defects since they may be at increased risk for sudden death.	
	MC		DYANAVEL XR SUS	MC		ADZENYS XR[3]		
				MC		DEXEDRINE CAP SR[2,3]	3. Dosing limits applly, please see dosing consolidation list.	DDI: : The concomitant use of Adzenys® XR is contraindicated with monoamine oxidase inhibitors (MAOIs) or within 14 days after discontinuing MAOI treatment.
				MC		DYANAVEL XR TAB	Use PA Form# 20420	
STIMULANT - METHYLPHENIDATE	MC/DEL		DEXMETHYLPHENIDATE IR TABS	MC/DEL		FOCALIN IR TABS	1. Preferred stimulants will be available without PA if diagnosis of ADHD.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Please refer to General Criteria category E.
	MC/DEL		METHYLPHENIDATE SOL	MC/DEL		METADATE ER		
	MC/DEL		**METHYLPHENIDATE TAB**	MC		METHYLPHENIDATE HCL CHEW	Use PA Form# 20420	
	MC/DEL		METHYLIN TABS[1,2]	MC		METHYLIN CHEWABLES	2. Dosing limits apply, please see dosing consolidation list. Maximum daily doses are as follows: 72mg daily for methylphenidate and 36mg daily for dexmethylphenidate.	
				MC/DEL		METHYLIN SOL		
				MC/DEL		RITALIN		
STIMULANT - METHYLPHENIDATE - LONG ACTING	MC		CONCERTA TBCR	MC	5	METADATE CD CPCR	1. Preferred stimulants will be available without PA if diagnosis of ADHD.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**DEXMETHYLPHENIDATE CAP ER 50/50**	MC/DEL	8	ADHANSIA XR[2,6]		
	MC/DEL		FOCALIN XR	MC	8	APTENSIO XR[2]	2. Non-preferred products must be used in specified step order.	
	MC/DEL		METHYLPHENIDATE LA CAPS	MC	8	AZSTARYS[6]		
	MC/DEL		METHYLPHENIDATE ER CAPS 50/50	MC	8	COTEMPLA XR[2]	3.FDA approval currently only for ages 6-16. Limit of one patch daily. Max dose of 30MG daily.	
	MC/DEL		METHYLPHENIDATE ER CAPS 40/60	MC	8	COTEMPLA XR ODT[2]		
	MC/DEL		METHYLPHENIDATE CD CAPS 30-70	MC/DEL	8	DAYTRANA[2,3]	4.Dosing limits apply, please see dosing consolidation list.	
	MC		QUILLICHEW ER[5,1]	MC/DEL	8	JORNAY PM[2,6]	5. Quillivant XR and Quillichew ER are only indicated for use in patients 6 years of age and older.	
	MC		QUILLIVANT XR SUS[1,5]	MC/DEL	8	METHYLPHENIDATE ER CAPS[2,4]		
	MC/DEL		RITALIN LA[4]				6. For the treatment of patients ≥ 6 years of age.	
							Use PA Form# 20420	
STIMULANT - STIMULANT LIKE	MC/DEL		**ATOMOXETINE HCL**	MC/DEL	7	PROVIGIL TABS[3]	1. Failure of both an amphetamine and methylphenidate is required for consideration for approval of Strattera, unless history of substance abuse without current use of abusable medication(s). Additionally, for patients <17 years of age, a trial of	Provigil requests require diagnosis of Narcolepsy, ADHD, or Obstructive Sleep Apnea. Previous failures of methylphenidate and amphetamine is required for Narcolepsy and ADHD diagnosis, with additional Strattera trial needed with ADHD diagnosis. Please refer to detailed criteria on Provigil PA form
	MC/DEL		ARMODAFINIL	MC	7	STRATTERA[1, 2]		
	MC/DEL		CLONIDINE ER	MC	8	CAFCIT SOLN[3]		
	MC/DEL		**GUANFACINE ER**	MC/DEL	8	INTUNIV		
					8	KAPVAY		Sunosi is non-preferred and is indicated for to improve wakefulness in adult patients with excessive daytime sleepiness associated with narcolepsy or obstructive sleep apnea (OSA).
	MC/DEL		MODAFINIL TABS	MC				
	MC		QELBREE[6,7]	MC/DEL	8	SUNOSI		Wakix is non-preferred and is indicated for the treatment of excessive daytime sleepiness (EDS) in adults with narcolepsy
				MC	8	WAKIX		DDI: Sunosi® is contraindicated with MAO inhibitors or within 14 days after discontinuing the MAO inhibitor.

				MC	8	XYREM SOL	quanfacine in required before approval of Strattera. 2. Strattera currently has dosing limitations allowing one tablet per day for all strengths if obtain approval. Max daily dose of Strattera is 100mg. Please see dosing consolidation list.	
				MC	8	XYWAV[5]		Xywav: Diagnosis of cataplexy associated with narcolepsy OR excessive daytime sleepiness associated with narcolepsy. Diagnosis must be confirmed by submission of supporting documentation to include the specialist's interpretation of the Polysomnography (PSG) and Multiple Sleep Latency Test (MSLT) results
				MC/DEL	9	NUVIGIL[3]	3. Non-preferred products must be used in specified	
				MC	9	DESOXYN TABS[3]	4. Please use generic Guanfacine.	FDA reminded healthcare professionals and patients that the combined use of Xyrem (sodium oxybate) with alcohol or central nervous system (CNS) depressant drugs can markedly impair consciousness and may lead to severe breathing problems (respiratory depression
				MC	9	DESOXYN CR[3]	5. For patients 7 years of age and older with narcolepsy	DDI: Concomitant use of Qelbree® with an MAO inhibitor or within 2 weeks after discontinuing an MAO inhibitor is contraindicated
							6. For pediatric patients 6 years of age or older	
							7. Preferred with a trial and fail either Atomoxetine OR any 2 preferred ADHD agents. Use PA Form# 20710 for Provigil, Nuvigil and Xyrem Use PA Form# 20420 for all others	DDI: Concomitant use of Qelbree® significantly increases the total exposure, but not peak exposure, of sensitive CYP1A2 substates, which may increase the risk of adverse reactions associated with these CYP1A2 substrates. Coadministration of Qelbree® with sensitive CYP1A2 substrates or CYP1A2 substrates with a narrow therapeutic range (e.g. alosetron, duloxetine, ramelteon, tasimelteon, tizanidine, theophylline), is contraindicated.
ANTI-CATAPLECTIC AGENTS								
PSYCHOTHERAPEUTIC AGENTS - MISC.				MC		NUEDEXTA		
				MC		XENAZINE	Use PA Form# 20710 for Xenazine	
WEIGHT LOSS								
WEIGHT LOSS							No longer covered: PHENTERMINE, XENICAL,DIDREX, and MERIDIA	Weight loss drugs are not covered as permitted by Federal Medicaid regulations and Maine Medicaid (MaineCare) Policy.
ALZHEIMER DISEASE								
ALZHEIMER - Cholinomimetics/Others	MC/DEL		DONEPEZIL HYDROCHLORIDE TABS[1]	MC	6	ARICEPT TABS[2]	1. PA is required to establish dementia diagnosis and baseline mental status score.	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		DONEPEZIL HYDROCHLORIDE ODT[1]	MC	6	ARICEPT ODT[2]		
	MC/DEL		EXELON DIS[1]	MC/DEL	7	DONEPEZIL HYDROCHLORIDE TABS 23MG	2. Must fail all preferred products before moving to non-preferred.	Kisunla and Leqembi: Testing to rule out reversible causes of dementia (CBC, CMP, TSH, B12, urine drug screen, RPR/VDRL, (folate (if alcohol abuse is present), HIV (if risk present) and an assessment including a review of current medications as a cause of intellectual decline
	MC/DEL		**GALANTAMINE CAPS**[1]	MC	8	ADLARITY[3]		- Prescribed by or in consultation with a neurologist or geriatrician or geriatric psychiatrist. Diagnosis of Alzheimer's disease defined as:
	MC/DEL		**GALANTAMINE TAB**[1]	MC/DEL	8	EXELON CAP	3. Approvals will require trials and failure or clinical rationale why preferred patches cant be used.	•Confirmed presence of amyloid pathology and mild cognitive impairment or mild dementia stage of disease, consistent with Stage 3 and Stage 4 Alzheimer's disease OR
	MC/DEL		MEMANTINE[1]	MC/DEL	8	GALANTAMINE HYDROBROMIDE SOL		•Confirmed presence of amyloid pathology and prodromal or mild dementia stage of disease, consistent with Stage 3 and Stage 4 Alzheimer's disease
	MC/DEL		RIVASTIGMINE TARTRATE CAPS[1]	MC	8	KISUNLA		-Testing:
				MC	8	LEQEMBI[1,2]		•Clinical Dementia Rating (CDR) global score of 0.5 or 1.0 OR
				MC/DEL	8	MEMANTINE HCL SOL		•Repeatable Battery for Assessment of Neuropsychological Status (RBANS) delayed memory index score ≤ 85 OR
				MC/DEL	8	NAMENDA		•Mini-Mental State Examination (MMSE) score of 20-30 OR
				MC/DEL	8	NAMENDA XR CAPS		•Montreal Cognitive Assessment (MoCA) score ≤ 22
				MC/DEL	8	NAMZARIC		- Member is age 50 or older
				MC	8	RAZADYNE[2]		- Obtain recent (within one year) brain magnetic resonance imaging (MRI) prior to initiating treatment
								- Provider attestation to obtain MRIs prior to the 7th infusion (first dose of 10 mg/kg) and 12th infusion (sixth dose of 10 mg/kg)

				MC	9	COGNEX CAPS[2]	Use PA Form# 20420	- Member does NOT have history or increased risk of amyloid related imaging abnormalities-edema (ARIA-E), which includes brain edema or sulcal effusions and amyloid related imaging abnormalities hemosiderin deposition (ARIA-H), which includes microhemorrhage and superficial siderosis - Member does NOT have hypersensitivity to any components of these drugs - Failure of or inability to tolerate at least two other preferred Alzheimer therapies for at least four months each, one of which should include a combination of a cholinesterase inhibitor with memantine •If the initial drug utilized is the combination of a cholinesterase inhibitor and memantine, then only that single trial of two drugs is required
SMOKING CESSATION								
NICOTINE PATCHES / TABLETS	MC/DEL MC/DEL MC/DEL MC/DEL		CHANTIX TAB[1] CHANTIX STARTER PACK NICOTINE DIS PT24[1] **VARENICLINE TAB**	MC/DEL		NICODERM CQ PT24[1]	Use PA Form# 20420 1. See criteria section for exemptions	As of July 1, 2014 per MaineCare policy, smoking cessation products will be covered without a copay(including MEDEL). No annual or lifetime limits, must follow FDA approved indications and therapy guidelines. Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Note:** MaineCare policy, smoking cessation product were "not covered" except for during pregnancy between 9/1/12 and 1/1/14, between 1/1/2014 and 7/1/14 smoking cessation products were covered with limitations Patients may qualify for the medication through The Maine Tobacco Helpline if they do not have MaineCare or MEDEL. Patients are encouraged to call The Maine Tobacco helpline at 1-800-207-1230.
NICOTINE REPLACEMENT - OTHER	MC/DEL MC/DEL MC/DEL		NICOTINE POLACRILEX GUM[1] NICOTINE LOZENGE MINI NICOTINE LOZENGE	MC/DEL MC/DEL MC/DEL MC	8 8 8 8	NICOTROL INHALER[1,2] NICOTROL NASAL SPRAY[1,2] NICORETTE GUM[1,2] NICORETTE LOZENGES	Use PA Form# 20420 1. See criteria section for exemptions 2. Must use non-preferred products in specified step order.	As of July 1, 2014 per MaineCare policy, smoking cessation products will be covered without a copay(including MEDEL). No annual or lifetime limits, must follow FDA approved indications and therapy guidelines. Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Note:** MaineCare policy, smoking cessation product were "not covered" except for during pregnancy between 9/1/12 and 1/1/14, between 1/1/2014 and 7/1/14 smoking cessation products were covered with limitations Patients may qualify for the medication through The Maine Tobacco Helpline if they do not have MaineCare or MEDEL. Patients are encouraged to call The Maine Tobacco helpline at 1-800-207-1230.
ALCOHOL DETERRENTS								
ALCOHOL DETERRENTS	MC/DEL MC MC MC/DEL		**ACAMPROSATE** ANTABUSE TABS DISULFIRAM TABS NALTREXONE HCL TABS	MC/DEL		**ACAMPRO**[1]	1. Should only be used in conjunction with formal structured outpatient detoxification program. Use PA Form# 20420	Preferred generic drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
MISCELLANEOUS ANALGESICS								
ANALGESICS - MISC.	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL		ACETAMINOPHEN **ASPIRIN** ASPRIN/ APAP/ CAFF TAB BUTAL/ASA/CAFF BUTALBITAL COMPOUND BUTALBITAL/ACET TABS BUTALBITAL/APAP CAPS BUTALBITAL/APAP/CAFFEINE TABS **CHOLINE MAGNESIUM TRISALI** **DIFLUNISAL TABS** EXCEDRIN **SALSALATE TABS**	MC MC/DEL MC/DEL MC MC MC/DEL MC MC MC MC MC MC		AXOCET CAPS ESGIC-PLUS FIORICET TABS FIORINAL CAPS FIORTAL CAPS FORTABS TABS PHRENILIN TABS PHRENILIN FORTE CAPS TRILISATE LIQD TRILISATE TABS ZEBUTAL CAPS ZORPRIN TBCR	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
LONG ACTING NARCOTICS								
NARCOTICS - LONG ACTING	MC/DEL MC/DEL		FENTANYL PATCH[4] BUTRANS[4]	MC MC	8 8	ARYMO ER AVINZA	Use PA Form# 20510 Use PA form #10300 for	Preferred drugs (Fentanyl Patch, Morphine Sulfate ER tab, Butrans and Embeda) must be tried for at least 2 weeks each & failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

	MC/DEL		MORPHINE SULFATE ER TB12	MC	8	BELBUCA	PAs over the opiate limit 1. Oxycontin will be available without PA for patients treated for or dying from cancer or hospice patients. CA (cancer) or HO (hospice) diag code may be used but store must verify since all scripts will be audited and stores will be liable. 2. Established users are grandfathered. 3. Oxycodone ER allowed only 2 per day for all strengths except 80 mg, where 4 are allowed to 4. Dosing limits apply. Please see dose consolidation list. 5. Non-preferred products must be used in specific order. 6. Methadone will be available without PA for patients treated for or dying from cancer or hospice patients or similar conditions as supported by clinical documentation. CA (cancer) or HO (hospice) diag code may be used but store must verify since all scripts will be audited and stores will be liable.	of the preferred drug or a significant potential drug interaction between another drug & the preferred drug(s) exists. Adequate trials include prevention/treatment of common adverse effects associated w/ narcotics (antinausea, antipruritics, etc.) as well as adequate equianalgesic dosing when converting from one narcotic to another.Also, adequate documentation of attempts to titrate dose of preferred agents to achieve adequate pain relief & desired clinical response must be provided. Member's drug regimen for additions &/or discontinuations of medications that may affect absorption &/or metabolism of preferred agents must be monitored. Approvals will not be granted if patient had access to either non-preferred products or high doses of short acting narcotics during the trial period. Non-preferred drugs will not be approved for patients showing evidence of usage patterns consistent w/ controlled substance abuse such as: 1.Frequent or persistent early refills of controlled drugs; 2.Multiple instances of early refill overrides due to reports of misplacement, stolen, dropped in toilet or sink, distant travel, etc.; 3.Breaches of narcotic contracts with any provider; 4.Failure to comply with patient responsibilities in attached opioid documentation (see PA form) including but not limited to failing to submit to and pass pill counts; 5.Failing to take or pass random drug testing; 6.Failing to provide old records regarding prior use of narcotics; 7.Receiving controlled substances from other prescribers that the provider submitting the PA is unaware of 8.Documented history of substance abuse. Substance abuse evaluations may be required for patients with medical records displaying documented substance abuse or potential signs of narcotic misuse and abuse such as chronic early refills, short dosing intervals, frequent dose increases, multiple lost/stolen etc scripts and intolerance or "allergy" to all products but Oxycontin. 9.Circumventing MaineCare prior authorization requirements for narcotics by paying cash for affected narcotics (prescribers failed to submit prior authorization prior to cash narcotic scripts being filled by member). 10.Requests for any Brand name controlled substance, considered by authorities to be highly abused and diverted (Oxycontin, Percocet, Typox, Vicodin, Dilaudid, Ultracet...) with an available AB rated generic equivalent will be denied unless it will be provided in a setting that virtually eliminates the risk of diversion. 11.Allergic reactions to any product within a specific narcotic class will justify and preclude use of any other product in the same class due to the risk of cross-hypersensitivity. Hysingla ER- Concomitant use should be avoided with mixed agonist/antagonist analgesics, partial agonist analgesics, and MAOIs. Verify prior trials and failures or intolerance of preferred treatments Methadone – Established users must have a trial and failure of at least 2preferred drugs for least 2 weeks. Otherwise they will be allowed 180 days to transition to a preferred product.
	MC/DEL		NUCYNTA ER	MC	8	EXALGO		
	MC		XTAMPZA ER	MC/DEL	8	HYSINGLA ER		
				MC	8	KADIAN		
				MC/DEL	8	METHADONE		
				MC/DEL	8	METHADOSE		
				MC/DEL	8	MORPHABOND ER		
				MC/DEL	8	MORPHINE SULFATE ER CAP		
				MC/DEL	8	MORPHINE SULFATE SUPP		
				MC/DEL	8	MS CONTIN TB12		
				MC	8	OPANA ER		
				MC/DEL	8	ORAMORPH SR TB12		
				MC/DEL	8	OXYCONTIN TB12[1]		
				MC	8	XARTEMIS ER		
				MC	8	ZOHYDRO ER		
				MC	8	OXYCODONECONC		
				MC/DEL	9	OXYCODONE ER[3,5]		
NARCOTICS - SELECTED	MC/DEL		TRAMADOL HCL TABS	MC/DEL	7	RYZOLT	Use PA Form# 20420 Use PA form #10300 for PAs over the opiate limit 1. Only available if component ingredients are unavailable.	Preferred drugs from this and other narcotic classes must be tried for at least 2 weeks each and failed due to lack of efficacy or intolerable side effects before non-preferred drugs from this class will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Approvals will not be granted if patient had access to either non-preferred products or high doses of short acting narcotics during the trial period. Substance abuse evaluations may be required for patients with medical records displaying potential signs of narcotic misuse and abuse such as chronic early refills, short dosing intervals, frequent dose increases, multiple lost/stolen etc scripts and intolerance or "allergy" to all products but desired product. Allergic reactions to any product within a specific narcotic class will justify and preclude use of any other product in the same class due to the risk of cross-hypersensitivity. Non-preferred drugs will not be approved for patients showing evidence of usage patterns consistent with controlled substance abouse such as: 1.frequent or persistant early refills of controlled drugs; 2.multiple instances of early refill overrides due to reports of misplacement, stolen, dropped in toilet or sink, distant travel; 3.breaches of narcotic contracts with any provider; 4.failure to comply with patient responsibilities in attached opiod documentaion (see PA form) including but not limited to failing to submit to and pass pill counts; 5.failing to take or pass random drug testing; 6.failing to provide old recoreds regarding prior use of narcotics; 7.receiving controlled substances from other prescribers that the provider submitting the PA is unaware of. in Substance abuse evaluations may be required for patients with medical records displaying potential signs of narcotic misuse and abuse such as chronic early refills, short dosing intervals, frequent dose increases, multiple lost/stolen etc scripts and intolerance or "allergy" to all products but Oxycontin. Allergic reactions to any product within a specific narcotic class will justify and preclude use of any other product in the same class due to the risk of cross-hypersensitivity.
	MC/DEL		TRAMADOL/APAP TABS	MC	8	BUPRENEX SOLN		
				MC/DEL	8	BUTORPHANOL		
				MC	8	NALBUPHINE HCL SOLN		
				MC	8	QDOLO SOLN		
				MC	8	SEGLENTIS[1]		
				MC	8	STADOL NS SOLN		
				MC	8	TRAMADOL ER		
				MC	8	ULTRACET TABS[1]		
				MC	9	ULTRAM ER		

								Beginning January 2017, all current opiate users who are above the maximum combined daily dose of 100 MME must titrate their total daily dose of opioid medications below 300 MME. Also, the maximum daily supply of an opiate prescription for acute pain will be limited to 7-day supplies. The maximum day supply of an opiate prescription for chronic pain will be limited to 30-day supplies. As of July 1, 2017 all users of opioid medications must comply with the maximum combined daily dose of 100 MME. However, for MaineCare members, effective January 1, 2017, opioid prescription(s) for more than a 7-day supply and/or more than 30 MME/ day will require a prior authorization. Please note that MaineCare implemented a 30 MME limit January 1, 2013 that is still effective. Post-surgical members may receive prior authorizations for opiates up to a 60 days in length if medical necessity is provided by the surgical provider. An MME conversion chart is available at www.mainecarepdl.org. Click on "General Pharmacy Info." **Please see the Pain Management Policy tab for the complete criteria**
MISCELLANEOUS NARCOTICS								
NARCOTICS - MISC.	MC/DEL		ACETAMINOPHEN/CODEINE	MC/DEL	8	ABSTRAL	1. Fentanyl OT loz (Barr) and Capital and codeine suspension products require PA for users over 18 years of age. PA is not required if under 18 years of age. 2. Oxycodone/acet 10/650 is 8 times more expensive. Use twice as many of oxycod/acet 5/325 instead. You can mix andmatch preferred strengths of oxycodone and oxycodone/acet to minimize acet. dose similar to certain non-preferred drugs. 3. Only preferred manufacturer's products will be available without prior authorization.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Please refer to General Criteria category E. Beginning January 2017, all current opiate users who are above the maximum combined daily dose of 100 MME must titrate their total daily dose of opioid medications below 300 MME. Also, the maximum daily supply of an opiate prescription for acute pain will be limited to 7-day supplies. The maximum day supply of an opiate prescription for chronic pain will be limited to 30-day supplies. As of July 1, 2017 all users of opioid medications must comply with the maximum combined daily dose of 100 MME. However, for MaineCare members, effective January 1, 2017, opioid prescription(s) for more than a 7-day supply and/or more than 30 MME/ day will require a prior authorization. Please note that MaineCare implemented a 30 MME limit January 1, 2013 that is still effective. Post-surgical members may receive prior authorizations for opiates up to a 60 days in length if medical necessity is provided by the surgical provider. An MME conversion chart is available at www.mainecarepdl.org. Click on "General Pharmacy Info." **Please see the Pain Management Policy for the complete criteria**
	MC/DEL		ASPIRIN/CODEINE TABS	MC/DEL	8	APADAZ		
	MC/DEL		BUTAL/ASA/CAFF/COD CAPS	MC/DEL	8	ASCOMP/CODEINE CAPS		
	MC		BUTALBITAL/ASPIRIN/CAFFEI CAPS	MC/DEL	8	BUTALBITAL/APAP/CAFFEINE/ CAPS		
	MC		CAPITAL AND CODEINE SUSP[1]	MC/DEL	8	BUTALBITAL COMPOUND- CODEINE CAP		
	MC		CAPITAL/CODEINE SUSP[1]	MC	8	DEMEROL		
	MC/DEL		CODEINE PHOSPHATE SOLN	MC/DEL	8	DILAUDID		
	MC/DEL		CODEINE SULFATE TABS	MC	8	DILAUDID-HP SOLN		
	MC/DEL		ENDOCET TABS[3]	MC	8	FENTANYL CITRATE SOLN		
	MC/DEL		ENDODAN TABS	MC/DEL	8	FENTORA		
	MC/DEL		FENTANYL OT LOZ[1]	MC/DEL	8	FIORICET/CODEINE CAPS		
	MC/DEL		FENTANYL OT LOZ1	MC	8	FIORINAL/CODEINE #3 CAPS		
	MC/DEL		HYDROCODONE/ACETAMINOPHEN	MC	8	FIORTAL/CODEINE CAPS		
	MC/DEL		HYDROMORPHONE HCL[3]	MC/DEL	8	HYDROCODONE/IBUPROFEN		
	MC		LORTAB ELX	MC/DEL	8	HYDROMORPHONE ER		
	MC/DEL		MEPERIDINE SOL	MC/DEL	8	HYDROMORPHONE RECTAL SUPP		
	MC/DEL		NUCYNTA	MC	8	IBUDONE		
	MC/DEL		OXYCODONE TAB	MC/DEL	8	**LEVORPHANOL TARTRATE TAB**		
	MC/DEL		OXYCODONE/ACETAMINOPHEN[2,3]	MC/DEL	8	LORCET		
	MC/DEL		ROXICET	MC	8	LORTAB		
	MC		ROXIPRIN TABS	MC	8	MAXIDONE TABS		
				MC/DEL	8	MEPERIDINE TABS		
				MC/DEL	8	NORCO TABS		
				MC/DEL	8	ONSOLIS		
				MC/DEL	8	OXECTA		
				MC/DEL	8	OXYCODONE CAP		
				MC/DEL	8	OXYCODONE/APAP 10/650		
				MC/DEL	8	OXYCODONE/APAP 7.5/500		
				MC/DEL	8	PENTAZOCINE/ACET TABS		
				MC/DEL	8	PENTAZOCINE/NALOXONE TABS		
				MC	8	PERCOCET TABS		
				MC	8	PERCOCET TABS		
				MC	8	PHRENILIN W/CAFFEINE/CODE CAPS		
				MC/DEL	8	ROXICET 5/500 TABS		
				MC	8	ROXICODONE TABS		
				MC/DEL	8	ROXYBOND		
				MC	8	SYNALGOS-DC CAPS		
				MC	8	TALACEN TABS		

				MC	8	TREZIX		
				MC	8	TYLENOL/CODEINE #3 TABS		
				MC	8	TYLOX CAPS		
				MC	8	XOLOX	Use PA Form# 20420	
				MC	8	VICODIN		
				MC	8	VICOPROFEN TABS	Use PA form #10300 for PAs over the opiate limit	
				MC	8	ZYDONE TABS		
				MC	9	ACTIQ LPOP		
				MC	9	CONZIP		
				MC	9	OPANA		
OPIOID DEPENDENCE TREATMENTS	MC		SUBOXONE FILM[2]	MC/DEL		BUPRENORPHINE[1]	Use PA Form #20100 1. Buprenorphine will only be approved for use during pregnancy. 2. See Criteria Section	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Members will continue to be required to follow the criteria listed below: 1-Induction period for 30 days 2-Max dose of 32 mg for induction 3-Max dose of 24 mg for maintenance 4-There is not more than one opioid fill in member's drug profile between current fill of buprenorphine and a prior buprenorphine fill within the past 90 days 5- Should provide evidence of monthly monitoring including random pill counts, urine drug tests and use of Maine Prescription Monitoring Program reports. 6- Buprenorphine monotherapy is preferred if member is pregnant and dose not > 24 mg day and pregnancy diagnosis is noted on the prescription.
	MC/DEL		BUPRENORPHINE/NALOXONE TABS[2]	MC		ZUBSOLV		
EXTENDED RELEASE BUPRENORPHINE	MC		BRIXADI[1]				Use PA form #20200 for Extended Release Buprenorphine 1. Clinical PA required.	Brixadi and Sublocade: The prescriber can attest (and medical record should document) that: −member has a documented history of opioid use disorder (OUD), −XRB is being used for the treatment of OUD (rather than pain or any other non-FDA approved indication) and −member's total daily dose of sublingual buprenorphine is less than or equal to 24 mg daily. AND at least one of the following is true: −The member's previous use of sublingual buprenorphine has included misuse, overuse, or diversion. −The member is at high risk of overdose (e.g., individuals leaving incarceration or abstinence-based treatment programs; individuals who are unhoused; or those facing potential gaps in care due to delays in care or geographically limited treatment access). −The member has experienced significant medical complications of OUD and/or of injection drug use. Occurrence should be in the last 5 years, or it should be clearly documented that the risk indicated by this infection or complication is ongoing (Examples of medical complications of OUD include: threatened the function of organs or life or limb threatening and required medical and/or surgical therapy. Examples of medical complications of injection drug use include osteomyelitis, endocarditis, renal failure, joint infection or other serious medical complications directly related to OUD.) −The member has treatment-resistant OUD, including those with ongoing illicit substance use in the context of sublingual buprenorphine treatment as documented by positive urine drug screens or other clear objective evidence, and/or further functional decline with explicit documentation of the functional decline. −The member has a significant intolerance of, or documented allergy to, sublingual buprenorphine (either buprenorphine monotherapy or buprenorphine/naloxone combination therapy) that has resulted in the patient's inability to comply with continued treatment using the sublingual product. (A true allergy is usually accompanied by rash, respiratory symptoms, or anaphylaxis. Other complaints such as bad taste, mouth tingling, etc. do not constitute evidence of allergy or significant intolerance. Formulation preference or convenience are not, in and of themselves, indications for using XRB.) −The member is in ongoing treatment with XRB and would like to continue the medication.
	MC		SUBLOCADE[1]					
OPIOID WITHDRAWAL AGENTS				MC		LUCEMYRA[1]	1. Clinical PA for appropriate approved use and patient has documented contraindication to clonidine Use PA Form#20420	
NARCOTIC ANTAGONISTS								
NARCOTIC - ANTAGONISTS	MC/DEL		NALTREXONE HCL TABS	MC		EVZIO	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		NALOXONE INJ	MC		OPVEE[2]		
	MC		NARCAN NS	MC		KLOXXADO	1. Will only be approved for	

	MC		NALOXONE SPRAY OTC	MC/DEL		REVIA TABS[1]	side effects experienced with generic that are not described in the literature as occurring with the brand version. 2. For the treatment of adult and pediatric patients 12 years of age and older.	
	MC		VIVITROL INJ					
	MC		ZIMHI					
COX 2 / NSAIDS								
COX 2 INHIBITORS - SELECTIVE / HIGHLY SELECTIVE	MC/DEL		**CELECOXIB**[4,5]	MC/DEL		CELEBREX CAPS[4,5]	Use PA Form# 20420 1. Meloxicam has dosing limits allowing one tablet daily of all strengths without PA. 2. Ketorolac Tromethamine is indicated for the short term (up to 5 days) managment of moderately severe acute pain that requires analgesic at the opiod level in adults. Not indicated for minor of chronic pain conditions. 3. Ketorolac has dosing limits allowing 24 tablets for a 5 day supply every 30 days. 4. Dosing limits will be set at a maximum of 400mg daily 5. The FDA has issued a Public Health Advisory warning of the potential for increased cardiovascular risk & GI bleeding with NSAID use.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		KETOROLAC TROMETHAMINE [2,3,5]	MC/DEL		MELOXICAM CAPS[5]		
	MC/DEL		NABUMETONE TABS[5]	MC/DEL		**MOBIC**[5]		
	MC/DEL		MELOXICAM TABS[1,5]	MC/DEL		MOBIC SUSP[5]		
				MC/DEL		**RELAFEN TABS**[5]		
				MC/DEL		**QMIIZ ODT**		
				MC/DEL		**VIVLODEX**		
NSAIDS	MC/DEL		**CHILDRENS IBUPROFEN**	MC		ADVIL TABS	The FDA has issued a Public Health Advisory warning of the potential for increased cardiovascular risk & GI bleeding with NSAID use. 1. Dosing limits apply, please see Dosage Consolidation List. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Approvals will be granted for other requests based on failure of at least one generic NSAID from at least 3 different NSAID classes as described in the COX-II PA form. **DDI:** Diclofenac will now be non-preferred and require prior authorization if it is currently being used in combination with lescol. The FDA has issued a Public Health Advisory warning of the potential for increased cardiovascular risk & GI bleeding with NSAID use.
	MC/DEL		**DICLOFENAC POTASSIUM TABS**	MC		ANAPROX TABS		
	MC/DEL		**DICLOFENAC SODIUM TABS**	MC		ANAPROX DS TABS		
	MC/DEL		**DICLOFENAC SODIUM 1% GEL**[1]	MC		CAMBIA		
	MC/DEL		**ETODOLAC**	MC/DEL		**CATAFLAM TABS**		
	MC/DEL		**FENOPROFEN CALCIUM TABS**	MC		CHILDRENS ADVIL SUSP		
	MC/DEL		**FLURBIPROFEN TABS**	MC		CHILD'S IBUPROFEN SUSP		
	MC/DEL		**IBUPROFEN**	MC/DEL		CHILDREN'S MOTRIN SUSP		
	MC/DEL		**INDOMETHACIN**	MC/DEL		**CLINORIL TABS**		
	MC/DEL		**KETOPROFEN**	MC/DEL		**DAYPRO TABS**		
	MC/DEL		**MECLOFENAMATE SODIUM CAPS**	MC/DEL		**DICLFENAC GEL**		
	MC/DEL		NAPROSYN SUSP	MC/DEL		**EC-NAPROSYN TBEC**		
	MC/DEL		NAPROXEN SUSP	MC/DEL		**ETODOLAC ER 600MG**		
	MC/DEL		**NAPROXEN TABS**	MC		FELDENE CAPS		
	MC/DEL		**NAPROXEN SODIUM TABS**	MC/DEL		FLECTOR PATCH		
	MC/DEL		**NAPROXEN SODIUM CAPS**	MC/DEL		IBU-200		
	MC/DEL		**NAPROXEN DR TBEC**	MC		INDOCIN		

	MC/DEL		**OXAPROZIN TABS**	MC		LICART		
	MC/DEL		**SULINDAC TABS**	MC/DEL		**LODINE**		
	MC/DEL		**TOLMETIN SODIUM**	MC		LOFENA		
	MC/DEL		VOLTAREN GEL	MC/DEL		**MOTRIN**		
				MC		NALFON CAPS		
				MC/DEL		NAPRELAN TBCR		
				MC/DEL		NAPROSYN TABS		
				MC/DEL		**NAPROXEN SODIUM TBCR**		
				MC		PENNSAID		
				MC/DEL		**PIROXICAM CAPS**		
				MC		PONSTEL CAPS		
				MC		RELAFEN DS		
				MC		SB IBUPROFEN TABS		
				MC		SPRIX		
				MC		TIVORBEX		
				MC		TOLECTIN		
				MC		V-R IBUPROFEN TABS		
				MC		ZORVOLEX		
NSAID - PPI				MC		PREVACID NAPRA-PAC	1. Use a preferred NSAID and PPI separately.	
				MC/DEL		VIMOVO[1]	Use PA Form# 20420	
RHEUMATOID ARTHRITIS								
RHEUMATOID ARTHRITIS	MC/DEL		ACTEMRA VIALS	MC		AMJEVITA	Use PA Form# 20900	See criteria as listed on Rheumatoid Arthritis PA form.
	MC/DEL		ACTEMRA SYRINGES	MC/DEL		**ARAVA**		
	MC/DEL		**ADALIMUMAB-FKJP**[3]	MC/DEL		CIMZIA	1. Dosing limits apply. Please see dose consolidation list.	Preferred injectable products allowed without PA if trial of a preferred oral agents (azathioprine, hydroxychloroquine, leflunomide, methotrexate, sulfasalazine tabs) are seen in the members drug profile. Dosing limits apply.
	MC		AVSOLA	MC/DEL		**CYLTEZO**		
	MC/DEL		**AZATHIOPRINE**	MC/DEL		ENTYVIO		
	MC		**ENBREL**[2]	MC		HADLIMA	2. Established users will be grandfathered.	
	MC		ENBREL SURECLICK[2]	MC/DEL		**HULIO**		
	MC		**KINERET SOLN**	MC/DEL		**HYDROXYCHLOROQUINE**[2]	3.Clinical PA is required to establish diagnosis and medical necessity.	**Xeljanz is limited to adults with moderate to severe RA and UC who have had an inadequate response or intolerance to methotrexate. Should not be used concomitantly with biologic DMARDs or potent Immunosuppressants.**
	MC/DEL		LEFLUNOMIDE	MC/DEL		**HYRIMOZ**		
	MC/DEL		METHOTREXATE	MC		IDACIO		
	MC		ORENCIA	MC/DEL		**ILARIS**[1,3,4]	4. Verification of age for appropriate indication.	Jylamvo will require using preferred methotrexate if unable please provide clinical rational as why inappropriate.
	MC/DEL		**SULFASALAZINE TABS**	MC/DEL		INFLECTRA		
	MC		SIMLANDI[3]	MC		INFLIXIMAB VIAL	5. Treatment failure or intolerance to other forms of preferred methotrexate	Zymfentra: In adults for maintenance treatment of:
	MC		SIMPONI PEN	MC		JYLAMVO		Moderately to severely active ulcerative colitis following treatment with an infliximab product administered intravenously.
	MC		SIMPONI AUTOINJECTOR	MC/DEL		**KEVZARA**		Moderately to severely active Crohn's disease following treatment with an infliximab product administered intravenously.
	MC/DEL		**RINVOQ**[3]	MC		OLUMIANT		
	MC		**HUMIRA**[1,2]	MC		OMVOH		
	MC/DEL		**XELJANZ**[3,6]	MC		OTREXUP	6. See criteria section	
	MC/DEL		**XELJANZ XR**	MC		RASUVO[7]		
	MC/DEL		**XELJANZ XR SOL**	MC		REDITREX		
				MC		**REMICADE**		
				MC/DEL		**RENFLEXIS**		
				MC		SIMLANDI		
				MC		VELSIPITY		
				MC		YUFLYMA		
				MC		YUSIMRY		DDI: The concomitant use of **Xeljanz® XR** with biologic DMARDs or potent immunosuppressants such as azathioprine and cyclosporine are not recommended. The concomitant use of **Xeljanz® XR** with potent CYP3A4 inducers (e.g. rifampin) is not recommended
				MC		XATMEP[5]		
				MC		ZYMFENTRA		
ALOPECIA AREATA AGENTS								
ALOPECIA AREATA AGENTS				MC	7	OLUMIANT		Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC/DEL	8	LITFULO		

							Use PA Form# 20420	
MISCELLANEOUS ARTHRITIS								
ARTHRITIS - MISC.	MC MC		RIDAURA CAPS MYOCHRYSINE SOLN	MC/DEL		**ARTHROTEC**[1]	1. The individual components of Arthrotec are available without PA. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. The individual components of Arthrotec are available without PA.
LUPUS-SLE								
LUPUS-SLE				MC MC MC		BENLYSTA[1] LUPKYNIS SAPHNELO	Use PA Form# 20420 1. Approvals will require previous trial of corticosteroids, antimalarials, NSAIDS and immunosuppressives.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. DDI: Lupkynis is a sensitive CYP3A4 substrate. Co-administration with strong or moderate CYP3A4 inhibitors increases voclosporin exposure, which may increase the risk of Lupkynis® adverse reactions. Co-administration of Lupkynis® with strong CYP3A4 inhibitors (e.g. ketoconazole, itraconazole, clarithromycin) is contraindicated. Reduce Lupkynis® dosage when co-administered with moderate CYP3A4 inhibitors (e.g. verapamil, fluconazole, diltiazem)
PIK3CA-Related Overgrowth Spectrum (PROS)								
PIK3CA-Related Overgrowth Spectrum (PROS)				MC		VIJOICE[1]	Use PA Form# 20420 1. PA required to confirm FDA approved indication.	Preferred drugs must be tried and failed, in step-order, due to lack of efficacy (failure to reach target IOP reduction) or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
MIGRAINE THERAPIES								
MIGRAINE - ERGOTAMINE DERIVATIVES				MC/DEL MC		D.H.E. 45 SOLN TRUDHESA	Use PA Form# 10110	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
MIGRAINE - CARBOXYLIC ACID DERIVATIVES	MC		DIVALPROEX ER TB24	MC		DEPAKOTE ER TB24	Use PA Form# 10110	
MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)--Tabs/Nasal	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	1 1 1 1 1 1 2	MIGRANAL NASAL SPRAY RELPAX[1] **RIZATRIPTAN ODT** **RIZATRIPTAN TABS** SUMATRIPTAN TABS[1] **ZOLMITRIPTAN TAB**[1] NARATRIPTAN HCI TABS[1]	MC MC MC/DEL MC MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		AMERGE TABS[1,2] AXERT TABS[1,2] FROVA TABS[1,2] IMITREX NASAL SPRAY[1] IMITREX TABS[1,2] MAXALT[1,2,3] MAXALT MLT[1,2,3] ONZETRA XSAIL[2] SUMATRIPTAN NASAL SPRAY[1] **ZOLMITRIPTAN ODT** **ZOLMITRIPTAN SPRAY** ZOMIG TABS[1,2] ZOMIG NASAL SPARY[1,2] ZOMIG ZMT TBDP[1,2]	1. All drugs in this category have dosing limits. Please refer to dose consolidation table. 2. Must fail all preferred products before non-preferred. 3.Established users will be grandfathered Use PA Form# 10110	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Quantity limit exceptions will require ongoing therapy with therapeutic doses of highly effective prophylactic medication as listed on the Triptan PA form.
MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)--Injectables	MC MC/DEL MC/DEL		IMITREX CARTRIDGE[1] SUMATRIPTAN SYRINGE[1] SUMATRIPTAN PEN INJCTR[1]	MC/DEL MC MC		TOSYMRA ZEMBRACE[1] IMITREX PEN INJCTR[1]	Use PA Form# 10110 1. Dosing limits apply. Please refer to the dose consolidation table.	
MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)--Combinations				MC/DEL		TREXIMET[1,2]	Use PA Form# 10110 1. Dosing limits apply. Please see dose consolidation list.	

							2. Use preferred Sumatriptan and Naproxen separately. Treximet only available if component ingredients of sumatriptan and naproxen are unavailable.	
MIGRAINE - PREVENTATIVE TREATMENT	MC MC/DEL MC/DEL MC/DEL MC/DEL		AIMOVIG[1] AJOVY[1] AJOVY AUTO INJCT[1] EMGALITY SYRINGE[1] 200mg/ml EMGALITY PEN[1]	MC MC MC		NURTEC ODT[2] QULIPTA VYEPTI[2]	Use PA Form# 10110 1. See criteria section 2. Dosing limits apply, please see the dose consolidation list.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Aimovig, Ajovy and Emgality: The patient is 18 years of age or older AND patient has a diagnosis of episodic migraine (4-14 headache days per month with migraine lasting 4 hours or more) or chronic migraine (≥ 15 headache days per month, of which ≥ 8 are migraine days, for at least 3 months) AND patient has failed or has a contraindication to an adequate trial (≥ 60 days) of at least 2 medications for migraine prophylaxis from at least 2 different classes. Ubrelvy is non-preferred and is indicated for the acute treatment of migraine with or without aura in adults. This is not indicated for the preventive treatment of migraine. Nurtec ODT will be preferred after 2 adequate trials of at least two preferred triptans
MIGRAINE - ACUTE TREATMENT	MC MC/DEL		NURTEC ODT[1] SPASTRIN TABS	MC MC MC/DEL MC/DEL MC MC MC/DEL		BELCOMP-PB SUPP ELYXYB MIGRAZONE CAPS MIGERGOT SUP REYVOW UBRELVY ZAVZPRET	1. Dosing limits apply, please see the dose consolidation list. Use PA Form# 10110	Reyvow is non-preferred and is indicated for the acute treatment of migraine with or without aura in adults. Reyvow® is not indicated for the preventive treatment of migraine. Zavzpret: The patient must have a documented side effect, allergy, or treatment failure to preferred oral CGRP Inhibitor and two non-preferred oral CGRP Inhibitors. Ubrelvy is non-preferred and is indicated for the acute treatment of migraine with or without aura in adults. This is not indicated for the preventive treatment of migraine. Nurtec ODT will be preferred after 2 adequate trials of at least two preferred triptans
GOUT								
GOUT	MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL		**ALLOPURINOL TABS** COLCHICINE TAB **FEBUXOSTAT TAB** MITIGARE **PROBENECID TABS** **PROBENECID/COLCHICINE TABS**	MC/DEL MC MC MC/DEL MC		**COLCHICINE CAP** COLCRYS GLOPERBA ULORIC[1] ZYLOPRIM TABS	Use PA Form# 20420 1. Failure of therapeutic (300mg) dose of Allopurinol (failure define as not being able to get uric acid levels below 6mg/dl) or severe renal disease.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** The concomitant use of Gloperba® and CYP3A4 inhibitors (e.g. clarithromycin, ketoconazole, grapefruit juice, erythromycin, verapamil, etc.) should be avoided due to the potential for serious and life-threatening toxicity.
MISC.								
ACID SPHINGOMYELINASE DEFICIENCY (ASMD)				MC		XENPOZYME[1,2]	1.For treatment of non-central nervous system manifestations of acid sphingomyelinase deficiency (ASMD) in adult and pediatric patients 2. Clinical PA required for appropriate diagnosis and clinical parameters.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANESTHETICS - MISC.	MC MC MC		BUPIVACAINE HCL SOLN LIDOCAINE HCL SOLN MARCAINE SOLN	MC MC/DEL MC		SENSORCAINE-MPF SOLN SYNVISC INJ XYLOCAINE SOLN	Use PA Form# 30130	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
COLD AGGLUTININ DISEASE (CAD)				MC		ENJAYMO[1]	1.Indicated to decrease the need for red blood cell transfusion due to hemolysis in adults with cold agglutinin disease (CAD).	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

PRIMARY HYPEROXALURIA TYPE 1 (PH1)						OXLUMO[1] RIVFLOZA	1. PA is required to establish diagnosis and medical necessity. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Rivfloza: The patient has a diagnosis of Primary Hyperoxaluria Type I (PH1) confirmed via genetic testing (identification of alanine: glyoxylate aminotransferase gene (AGXT) mutation) AND urinary oxalate excretion > 0.5mmol/1.73 m2 or urinary oxalate: creatinine ratio is above the upper limit of normal for age AND is at least 9 years of age AND medication is being prescribed by, or in consultation, with a nephrologist or urologist
SICKLE CELL DISEASE	MC/DEL MC		**HYDROXYUREA** DROXIA	MC MC MC MC MC/DEL		ADAKVEO CASGEVY[2,3] ENDARI[1] LYFGENIA[2,3] SIKLOS	1.Evidence of other preferred L-glutamine products utilization and reason for failure. 2. For the treatment of patients ≥ 12 years of age. 3. PA required to confirm FDA approved indication. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
HUTCHINSON- GILFORD PROGERIA SYNDROME (HGPS)				MC		ZOKINVY[1,2]	1.In patients 12 months of age and older with a body surface area (BSA) of 0.39m2 and above 2. PA required to confirm FDA approved indication. Use PA Form# 20420	ZOKINVY: To reduce the risk of mortality in Hutchinson-Gilford Progeria Syndrome (HGPS). For the treatment of processing-deficient Progeroid Laminopathies with either: Heterozygous LMNA mutation with progerin-like protein accumulation OR Homozygous or compound heterozygous ZMPSTE24 mutations
VACCINES	MC/DEL MC MC/DEL MC/DEL		ABRYSVO AREXVY GARDASIL 9 SHINGRIX				Use PA Form# 20420	Gardasil 9 will be preferred by MaineCare for ages 19-45 for FDA approved indications. Under the Maine Immunization Program Gardasil 9 is covered under the Vaccine for Children Program for ages 9-18. Please contact 1-800-867-4775 or 207-287-3746 for assistance. Abrysvo will be a preferred vaccine indicated for active immunization for the prevention of lower respiratory tract disease (LRTD) caused by respiratory syncytial virus (RSV) in individuals 60 years of age and older. Active immunization of pregnant individuals at 32 through 36 weeks gestational age for the prevention of LRTD and severe LRTD caused by RSV in infants from birth through 6 months of age. Arexvy will be preferred for active immunization for the prevention of LRTD caused by respiratory syncytial virus (RSV) in individuals 60 years of age and older. SHINGRIX (>= 50yo) is preferred as of 11-20-20 with respective age edit.
APDS				MC		JOENJA[1,2,3]	Use PA Form# 20420 1.Clinical PA required for appropriate diagnosis 2. For the treatment of patients 2 years of age and older. 3. Avoid CYP3A drug drug interaction.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ALPHA- MANNOSIDOSIS				MC		LAMZEDE	Use PA Form# 20420 1.Clinical PA required for appropriate diagnosis	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTI-CONVULSANTS								
ANTICONVULSANTS	MC/DEL		BRIVIACT	MC	8	APTIOM	Use PA Form# 20420	

	MC/DEL		CARBAMAZEPINE	MC	8	BANZEL		Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		CARBAMAZEPINE ER CAP	MC	8	CARBAMAZEPINE SUS	All non-preferred meds must be used in specified order	
	MC/DEL		CARBATROL CP12	MC	8	DEPAKOTE		
	MC/DEL		CELONTIN CAPS	MC	8	DEPAKOTE ER		
	MC/DEL		**CLOBAZAM**	MC	8	DIACOMIT		
	MC/DEL		CLONAZEPAM TABS	MC/DEL	8	DIVALPROEX SODIUM SPRINKLE CAPS	1. Quantity limit. 5/month	
	MC		DEPAKOTE SPRINKLES CPSP	MC	8	ELEPSIA XR[9]	2. Dosing limits apply, please see dose consolidation list.	
	MC/DEL		DIAZEPAM GEL[1]	MC	8	EPRONTIA SOLN[10]		
	MC/DEL		DILANTIN	MC/DEL	8	FELBATOL		Approvals will be for patients with a variety of drug-specific FDA-approved indications and for specific conditions supported by at least two published peer-reviewed double-blinded, placebo-controlled randomized trials that are not contradicted by other studies of similar quality after recommendation by the DUR Committee and as long as all first line therapies have been tried and failed at full therapeutic doses for adequate durations (at least two weeks).
	MC/DEL		DIVALPROEX SODIUM	MC/DEL	8	FELBATOL SUS	3. Dosing limits apply per strength as well as a maximum daily dose of 600mg. Please see dose consolidation list.	
	MC		DIVALPROEX SPRINKLE CAP	MC/DEL	8	FELBAMATE SUS		
	MC/DEL		EPIDIOLEX[7]	MC	8	FINTEPLA[8]		
	MC/DEL		EPITOL TABS	MC	8	FYCOMPA[2]		
	MC/DEL		ETHOSUXIMIDE SYRP	MC/DEL	8	HORIZANT		
	MC/DEL		EQUETRO	MC	8	GRALISE	4. Adjunctive therapy 17 and older.	*** SEE CHART AT END OF DOCUMENT
	MC/DEL		GABAPENTIN[2] CAP	MC/DEL	8	KEPPRA TABS		
	MC/DEL		GABAPENTIN[2] TAB	MC/DEL	8	KEPPRA SOLN	5. Max dose 2400mg	
	MC/DEL		GABAPENTIN SOL	MC/DEL	8	KLONOPIN TABS	6. Clinical PA required for appropriate diagnosis	
	MC/DEL		GABITRIL TABS	MC	8	LAMICTAL IR		Topamax and Neurontin - Second line therapy for migraine prophalaxis after trial of at least three preferred preventive medications from Group 1 listed on page 2 of the Acute Migraine PA form.
	MC/DEL		**LACOSAMIDE SOL**	MC	8	LAMICTAL ODT		
	MC/DEL		**LACOSAMIDE TAB**	MC	8	LAMICTAL XR	7. Epidiolex is for the treatment of seizures associated with Lennox-Gastaut syndrome (LGS), Dravet syndrome (DS) or TS (Tuberous Sclerosis Complex) in patients 1 years of age and older.	
	MC		LAMICTAL CHEW	MC/DEL	8	**LEVETIRACETAM INJ**		All non-preferred meds must be used in specified order.
	MC/DEL		LAMOTRIGINE ER ODT	MC	8	LIBERVANT		
	MC/DEL		LAMOTRIGINE IR[2]	MC/DEL	8	LYRICA CR		
	MC/DEL		LAMOTRIGINE XR	MC/DEL	8	LYRICA SOL[3]		Please use Drug-Drug Interaction PA form #10400 for this combination.
	MC/DEL		LEVETIRACETAM SOLN	MC	8	MOTPOLY XR		
	MC/DEL		LEVETIRACETAM TABS	MC/DEL	8	MYSOLINE TABS		
	MC/DEL		**LEVETIRACETAM ER TABS**	MC	8	ONFI	8. For seizures associated with Dravet syndrome in patients 2 years of age and older	Epidiolex Criteria for Lennox-Gastaut syndrome (LGS) and Dravet: a trial of two drugs (clobazam, levetiracetam, valproate derivatives, lamotrigine, topiramate, rufinamide, or felbamate).
	MC/DEL		LYRICA[3]	MC/DEL	8	OXCARBAZEPINE SUS		**Diacomit** is for the treatment of seizures associated with Dravet syndrome (DS) in patients 6 months of of age and older and wrighing 7kg or more There are no clinical data to support the use of Diacomit® as monotherapy in DS.
	MC/DEL		NAYZILAM[1]	MC	8	OXTELLAR XR[5]		
	MC/DEL		OXCARBAZEPINE	MC/DEL	8	PHENYTEK CAPS		
	MC/DEL		PREGABALIN CAPS	MC/DEL	8	POTIGA	9. Adjunctive therapy 12 and older.	
	MC/DEL		PHENYTOIN	MC/DEL	8	PREGABALIN (ORAL) SOL		DDI: Concomitant use of Diacomit® with other CNS depressants, including alcohol, may increase the risk of sedation and somnolence. Concomitant use of strong inducers (CYP1A2, CYP3A4, or CYP2C19 inducers, such as rifampin, phenytoin, phenobarbital, and carbamazepine) should be avoided, or dosage adjustments should be made.
	MC/DEL		PRIMIDONE TABS	MC	8	ROWEEPRA TAB		
	MC/DEL		QUDEXY XR	MC	8	SABRIL		
	MC/DEL		TEGRETOL SUS	MC	8	SEZABY		DDI: Avoid concomitant use of Nayzilam® with moderate or strong CYP3A inhibitors.
	MC/DEL		TOPIRAMATE	MC	8	SPRITAM	10. Initial monotherapy for the treatment of partial-onset or primary generalized tonic-clonic seizures in patients 2 years of age and older. Adjunctive therapy for the treatment of partial-onset seizures, primary generalized tonic-clonic seizures, and seizures associated with Lennox Gastaut syndrome in patients 2 years of age and older. The preventive treatment of migraine in patients 12 years and older. Will require a step though topiramate.	
	MC/DEL		TOPIRAMATE SPRINKLE IR CAPS	MC	8	SYMPAZAN		Xcopri criteria: History of trials with at least 4 AEDs (2 generic, 2 branded or Uncontrolled seizures on three AEDs; or Uncontrolled on 2 AEDs given along with VNS. Uncontrolled defined as 3 or more TC seizures per year (increases risk of SUDEP); > 6 disabling seizures per year . Any patient who has gone to the ED 2 or more times in the prior 12 months (who has also tried and failed at least 3 other drugs). Ongoing use requires 50 percent reduction in seizure frequency after three months.
	MC/DEL		TRILEPTAL SUS	MC/DEL	8	TEGRETOL TAB		
	MC/DEL		VALPROIC ACID TABS	MC/DEL	8	TIAGABINE		
	MC/DEL		VALPROIC ACID SOL	MC	8	TOPAMAX		
	MC		VALTOCO[2]	MC/DEL	8	TOPIRAMATE ER CAPS		Motpoly XR: pediatric patient weight must be > 50kg and requires multiple preferred medication trials including generic lacosamide
	MC/DEL		ZONISAMIDE	MC	8	TOPAMAX SPRINKLE ER CAPS[2]		
				MC	8	TOPAMAX SPRINKLE IR CAPS[2]		
				MC/DEL	8	TOPIRAMATE SPRINKLE ER CAPS[2]		
				MC	8	TROKENDI[2,6]		
				MC/DEL	8	VIMPAT[4]		**Libervant:** For the acute treatment of intermittent, stereotypic episodes of frequent seizure activity (i.e., seizure clusters, acute repetitive seizures) that are distinct from a patient's usual seizure pattern in patients with epilepsy 2 to 5 years of age as long as all preferred therapies have been tried and failed at full therapeutic doses.
				MC/DEL	8	VIMPAT SOL[4]		
				MC	8	XCOPRI		
				MC/DEL	8	ZARONTIN SYRP		
				MC/DEL	8	ZARONTIN CAP		
				MC/DEL	8	ZARONTIN SOL		
				MC	8	ZONISADE		
				MC	8	ZTALMY		
				MC/DEL	9	KEPPRA XR		
				MC/DEL	9	NEURONTIN		
				MC/DEL	9	TEGRETOL-XR TB12		

						BIPOLAR DISORDER: STEP ORDER	SEE ANTICONVULSANT INDICATION CHART AT THE END OF THIS DOCUMENT M= Monotherapy A= Adjunctive 9= No Evidence The step orders show the relative strength of evidence for use in bi-polar and will guide prior authorization determinations. Step 4 drugs-no PA required.	
					M ~ A			
					4 ~ 4	LAMICTAL		
					4 ~ 4	LITHIUM		
					4 ~ 4	CARBAMAZEPINE		
					4 ~ 4	VALPROATE		
					4 ~ 4	ATYPICAL ANTIPSYCHOTICS EXC. CLOZAPINE		
					5 ~ 5	TRILEPTAL		
					9 ~ 6	TOPAMAX		
					9 ~ 7	KEPPRA TABS		
					9 ~ 8	GABITRIL TABS		
					9 ~ 9	NEURONTIN		
						PEDIATRIC BIPOLAR1 DISORDER: STEP ORDER		
					M ~ A	(6-18 YEARS WITH OR WITHOUT PSYCHOSIS)	Two-step 1 preferred drugs must be tried before Trileptal. The step orders show the relative strength of evidence for use in bi-polar and will guide prior authorization determinations. Step 4 drugs-no PA required.	
					4 ~ 4	LITHIUM		
					4 ~ 4	CARBAMAZEPINE		
					4 ~ 4	VALPROATE		
					4 ~ 4	ATYPICAL ANTIPSYCHOTICS EXC.CLOZAPINE		
					4 ~ 4	LAMICTAL		
					5 ~ 5	TRILEPTA		
ANTI-PARKINSON DRUGS								
PARKINSONS - ANTICHOLINERGICS	MC/DEL MC MC/DEL		BENZTROPINE MESYLATE TABS COGENTIN SOLN **TRIHEXYPHENIDYL**				Use PA Form# 20420	
PARKINSONS - ADENOSINE RECEPTOR ANTAGONIST				MC/DEL		**NOURIANZ**	Use PA Form# 20420	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. DDI: Avoid use of Nourianz® with strong CYP3A4 inducers (e.g. carbamazepine, rifampin, phenytoin, St. John's wort).
PARKINSONS - COMT INHIBITORS				MC/DEL MC MC/DEL		**COMTAN TABS** ONGENTYS **TASMAR TABS**	Use PA Form# 20420	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
PARKINSONS - SELECTED DOPAMIN AGONISTS	MC/DEL MC/DEL		**PRAMIPEXOLE** **ROPINIROLE**	MC/DEL MC MC/DEL MC/DEL	5 8 8 8	**MIRAPEX TABS**[1] **REQUIP TABS** **MIRAPEX ER** **NEUPRO PATCH**	Use PA Form# 20420 1. As of 12/08 users of Mirapex will be grandfathered if diagnosis is Parkinsons.	Preferred drug must be tried and failed in step-order due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

PARKINSONS- MAOIS				**MC**		XADAGO	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
PARKINSONS - DOPAMINERGICS/CARBII/ LEVO	**MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL** **MC** **MC/DEL** **MC/DEL**		**AMANTADINE HCLCAPS** **AMANTADINE HCL TABS** **BROMOCRIPTINE MESYLATE TABS** **BROMOCRIPTINE MESYLATE CAPS** **CARBIDOPA/LEVODOPA TABS**[3] **CARBIDOPA/LEVODOPA ER** **CARBIDOPA/LEVO/ENTACAPONE TAB** LARODOPA TABS **SELEGILINE CAPS HCL** **SELEGILINE TABS HCL**	**MC/DEL** **MC** **MC/DEL** **MC** **MC** **MC/DEL** **MC** **MC** **MC** **MC/DEL** **MC/DEL** **MC** **MC** **MC** **MC**		**APOKYN** AZILECT[2] **CARBIDOPA/LEVODOPA RAPDIS** ELDEPRYL CAPS GOCOVRI **INBRIJA** KYNMOBI LODOSYN TABS OSMOLEX ER **PARLODEL CAPS** **PARLODEL TABS** RYTARY SINEMET TABS SINEMET TBCR ZELAPAR[1]	1. Approvals will require concurrent therapy with Levodopa and failed trials of Selegiline, Comtan, and Stalevo. 2. Approvals will require trials of Carbidopa/Levodopa, Selegiline, Comtan, and Stalevo. 3. Only preferred manufacturer's products will be available without prior authorization. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Inbrija is recommended for the intermittent treatment of OFF episodes in patients with Parkinson's disease treated with carbidopa/levodopa.
PARKINSONS - COMBO.				**MC/DEL** **MC**		STALEVO[1] CARBIDOPA/LEVODOPA/ENTACA[1]	Use PA Form# 20420 1.Clinical PA is required to establish diagnosis and medical necessity.	
MUSCLE RELAXANTS								
MUSCLE RELAXANTS	**MC/DEL** **MC/DEL** **MC/DEL** **MC** **MC/DEL** **MC/DEL**		**BACLOFEN TABS** **CHLORZOXAZONE TABS** **CYCLOBENZAPRINE HCL 5mg & 10mg TABS** LIORESAL INTRATHECAL KIT **METHOCARBAMOL TABS** **TIZANIDINE HCL TABS**	**MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL** **MC** **MC**	7 8 8 8 8 8	**ORPHENADRINE CITRATE** **CARISOPRODOL 350MG TABS** AMRIX DANTRIUM CAPS FLEQSUVY LIORESAL TABS		At least 4 preferred drugs (including tizanidine) must be tried for at least 2 weeks and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an…… acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Elderly patients, over 65, will require written notice of the increased sedative risks and impaired driving.Prior Authorization will not be given for:1. frequent or persistent early refills of controlled drugs; 2. multiple instances of early refill overrides due to reports of misplacement, stolen, dropped in toilet or sink, distant travel, etc.
				MC	8	LORZONE		
				MC	8	LYVISPAH		
				MC/DEL	8	**METAXALONE**		Non-preferred drugs will not be approved if members circumventing MaineCare prior authorization requirements by paying (prescribers failed to submit prior authorization prior to cash narcotic scripts being filled by member).
				MC	8	NORFLEX TBCR		
				MC	8	OZOBAX		Non-preferred products must be used in specified step order.
				MC	8	ROBAXIN-750 TABS		
				MC	8	VECUROMIUM INJ		**Lorzone** is non preferred and requires at least 4 preferred drugs (including tizanidine) and step care therapy (orphenadrine), as well as reasons for why chlorzoxazone is not acceptable.
				MC/DEL	8	**ZANAFLEX TABS**		
				MC/DEL	9	**CARISOPRODOL 250MG TABS**		
				MC/DEL	9	**CHLORZOXAZONE 250mg TABS**		
				MC/DEL	9	**SKELAXIN TAB**		
				MC/DEL	9	**SOMA TABS**	Use PA Form# 20420	
MUSCLE RELAXANT - COMBO.				**MC/DEL** **MC/DEL** **MC** **MC/DEL** **MC/DEL** **MC**		CARISOPRODOL/ASPIRIN TABS CARISOPRODOL/ASPIRIN/CODE NORGESIC TABS ORPHENADRINE COMPOUND ORPHENADRINE/ASA/CAFF ORPHENGESIC	Use PA Form# 20420	Individual components are available with PA described in the section above.1. frequent or persistent early refills of non-controlled drugs; 2. multiple instances of early refill overrides due to reports of misplacement stolen, dropped in toilet or sink, distant travel, etc.

PARATHYROID HORMONE								
PARATHYOID HORMONE				MC		NATPARA[1]	1. Recommended only for those who cannot be well-controlled on calcium supplements and active forms of vitamin D alone. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
VITAMINS								
VITAMINS	MC		CYANOCOBALAMIN SOLN	MC		AQUASOL E SOLN	Use PA Form# 20420 **Please refer to OTC list for covered products.** Click here for the OTC List	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Certain drugs require specific diagnoses for approval. **Please refer to OTC list for covered products.** **DDI:** B-12 will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, pantoprazole, Prilosec, or any currently non preferred PPI. Preferred products that used to require diag codes still require diag codes unless indicated otherwise.
	MC		FERIVA CAP	MC		AQUAVIT-E SOLN		
	MC		FERIVAFA CAP	MC		DHT SOLN		
	MC/DEL		FOLIC ACID TABS	MC		FUSION PLUS CAP		
	MC/DEL		MEPHYTON TABS			HEMOCYTE PLU CAP		
				MC				
	MC/DEL		NIACIN	MC		INTEGRA CAP		
	MC		NIACOR TABS	MC		INTEGRA F CAP		
	MC/DEL		NICOTINIC ACID SR CPCR	MC		INTEGRA PLUS CAP		
	MC		PYRIDOXINE HCL TABS	MC		NASCOBAL GEL		
	MC		TANDEM CAP	MC		TANDEM PLUS CAP		
	MC/DEL		THIAMINE HCL SOLN					
	MC/DEL		VITAMIN B-1 TABS					
	MC/DEL		VITAMIN B-12					
	MC		VITAMIN B-6 TABS					
	MC/DEL		VITAMIN C					
	MC/DEL		VITAMIN E CAPS					
	MC/DEL		VITAMIN E/D-ALPHA CAPS					
	MC		VITAMIN K1 SOLN					
	MC		V-R VITAMIN E CAPS					
VITAMIN D's	MC/DEL		**CALCITRIOL CAPS[1]**	MC		CALCIJEX	1. Diagnosis of dialysis (renal failure) required. 2. Only specific NDCs available Use PA Form# 20420	Preferred products require dialysis/renal failure diagnosis. Rayaldee requires clinical PA to verify stage 3 or 4 CKD.
	MC/DEL		**ROCALTROL**	MC/DEL		**DOXERCALCIF CAP**		
	MC/DEL		**VITAMIN D2[2]**	MC/DEL		**DOXERCALCIF INJ**		
	MC/DEL		**VITAMIN D3[2]**	MC/DEL		**PARICALCITROL CAP**		
	MC/DEL		**VITAMIN DROPS**	MC/DEL		**PARICALCITROL INJ**		
	MC		PARICALCITOL CAPS	MC/DEL		HECTOROL (ORAL)		
				MC/DEL		HECTOROL (PARENTERAL)		
				MC		RAYALDEE		
				MC		ZEMPLAR INJ		
				MC		ZEMPLAR CAPS		
EMZYMES								
POMPE DISEASE AGENTS				MC		NEXVIAZYME[1]	1. For patients 1 year of age and older with late-onset Pompe disease (lysosomal acid alpha-glucosidase [GAA] deficiency). Use PA Form# 20420	All preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Pombiliti and Opfolda are for the treatment of adult patients with late-onset Pompe disease (lysosomal acid alpha-glucosidase [GAA] deficiency) weighing ≥40kg and who are not improving on their current enzyme replacement therapy (ERT).
				MC		LUMIZYME		
				MC		OPFOLDA		
				MC		POMBILITI		
MISC MULTI-VITAMINS								
VITAMINS - MISC.	MC		CENTRUM TABS	MC		ADEKS	1. Diag codes are no longer required on prenatal vitamins. **Please refer to OTC list.** Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Certain drugs require specific diagnoses for approval. **Please refer to OTC list.**
	MC		CENTRUM JR/IRON CHEW	MC/DEL		ADVANCED NATALCARE TABS		
	MC		CENTRUM-LUTEIN TABS	MC		AQUADEKS		
	MC		CEROVITE ADVANCED FO TABS	MC		CENTRUM JR/EXTRA C CHEW		
	MC/DEL		CHEWABLE MULTIVIT/FL CHEW	MC		CENTRUM PERFORMANCE TABS		
	MC		COD LIVER OIL CAPS	MC		CENTRUM SILVER TABS		

				MC		DALYVITE LIQD		Preferred products that used to require diag codes still require diag codes unless indicated otherwise.
	MC/DEL		COMPLETE NATAL DHA (ORAL) COMBO PKG					
	MC		COMPLETE SENIOR TABS	MC		EMBREX 600 MISC		
	MC		DAILY MULTI VIT/IRON					
				MC		FERRALET 90	Click here for the OTC List	
	MC/DEL		DIALYVITE 1MG	MC		IBERET		
	MC/DEL		DIALYVITE 800MG	MC		MATERNA TABS		
	MC/DEL		FULL SPECTRUM B	MC		MAXARON		
	MC		M.V.I.-12 INJ	MC		MULTIRET FOLIC -500 TBCR		
	MC		MULTI-VIT/FLUORIDE	MC/DEL		NATAFORT TABS		
	MC/DEL		NATALCARE RX TABS	MC/DEL		NATALCARE CFE 60 TABS[1]		
	MC/DEL		NEPHRONEX	MC/DEL		NATALCARE GLOSS TABS[1]		
	MC/DEL		NIVA-PLUS (ORAL) TABLET	MC		NATALCARE PIC TABS[1]		
	MC/DEL		ONE DAILY TABS	MC		NATALCARE PIC FORTE TABS[1]		
	MC/DEL		ONE-DAILY MULTIVITAMINS	MC/DEL		NATALCARE PLUS TABS[1]		
	MC/DEL		ONE-TABLET-DAILY	MC		NATALCARE THREE TABS[1]		
	MC/DEL		POLY-VIT/IRON/FLUORID SOLN	MC/DEL		NATACHEW CHEW		
	MC/DEL		POLY-VITAMIN/FLUORIDE SOLN	MC		NATALFIRST TABS		
	MC/DEL		POLY-VITAMINS/IRON SOLN	MC		NATATAB RX TABS		
	MC		PRENATA (ORAL) TAB CHEW	MC/DEL		NEPHPLEX RX TABS		
	MC/DEL		PRENATAL TABS[1]	MC/DEL		NEPHROCAPS CAPS		
	MC/DEL		PRENATAL FORMULA 3 TABS[1]	MC/DEL		NEPHRO-VITE TABS		
	MC/DEL		PRENATAL PLUS TABS[1]	MC		NESTABS RX TABS		
	MC/DEL		PRENATAL PLUS NF TABS[1]	MC/DEL		NIFEREX		
	MC		PRENATAL PLUS/27MG IRON[1]	MC/DEL		OCUVITE TABS		
	MC		PRENATAL PLUS/IRON TABS[1]	MC		POLY-VI-FLOR SOLN		
	MC		PRENATAL VITAMIN PLUS LOW IRON (ORAL) TAB	MC		POLY-VI-SOL SOLN		
	MC/DEL		PRENATAL RX/BETA-CAROTENE[1]	MC		POLY-VI-SOL/IRON SOLN		
	MC/DEL		PREPLUS (ORAL) TABLET	MC		POLY-VITAMIN DROPS SOLN		
	MC/DEL		RENAL CAPS	MC		PRECARE		
	MC/DEL		RENAPHRO CAPS	MC		PREFERA OB		
	MC		STRESS TAB NF TABS	MC		PREMESIS RX TABS		
	MC		THERAPEUTIC-M TABS	MC		PRENATABS CBF TABS[1]		
	MC		THERAVITE LIQD	MC		PRENATAL CARE TABS[1]		
	MC/DEL		TRINATAL RX 1 (ORAL) TABLET	MC		PRENATAL MR 90 TBCR[1]		
	MC/DEL		TRIVEEN-DUO DHA (ORAL) COMBO. PKG	MC/DEL		PRENATAL MTR/SELENIUM TABS[1]		
	MC/DEL		TRI-VITAMIN/FLUORIDE SOLN	MC		PRENATAL OPTIMA ADVANCE TABS[1]		
	MC		VITA CON FORTE CAPS	MC		PRENATAL PC 40 TABS[1]		
	MC		VITAPLEX PLUS TABS	MC/DEL		PRENATAL RX TABS[1]		
				MC		PRENATE[1]		
				MC		PRENATE ELITE[1]		
				MC		PRIMACARE MISC		
				MC		PROTEGRA CAPS		
				MC		STUARTNATAL PLUS 3 TABS[1]		
				MC		TRI-VI-SOL SOLN		
				MC		TRI-VI-SOL/IRON SOLN		
				MC/DEL		ULTRA NATALCARE TABS		
				MC		ULTRA-NATAL TABS[1]		
				MC		VICON FORTE CAPS		
				MC		VINATAL FORTE TABS[1]		
				MC		VINATE[1]		
				MC/DEL		VINATE ADVANCED TABS[1]		
MISCELLANEOUS MINERALS								
MINERALS	MC		CALCARB	MC		ANEMAGEN	Use PA Form# 20420 **Please refer to OTC list.**	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Certain drugs require specific diagnoses for approval.
	MC		CALCI-MIX CAPSULE CAPS	MC		CALCET TABS		
	MC		CALCIQUID SYRP	MC/DEL		**CALCIUM 600-D TABS**		
	MC		CALCITRATE/VITAMIN D TABS	MC		CALCIUM/VITAMIN D TABS		

MC/DEL	CALCIUM
MC/DEL	CALCIUM CARBONATE
MC/DEL	CALCIUM CITRATE TABS
MC/DEL	CALCIUM GLUCONATE TABS
MC/DEL	CALCIUM LACTATE TABS
MC	CALCIUM/MAGNESIUM TABS
MC/DEL	**CALCIUM/VITAMIN D TABS**
MC	CALTRATE 600 TABS
MC/DEL	CHEWABLE CALCIUM CHEW
MC	CITRACAL TABS
MC	CITRACAL + D TABS
MC	CITRUS CALCIUM TABS
MC	CITRUS CALCIUM 1500 + D TABS
MC	EFFERVESCENT POTASSIUM TBEF
MC/DEL	FEOSTAT CHEW
MC	FERATAB TABS
MC/DEL	FER-GEN-SOL SOLN
MC	FER-IRON SOLN
MC	FERRONATE TABS
MC/DEL	FERROUS SULFATE
MC/DEL	FLUOR-A-DAY CHEW
MC	FLUORIDE CHEW
MC	FLUORIDE SODIUM CHEW
MC	FLUORITAB CHEW
MC	HM CALCIUM TABS
MC	K+ POTASSIUM PACK
MC	KAON ELIX
MC	KAON-CL-10 TBCR
MC	KCL 0.075%/D5W/NACL 0.2% SOLN
MC	K-EFFERVESCENT TBEF
MC	KLOR-CON
MC	KLOTRIX TBCR
MC/DEL	K-PHOS TABS
MC/DEL	K-VESCENT TBEF
MC/DEL	LURIDE CHEW
MC/DEL	MAGNESIUM GLUCONATE TABS
MC/DEL	MAGNESIUM SULFATE SOLN
MC	MAGTABS
MC	MICRO-K 8 MEG
MC/DEL	OS-CAL TABS
MC/DEL	**OS-CAL 500 + D TABS**
MC/DEL	**OYSCO**
MC/DEL	OYST-CAL TABS
MC/DEL	**OYST-CAL D TABS**
MC/DEL	**OYST-CAL/VITAMIN D TABS**
MC/DEL	OYSTER CALCIUM TABS
MC/DEL	OYSTER SHELL
MC	PHARMA FLUR
MC/DEL	PHOSPHA 250 NEUTRAL TABS
MC	POTASSIUM BICARBONATE TBEF
MC/DEL	POTASSIUM CHLORIDE 8MEQ
MC	POTASSIUM EFFERVESCENT
MC/DEL	SELENIUM TABS
MC	SLOW-MAG TBCR
MC/DEL	SODIUM FLUORIDE
MC	V-R CALCIUM

MC	CALTRATE 600 PLUS/VIT D TABS
MC	CALTRATE PLUS TABS
MC	CHROMAGEN
MC	CITRACAL PLUS TABS
MC	CONTRIN CAPS
MC	FEOGEN FORTE CAPS
MC	FEROCON CAPS
MC/DEL	FERREX 150 CAPS
MC	FERRO-SEQUELS TBCR
MC	FE-TINIC CAPS
MC	FE-TINIC 150 FORTE CAPS
MC/DEL	FLUOR-A-DAY SOLN
MC	HEMOCYTE TABS
MC/DEL	K-DUR TBCR
MC	KLOR-CON PACK
MC	K-LYTE
MC/DEL	K-PHOS TABS NEUTRAL
MC	K-TABS TBCR
MC	K-VESCENT PACK
MC	MICRO-K 10 MEG CPCR
MC	NU-IRON 150 CAPS
MC/DEL	**OYSTER SHELL CALCIUM/VITA TABS**
MC/DEL	POLY-IRON 150 CAPS
MC/DEL	POLYSACCHARIDE IRON CAPS
MC/DEL	POTASSIUM BICARB/CHLORIDE
MC/DEL	POTASSIUM CHLORIDE 10MEQ CAPS
MC/DEL	POTASSIUM CHLORIDE 8MEQ CAPS
MC	TUMS 500 CHEW
MC	VIACTIV CHEW

Click here for the OTC List

DDI: Fe salts will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, pantoprazole, Prilosec, or any currently non preferred PPI.

Please refer to OTC list.

Preferred products that used to require diag codes still require diag codes unless indicated otherwise.

	MC		V-R OYSTER SHELL CALCIUM					
	MC		ZINC SULFATE CAPS					
PHENYLKETONURIA (PKU) TREATMENT AGENTS								
PHENYLKETONURIA (PKU) TREATMENT AGENTS- INJECTABLES				MC		PALYNZIQ[1]	1. For the treatment of patients ≥ 18 years of age. Use PA Form# 20420	Palynziq is not to be used in combination with Kuvan
PHENYLKETONURIA (PKU) TREATMENT AGENTS- ORAL				MC		KUVAN	Use PA Form# 20420	
MISC. ELECTROLYTES/NUTRITIONALS								
ELECTROLYTES/ NUTRITIONALS	MC		INTRALIPID EMUL[1]	MC		BOOST[1]	1. This list of nutritionals is incomplete. All nutritionals still require a PA except for the miscellaneous products listed as preferred. SGA form required for nutritionals unless member has a G/I tube.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Certain drugs require specific diagnoses for approval. Medical foods are not to be authorized solely for the purpose of enhancing nutrient intake or managing body weight if the participant is able to eat conventional foods adequately. Medical foods may be approved if the member has a medical condition which precludes or restricts the use of conventional foods and necessitates the use of a formula. Concurrent Stimulant therapy is not an acceptable medical reason/condition for use of medical foods for enhancing nutrient intake or managing body weight.
	MC		P.T.E. -5 SOLN[1]	MC		CASEC POWD[1]		
	MC		SEA-OMEGA CAPS[1]	MC		CHOICE DM LIQD[1]		
				MC		DELIVER 2.0 LIQD[1]		
				MC		DOJOLVI		
				MC		ENFAMIL[1]		
				MC		ENSURE[1]		
				MC		GLUCERNA[1]		
				MC		ISOCAL LIQD[1]		
				MC		KINDERCAL TF LIQD[1]	2. Formerly known as Omacor.	For children under the age of 5, MaineCare will not provide milk- or soy-based standard infant formulas. Regular formulas may be sought through your nearest WIC office. MaineCare will continue to cover medical food for all participants in MaineCare when medical necessity is met.
				MC		KINDERCAL TF/FIBER LIQD[1]		
				MC		L-CARNITINE CAPS[1]		
				MC		LIPISORB LIQD[1]	Use PA Form# 20420 & SGA Form	
				MC		LOVAZA[1,2]		Vascepa requires adjunct therapy for specific indication to reduce TG in those with severe hypertriglyceridemia (500mg per deciliter or more). Proper indication per lab values is required before approval
				MC		MODULEN IBD POWD[1]		
				MC		NUTRAMIGEN POWD[1]		
				MC		NUTREN[1]		
				MC		NUTRITIONAL SUPPLEMENT LIQD[1]		
				MC		NUTRIVENT 1.5 LIQD[1]		
				MC		PEPTAMEN[1]		
				MC		PHENYLADE[1]		
				MC		PHENYL-FREE[1]		
				MC		PKU 3 POWD[1]		
				MC		PREGESTIMIL POWD[1]		
				MC		PROBALANCE LIQD[1]		
				MC		PROSOBEE[1]		
				MC		SCANDISHAKE PACK[1]		
				MC		VASCEPA		
ERYTHROPOEITINS	MC		EPOGEN SOLN	MC	8	ARANESP SOLN[1]	Use PA Form# 10520 1. Clinical PA is required to establish medical necessity and that appropriate lab monitoring is being done.	Non-Preferred drugs must be tried and failed in step-order, due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Please see the EPO PA form for other approval and renewal criteria.
	MC		MIRCERA SYRINGE	MC	8	PROCRIT SOLN[1]		
	MC		RETACRIT					
GRANULOCYTE CSF								
GRANULOCYTE CSF	MC		FULPHILA	MC	8	FYLNETRA	1. Must be used in specified step order.	See approval criteria detailed on Granulocyte Colony Stimulating Factor PA form.
	MC		NEUPOGEN SYRINGE	MC	8	GRANIX SYRINGE		
	MC		NEUPOGEN VIAL	MC	8	GRANIX VIAL		
	MC/DEL		**NYVEPRIA SYRINGE**	MC	8	LEUKINE		

				MC/DEL	8	NIVESTYM		
				MC	8	ROLVEDON		
				MC	8	STIMUFEND		
				MC/DEL	8	ZARXIO		
				MC/DEL		ZIEXTENZO		
				MC	9	NEULASTA[1]	Use PA Form# 20520	
GAUCHER DISEASE								
GAUCHER DISEASE				MC		CERDELGA[1]	1. Clinical PA for indication required.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Exceeding days supply limits for LMWH class requires PA. Yargesa: As monotherapy for the treatment of adult patients with mild to moderate type 1 Gaucher disease for whom enzyme replacement therapy is not a therapeutic option (e.g., due to allergy, hypersensitivity, or poor venous access).
				MC		YARGESA[1]	Use PA Form# 20420	
ANTICOAGULANTS / PLATELET AGENTS								
ANTICOAGULANTS	MC		COUMADIN TABS	MC		ARIXTRA SOLN	1. Enoxaparin therapy durations greater than 7 days every 30 days require PA 2. Use other strengths available to obtain desired dose. 3. Diagnosis required 4. For the treatment of patients aged 3 months to less than 12 years of age.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Exceeding days supply limits for LMWH class requires PA.
	MC/DEL		ENOXAPARIN[1]	MC/DEL		FONDAPARINUX		
	MC		ELIQUIS	MC/DEL		FRAGMIN INJ		
	MC		ELIQUIS STARTER PACK	MC/DEL		FRAGMIN VIAL		
	MC		HEPARIN SODIUM/NACL 0.9% SOLN	MC/DEL		**LOVENOX SOLN**		
	MC		HEP-LOCK SOLN	MC/DEL		LOVENOX 300[2]		
	MC		**INNOHEP**	MC/DEL		LOVENOX SUBQ SYRINGE		**DDI:** Warfarin will require prior authorization if being used in combination with fluconazole, miconazole, or voriconazole.
	MC		HEPARIN LOCK SOLN	MC/DEL		PRADAXA ORAL PELLETS[4]		
	MC/DEL		HEPARIN LOCK FLUSH SOLN	MC		IPRIVASK		
	MC/DEL		HEPARIN SODIUM SOLN	MC/DEL		SAVAYSAS[3]		**DDI:** Warfarin will require prior authorization if being used in conjunction with Gemfibrozil or Fenofibrate.
	MC/DEL		HEPARIN SODIUM LOCK FLUSH SOLN					
	MC/DEL		PRADAXA					
	MC/DEL		JANTOVEN					
	MC/DEL		**WARFARIN SODIUM TABS**					**DDI:** Rifampin will require prior authorization if being used in combination with Savaysa
	MC/DEL		XARELTO					
	MC/DEL		XARELTO STARTER PACK				Use PA form# 20420	
ANTIHEMOPHILIC AGENTS	MC		ALPHANATE	MC/DEL		ADYNOVATE VIAL	1. Only if other products unavailable. 2. Advate may be available with PA in cases of large volume dosing in patients with poor venous access. 3. Not indicated for use in children <12 years of age due to greater risk for hypersensitivity reactions and is not indicated for use in previously untreated patients. 4. Clinical PA required for appropriate diagnosis. 5. Established users will be	Non-preferred will only be approved if other preferred products are unavailable. Beqvez:FDA Approved Indication: An adeno-associated virus vector-based gene therapy indicated for the treatment of adults with moderate to severe hemophilia B (congenital factor IX deficiency) who: · Currently use factor IX prophylaxis therapy, or · Have current or historical life-threatening hemorrhage, or · Have repeated, serious spontaneous bleeding episodes, and, · Do not have neutralizing antibodies to adeno-associated virus serotype Rh74var (AAVRh74var) capsid as detected by an FDA- approved test. Hemgenix® is an adeno-associated viral vector-based gene therapy for IV infusion after dilution. For treatment of adults with Hemophilia B (congenital Factor IX deficiency) who: Currently use Factor IX prophylaxis therapy, or have current or historical life-threatening hemorrhage, or Have repeated, serious spontaneous bleeding episodes. Altuviiio is a von Willebrand Factor (VWF) independent recombinant DNA-derived, Factor VIII concentrate indicated for use in adults and children with hemophilia A (congenital factor VIII deficiency) for: Routine prophylaxis to reduce the frequency of bleeding episodes, On-demand treatment and control of bleeding episodes,Perioperative management of bleeding. Roctavian: For the treatment of adults with severe hemophilia A (congenital factor VIII deficiency with factor VIII activity <1 IU/dL) without antibodies to adeno-associated virus serotype Inclusion: Severe factor VIII deficiency (less than 1% native factor VIII). Exclusion Criteria: Antibodies to the virus AAV5 Factor VIII inhibitors (or history of)
	MC/DEL		ALPHANINE SD	MC		ADVATE[1,2,5]		
	MC/DEL		ALPROLIX VIAL	MC		ALTUVIIIO[4]		
	MC/DEL		BEBULIN VIAL	MC/DEL		AFSTYLA		
	MC/DEL		BENEFIX SOLR	MC/DEL		BEQVEZ		
	MC/DEL		HELIXATE FS KIT	MC/DEL		ESPEROCT		
	MC		HEMLIBRA	MC/DEL		ELOCTATE		
	MC		HEMOFIL - M	MC/DEL		HEMGENIX		
	MC		HUMATE-P SOLR	MC/DEL		IDELVION		
	MC/DEL		IXINITY VIAL	MC/DEL		KOGENATE FS[5]		
	MC/DEL		JIVI[3]	MC		RECOMBINATE VIAL[5]		
	MC		KOATE-DVI	MC		ROCTAVIAN[4]		
	MC		KONYNE - 80	MC		SEVENFACT		
	MC/DEL		KOVALTRY					
	MC/DEL		REBINYN					
	MC		MONARC - M					
	MC		MONOCLATE - P					
	MC		MONONINE					
	MC/DEL		NOVOEIGHT					
	MC		NOVOSEVEN SOLR					
	MC		NUWIQ					

	MC/DEL		PROFILNINE				grandfathered	Known significant fibrosis of cirrhosis of the liver, or unexplained elevated LFTs
	MC		RECOMBINATE SOLR					History of inadequate compliance with prophylaxis, or regular bleeds despite adequate prophylaxis
	MC		REFACTO					Conditions in which high-dose steroids are contraindicated.
	MC/DEL		RIXUBIS VIAL					-Inability to abstain from alcohol for one year
	MC		WILATE INJ					Plan to impregnate a partner within 6 months of infusion
	MC/DEL		XYNTHA					-Hypersensitivity to mannitol
								-Active infections, either acute or uncontrolled chronic
							Use PA Form# 20420	-HIV infection (limited information on use in this population)
PLATELET AGGREGATION INHIBITORS	MC/DEL		ASPIRIN	MC/DEL	7	TICLOPIDINE HCL TABS	Use PA Form# 20715 for Plavix,Effent & Brilinta Use PA form# 20420 for other requests 1. Dosing limits apply, please see dose consolidation list.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. A special PA may be obtained at the pharmacy for members scheduled for "stent" placement or have had placement if in the last 12months. Please indicate on prescription date of stent placement. **DDI:** Plavix will require prior authorization if being used in combination with omeprazole, esomeprazole, cimetidine, fluconazole, ketoconazole, intelence, fluoxetine, ticlopidine, and fluvoxamine. **DDI:** exists for using maintenance ASA dose >100mg, as it reduces the effectiveness of Brilinta Brilianta- Concomitant use with strong CYP3A4 inhibitors should be avoided (including ketoconazole, itraconazole, atazanavir, and telithromycin). Doses of simvastatin and lovastatin >40mg should be avoided.
	MC		ASPIRIN-DIPYRIDAMOLE ER CPMP 12HR	MC/DEL	8	BRILINTA 60mg		
	MC/DEL		BRILINTA 90mg	MC	8	DURLAZA		
	MC/DEL		**DIPYRIDAMOLE TABS**	MC	8	EFFIENT		
	MC/DEL		**CLOPIDOGREL 75MG**	MC/DEL	8	PERSANTINE TABS		
	MC/DEL		**PRASUGREL HCL TAB**	MC/DEL	8	PLAVIX TABS		
				MC/DEL	8	**ZONTIVITY**		
PLATELET AGGR. INHIBITORS / COMBO'S - MISC.	MC/DEL		**CILOSTAZOL**	MC/DEL		**AGRYLIN CAPS**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		PENTOXIFYLLINE ER TBCR	MC/DEL		**ANAGRELIDE CAPS**		
				MC/DEL		**PLETAL TABS**		
				MC		TRENTAL TBCR		
				MC		YOSPRALA		
HEMATOLOGICALS								
MONOCLONAL ANTIBODY						EMPAVELI	Use PA Form# 20420	A diagnosis of Paroxysmal nocturnal hemoglobinuria (PNH) using the HAM test or flow cytometry is required. In addition, the patient must show evidence of having received a meningitis vaccine at least 2 weeks prior to the start of therapy. Gamifant is recommended for the treatment of adult and pediatric (newborn and older) patients with primary hemophagocytic lymphohistiocytosis (HLH) with refractory, recurrent, or progressive disease or intolerance with conventional HLH therapy. Fabhalta and Ultomiris are recommended for the treatment of adults with paroxysmal nocturnal hemoglobinuria (PNH).
				MC/DEL		ENSPRYNG		
				MC		FABHALTA		
				MC/DEL		GAMIFANT		
				MC		SOLIRIS		
				MC/DEL		ULTOMIRIS		
				MC		UPLIZNA		
				MC		VOYDEYA		
IMMUNE GLOBULIN	MC		BIVIGAM[1]	MC		ASCENIV[2]	Use PA Form# 20420 1. Clinical PA required 2. For the treatment of patients between 12 to 17 years of age.	Cutaquig is indicated as replacement therapy for primary humoral immunodeficiency (PI) in adults. Xembify is indicated for treatment of primary humoral immunodeficiency (PI) in patients 2 years of age and older. Asceniv indicated for the treatment of primary humoral immunodeficiency (PI) in adults and adolescents (12 to 17 years of age). PI includes but is not limited to the humoral immune defect in congenital agammaglobulinemia, common variable immunodeficiency (CVID), X-linked agammaglobulinemia, Wiskott-Aldrich syndrome, and severe combined immunodeficiencies (SCID).
	MC/DEL		CUTAQUIG[1]	MC/DEL		CUVITRU		
	MC		GAMUNEX-C	MC		GAMMAPLEX INJ		
	MC		GAMMAGARD S-D[1]	MC/DEL		HYQVIA		
	MC/DEL		HIZENTRA[1]	MC		OCTAGAM INJ[1]		
	MC/DEL		PANZYGA[1]	MC/DEL		XEMBIFY		
	MC		PRIVIGEN[1]					
HEREDITARY ANGIOEDEMA			**PROPHYLAXIS**			**PROPHYHLAXIS**	1. Clinical PA is required to establish diagnosis and medical necessity. 2. For the treatment of patients ≥ 12 years of age.	Haegarda is indicated for routine prophylaxis to prevent Hereditary Angioedema (HAE) attacks in adolescent and adult patients
	MC		CINRYZE[1]					
	MC		HAEGARDA[1]					
	MC		ORLADEYO[1,2]					
	MC/DEL		TAKHZYRO[1]					
			TREATMENT			**TREATMENT**		
	MC/DEL		BERINERT KIT[1]	MC/DEL		KALBITOR VIAL		
	MC		FIRAZYR[1]					

	MC/DEL		RUCONEST VIAL[1]				Use PA Form# 20420	
HEMATOLOGICAL AGENTS-THROMBOPOIETIN RECEPTOR AGONISTS	MC MC		PROMACTA[1] NPLATE[1]	MC MC/DEL MC/DEL		ALVAIZ DOPTELET MULPLETA	Use PA Form# 20420 1. Clinical PA required. Must see prior trial with insufficient response to corticosteroids and immunoglobulins.	Doptelet and Mulpelta: For the treatment of thrombocytopenia in adults with chronic liver disease who are scheduled to undergo a procedure.
HEMATOLOGICAL AGENTS-IgAN				MC/DEL MC		FILSPARI[1] TARPEYO	Use PA Form# 20420 1. PA required to confirm FDA approved indication.	All preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists
ANEMIA- BETA THALASSEMIA				MC MC		REBLOZYL ZYNTEGLO	Use PA Form# 20420	Reblozyl is indicated for the the treatment of anemia in adult patients with beta thalassemia who require regular red blood cell (RBC) transfusion. It is not indicated for use as a substitute for RBC transfusions in patients who require immediate correction of anemia. Zynteglo is indicated for the treatment of adult and pediatric patients with β-thalassemia who require regular red blood cell (RBC) transfusions.
HEMATOLOGIC DISORDER TREATMENT AGENTS				MC/DEL MC		**CABLIVI** TAVALISSE	Use PA Form# 20420	Tavalisse is recommended for patients at risk of bleeding when one line of therapy (steroids, IVIG, splenectomy) has failed. Cablivi is recommended for the treatment of adult patients with acquired thrombotic thrombocytopenic purpura (aTTP), in combination with plasma exchange and immunosuppressive therapy.
COMPLEMENT RECEPTOR ANTAGONIST				MC		TAVNEOS	Use PA Form# 20420	
WHIM SYNDROME AGENTS				MC		XOLREMDI	Use PA Form#20420	Xolremdi: In patients 12 years of age and older with WHIM syndrome (warts, hypogammaglobulinemia, infections, and myelokathexis) to increase the number of circulating mature neutrophils and lymphocytes.
HEMOSTATIC								
HEMOSTATIC	MC/DEL MC		AMICAR AMINOCAPROIC ACID	MC MC		FIBRYGA RIASTAP	Use PA Form# 20420	Fibryga and Riastap are indicated for the treatment of acute bleeding episodes in adults and adolescents with congenital fibrinogen deficiency, including afibrinogenemia and hypofibrinogenemia. Fibryga® is not indicated for dysfibrinogenemia.
ACUTE HEPATIC PORPHYRIA (AHP)								
ACUTE HEPATIC PORPHYRIA (AHP)				MC		GIVLAARI	Use PA Form# 20420	Givlaari is indicated for the treatment of adults with acute hepatic porphyria (AHP).
PYRUVATE KINASE DEFICIENCY AGENTS								
PYRUVATE KINASE DEFICIENCY AGENTS				MC		PYRUKYND[1]	Use PA Form# 20420 1.PA required to confirm FDA approved indication.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s)
OP. - ANTIBIOTICS	MC MC MC/DEL MC MC/DEL MC MC MC/DEL MC/DEL		AK-SPORE OINT BACITRACIN/NEOMYCIN/POLYM BACITRACIN/POLYMYXIN B OINT CHLOROPTIC SOLN ERYTHROMYCIN OINT NEOSPORIN SOLN POLYSPORIN TRIMETHOPRIM SULFATE/POLY TOBRAMYCIN SULFATE SOLN	MC MC MC MC MC MC MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC/DEL		AK-POLY-BAC OINT AK-SULF OINT AK-TOB SOLN AZASITE BACITRACIN OINT BLEPH-10 SOLN **GATIFLOXACIN DROPS** GENTAMICIN SULFATE GENTAK ILOTYCIN OINT **LEVOFLOXACIN DROPS** NEOMYCIN/BACI/POLYM OINT NEOMYCIN/POLYMYXIN/GRAMIC	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

				MC		NEOSPORIN OINT		
				MC		OCUSULF-10 SOLN		
				MC		OCUTRICIN SOLN		
				MC/DEL		POLYTRIM DROPS		
				MC/DEL		SULFACETAMIDE SODIUM DROPS		
				MC/DEL		SULFACETAMIDE SODIUM OINT		
				MC		TERAK OINT		
OP. -ANTI-PARASITIC				MC		XDEMVY[1]	Use PA Form# 20420 1. For the treatment of Demodex biepharitis.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
OP. - RHO KINASE INHIBITORS	MC		RHOPRESSA				Use PA Form# 20420	on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s)
OP. - QUINOLONES	MC/DEL		CILOXAN OINT	MC/DEL		BESIVANCE	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		CIPROFLOXACIN SOL 0.3%	MC/DEL		CILOXAN SOLN		
	MC/DEL		OFLOXACIN	MC		OCUFLOX SOLN		
	MC/DEL		QUIXIN SOLN					
OP. -QUINOLONES-4TH GENERATION	MC/DEL		**MOXIFLOXACIN 0.5% SOLN (Generic Vigamox)**	MC		ZYMAXID	Use PA Form# 20420	
OP. - ARTIFICIAL TEARS AND LUBRICANTS	MC/DEL		ARTIFICIAL TEARS OINT	MC/DEL		ARTIFICIAL TEARS SOLN OP	Use PA Form# 20420 1. Dosing limits apply, please see dose consolidation list.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		ARTIFICIAL TEARS SOLN	MC		BION TEARS SOLN		
	MC		CELLUVISC SOLN	MC		DRY EYES OINT		
	MC		EYE LUBRICANT OINT	MC		DURATEARS OINT		
	MC/DEL		GENTEAL	MC/DEL		HYPO TEARS		
	MC		LIQUITEARS SOLN	MC/DEL		ISOPTO TEARS SOLN		
	MC		MAJOR TEARS SOLN	MC		LACRI-LUBE		
	MC		PURALUBE OINT	MC		LUBRIFRESH P.M. OINT		
	MC		PURALUBE TEARS SOLN	MC		MURINE SOLN		
	MC		REFRESH SOLN OP	MC/DEL		MUROCEL SOLN		
	MC		REFRESH PLUS SOLN[1]	MC/DEL		NATURE'S TEARS SOLN		
	MC		REFRESH PM OINT	MC		REFRESH SOLN		
				MC		REFRESH TEARS SOLN[1]		
				MC		TEARGEN SOLN		
				MC		TEARISOL SOLN		
				MC/DEL		TEARS NATURALE		
				MC/DEL		TEARS PURE SOLN		
				MC		TEARS RENEWED OINT		
				MC/DEL		THERATEARS SOLN		
				MC		V-R ARTIFICIAL TEARS SOLN		
OP. - BETA - BLOCKERS	MC/DEL		**BETOPTIC-S SUSP**	MC		BETAGAN SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**CARTEOLOL HCL SOLN**	MC/DEL		**BETAXOLOL HCL SOLN**		
	MC/DEL		**LEVOBUNOLOL HCL SOLN**	MC		ISTALOL		
	MC/DEL		METIPRANOLOL SOLN	MC/DEL		**OCUPRESS SOLN**		
				MC		OPTIPRANOLOL SOLN		
				MC/DEL		**TIMOPTIC SOLN**		
				MC		TIMOLOL DROP		
				MC/DEL		**TIMOLOL SOL-GEL**		
				MC/DEL		**TIMOPTIC-XE SOLG**		

OP. - ANTI-INFLAMMATORY / STEROIDS OPHTH.	MC		AK-SPORE HC OINT	MC		AK-TROL SUSP	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		ALREX SUSP	MC		BAC/POLY/NEOMY/HC OINT		
	MC/DEL		DEXAMETH SOD PHOS SOLN	MC		BLEPHAMIDE S.O.P. OINT		
	MC/DEL		FLUOROMETHOLONE SUSP	MC		BLEPHAMIDE SUSP		
	MC		FML DROPS SUSP 1%	MC		BROMDAY		
	MC		FML FORTE SUSP	MC		EFLONE SUSP		
	MC		FML S.O.P. OINT	MC/DEL		FLAREX SUSP		
	MC/DEL		**LOTEMAX OINT**	MC		FLUOR-OP SUSP		
	MC/DEL		**LOTEMAX GEL**	MC/DEL		**ILUVIEN IMPLANT**		
	MC/DEL		LOTEMAX SUSP	MC/DEL		**INVELTYS**		
	MC/DEL		**LOTEMAX SM DROPS GEL 0.38%**	MC		MAXITROL OPTH OINT 0.1%		
	MC/DEL		NEO/POLY/DEXAMETH OINT	MC		NEO/POLY/BAC/HC OINT		
	MC		NEO/POLY/DEXAMETH SUSP	MC/DEL		NEOM/POLY/DEX OPTH OINT 0.1%		
	MC		PRED-G SUSP	MC/DEL		**OMNIPRED DROPS SUSP**		
	MC		PRED FORTE SUSP 1%	MC/DEL		OZURDEX		
	MC		PRED MILD SUSP	MC		PRED-G S.O.P. OINT		
	MC/DEL		PREDNISOLONE	MC/DEL		PREDNISOLONE SODIUM PHOSHATE SOL		
	MC/DEL		TOBRADEX OINT	MC/DEL		**RETISERT IMPLANT**		
	MC/DEL		TOBREX OINT	MC/DEL		SULFACET SOD/PRED SOLN		
	MC		SULFACETAMIDE/PREDNISOLONE	MC/DEL		**TRIESENCE VIAL**		
	MC/DEL		ZYLET SUSP	MC/DEL		TOBRADEX ST		
				MC/DEL		TOBRAMYCIN SUSP DEXAMETHASONE		
				MC		VASOCIDIN SOLN		
				MC/DEL		VEXOL SUSP		
				MC		XIPERE		
OP. - PROSTAGLANDINS	MC/DEL		**LATANOPROST SOL 0.005%**	MC/DEL	7	**ZIOPTAN**	1. All preferreds must be tried. 2. Dosing limits apply, please see dosing consolidation list. 3. Clinical PA is required to establish diagnosis and medical necessity.	Preferred drugs must be tried and failed, in step-order, due to lack of efficacy (failure to reach target IOP reduction) or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		LUMIGAN SOLN	MC/DEL	8	**BIMATOPROST 0.03% DROPS**		
	MC/DEL		ROCKLATAN	MC	8	DURYSTA		
	MC/DEL		**TRAVATAN-Z**	MC	8	IYUZEH		
				MC	8	RESCULA[1,2,3]		
				MC/DEL	8	**TRAVATAN SOLN**		
				MC/DEL	8	**TRAVOPROST**		
				MC/DEL	8	**VYZULTA**		
				MC/DEL	8	XALATAN SOLN[1]	Use PA Form# 20420	
				MC/DEL	8	**XELPROS**		
OP. - CYCLOPLEGICS	MC		AK-PENTOLATE SOLN	MC/DEL		CYCLOGYL SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		ATROPINE SULFATE	MC		ISOPTO ATROPINE SOLN		
	MC/DEL		CYCLOPENTOLATE HCL SOLN	MC/DEL		ISOPTO HOMATROPINE SOLN		
	MC/DEL		ISOPTO HYOSCINE SOLN	MC		MUROCOLL-2 SOLN		
OP. - MIOTICS - DIRECT ACTING	MC/DEL		**ISOPTO CARBACHOL SOLN**				Use PA Form# 20420	
	MC		ISOPTO CARPINE SOLN					
	MC		PILOCAR SOLN					
	MC/DEL		**PILOCARPINE HCL SOLN**					
	MC/DEL		**PILOPINE HS GEL**					
OP. - SELECTIVE ALPHA ADRENERGIC AGONISTS	MC		ALPHAGAN SOLN	MC/DEL		**BRIMONIDINE TARTRATE DROPS 0.15 %**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		ALPHAGAN P 0.1% SOLN	MC/DEL		**IOPIDINE SOLN**		
	MC		ALPHAGAN P 0.15% SOLN					
	MC/DEL		BRIMONIDINE DROPS 0.2 %					
	MC/DEL		SIMBRINZA					
OP. - ANTI-ALLERGICS	MC/DEL		AZELASTINE HCL DROPS	MC	8	ALOCRIL SOLN	Use PA Form# 20420	All preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		BEPREVE	MC/DEL	8	ALOMIDE SOLN		

	MC/DEL		CROMOLYN SODIUM DROPS	MC/DEL	8	EMADINE SOLN		and the preferred drug(s) exists.
	MC/DEL		**KETOTIFEN FUMARATE DROPS**	MC	8	OPTICROM SOLN		
	MC		LASTACAFT	MC/DEL	8	PATANOL SOLN		
	MC/DEL		**OLOPATADINE HCL 0.1%**	MC	8	ZERVIATE		
	MC/DEL		**OLOPATADINE HCL 0.2%**	MC/DEL	9	EPINASTINE		
	MC/DEL		ZADITOR SOLN					
OP. ANTI-ALLERGICS- MASTCELL STABILIZER CLASS				MC/DEL		ALAMAST SOLN	Use PA Form# 20420	
OP. - CARBONIC ANHYDRASE INHIBITORS/COMBO	MC/DEL		**AZOPT SUSP**	MC/DEL		**COSOPT SOLN PF**	Use PA Form# 20420	
	MC		COMBIGAN					
	MC/DEL		DORZOLAMIDE					
	MC/DEL		DORZOLAMIDE/TIMOLOL					
OP. - NSAID'S	MC		ACULAR SOLN[1]	MC	8	ACULAR LS[1]	1. Must fail all preferred products before non-preferred.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**DUREZOL**	MC	8	BROMSITE[1]		
	MC/DEL		KETOROLAC OPTH 0.4%	MC/DEL	8	DEXAMETHASONE DROPS		
	MC/DEL		KETOROLAC OPTH 0.5%	MC/DEL	8	DICLOFENAC OPTH 0.1%		
	MC/DEL		**MAXIDEX SUSP**	MC	8	FLURBIPROFEN SODIUM SOLN		
	MC/DEL		NEVANAC	MC/DEL	8	ILEVRO		
	MC/DEL		PREDNISOLONE DROPS	MC/DEL	**8**	**LOTEMAX DROPS GEL SM**		
				MC/DEL	8	PROLENSA		
				MC	8	OCUFEN SOLN[1]		
				MC	8	XIBROM[1]		
				MC	8	VOLTAREN SOLN[1]		
				MC	8	ACUVAIL[1]		
				MC/DEL	9	BROMFENAC	Use PA Form# 20420	
OP. - OF INTEREST	MC/DEL		**CYCLOSPORINE OPTH 0.05%**	MC		BYOOVIZ	1. PA required to confirm appropriate diagnosis and clinical parameters for use. 2. For the short-term (up to two weeks) treatment of the signs and symptoms of dry eye disease.	Must fail adequate trials of multi agents from artificial tears and lubricant category.
	MC		EYSUVIS[2]	MC		BEOVU		
	MC		LUCENTIS	MC		BOTOX SOLR		
	MC		RESTASIS DROPPERETTE	MC/DEL		CEQUA		Beovu is non-preferred and indicated for the treatment of Neovascular (wet) Age-Related Macular Degeneration (AMD)
	MC		XIIDRA	MC		CIMERLI		
				MC		CYCLOSPORINE DROPERETTE		
				MC		CYSTADROPS[1]		
				MC		CYSTARAN[1]		**Luxturna** will be considered for the treatment of patients with confirmed biallelic RPE65 mutation-associated retinal dystrophy. Patients must have viable retinal cells as determined by the treating physician(s).
				MC		EYLEA		
				MC		EYLEA HD[1]		
				MC		IZERVAY[1]		Vevye - Must fail adequate trials of multi agents from artificial tears and lubricant category and a preferred cyclosporine alternative.
				MC/DEL		OXERVATE		
				MC		LUCENTIS		
				MC		LUXTURNA		**Oxervate** is non-preferred and is indicated for the treatment of neurotrophic keratits.
				MC/DEL		MIEBO		
				MC/DEL		RESTASIS MULTIDOSE DROPS		
				MC		SUSVIMO		Eylea is non-preferred and indicated for the treatment of: Neovascular (wet) Age-Related Macular Degeneration (AMD), Macular Edema following Retinal Vein Occlusion (RVO), Diabetic Macular Edema (DME), Diabetic Retinopathy (DR)
				MC		SYFOVRE		
				MC		TYRVAYA		
				MC		VABYSMO		Miebo is non-preferred and is indicated for the treatment of the signs and symptoms of dry eye disease (DED).
				MC		VERKAZIA		
				MC		VEVYE		Syfovre is non-preferred and is indicated for the treatment of geographic atrophy (GA) secondary to age-related macular degeneration (AMD).
							Use PA Form# 20420	
DERMATOLOGICAL								
ISOTRETINION, ACNE	MC		AMNESTEEM[1]	MC		ABSORICA	1. Users 24 or under, PA will not be required.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		CLARAVIS[1]	MC		ABSORICA LD		
	MC		MYORISAN[1]					
	MC		ZENATANE[1]				Use PA Form# 20420	

TOPICAL - ACNE PREPARATIONS	MC		ERYDERM SOLN	MC/DEL		ADAPALENE 0.3% GEL	1. Users 24 or under, PA will not be required. 2. Dosing limits allowing one package per month. Please refer to Dose Consolidation List. 3. Only available if component ingredients are unavailable. 4. Dosing limits apply, please see dosing consolidation list. 5. Not approved for use in children <12 years of age 6. For the treatment of patients ≥ 9 years of age. Use PA Form# 10220 for Brand Name requests Use PA Form# 20420 for all other requests	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		ERYTHROMYCIN GEL	MC/DEL		AKLIEF[6]		
	MC/DEL		ERYTHROMYCIN SOLN	MC		ALTINAC CREA		
	MC/DEL		EVOCLIN	MC/DEL		ALTRENO		
	MC		ISOTRETINOIN	MC		AMZEEQ[6]		
	MC		METRONIDAZOLE CREA[2]	MC		ARAZLO LOTION[6]		
	MC		METRONIDAZOLE GEL[2]	MC		AVITA CREA		
	MC		METRONIDAZOLE LOTN[2]	MC		BENZAC		
	MC/DEL		TRETINOIN .025%, .05%, .01% GEL[1]	MC/DEL		BENZACLIN GEL[3]		
	MC		TRETINOIN CREA[1,2]	MC/DEL		BENZAGEL-10 GEL		
				MC/DEL		BENZAMYCIN GEL		
				MC/DEL		BENZAMYCINPAK PACK		
				MC		BENZEFOAM		
				MC		BENZOYL PEROXIDE		
				MC		BREVOXYL		
				MC		CABTREO GEL[5]		
				MC/DEL		CLEOCIN-T[2]		
				MC		CLINAC BPO GEL		
				MC		CLINDAGEL GEL		
				MC/DEL		CLINDAMYCIN PHOSPHATE CREAM[2]		
				MC		CLINDETS SWAB		
				MC		DESQUAM-E GEL		
				MC		DESQUAM-X		
				MC		DIFFERIN 0.3% GEL		
				MC		DIFFERIN		
				MC		EMGEL GEL		
				MC		EPIDUO		
				MC		EPSOLAY		
				MC		ERYCETTE PADS		
				MC		FINEVIN CREA		
				MC/DEL		KLARON LOTN		
				MC		METROCREAM CREA[2]		
				MC		METROGEL GEL[2]		
				MC		METROLOTION LOTN[2]		
				MC		NEOBENZ MICRO		
				MC/DEL		NORITATE CREA		
				MC		ONEXTON[5]		
				MC/DEL		PLIXDA		
				MC		RETIN-A GEL[2]		
				MC		RETIN-A CREA[2]		
				MC		RETIN-A MICRO GEL		
				MC		RHOFADE		
				MC/DEL		SODIUM SULFACET/SULF LOTN		
				MC		SOOLANTRA[4]		
				MC/DEL		TRIAZ		
				MC		TWYNEO		
				MC		VELTIN		
				MC		WINLEVI[5]		
				MC		ZENCIA WASH		
				MC		ZETACET		
				MC/DEL		ZIANA		
				MC		ZILXI		
TOPICAL- ATOPIC DERMATITIS	MC/DEL	1	ELIDEL CREA	MC/DEL		CIBINQO		

	MC/DEL	1	PIMECROLIMUS CRE (AUTH GENERIC LABELER 68682 Oceanside Pharmaceuticals)				1.Avoid live vaccines if treated with Dupixent 2. Clinical PA required. 3. For the treatment of patients ≥ 12 years of age. 4. Preferred after a trial and failure of TCSs and TCIs. Use PA Form# 20420	Preferred drugs also indicated for this condition, including topical steroids, cyclosporin AND calcineurin inhibitors must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Note: If unable to use TCIs then a trial of Eucrisa could be recommended before Dupixent.
	MC/DEL	1	PROTOPIC OINT					
	MC/DEL	1	TACROLIMUS OINT					
	MC	2	ADBRY[2,4]					
	MC/DEL	2	DUPIXENT[1,2,4]					
	MC	2	EUCRISA[2,4]					
	MC	2	OPZELURA[2,3,4]					
TOPICAL - ANTIBIOTIC	MC		BACIT/NEOMYCIN/POLYM OINT	MC/DEL		CENTANY OINT 2%[1]	1. Dosing limits apply, please see dosing consolidation list. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		BACITRACIN OINT	MC/DEL		MUPIROCIN CREA[1]		
	MC/DEL		GENTAMICIN SULFATE	MC/DEL		TRIPLE ANTIBIOTIC OINT		
	MC/DEL		MUPIROCIN OINT[1]	MC		XEPI		
TOPICAL - ANTIFUNGALS	MC/DEL		BETAMETHASONE CLOTRIMAZOLE CREA	MC/DEL	8	CICLOPIROX SOLN	Use PA Form# 10120 1. Diagnosis required	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Ketoconazole will now be non-preferred and require prior authorization if they are currently being used in combination with any of the following medications: Prevacid, pantoprazole, Onglyza or Omeprazole. Kerydin- Verify prior trials and failures or intolerance of preferred treatments, including both topical and oral agents
	MC/DEL		BETAMETHASONE CLOTRIMAZOLE LOT	MC	8	EXELDERM		
	MC		CICLOPIROX 0.77 CREA	MC	8	FUNGIZONE CREA		
	MC		CICLOPIROX 0.77 SUSP	MC/DEL	8	HYDROCORT/IODOQ CREA		
	MC/DEL		CLOTRIMAZOLE	MC	8	JUBLIA		
	MC		ECONAZOLE NITRATE CREA	MC	8	KERYDIN[1]		
	MC/DEL		KETOCONAZOLE CREA	MC/DEL	8	LOPROX 0.77 LOTN		
	MC/DEL		KETOCONAZOLE SHAM	MC/DEL	8	LOPROX 0.77 CREA		
	MC/DEL		LOPROX 1.0 CREA	MC/DEL	8	LOPROX 0.77 SUSP		
	MC/DEL		LOPROX 1.O LOTN	MC/DEL	8	LOPROX SHAMPOO SHAM		
	MC/DEL		LOPROX GEL	MC	8	LOTRIMIN		
	MC/DEL		LOPROX TS LOTN	MC/DEL	8	LOTRISONE LOT		
	MC/DEL		MICONAZOLE NITRATE CREA	MC/DEL	8	LOTRISONE CREA		
	MC		MYCO-TRIACET II CREA	MC	8	LUZU		
	MC/DEL		NYSTATIN	MC/DEL	8	MENTAX CREA		
	MC/DEL		NYSTATIN/TRIAMCINOLONE CREA	MC	8	MYCOGEN II CREA		
	MC/DEL		NYSTOP POWD	MC	8	NAFTIN		
	MC		TRI-STATIN II CREA	MC	8	NIZORAL SHAM		
				MC/DEL	8	NYSTATIN/TRIAMCINOLONE OINT		
				MC	8	NYSTAT-RX POWD		
				MC/DEL	8	OXISTAT		
				MC/DEL	9	PENLAC NAIL LACQUER SOLN		
TOPICAL - ANTIPRURITICS	MC		ZONALON CREA	MC		KORSUVA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC		PRUDOXIN CREA		
TOPICAL - ANTIPSORIATICS	MC/DEL		CALCIP/BETAMETHASONE SUS	MC/DEL	7	TACLONEX[1]	1. Must fail all preferred products before non-preferred. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC/DEL	8	DUOBRII		
				MC	8	ENSTILAR		
				MC	8	OXSORALEN ULTRA CAPS[1]		
				MC	8	PSORIATEC CREA[1]		
				MC/DEL	8	SORIATANE CK KIT[1]		
				MC	8	VECTICAL[1]		
				MC	8	VTAMA		
				MC	8	ZORYVE		

TOPICAL - ANTISEBORRHEICS	**MC/DEL**		SELENIUM SULFIDE SHAM	**MC**		CARMOL SCALP TREATMENT KIT	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Zoryve Foam: For the treatment of seborrheic dermatitis in adult and pediatric patients 9 years of age and older.
				MC		ZNP BAR		
				MC		ZORYVE FOAM		
TOPICAL - ANTIVIRALS				**MC/DEL**		**ACYCLOVIR OINT**	1. Must fail oral treatment with Acyclovir or Valacyclovir. 2. Approvals limited to 1 tube per 180 days. 3. Dosing limits apply, please see dosing consolidation list. 4. For the treatment of molluscum contagiosum in adult and pediatric patients 2 years of age and older. Use PA Form# 20420	
				MC/DEL		DENAVIR CREA[1,3]		
				MC		YCANTH		
				MC		ZOVIRAX OINT[1,2]		
TOPICAL - ANTINEOPLASTICS	**MC**		EFUDEX	**MC/DEL**		CARAC CREA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC/DEL		FLUOROURACIL		
				MC		SOLARAZE GEL		
				MC/DEL		ZYCLARA		
TOPICAL - BURN PRODUCTS	**MC**		FURACIN CREA	**MC/DEL**		SILVADENE CREA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		SILVER SULFADIAZINE CREA					
	MC		SSD AF CREA					
	MC		SSD CREA					
	MC/DEL		THERMAZENE CREA					
TOPICAL - CORTICOSTEROIDS			**LOW POTENCY**			**LOW POTENCY**	Use PA Form# 20420 1. Dosing limits apply, please see dosing consolidation list. 2. Treatment beyond 4 weeks is not recommended. 3. For the treatment of patients ≥ 12 years of age. 4. For the treatment of patients ≥ 18 years of age.	At least 1 drug from each potency of preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		DERMA-SMOOTHE- FS BODY	**MC/DEL**		ACLOVATE		
	MC/DEL		HYDROCORTISONE CREA	**MC**		ANUSOL HC-1 OINT		
	MC		HYDROCORTISONE LOTN	**MC**		DESONATE GEL		
	MC		HYDROCORTISONE LOTN	**MC/DEL**		**FLUOCINOLONE ACETONIDE**		
	MC		TEXACORT SOLN	**MC/DEL**		**FLUOCINOLONE**		
				MC		HALOG		
				MC		HYDROCORTISONE POWD		
			MEDIUM POTENCY	**MC**		LIDA MANTLE HC CREA		
	MC/DEL		DESOXIMETASONE 0.05% CREA/GEL	**MC**		PROCTOCORT CREA		
	MC		FLUTICASONE PROPIONATE CREA/OINT	**MC/DEL**		VERDESO		
	MC		HYDROCORTISONE BUTYRATE					
	MC		HYDROCORTISONE OINT			**MEDIUM POTENCY**		
	MC		HYDROCORTISONE VALERATE	**MC/DEL**		**BESER LOTION**[3]		
	MC		MOMETASONE FUROATE OINT	**MC**		CLODERM CREA		
	MC		TRIAMCINOLONE ACETONIDE .025-.1%	**MC/DEL**		CORDRAN		
				MC/DEL		CUTIVATE CREA / OINT		
				MC/DEL		CUTIVATE LOTN		

				MC/DEL		DERMATOP		
				MC		ELOCON OINT		
				MC		KENALOG AERS		
			HIGH POTENCY	MC/DEL		LOCOID		
	MC/DEL		DESONIDE[1]	MC/DEL		LUXIQ FOAM		
	MC		TRIAMCINOLONE ACETONIDE .5%	MC		PANDEL CREA		
				MC		TOPICORT		
				MC		TOPICORT LP CREA		
				MC/DEL		TOVET FOAM[3]		
				MC		WESTCORT		
						HIGH POTENCY		
				MC		AMCINONIDE CREA		
				MC		BETAMETHASONE DIPROPIONATE		
			VERY HIGH POTENCY	MC/DEL		**DESOXIMETASONE 0.25% CREA/OINT**		
	MC/DEL		AUGMENTED BETA DIP			**VERY HIGH POTENCY**		
	MC/DEL		BETAMETHASONE VALERATE	MC/DEL		BRYHALI LOTN		
	MC		DIFLORASONE DIACETATE	MC/DEL		**CLOBETASOL PROPINATE LOTN**		
	MC		HALOBETASOL	MC/DEL		CLOBETASOL PROPINATE SHAMPOO 0.05%		
				MC/DEL		CORMAX		
				MC/DEL		DIPROLENE		
				MC/DEL		IMPEKLO[4]		
			MISCELLANEOUS	MC/DEL		LEXETTE		
	MC		PROCTO-KIT CREA 1%	MC/DEL		OLUX FOAM		
				MC/DEL		PSORCON		
				MC/DEL		PSORCON E		
				MC		SERNIVO SPRAY[2]		
				MC/DEL		TEMOVATE		
				MC		ULTRAVATE		
TOPICAL - STEROID LOCAL ANESTHETICS				MC		EPIFOAM FOAM	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - STEROID COMBINATIONS	MC		DERMA-SMOOTHE-FS SCALP	MC		CARMOL-HC CREA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - EMOLLIENTS	MC/DEL		AMMONIUM LACTATE CREA[1]	MC		LAC-HYDRIN CREA[1]	Use PA Form# 20420 1. Dosing limits still apply. Please see dose consolidation list.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		AMMONIUM LACTATE LOTN 12%[1]	MC		LAC-HYDRIN LOTN 12%		
	MC		VITAMIN A & D MEDICATED OINT	MC		MEDERMA GEL		
				MC		MIMYX		
				MC		RENOVA CREA		
TOPICAL - ENZYMES / KERATOLYTICS / UREA				MC		CARMOL 40 CREA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Ziox, Panafil and Papain products have been removed from the PDL due to FDA safety concerns regarding drugs containing Papain.
				MC		SALEX CREA		
				MC		SALEX LOTN		
TOPICAL - GENITAL WARTS	MC/DEL		IMIQUIMOD 5%[2]	MC/DEL	5	PODOFILOX SOLN	Use PA Form# 20420 1. Non-preferred products must be used in specified order. 2. Dosing limits still apply. Please see dose consolidation list.	
				MC/DEL	8	CONDYLOX[1]		
				MC/DEL	8	ALDARA[1]		
				MC	8	PICATO		
				MC	8	VEREGEN[1]		
				MC	8	ZYCLARA[1]		
TOPICAL - LOCAL ANESTHETICS	MC		AF CAPSICUM OLEORESIN CREA	MC/DEL		EMLA PADS	1. Lidocaine/Prilocaine cream and Ela-Max products	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the
	MC/DEL		CAPSAICIN CREA	MC/DEL		EMLA CREA		

	MC/DEL		CAPSAICIN PATCH	MC		LIDA MANTLE CREA	require PA for users over 18 years of age.	preferred drug(s) exists.
	MC/DEL		**DIBUCAINE OINT**	MC		PONTOCAINE SOLN		
	MC		ELA-MAX[1]	MC		SYNERA		
	MC/DEL		LIDOCAINE/PRILOCAINE CREA[1]	MC		ZOSTRIX		
	MC/DEL		LIDOCAINE CREAM	MC/DEL		ZTLIDO[2]	2. Dosing limits still apply. Please see dose consolidation list.	
	MC/DEL		LIDOCAINE GEL					
	MC/DEL		**LIDOCAINE PTCH 5%**				Use PA Form# 20420	
TOPICAL - DEPIGMENTING AGENTS				MC	8	ALUSTRA CREA		As per Medicaid Policy, cosmetic drugs are not covered. Non-cosmetic clinical applications will be considered by prior authorization on a case by case basis.
				MC	8	EPIQUIN MICRO		
				MC	8	GLYQUIN CREA		
				MC/DEL	8	HYDROQUINONE CREA	Use PA Form# 20420	
				MC/DEL	8	HYDROQUINONE/SUNSCREENS		
				MC	8	SOLAQUIN FORTE CREA		
				MC	8	TRI-LUMA CREA		
				MC	9	ELDOQUIN		
TOPICAL - SCABICIDES AND PEDICULICIDES	MC/DEL		ACTICIN CREA	MC		ELIMITE CREA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		LICE KILLING SHAM	MC		EURAX	1. Dosing limits apply, please refer to dosage consolidation list.	
	MC/DEL		LICE TREATMENT CREME RINS LIQD	MC/DEL		LINDANE		
	MC/DEL		PERMETHRIN LOTN	MC		MALATHION		
	MC		NATROBA[1]	MC		OVIDE LOTN		
				MC/DEL		**SPINOSAD SUSP**		
TOPICAL - WOUND / DECUBITUS CARE				MC		FILSUVEZ	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Regranex will be approved for diabetic patients in good control (hgba1c <8), who are not smoking, with a stage III or IV WOCN AND NPUAP lower extremity diabetic ulcer and with an adequate blood supply (Tcp 02 >30, ABI>0.7 or ASP> 70), and where the underlying cause has been corrected. The wound must be free of infection and have been previously treated with preferred standard therapies for at least 2 months. Maximum approval for 20 weeks. Vyjuvek: For the treatment of wounds in patients 6 months of age and older with dystrophic epidermolysis bullosa (DEB) with mutation(s) in the collagen type VII alpha 1 chain (COL7A1) gene. Filsuvez: The patient has a diagnosis of dystrophic or junctional epidermolysis bullosa. The patient is at least 6 months old and does not have current evidence or history of squamous cell carcinoma or active infection in the area requiring Filsuvez application. The patient has used standard wound care treatments, including silicone or foam dressings without wound resolution Accuzyme and Ethezyme products have been removed from the PDL due to FDA concerns regarding drugs containing Papain.
				MC		REGRANEX GEL		
				MC		VYJUVEK		
TOPICAL - ASTRINGENTS / PROTECTANTS	MC		XERAC AC SOLN	MC		LOWILA BAR	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC		MOISTURIN DRY SKIN CREA	1. Dosing limits apply, please refer to dosage consolidation list.	
				MC		PROSHIELD PLUS SKIN PROTE CREA		
				MC		SURGILUBE GEL		
TOPICAL - ANTISEPTICS / DISINFECTANTS	MC/DEL		POVIDONE-IODINE SOLN	MC		BETADINE OINT	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC		FORMALYDE-10 AERS		
				MC		IODOSORB		
				MC		LAZERFORMALYDE SOLUTION SOLN		
MISCELLANEOUS EYE								
OP. - EYE	MC		AK-DILATE SOLN	MC		LENS PLUS REWETTING DROPS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		EYE WASH SOLN	MC/DEL		MURO 128		
	MC		NAPHAZOLINE HCL SOLN	MC		NEO-SYNEPHRINE SOLN		
	MC		PHENYLEPHRINE HCL SOLN					
	MC		PONTOCAINE SOLN					
	MC/DEL		SODIUM CHLORIDE					
MISCELLANEOUS EAR								
EAR	MC/DEL		A/B OTIC SOLN	MC		ANTIBIOTIC EAR SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		ACETASOL SOLN	MC		ANTIBIOTIC EAR SUSP		
	MC/DEL		ACETASOL HC SOLN	MC/DEL		CIPRODEX		

	MC/DEL		ACETIC ACID	MC/DEL		**CIPROFLOXACIN HCL**		
	MC/DEL		ACETIC ACID/HYDROCORTISON	MC/DEL		DEBROX SOLN		
	MC/DEL		ALLERGEN SOLN	MC		DERMOTIC		
	MC		CARBAMIDE PEROXIDE 6.5% OTIC SOLN.	MC		FLOXIN		
	MC/DEL		CIPRO HC SUSP	MC		OTIPRIO		
	MC/DEL		CORTISPORIN-TC SUSP	MC		OTOVEL		
	MC/DEL		CORTOMYCIN					
	MC		COLY-MYCIN-S SUSP					
	MC		EAR DROPS SOLN					
	MC		EAR DROPS RX SOLN					
	MC/DEL		EAR WAX REMOVAL DROPS					
	MC		FLUOCINOLONE ACETONIDE OIL DROPS 0.01%					
	MC/DEL		NEOMYCIN/POLYMYXIN/HC					
	MC/DEL		OFLOXACIN 0.3% OTIC					
MOUTH ANTISEPTICS								
MOUTH ANTI-INFECTIVES	MC		NILSTAT SUSP	MC		MYCELEX TROC	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		NYSTATIN SUSP	MC		ORAVIG		
MOUTH ANTISEPTICS	MC/DEL		CHLORHEXIDINE GLUCONATE	MC		APHTHASOL PSTE[1]	Use PA Form# 20420 1. Must fail all preferred products before non-preferred.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		LIDOCAINE VISCOUS SOLN	MC		PERIOGARD SOLN[1]		
	MC		TRIAMCINOLONE IN ORABASE PSTE	MC		TRIAMCINOLONE ACETONIDE PSTE[1]		
	MC		TRIAMCINOLONE ORADENT PSTE					
DENTAL PRODUCTS								
DENTAL PRODUCTS	MC/DEL		ETHEDENT CREA	MC0MC		APF GEL GEL	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		GEL-KAM CONC	MC/DEL		DENTAGEL GEL		
	MC/DEL		GEL-KAM GEL 0.4%	MC/DEL		PHOS-FLUR GEL		
	MC/DEL		PHOS FLUR SOLN	MC		THERA-FLUR-N GEL		
	MC/DEL		SF 5000 PLUS CREA					
	MC/DEL		SF GEL					
	MC		STANNOUS FLUORIDE ORAL RI CONC					
ARTIFICIAL SALIVA/STIMULANTS								
ARTIFICIAL SALIVA/STIMULANTS	MC		SALIVA SUBSTITUTE SOLN	MC		EVOXAC CAPS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC		RADIACARE SOLR		
				MC		SALAGEN TABS		
MISCELLANEOUS ANORECTAL								
ANORECTAL - MISC.	MC		CORTENEMA ENEM	MC/DEL		ANUSOL-HC CREA	Use PA Form# 20420	
	MC		ELA-MAX 5 CREA	MC/DEL		CORTIFOAM FOAM		
	MC/DEL		HYDROCORTISONE ENEM	MC/DEL		PROCTOFOAM HC FOAM		
	MC/DEL		PROCTOSOL HC CREA	MC/DEL		PROCTO-KIT CREA 2.5%		
	MC/DEL		PROCTOZONE-HC CREA	MC		RECTIV OINT		
T-CELL ACTIVATION INHIBITOR								
PSORIASIS BIOLOGICALS			ADALIMUMAB-FKJP	MC		AMJEVITA	1. Dosing limits apply, please refer to dosage consolidation list. 2.Clinical PA required and will be preferred for the indication of plaque psoriasis, psoriatic arthritis and ankylosing spondylitis. 3. For the treatment of adults with moderate-to-severe plaque psoriasis who	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Cosentyx approvals for 300mg dose(s) must use "300DOSE" package (containing 2 x 150mg pens or syringes). It is recommended to assess for TB infection prior to starting treatment with Taltz®. Stelara will require using preferred trial of Skyrizi if unable please provide clinical rational as why inappropriate.
	MC		ENBREL[1,5]	MC/DEL		BIMZELX[3]		
	MC		ENBREL SURECLICK[1]	MC		**COSENTYX**[4]		
	MC		HUMIRA[1,5]	MC/DEL		CYLTEZO		
	MC		OTEZLA	MC		HADLIMA		
			SIMLANDI	MC/DEL		HULIO		
	MC/DEL		SKYRIZI[6]	MC/DEL		HYRIMOZ		
	MC		TALTZ[2]	MC		IDACIO		
				MC/DEL		ILUMYA[3]		
				MC		SOTYKTU		
				MC/DEL		SPEVIGO		

				MC		SILIQ	severe plaque psoriasis who are candidates for systemic therapy or phototherapy.	
				MC		STELARA		
				MC		TREMFYA		
				MC		YUFLYMA		
				MC		YUSIMRY	4. Please see criteria section 5. Will not require a PA if at least one systemic drug such as methotrexate, cyclosporine, methoxsalen or acitretin is in members drug profile. 6. Clinical PA required and will be preferred for the indication of plaque psoriasis, psoriatic arthritis, crohn's disease and ulcerative colitis. Use PA Form# 20910	
ALTERNATIVE MEDICINES								
ALTERNATIVE MEDICINES	MC MC		DIMETHYL SULFOXIDE SOLN MELATONIN	MC/DEL		CO-ENZYME Q-10	Use PA Form# 20420	Will only be approved for specific conditions supported by at least two double-blinded, placebo-controlled randomized trials that are not contradicted by other studies of similar quality.
CHELATING AGENTS								
CHELATING AGENTS	MC/DEL		**CUPRIMINE CAPS**	MC		CLOVIQUE	Use PA Form# 20420 1. FDA indication of treatment of chronic iron ovrload due to blood transfustions in membes 2	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Clovique® should be used when continued treatment with penicillamine is no longer possible because of intolerable or life endangering side effects.
				MC		DEPEN TITRATABS TABS		
				MC/DEL		EXJADE[1]		
				MC		SYPRINE		
				MC/DEL		**TRIENTINE CAPS**		
ANTILEPROTIC								
ANTILEPROTIC				MC		THALOMID CAPS[1]	1. All PA requests for 150mg dosing will require use of Thalomid 100mg and 50mg capsules. Use PA Form# 20420	Approved for indications of leprosy, treatment-resistant multiple myeloma and AIDS.
ANTINEOPLASTIC AGENTS								
ANTINEOPLASTIC AGENTS - ANTIADNDROGENS	MC/DEL		BICALUTAMIDE	MC/DEL		CASODEX	Use PA Form# 20420	
ANTINEOPLASTIC AGENTS- LHRH ANALOGS	MC/DEL		LUPRON DEPOTSYRINGEKIT[1]	MC/DEL		LUPRON DEPOT SYRINGEKIT	1. Dosing limits apply, please refer to dosage consolidation list. 2. PA required to confirm FDA approved indication. Use PA Form# 20420	
	MC/DEL		LUPRON DEPOT- PED KIT[1](1-month)	MC/DEL		FIRMAGON[2]		
	MC/DEL		LUPRON DEPOT-PED SYRINGEKIT (3-month)					
				MC/DEL		SUPPRELIN LA (IMPLANT) KIT		
	MC/DEL		TRIPTODUR VIAL	MC/DEL		TRELSTAR		
				MC		VANTAS[2]		
ANTINEOPLASTIC AGENTS - TYROSINE KINASE INHIBITORS				MC		SPRYCEL[1]	Use PA Form# 20420 1. Verification of diagnosis	
				MC/DEL		TYKERB[2]		

				MC		GLEEVEC[1]	is required. 2. PA required to confirm FDA approved indication and to monitor for potential drug-drug interactions.	
ANTINEOPLASTICS-MISCELLANEOUS	MC		AMIFOSTINE	MC		DOCEFREZ	Use PA Form# 20420	
	MC/DEL		MERCAPTOPURINE	MC/DEL		ELOXATIN		
	MC/DEL		**OXALIPLATIN**	MC/DEL		ETHYOL		
				MC		LEUPROLIDE		
				MC/DEL		PURINETHOL		
				MC/DEL		ZOLINZA		
ANTINEOPLASTICS- MONOCLONAL ANTIBODIES	MC/DEL		TRAZIMERA	MC/DEL		ENHERTU		
				MC/DEL		HERCEPTIN		
				MC.DEL		HERZUMA		
				MC		KANJINTI		
				MC		OGIVRI		
				MC/DEL		ONTRUZANT	Use PA Form# 20420	
CANCER								
CANCER	MC		ALIMTA	MC		ABECMA	1. PA required to confirm appropriate diagnosis and testing.	All non-preferred: A clinical PA is required to confirm appropriate clinical indication for the individual drug request. Specific to each drug all age, clinical testing requirements, previous step therapies, adjunctive drug therapy requirements, and response without disease progression will be also be evaluated for clinical appropriateness. The standard for the appropriate indication will include the FDA label as well as current NCCN guidelines
	MC/DEL		ANASTROZOLE TABS	MC		AKEEGA		
	MC		ERBITUX	MC		ALECENSA		
	MC		**IMATINIB MESYLATE**	MC/DEL		ALIQOPA[3]	2. Avoid CYP3A drug drug interaction.	
	MC/DEL		LETROZOLE	MC		ALUNBRIG[1]		Scemblix is for the treatment of adult patients with: Philadelphia chromosome-positive chronic myeloid leukemia (Ph+ CML) in chronic phase (CP), previously treated with two or more
	MC		RUXIENCE	MC		ALYMSYS		
	MC/DEL		VIDAZA	MC/DEL		ARIMIDEX		
	MC		ZIRABEV	MC		AUGTYRO	3. Clinical PA required for appropriate diagnosis	
				MC		AYVAKIT		
				MC/DEL		AVASTIN	4. Re-approval will require documentation of response without disease progression and tolerance to treatment	
				MC/DEL		BALVERSA		
				MC		BAVENCIO[1,8]		
				MC/DEL		BENDEKA[3]	5. Dosing limits apply, please see dosage consolidation list.	
				MC/DEL		BESPONSA[3]		
				MC		BESREMI[1]		
				MC		BLENREP	6. Max daily dose of 300mg.	
				MC/DEL		BOSULIF		
				MC/DEL		BRAFTOVI[1]		
				MC		BREYANZI	7. Monitor liver enzymes periodically and stop treatment upon Grade 3 or higher elevation of liver enzymes approved indication	
				MC		BRUKINSA		
				MC		CABOMETYX[3]		
				MC		CAMCEVI		
				MC/DEL		CALQUENCE[3]		
				MC		COMETRIQ[3,4,5]	8. For patients ≥ 12 years of age	
				MC		COTELLIC		
				MC/DEL		COPIKTRA	9. For the treatment of patients up to 25 years of age with B-cell acute lymphoblastic leukemia (ALL) that is refractory or in second or later relapse.	
				MC		DARZALEX[3]		
				MC/DEL		DAURISMO		
				MC/DEL		ELREXFIO		
				MC/DEL		EMPLICITI(IV)[8]		
				MC		EPKINLY		
				MC/DEL		**ERLEADA**		
				MC/DEL		ERIVEDGE		
				MC		EXKIVITY		
				MC		FARYDAK		

				MC/DEL		FEMARA	Use PA Form# 20420
				MC		FOLOTYN	
				MC		FOTIVDA	
				MC		FRUZAQLA	
				MC		GAVRETO	
				MC/DEL		GILOTRIF[4,5]	
				MC/DEL		IBRANCE	
				MC		ICLUSIG[3]	
				MC/DEL		IDHIFA[3]	
				MC		IMBRUVICA	
				MC		IMDELLTRA	
				MC/DEL		IMFINZI	
				MC/DEL		IMJUDO	
				MC		IMLYGIC	
				MC/DEL		INLYTA	
				MC/DEL		INREBIC	
				MC		INQOVI	
				MC		IWILFIN	
				MC		JAKAFI	
				MC		JAYPIRCA[1,2]	
				MC		JEMPERLI	
				MC/DEL		KEYTRUDA[1]	
				MC		KIMMTRAK	
				MC		KISQALI[1]	
				MC/DEL		KOSELUGO	
				MC		KRAZATI[3]	
				MC		KYMRIAH[3,9]	
				MC		KYPROLIS[1]	
				MC		LARTRUVO[1]	
				MC		LENVIMA	
				MC/DEL		LIBTAYO[1]	
				MC		LONSURF	
				MC/DEL		LORBRENA	
				MC		LOQTORZI	
				MC		LUMAKRAS	
				MC/DEL		LUMOXITI[1]	
				MC		LUNSUMIO[1]	
				MC		LYNPARZA[1]	
				MC		LYTGOBI	
				MC		NEXAVAR[1]	
				MC		NERLYNX[3]	
				MC		NINLARO(PO)	
				MC/DEL		NUBEQA	
				MC		MARGENZA	
				MC/DEL		MEKINIST[3,4]	
				MC/DEL		MEKTOVI[1]	
				MC		MONJUVI	
				MC/DEL		MYLOTARG[3]	
				MC/DEL		MVASI	
				MC		ODOMZO[1,2,5]	
				MC		OGSIVEO	
				MC		OJEMDA	
				MC		OJJAARA	
				MC		OMISIRGE	
				MC		ONUREG	
				MC/DEL		OPDIVO[3]	

MC	OPDUALAG
MC	ORGOVYX
MC	ORSERDU[2,3]
MC	PADCEV
MC	PEMAZYRE
MC	PEPAXTO
MC	PHESGO
MC/DEL	PIQRAY
MC	POLIVY
MC	POMALYST
MC	PORTRAZZA[3]
MC	QINLOCK
MC	RETEVMO
MC	REZLIDHIA
MC/DEL	ROZLYTREK
MC	RUBRACA
MC	RITUXAN
MC	RYBREVANT
MC	RYDAPT
MC	RYLAZE
MC	RYTELO
MC/DEL	SARCLISA
MC	SCEMBLIX[1]
MC/DEL	STIVARGA
MC/DEL	SUTENT[1,2]
MC/DEL	SYLATRON
MC	TABRECTA
MC	TALVEY
MC/DEL	TAFINLAR[3,4,5,6]
MC	TAZVERIK
MC/DEL	TALZENNA[1]
MC/DEL	TAGRISSO
MC	TECARTUS
MC	TECENTRIQ[1]
MC	TEPMETKO
MC/DEL	TIBSOVO[1]
MC	TIVDAK
MC	TRODELVY
MC	TRUSELTIQ
MC/DEL	TRUXIMA
MC/DEL	TRUQAP
MC	TUKYSA
MC	UKONIQ
MC/DEL	VANFLYTA
MC	VEGZELMA
MC	VENCLEXTA[3]
MC	VERZENIO[3]
MC/DEL	VITRAKVI
MC/DEL	VIZIMPRO[1]
MC	VONJO
MC/DEL	WELIREG
MC/DEL	XALKORI
MC/DEL	XPOVIO
MC/DEL	XOSPATA
MC/DEL	XTANDI
MC/DEL	YERVOY

				MC		YESCARTA[3]		
				MC/DEL		ZALTRAP		
				MC		ZEJULA[1]		
				MC/DEL		ZELBORAF		
				MC		ZEPZELCA		
				MC		ZYDELIG		
				MC/DEL		ZYKADIA		
				MC		ZYNLONTA		
				MC		ZYNYZ[1]		
				MC		ZYTIGA		
IMMUNOSUPPRESSANTS								
IMMUNOSUPPRESSANTS	MC/DEL		CYCLOSPORINE MODIFIED	MC/DEL		CELLCEPT	1. For the treatment of adult and pediatric patients 12 years and older with chronic graft-versus-host disease (chronic GVHD) after failure of at least 2 prior lines of systemic therapy Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Cyclosporine will now be non-preferred and require prior authorization if it is currently being used in combination with either Lipitor (doses greater than 20mg/day), Crestor, or lovastatin (doses greater than 20mg). **DDI:** Cyclosporine will require prior authorization when used with Livalo. **DDI:** All preferred immunosuppressants will require clinical PA for patients over 60 that are currently on fluoroquinolone therapy.
	MC		GENGRAF CAPS	MC/DEL		CYCLOSPORINE CAPS		
	MC/DEL		MYCOPHENOLATE	MC/DEL		CYCLOSPORINE SOL. MODIFIED		
	MC/DEL		MYFORTIC	MC		ENVARSUS XR		
	MC/DEL		NEORAL SOL	MC/DEL		NEORAL CAP		
	MC/DEL		RAPAMUNE	MC		PROGRAF CAPS		
	MC/DEL		SANDIMMUNE	MC		REZUROCK[1]		
	MC/DEL		**TACROLIMUS CAPS**	MC/DEL		ZORTRESS		
IMMUNOSUPPRESSANTS- Misc.				MC		HYFTOR[1,2]	1. For the treatment of patients ≥ 6 years of age. 2. Clinical PA required for appropriate diagnosis and clinical parameters. Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
PURINE ANALOG								
PURINE ANALOG	MC		AZASAN TABS	MC/DEL		**IMURAN TABS**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**AZATHIOPRINE TABS**					
K REMOVING RESINS								
K REMOVING RESINS	MC/DEL		LOKELMA	MC/DEL		SPS SUSP	Use PA Form# 20420	
	MC/DEL		SODIUM POLYSTYRENE SULFON	MC/DEL		SPS 30GM/120ML ENEMA SUSP		
				MC		VELTASSA		

New drugs are initially non-preferred until reviewed by the DUR Committee and the State. According to State policy, any drug requiring specific diagnosis still requires the specific diagnosis unless otherwise noted within this document.

Last update 01/17

PDL DOSAGE CONSOLIDATION LIST

Tabs/Caps/Patches: Quantities in units

Sprays/Inhalers/Nebulizers: Quantities in GM, ML, OR MCG

Injectibles: Quantities in ML

Shaded areas are non-preferred agents - Quantities of these non-preferred agents are available up the limit only with prior authorization

Drug Name	Strength	Limit/Day	Limit/Days
ABILIFY SOLUTION	1MG/ML	30ML	1020/34
ACCUPRIL	5MG	1	35/35
ACCUPRIL	10MG	1	35/35
ACCUPRIL	20MG	1	35/35
ACEON	2MG	1	35/35
ACEON	4MG	1	35/35
ACTONEL	5MG	1	35/35
ACTONEL	35MG	1/WK	5/35
ACTOS	All Strengths	1	35/35
ADDERALL XR	5MG	3	90/30
ADDERALL XR	10MG	3	90/30
ADDERALL XR	15MG	3	90/30
ADDERALL XR	20MG	2	60/30
ADDERALL XR	30MG	1	35/35
ADEMPAS	All Strengths	1	35/35
ADVAIR DISKUS	All Strengths	2	60/30
ADVAIR HFA	All Strengths	4	120/30
ADZENYS XR	All Strengths	1	30/30
AEROBID	250MCG	8 INHALATIONS	21/35
AEROBID-M	250MCG	8 INHALATIONS	21/35
ALAVERT-NON DROW	TAB	1	96/96
ALENDRONATE	All Strengths	1/WK	35/35
ALTABAX	5GM		1 TUBE/30
ALTABAX	15GM		1 TUBE/30
ALTABAX	30GM		1 TUBE/30
ALTACE	1.25MG	1	35/35
ALTACE	2.5MG	1	35/35
ALTACE	5MG	1	35/35
AMARYL	1MG	1	35/35
AMARYL	2MG	1	35/35
AMBIEN	5MG		12/34
AMBIEN	10MG		12/34
AMBIEN CR	6.25MG		12/34
AMBIEN CR	12.5MG		12/34
AMERGE (Step 8)	1MG		12/30
AMERGE (Step 8)	2.5MG	2.5MG	12/30
AMLODIPINE	2.5MG	1.5	53/35 DAYS
AMLODIPINE	5MG	1.5	53/35 DAYS
AMMONIUM LACTATE CREA	12%		1 TUBE/10
AMMONIUM LACTATE LOTN	12%		1TUBE/8
AMPHETAMINE/DEXTROAMPHET ER	5MG	3	90/30
AMPHETAMINE/DEXTROAMPHET ER	10MG	3	90/30
AMPHETAMINE/DEXTROAMPHET ER	15MG	3	90/30
AMPHETAMINE/DEXTROAMPHET ER	20MG	2	60/30
AMPHETAMINE/DEXTROAMPHET ER	30MG	1	90/90
AMPHETAMINE SALT	5,10,15MG	3	105/35
AMPHETAMINE SALT	20MG	2	70/35
AMPHETAMINE SALT	30MG	1	35/35
ANDRODERM	2.5MG	2	60/30
ANDRODERM	5MG	1	30/30
ARAVA	10MG	1	35/35
ARCAPTA	75MCG	1 INHALATION	35/35
ARICEPT	5MG	1	35/35
ARICEPT	10MG	1	35/35
ARIPIPRAZOLE	2MG	2	180/90
ARIPIPRAZOLE	5MG	2	180/90
ARIPIPRAZOLE	10MG	2	180/90
ARIPIPRAZOLE	15MG	2	180/90
ARIPIPRAZOLE	20MG	1.5	135/90
ARIPIPRAZOLE	30MG	1	90/90
ARIXTRA INJECTION	2.5MG/0.5ML		7/30
ARIXTRA INJECTION	5MG/0.4ML		7/30
ARIXTRA INJECTION	7.5MG/0.6ML		7/30
ARIXTRA INJECTION	10MG/0.8ML		7/30
ARMONAIR	All Strengths	I INHALATION	60U/30
ASMANEX 30 UNITS	220MCG	1 INHALATION	30U/30
ASMANEX 60 UNITS	220MCG	2 INHALATIONS	60U/30
ASMANEX 120 UNITS	220MCG	4 INHALATIONS	120U/30
ATACAND	4MG	1.5	53/35
ATACAND	8MG	1.5	53/35
ATROVENT HFA	17MCG	12 INHALATIONS	25.8/34
ATROVENT 30ML	0.03%	12 SPRAYS	30/30
ATROVENT 15ML	0.06%	16 SPRAYS	45/30
AVANDIA	2MG	1.5	53/35
AVANDIA	4MG	1	35/35
AVAPRO	75MG	1.5	53/35
AVAPRO	150MG	1	35/35
AXERT (Step 8)	6.25MG		12/30
AXERT (Step 8)	12.5MG		12/30
AZELEX	20%		1 TUBE/18
AZILECT	All Strengths	1	35/35
BACTROBAN CREAM			1 TUBE/30
BECONASE AQ	42MCG	8 INHALATIONS	50/30
BENICAR-HCT	All Strengths	1	30/30
BENAZEPRIL	5MG	1	35/35
BENAZEPRIL	10MG	1.5	53/35
BENAZEPRIL	20MG	1	35/35
BENAZEP/HCTZ	5-6.25	1	35/35
BENAZEP/HCTZ	10/12.5	1	35/35
BEVESPI AERO		4 INHALATIONS	120/30
BONIVA	2.5MG	1	35/35
BOTOX (ADULTS)	100U/ML	1 session/90 days	600U/90
BOTOX (CHILDREN>12)	100U/ML	1 session/90 days	400U/90
BREO ELLIPTA	100/25MCG	1 INHALATIONS	60/60
BRILINTA	All Strengths	2	70/35
BRINTELLIX	All Strengths	1	35/35
BUTRANS		1 patch/WK	4/28
BYETTA	5mcg inj	0.04ML	1.2ML/30
BYETTA	10mcg inj	0.08ML	2.4ML/30
CALAN SR	120MG	1	35/35
CALAN SR	180MG	2	70/35
CALAN SR	240MG	2	70/35
CARDIZEM CD	120MG/24	1	35/35
CARDIZEM CD	180MG/24	1	35/35
CARDIZEM CD	240MG/24	1	35/35
CARDIZEM CD	300MG/24	1	35/35
CARDIZEM CD	360MG/24	1	35/35
CARDIZEM LA	120MG/24	1	35/35
CARDIZEM LA	180MG/24	1	35/35
CARDIZEM LA	240MG/24	1	35/35
CARDIZEM LA	300MG/24	1	35/35
CARDIZEM LA	360MG/24	1	35/35
CARDURA	1MG	1	35/35
CARDURA	2MG	1.5	53/35
CARDURA	4MG	1.5	53/35
CARTIA XT	120MG	1	90/90
CARTIA XT	180MG	1	90/90
CARTIA XT	240MG	1	90/90
CARTIA XT	300MG	1	90/90
CATAPRES-TTS1	0.1 MG/24HR		5/35
CATAPRES- TTS2	0.2 MG/24HR		5/35
CATAPRES- TTS3	0.3 MG/24HR		5/35
CEFIXIME	400MG	2	2/7
CELEBREX	100MG	1	35/35
CELEBREX	200MG	2	70/35
CELEBREX	400MG	1	35/35
CELEXA	20mg	0.5	17/34
CELEXA	40mg	1	51/34
CITALOPRAM	10MG	2	180/90
CITALOPRAM	20MG	2	180/90
CITALOPRAM	40MG	1	90/90
CLARINEX	REDI TAB	1	35/35
CLEOCIN-T		1 PACKAGE	1/30
CLINDAMYCIN PHOSPHATE		1 PACKAGE	1/30
COMBIVENT	103-18MCG	12 INHALATIONS	30/35
Drug Name	Strength	Limit/Day	Limit/Days
EFFEXOR XR	37.5MG	1	35/35
EFFEXOR XR	75MG	1	35/35
EMSAM	All Strengths	1	34/34
ENALAPRIL	2.5	1	90/90

ATACAND	16MG	1	35/35
ATRIPLA	600MG	1	35/35
Drug Name	**Strength**	**Limit/Day**	**Limit/Days**
COMETRIQ	80MG	1	35/35
COMETRIQ	20MG	3	105/35
CONCERTA	18MG	1	30/30
CONCERTA	27MG	1	30/30
CONCERTA	36MG	2	60/30
COPAXONE INJ	20MG		1/32
COPAXONE KIT	20MG/ML		1/30
COREG CR	All Strengths	1	34/34
COSENTYX	150MG	1	1/30
CRESTOR	5MG	1	35/35
CRESTOR	10MG	1	35/35
CRESTOR	20MG	1	35/35
CRESTOR	40MG	1	35/35
CYMBALTA	All Strengths	1	35/35
DALMANE	15MG		10/30
DALMANE	30MG		10/30
DAYPRO	600MG	2	70/35
DAYTRANA	10mg/9hr (27.5mg)	1	34/34
DAYTRANA	15mg/9hr (41.3mg)	1	34/34
DAYTRANA	20mg/9hr (55.0mg)	1	34/34
DAYTRANA	30mg/9hr (82.5mg)	1	34/34
DDAVP	5ML		15/34
DENAVIR CREAM			2gm/30
DEPO-PROVERA	150MG/ML		1/90
DEPO-PROVERA	400MG/ML		2.5/90
DEPO-TESTOSTERONE	200MG/ML		20/90
DESMOPRESSIN	0.1MG	12	420/35
DESMOPRESSIN	0.2MG	6	210/35
DESONIDE	0.05%		2 TUBES/30
DESOWEN	0.05%		2 TUBES/30
DETROL LA	2MG	1	35/35
DEXEDRINE	All Strengths	3	90/30
DEXILANT	All Strengths	1	35/35
DEXTROAMPHETAMINE	All Strengths	3	90/30
DICLOFENAC 1% GEL	1% GEL		2 TUBES/30
DIFLUCAN	150MG		1/7
DILACOR XR	240MG/24	1	35/35
DILACOR XR	120MG/24	1	35/35
DILACOR XR	180MG/24	1	35/35
DILTIA - XT	120MG/24	1	90/90
DILTIA - XT	180MG	1	90/90
DILTIA - XT	240MG/24	1	90/90
DILTIAZEM CAP ER	120MG	1	90/90
DILTIAZEM CAP XR	120MG	1	90/90
DILTIAZEM CAP	120MG/24	1	90/90
DILTIAZEM CAP	180MG/24	1	90/90
DILTIAZEM CAP ER	240MG	1	90/90
DILTIAZEM CAP XR	240MG	1	90/90
DILTIAZEM XR CAP	240MG/24	1	90/90
DILTIAZEM CAP	240MG/24	1	90/90
DILTIAZEM CAP	300MG/24	1	90/90
DILTIAZEM CAP	360MG/24	1	90/90
DIOVAN	80MG	1	35/35
DIOVAN - HCT	80 - 12.5	1	35/35
DITROPAN XL	5MG	1	35/35
DITROPAN XL	10MG	2	70/35
DORAL	7.5MG		10/30
DOXAZOSIN	1MG	1	90/90
DOXAZOSIN	2MG	1.5	135/90
DOXAZOSIN	4MG	1.5	135/90
DRYSOL SOL	20%		1 BOTTLE/30DAYS
DURAGESIC PATCHES	12.5MCG/HR		11/33
DURAGESIC PATCHES	25MCG/HR		11/33
DURAGESIC PATCHES	50MCG/HR		11/33
DURAGESIC PATCHES	75MCG/HR		11/33
DURAGESIC PATCHES	100MCG/HR		22/33
DULOXETINE	20MG	3	270/90
DULOXETINE	30MG	3	270/90
DULOXETINE	60MG	2	180/90
EDEX	All Strengths		1/30
Drug Name	**Strength**	**Limit/Day**	**Limit/Days**
ILARIS			2/28

ENALAPRIL	5MG	1.5	135/90
ENALAPRIL	10MG	1.5	135/90
ENALAPR/HCTZ	5-12.5	1	90/90
ENBREL	25MG/ML		8/28
ENBREL SURECLICK			8/28
ESTAZOLAM	1MG		10/30
ESTAZOLAM	2MG		10/30
ESTRING MIS	2MG		1/90
EVENITY		12 DOSES/LIFETIME	12 DOSES/LIFETIME
EVOTAZ	All Strengths	1	30/30
FELODIPINE	2.5MG	1	90/90
FELODIPINE	5MG	1.5	135/90
FENTANYL	25MCG/HR		11/33
FENTANYL	50MCG/HR		11/33
FENTANYL	75MCG/HR		11/33
FENTANYL	100MCG/HR		22/33
FETZIMA	All Strengths	1	35/35
FINASTERIDE	5MG	1	90/90
FLONASE	50MCG	4 SPRAYS	32/34
FLOVENT HFA 44MCG	44MCG	4 INHALATIONS	10.6/30
FLOVENT HFA 110MCG	110MCG	4 INHALATIONS	12/30
FLOVENT HFA 220MCG	220MCG	8 INHALATIONS	24/30
FLOVENT DISKUS	50MCG, 100MCG	4 INHALATIONS	60/30
FLOVENT DISKUS	250MCG	3 INHALATIONS	120/30
FLUCONAZOLE	150MG		1/7
FLUNISOLIDE SOLN	0.025%	16 SPRAYS	75/30
FLUOXETINE CAP	40MG	2	180/90
FLUOXETINE CAP	20MG	4	360/90
FLUOXETINE CAP	10MG	3	270/90
FLURAZEPAM	15MG		10/30
FLURAZEPAM	30MG		10/30
FLUTICASONE SPR		4 SPRAYS	48/90
FLUVOXAMINE	25MG	3	270/90
FLUVOXAMINE	50MG	3	270/90
FOCALIN	All Strengths	3	105/35
FOCALIN XR	All Strengths	1	35/35
FORFIVO XL	All Strengths	1	35/35
FOSAMAX	5MG	1	35/35
FOSAMAX	10MG	1	35/35
FOSAMAX	70MG	1/WK	5/35
FOSAMAX	40MG	2/WK	10/35
FOSINOPRIL	10MG	1.5	135/90
FOSINOPRIL	20MG	2	180/90
FRAGMIN INJ	10000U/ML	2ML	14/7
FRAGMIN INJ	2500U/.2ML	0.4ML	2.80/7
FRAGMIN INJ	25000U/ML	0.8ML	5.6/7
FRAGMIN INJ	5000U/.2ML	0.4ML	2.80/7
FRAGMIN INJ	7500U/.3ML	0.6ML	4.2/7
FROVA TAB (Step 8)	2.5MG		12/30
FULYZAQ	125MG	2	70/35
FUZEON	KIT	1	1/30
FYCOMPA	All Strengths	1	35/35
GABAPENTIN	300MG	9	810/90
GABAPENTIN	400MG	9	810/90
GABAPENTIN	600MG	6	540/90
GABAPENTIN	800MG	4	360/90
GEODON	20MG	2	70/35
GEODON	40MG	2	70/35
GEODON	60MG	2	70/35
GEODON	80MG	2	70/35
GEODON	INJ	2	70/35
GILOTRIF	All Strengths	1	35/35
GLIMEPIRIDE	1MG	1	90/90
GLIMEPIRIDE	2MG	1	90/90
GLUCOSE TES STRP		12	420/35
GLUCAGEN INJ. HYPOKIT			2/30
GLYCOLAX*	255GM		255GM/90

*** Available for once daily dosing to members under the age of 18 years**

Drug Name	**Strength**	**Limit/Day**	**Limit/Days**
LUNESTA	2MG		12/34
LUNESTA	3MG		12/34
LUPRON DEPOT INJ	11.25MG	KIT	1/90
LUPRON DEPOT INJ	22.5	KIT	1/90
LUPRON DEPOT INJ	30MG		1/90

HALCION	0.125MG		10/35
HALCION	0.25		10/35
HUMIRA	40mg/0.8ml		4/28
HYDROXYZINE TAB	All Strengths	3	270/90
HYTRIN	1MG	1	35/35
HYTRIN	5MG	1	35/35
HYZAAR	50-12.5	1	35/35
IMDUR	30MG	1.5	53/35
IMDUR	60MG	1.5	53/35
IMITREX (step 8)	25MG		12/30
IMITREX (step 8)	50MG		12/30
IMITREX (step 8)	100MG		12/30
IMITREX VIAL	All Strengths		6 boxes/30
IMITREX CARTRIDGE	All Strengths		12/30
IMITREX NASAL SPRAY	All Strengths		12/30
IMITREX PEN INJCTR	All Strengths		12/30
IMIQUIMOD	5%		12/30
IMIQUIMOD	5%		12/30
INTAL	800MCG	8 INHALATIONS	28.4/34
INVOKANA	All Strengths	1	35/35
IPRATROPIUM 30ML	0.03%	12 SPRAYS	90/90
IPRATROPIUM 15ML	0.06%	16 SPRAYS	135/90
ISOPTIN SR	180MG	2	70/35
IRBESARTAN	All Strengths	1	90/90
ISOPTIN SR	240MG	2	70/35
ISOSORBIDE MONO	30MG	2	180/90
ISOSORBIDE MONO	60 MG	1.5	135/90
JANUMET	All Strengths	2	70/35
JANUVIA	All Strengths	1	35/35
JUVISYNC	All Strengths	1	35/35
KETOPROFEN	100MG	2	180/90
KETOPROFEN	200MG	1	90/90
KETOROLAC	10MG	4.8	24/30
KHEDEZLA	All Strengths	1	35/35
LAC-HYDRIN CREAM	12%		1TUBE/30
LAMICTAL	25MG	6	210/35
LAMICTAL	25MG CHW	6	210/35
LAMICTAL	100MG	2	70/35
LAMISIL	250MG	1	35/35
LAMOTRIGINE	25MG	6	540/90
LAMOTRIGINE	100MG	2	180/90
LANSOPRAZOLE CAPS	All Strengths	2	180/90
LATUDA	All Strengths	1	17/34
LESCOL	20MG	1	35/35
LEVAQUIN	250MG	1	35/35
LEXAPRO	5MG	0.5	15/30
LIPITOR	10MG	1	35/35
LIPITOR	20MG	1	35/35
LIPITOR	40MG	1.5	53/35
LISINOP/HCTZ	10/12.5MG	1	90/90
LINEZOLID	600mg		14/60
LOSARTAN	All Strengths	1	90/90
LOSARTAN- HCT	All Strengths	1	90/90
LOTENSIN	5MG	1	35/35
LOTENSIN	10MG	1.5	35/35
LOTENSIN	20MG	1	53/35
LOTENSIN - HCT	5 - 6.25	1	35/35
LOTENSIN - HCT	10 - 12.5	1	35/35
LOVASTATIN	10MG	1.5	135/90
LOVASTATIN	20MG	1.5	135/90
LOVENOX INJ	30MG/.3ML	0.6	14 injections/7
LOVENOX INJ	40MG/.4ML	0.8	14 injections/7
LOVENOX INJ	60MG/.6ML	1.2	14 injections/7
LOVENOX INJ	80MG/.8ML	1.6	14 injections/7
LOVENOX INJ	100MG/ML	2	14 injections/7
LOVENOX INJ	120MG/.8ML	1.6	14 injections/7
LOVENOX INJ	150MG/ML	2	14 injections/7
LUNESTA	1MG		12/34
Drug Name	Strength	Limit/Day	Limit/Days
NIFEDIPINE ER	90MG	1	90/90
NIFEDIPINE ER,CR	30MG	1	90/90
NORVASC	2.5MG	1.5	53/35 DAYS
NORVASC	5MG	1.5	53/35 DAYS
NURTEC ODT	All Strengths		8/30
NUVARING		1/MO	1/28

LUPRON DEPOT INJ	30MG	KIT	1/90
LYRICA	25,50,75MG	3	102/35
LYRICA	100,150,200MG	3	102/35
LYRICA	225,300MG	2	70/35
MAVIK	1MG	1	35/35
MAVIK	2MG	1	35/35
MAXAIR AUTO	200MCG	12 INHALATIONS	14/30
MAXALT (step 8)	5MG		12/30
MAXALT (step 8)	10MG		12/30
MAXALT MLT (step 1)	5MG		12/30
MAXALT MLT (step 1)	10MG		12/30
MEDROXYPR AC	150MG/ML		1/90
MELOXICAM TABS	All Strengths	1	90/90
METADATE ER	10,20MG	3	90/30
METFORMIN ER	500MG	4	360/90
METHYLIN	All Strengths	3	90/30
METHYLPHENIDATE ER	36mg	2	180/90
METHYLPHENIDATE	All Strengths	3	90/30
METROCREAM		1 PACKAGE	1/30
METROGEL		1 PACKAGE	1/30
METROLOTION		1 PACKAGE	1/30
METRONIDAZOLE CREAM		1 PACKAGE	1/30
METRONIDAZOLE GEL		1 PACKAGE	1/30
METRONIDAZOLE LOTION		1 PACKAGE	1/30
MEVACOR	10MG	1.5	53/35
MEVACOR	20MG	1.5	53/35
MIACALCIN		3.75ml	1 bottle/34
MICARDIS	All Strengths	1	30/30
MICARDIS-HCT	All Strengths	1	30/30
MIGRANAL NASAL SPRAY	All Strengths		12/30
MIRALAX	255G	8.5G	1 bottle/30
MIRALAX	17G/PACKET	0.5 packet	15 packets/30
MIRTAZAPINE	15mg	3	270/90
MOBIC	7.5 MG	1	35/35
MOBIC	15MG	1	35/35
MOEXIPRIL	7.5	1.5	135/90
MONOPRIL	10MG	1.5	53/35
MONOPRIL	20MG	2	70/35
MUPIROCIN			1 TUBE/30
NABUMETONE	500MG	2	180/90
NABUMETONE	750MG	2	180/90
NARATRIPTAN			12/30
NASACORT AERS	55 MCG	4 SPRAYS	9.3/25
NASONEX	50MCG	4 SPRAYS	17/30
NATROBA		120ML	1 bottle/30
NAYZILAM	All Strengths		5/30
NEUPOGEN INJ	300MCG/ML		10/30
NEUPOGEN INJ	480MCG/1.6		16/30
NEUPOGEN INJ	300MCG/.5ML		5/30
NEUPOGEN INJ	480MCG/.8ML		8/30
NEURONTIN	300MG	9	315/35
NEURONTIN	600MG	9	315/35
NEXIUM	20MG	1	35/35
NEXIUM	40MG	2	70/35
NEXIUM SUS	All Strengths	1	30/30
NIFEDIPINE CR	90MG	1	90/90
NIFEDIPINE ER	60MG	1	90/90
NIFEDIPINE ER	30MG	1	90/90
NIFEDIPINE ER	60MG	1	90/90
Drug Name	Strength	Limit/Day	Limit/Days
RELPAX	All Strengths		12/30
REMODULIN	All Strengths		1 MDV/30
RESTORIL	7.5MG		10/30
RESTORIL	15MG		10/30
RESTORIL	30MG		10/30
RETIN-A		1 TUBE	1 TUBE/30
REVLIMID	All Strengths	1	35/35
REYVOW	All Strengths		4/30
RHINOCORT AQ	32MCG	8 SPRAYS	18/30
REFRESH PLUS		15 ML	1 bottle/30
REFRESH PLUS		30 ML	2 bottles/30
REFRESH TEARS		15 ML	1 bottle/30
REFRESH TEARS		30 ML	2 bottles/30
RESCULA			2 bottles/35

ODOMZO	200mg	1	30/30
OLMESARTAN	All Strengths	1	90/90
OLANZAPINE	2.5MG	3	270/90
OLANZAPINE	5MG	3	270/90
OLANZAPINE	7.5MG	3	270/90
OLANZAPINE	10MG	3	270/90
OLANZAPINE	15MH	2	180/90
OLANZAPINE	20MG	1.5	135/90
OLANZAPINE ODT	All Strengths	1	90/90
OMEPRAZOLE	10MG	2	180/90
OMEPRAZOLE	20MG	2	180/90
OMEPRAZOLE	40MG	2	180/90
OMNARIS	50MCG	4 sprays	12.5/30
ONGLYZA	All Strengths	1	35/35
OPSUMIT	All Strengths	1	35/35
ORUVAIL	100MG	2	70/35
ORUVAIL	200MG	1	35/35
OXAPROZIN	600MG	2	180/90
OXYCODONE ER	10,20,40MG	2	70/35
OXYCODONE ER	80MG	4	140/35
OXYCONTIN**	10,20,30,40MG	2	70/35
OXYCONTIN**	80MG	4	140/35
PANTOPRAZOLE	All Strengths	2	180/90
PAROXETINE	10MG	2	180/90
PAROXETINE	20MG	2	180/90
PAXIL	10MG	1.5	53/35
PAXIL	20MG	1	35/35
PEGASYS KIT		KIT	1/28
PLAN B			2/15 or 4/30
PLENDIL	2.5MG	1	35/35
PLENDIL	5MG	1.5	53/35
PRAVACHOL	10MG	1	35/35
PRAVACHOL	20MG	1	35/35
PRAVACHOL	40MG	1	35/35
PRAVACHOL	80MG	1	35/35
PRAVASTATIN	10MG	1	35/35
PRAVASTATIN	20MG	1	35/35
PRAVASTATIN	40MG	2	180/90
PRAVASTATIN	80MG	1	35/35
PREVPAC MIS	500MG-30MG		14/30
PRILOSEC OTC	20MG	2	168/84
PRINIVIL	2.5MG	1	35/35
PRINIVIL	5MG	1	35/35
PRINIVIL	10MG	1.5	53/35
PRINIVIL	20MG	1.5	53/35
PRINZIDE	10-12.5	1	35/35
PROAIR HFA	90mcg	12 INHALATIONS	17/34
PROTONIX	20MG	2	70/35
PROTONIX	40MG	2	70/35
PROZAC	10MG	1.5	53/35
PULMICORT	200MCG	8 INHALATIONS	1/25
PULMICORT FLEX	All Strengths	8 Inhalations	2/30
QUETIAPINE	25MG	3	270/90
QUETIAPINE	50MG	3	270/90
QUETIAPINE	100MG	3	270/90
QUETIAPINE	200MG	3	270/90
QUINAPRIL	5MG	1	90/90
QUINAPRIL	10MG	1	90/90
QUINAPRIL	20MG	1	90/90
QVAR AERS	All Strengths	8 Inhalations	14.6/25
RANITIDINE SYRUP***	15MG/ML	20ML	700ML/35
RELAFEN	500MG	2	70/35
RELAFEN	750MG	2	70/35
REMERON	15MG	1.5	53/35

Drug Name	Strength	Limit/Day	Limit/Days
SULAR	10MG	1.5	53/35
SULAR	20MG	1	35/35
SUMATRIPTAN PEN INJ	All Strengths		12/30
SUMATRIPTAN NASAL SPRAY	All Strengths		12/30
SUMATRIPTAN SYRINGE	All Strengths		12/30
SUMATRIPTAN TAB	All Strengths		12/30
SYNVISC INJ	8MG/ML		2/30
SYRINGES		10	1000/100
TAFINLAR	50MG	6	210/35
TAFINLAR	75MG	4	140/35
REYATAZ	All Strengths	1	35/35
RISPERDAL	0.5MG	1.5	53/35
RISPERDAL	0.25MG	1.5	53/35
RISPERDAL	1MG	1.5	53/35
RISPERDAL	2MG	1.5	53/35
RISPERDAL	3MG	2	70/35
RISPERDAL	4MG	2	70/35
RISPERDAL INJ	25MG		2/28
RISPERDAL INJ	37.5		2/28
RISPERDAL INJ	50MG		2/28
RISPERDAL M-TAB	0.5MG	1.5	53/35
RISPERDAL M-TAB	1MG	1.5	53/35
RISPERDAL M-TAB	2MG	4	140/35
RISPERDAL SOL.	1MG/ML	8ML	280/35
RISPERIDONE	0.5MG	3	270/90
RISPERIDONE	0.25MG	3	270/90
RISPERIDONE	1MG	3	270/90
RISPERIDONE	2MG	3	270/90
RISPERIDONE	3MG	2	180/90
RISPERIDONE	4MG	2	180/90
RISPERIDONE SOL.	1MG/ML	8ML	280/35
RITALIN LA	All Strengths	1	35/35
RITALIN LA	30mg	2	70/35
SAVELLA	All Strengths	2	70/35
SEREVENT DISKUS	50MCG	2 INHALATIONS	60/30
SEROQUEL	100MG		45/30
SEROQUEL XR	150MG	1	35/35
SEROQUEL XR	200MG	1	35/35
SEROQUEL XR	300MG	2	70/35
SEROQUEL XR	400MG	2	70/35
SERTRALINE	25MG	3	270/90
SERTRALINE	50MG	3	270/90
SERTRALINE	100MG	3	270/90
SIMVASTATIN	5MG	1	35/35
SIMVASTATIN	10MG	1.5	53/35
SIMVASTATIN	20MG	1.5	53/35
SIMVASTATIN	40MG	1.5	53/35
SIMVASTATIN	80MG	1	35/35
SINGULAIR	4MG	1	35/35
SINGULAIR	5MG	1	35/35
SINGULAIR	10MG	1	35/35
SONATA	5MG		12/34
SONATA	10MG		12/34
SPIRIVA	HANDIHLR	1 INHALTION	30/30
SPORANOX SOL	10MG/ML	10ML/ML	300cc/30
SPORANOX PULSEPAK	F		30/30
SPORANOX	100MG		30/30
STADOL INJ	1MG/ML		9/35
STADOL INJ	2MG/ML		9/35
STRATTERA	All Strengths	1	35/35
SUPRAX	400MG	1	1/7

Drug Name	Strength	Limit/Day	Limit/Days
XOPENEX HFA		12 INHALATIONS	2 INHALERS/34
XOPENEX NEB		12CC	408/34
ZALEPLON	All Strengths		30/30
ZECUITY	6.5		4/28
ZEMBRACE	All Strengths		3boxes/30
ZESTORETIC	10-12.5	1	35/35
ZESTRIL	2.5MG	1	35/35
ZESTRIL	5MG	1	35/35
ZESTRIL	10MG	1.5	53/35
ZESTRIL	20MG	1.5	53/35
ZETONNA	37MCG	2	60/30
ZIPRASIDONE	20MG	3	270/90
ZIPRASIDONE	40MG	3	270/90
ZOCOR	5MG	1	35/35
ZOCOR	10MG	1.5	53/35
ZOCOR	20MG	1.5	53/35
ZOCOR	40MG	1.5	53/35
ZOFRAN*	4MG	3	90/30
ZOFRAN*	8MG	1.5	45/30
ZOFRAN*	24MG	0.5	15/30
ZOFRAN*	4MG/5ML	15ML	450/30
ZOLMITRIPTAN TAB	All Strengths		12/30

TAMIFLU CAPS	75MG		10/30
TAZTIA XT CAP	120MG/24	1	90/90
TAZTIA XT CAP	180MG/24	1	90/90
TAZTIA XT CAP	240MG/24	1	90/90
TAZTIA XT CAP	300MG/24	1	90/90
TAZTIA XT CAP	360MG/24	1	90/90
TELMISARTAN	All Strengths	1	90/90
TEMAZEPAM	7.5MG		10/30
TEMAZEPAM	15MG		10/30
TEMAZEPAM	30MG		10/30
TEQUIN	200MG	1	35/35
TERAZOSIN	1MG	1	90/90
TERAZOSIN	5MG	1	90/90
TERBINAFINE	250MG	1	35/35
TEST STRIPS	Blood Glucose	12	420/35
TIAZAC	120MG/24	1	35/35
TIAZAC	180MG/24	1	35/35
TIAZAC	240MG/24	1	35/35
TIAZAC	300MG/24	1	35/35
TIAZAC	360MG/24	1	35/35
TIAZAC	420MG/24	1	35/35
TILADE	1.75MG	8 INHALATIONS	48.6/35
TOPAMAX SPRINKLES	All Strengths	1	35/35
TOPROL XL	25MG	1.5	53/35
TOPROL XL	50MG	1.5	53/35
TRADJENTA	All Strengths	1	35/35
TRAMADOL	50MG	8	720/90
TRAMADOL/ APAP	37.5/325MG	8	720/90
TRETINOIN		1 TUBE	1 TUBE/30
TRELEGY ELLIPTA	All Strengths	1INHALATION	30U/30
TREXIMET	85/500	2.5	12/30
TRIAZOLAM	0.125MG		10/30
TRIAZOLAM	0.25MG		10/30
TROKENDI XR	25MG	1	35/35
TROKENDI XR	50MG	1	35/35
TROKENDI XR	100MG	1	35/35
TROKENDI XR	200MG	2	70/35
UBRELVY	All Strengths		10/30
ULTRAM	50MG	8	280/35
UNIVASC	7.5MG	1.5	53/35 DAYS
UTIBRON	7.5mcg/15.6mc	2 INHALATIONS	60/30
VALTOCO	All Strengths		10/30
VALSARTAN-HCT	All Strengths	1	90/90
VASERETIC	5-12.5MG	1	35/35
VASOTEC	2.5MG	1	35/35
VASOTEC	5MG	1.5	53/35
VASOTEC	10MG	1.5	53/35
VENLAFAXINE TABS	25	3	270/90
VENLAFAXINE TABS	37.5	3	270/90
VENLAFAXINE TABS	100	3	270/90
VENLAFAXINE ER CAPS	37.5	3	270/90
VENLAFAXINE ER CAPS	75	3	270/90
VENLAFAXINE ER	150	2	180/90
VENTOLIN HFA	90MCG	12 INHALATIONS	36/34
VERAPAMIL ER, SR	120MG	1	90/90
VERAPAMIL ER, CR, SR	180MG	2	90/90
VERAPAMIL ER, CR, SR	240MG	2	90/90
VERELAN	180MG	1	35/35
VERELAN SR	120MG	1	35/35
VERELAN SR	180MG	1	35/35
VERELAN SR	240MG	2	70/35
VERAMYST	27.5MCG	4 sprays	10/30
VYEPTI	All Strengths		4/30
VYVANSE	All Strengths	1	35/35
VYVANSE CHEW	All Strengths	1	35/35

ZOLOFT	25MG	0.5	18/35
ZOLOFT	50MG	0.5	18/35
ZOLOFT	100MG	3	105/35
ZOLPIDEM (step 1)	5MG		30/30
ZOLPIDEM (step 1)	10MG		30/30
ZOMIG (Step 8)	5MG		12/30
ZTLIDO	All Strengths	3	90/30
ZYPREXA	2.5MG	1.5	53/35
ZYPREXA	5MG	1	35/35
ZYPREXA	7.5MG	1	35/35
ZYPREXA	10MG	1	35/35
ZYPREXA	15MG	1	35/35
ZYPREXA	20MG	1	35/35
ZYPREXA ZYDIS	5MG	1	35/35
ZYPREXA ZYDIS	10MG	1	35/35
ZYPREXA ZYDIS	15MG	1	35/35
ZYPREXA ZYDIS	20MG	1	35/35

*Cancer diagnosis with non-daily chemotherapy required

**Available without pa with CA and HO diag.

*** Ranitidine syrup available without PA to users less than 6 years old.

MDV=Multidose Vial

Pain Management Policy

Back to Index

Beginning January 2017, all current opiate users who are above the maximum combined daily dose of 100 MME must titrate their total daily dose of opioid medications below 300 MME. Also, the maximum daily supply of an opiate prescription for acute pain will be limited to 7-day supplies. The maximum day supply of an opiate prescription for chronic pain will be limited to 30-day supplies. As of July 1, 2017 all users of opioid medications must comply with the maximum combined daily dose of 100 MME.

However, for MaineCare members, effective January 1, 2017, opioid prescription(s) for more than a 7-day supply and/or more than 30 MME/ day will require a prior authorization. Please note that MaineCare implemented a 30 MME limit January 1, 2013 that is still effective.

The following are general exceptions: pain associated with cancer treatment, end-of-life and hospice care, palliative care, and symptoms related to HIV/AIDS. Per MaineCare criteria, the diagnosis of cancer must be written on the prescription. A palliative care exception for any MaineCare opioid prescription will require prior authorization (PA) with appropriate clinical documentation.

Post-surgical members may receive prior authorizations for opiates up to a 60 days in length if medical necessity is provided by the surgical provider.

An MME conversion chart is available at www.mainecarepdl.org. Click on “General Pharmacy Info.”