CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
PDL Effective January 24, 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					
	MC		BICILLIN L-A SUSP					
	MC/DEL		DICLOXACILLIN SODIUM CAPS					
	MC		OXACILLIN SODIUM SOLR				4. Use preferred generic amoxicillin/clavulanate potassium alternatives.	**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/DEL		PENICILLIN V POTASSIUM				Use PA Form# 20420	
	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	
	MC/DEL		CEFIXIME 400MG[2] CAP	MC		DAXBIA		

	MC/DEL		CEFPROZIL	MC		FETROJA[3]	years of age or older who have limited or no alternative treatment options for the treatment of complicated urinary tract infections (cUTIs) Use PA Form# 20420	**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 preferred PPI. 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		CEPHALEXIN 250MG & 500MG CAPS	MC/DEL		FORTAZ		
	MC		CEFTAZIDIME 6MG	MC/DEL		FORTAZ SOLN		
	MC/DEL		CEFTIN SUSP	MC		KEFLEX CAPS		
	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					
MACROLIDES / ERYTHROMYCIN'S	MC/DEL		AZITHROMYCIN TABS	MC/DEL		AZITHROMYCIN POW	1. 7- Day supply per month 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. **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. **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. 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.
	MC/DEL		AZITHROMYCIN SUSP	MC/DEL		CLARITHROMYCIN SUSP		
	MC		E.E.S.	MC/DEL		CLARITHROMYCIN TABS		
	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		
	MC/DEL		ERYTHROMYCIN	MC/DEL		ZITHROMAX TRI-PAK		
				MC/DEL		ZITHROMAX SUSP		
				MC/DEL		ZMAX		
				MC/DEL		ZINPLAVA		
TETRACYCLINES	MC/DEL		DOXYCYCLINE MONOHYDRATE 100mg & 50mg CAPS	MC		DECLOMYCIN TABS	Use PA Form# 20420 1. For the treatment of patients ≥ 8 years of age. 2. For the treatment of patients ≥ 9 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		MINOCYCLINE HCL CAPS	MC/DEL		DORYX CPEP		
	MC/DEL		TETRACYCLINE HCL CAPS	MC/DEL		DOXYCYCLINE HYCLATE		
				MC/DEL		DOXYCYCLINE MONOHYDRATE 150mg & 75mg CAPS		
				MC/DEL		DYNACIN CAPS		
				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	Use PA Form# 20420 1. Dosing limits apply, 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. **DDI:** Preferred ofloxacin will now be non-preferred and require prior authorization if they are currently being used in combination with amiodarone. **DDI:** Preferred levofloxacin will now be non-preferred and require prior authorization if they are currently being used in combination with amiodarone. **DDI:** Preferred Avelox will now be non-preferred and require prior authorization if they are currently being used in combination with amiodarone. **DDI:** All preferred fluoroquinolones will require clinical PA for patients over 60 that are currently on immunosuppressants or steroid therapy. **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/DEL		LEVOFLOXACIN	MC		AVELOX ABC PACK TABS		
	MC/DEL		OFLOXACIN	MC		BAXDELA		
				MC		CIPRO		
				MC		FACTIVE		
				MC		LEVAQUIN TABS SOLN/INJ		
				MC		LEVAQUIN TABS[1]		
				MC		NOROXIN TABS		
				MC		PROQUIN XR		
AMINO GLYCOSIDES	MC		GENTAMICIN	MC/DEL		ARIKAYCE[1,2]	Use PA Form# 20420 1. Clinial PA to verify appropriate diag 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. TOBI Podhaler is limited to patients with significant impairment from using nebulized version of medication
	MC		KITABIS PAK	MC		BETHKIS[1]		
	MC/DEL		NEOMYCIN SULFATE TABS	MC/DEL		TOBI PODHALER[1]		
	MC/DEL		**TOBRAMYCIN AMPUL-NEB**	MC		TOBI NEBU[2]		
				MC/DEL		TOBRAMYCIN SULFATE SOLN[2]		

				MC/DEL		ZEMDRI[2]		Current users of Tobi Nebu and Tobramycin Soln will be allowed a grace period until 10/1/15 to transition to preferred Kitabis. 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/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC 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		INVANZ SOLR	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

				MC		MERREM SOLR		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		PRIMAXIN		
				MC/DEL		RECARBRIO		
LINCOSAMIDES / OXAZOLIDINONES / LEPROSTATICS	MC/DEL		CLEOCIN SOLN	MC/DEL	8	CLEOCIN CAPS	1. Use multiple 150's for Clindamycin instead of 300's.	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	2. Quantity limit of 14 days supply within a 60day period.	
				MC/DEL	9	ZYVOX TABS		
							Use PA Form# 30820 for Zyvox & Vibativ	
							Use PA Form# 20420 for all others	
ANTI INFECTIVE COMBO'S - MISC.	MC/DEL		ERYTHROMYCIN/SULF SUSR	MC		BACTRIM DS 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		SEPTRA/DS TABS	MC		VABOMERE[1]	1. For the treatment of patients ≥ 18 years of age.	
	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.	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]				2. Clinical PA required for appropriate diagnosis.	
							Use PA Form# 20420	
ANTI - FUNGALS								
ANTIFUNGALS - ASSORTED	MC		ANCOBON CAPS	MC/DEL	6	LAMISIL TABS[4]	See quantity limit table.	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.
	MC/DEL		FLUCONAZOLE[1]	MC/DEL	6	ITRACONAZOLE	Non-preferred products must be used in specified step order.	
	MC/DEL		KETOCONAZOLE TABS[7]	MC	8	BREXAFEMME		
	MC/DEL		NYSTATIN	MC/DEL	8	CRESEMBA[9]	Continue to use Anti-Fungal PA form for non-preferred products.	
	MC/DEL		TERBINAFINE TABS[4]	MC/DEL	8	GRIFULVIN V TABS		
	MC/DEL		**VORICONAZOLE TABS**	MC	8	GRISEOFULVIN SUSP		**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.
				MC	8	GRISEOFULVIN ULTRAMICROSI TABS	1. QL--1/every 7-day period (150mg only).	
				MC	8	GRIS-PEG TABS		
				MC	8	REZZAYO[9]	2. Sporanox QL 300cc/month with PA. See quantity limit table.	**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.
				MC/DEL	8	SPORANOX SOLN[2]		
				MC/DEL	8	SPORANOX PULSEPAK CAPS[3]		
				MC/DEL	8	SPORANOX CAPS[3]	3. Sporanox QL 30/month with PA.	
				MC/DEL	8	DIFLUCAN		
				MC/DEL	8	ERAXIS INJ[6]	4. Quantity limit of one tablet daily. Please see dosage consolidation list.	**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.
				MC	8	GRIFULVIN SUSP		
				MC/DEL	8	ONMEL		
				MC/DEL	8	NOXAFIL[5]		**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 15mg, or Vesicare 10mg.
				MC/DEL	8	TOLSURA	5. Approved if immuno suppressed/ HIV or if the member has failed a 7 day trial of a preferred antifungal therapy.	
				MC/DEL	8	VFEND TABS		**DDI:** Fluconazole will require prior authorization if being used in combination with Plavix or Warfarin.
				MC	8	VIVJOA		**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.
							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.	Rezzayo: In patients 18 years of age or older who have limited or no alternative options for the treatment of candidemia and invasive candidiasis.

								7. Quantity limits allowing 30 day supply without PA. PA will be required if using > 30 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 1. Quantity limit of one per day 2. Only preferred if Norvir script is in member's profile within the past 30 days of filling Prezista 3.Isentress Chewable will only be approved if between the age of 2-12 years old 4. Clinical PA required. 5. Only preferred for post-exposure prophylaxis.	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. **DDI:** Reyataz requires prior authorization if it is currently being used in combination with either Prevacid, pantoprazole, Prilosec, or any currently non preferred PPI . **DDI:** Norvir requires prior authorization if it is currently being used in combination with either Enablex 15mg or Vesicare 10mg. **DDI:** Preferred Crixivan caps requires prior authorization if it is currently being used in combination with either Enablex 15mg or Vesicare 10mg. 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. 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. 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. DDI: Tivicay will require prior authorization is used with nevirapine, oxcarbazepine, phenytion, phenobarbital, carbamazepine, and St. John's wort. 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. 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. 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
	MC/DEL		**ATAZANAVIR**	MC	8	ATRIPLA[1]			
	MC		BIKTARVY	MC/DEL	8	CIMDUO			
	MC		CABENUVA	MC/DEL	8	COMBIVIR TABS			
	MC		COMPLERA[1]	MC/DEL	8	EDURANT			
	MC/DEL		DELSTRIGO	MC/DEL	8	EPZICOM[1]			
	MC		DESCOVY[1]	MC/DEL	8	FUZEON			
	MC		DIDANOSINE	MC/DEL	8	INTELENCE			
	MC/DEL		DOVATO	MC/DEL	8	ISENTRESS[3]			
	MC		EFAVIRENZ TAB	MC/DEL	8	ISENTRESS HD			
	MC/DEL		**EFAVIRENZ CAP**	MC	8	JULUCA			
	MC		EFAVIRENZ-EMTRICITABINE-TENOFOVIR DF TAB	MC	8	KALETRA			
	MC		EMTRICITABINE-TENOFOVIR	MC/DEL	8	**LAMIVUDINE SOLN**			
	MC		EMTRIVA[1]	MC/DEL	8	LEXIVA			
	MC		EPIVIR SOL	MC/DEL	8	NEVIRAPINE			
	MC/DEL		EVOTAZ[1]	MC	8	NORVIR			
	MC		GENVOYA[1,4]	MC/DEL	8	PIFELTRO			
	MC/DEL		ISENTRESS 400MG[5]	MC	8	RETROVIR			
	MC/DEL		ISENTRESS CHEW[3]	MC	8	REYATAZ			
	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]			
	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			
	MC		RUKOBIA[4]	MC	8	VITEKTA			
	MC		SUNLENCA[4]	MC	8	ZERIT			
	MC		SUSTIVA[1]	MC	8	VIDEX EC			
	MC		TIVICAY	MC	8	VIREAD TABS[1]			
	MC		TIVICAY PD	MC/DEL	8	ZIAGEN TABS			
	MC		TRIUMEQ[1]	MC/DEL	8	ZIAGEN SOL			
	MC		TROGARZO[4]	MC/DEL	9	VIRAMUNE XR			

	MC		TYBOST					antiretroviral regimen due to resistance, intolerance, or safety considerations.
	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 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		FOSCARNET SODIUM	MC/DEL		FOSCAVIR		
	MC/DEL		GANCICLOVIR	MC/DEL		LIVTENCITY[1]	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.
	MC/DEL		VALGANCICLOVIR	MC/DEL		PREVYMIS		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.	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]	Use PA Form# 20420	
INFLUENZA AGENTS	MC		AMANTADINE CAPS	MC		AMANTADINE TABS		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	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.	
				MC/DEL		RIMANTADINE HCL TABS		
				MC/DEL		TAMIFLU[1]		
				MC/DEL		TAMIFLU SUS		
				MC/DEL		XOFLUZA	Use PA Form# 20420 for all others	
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.	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		MAVYRET[2]	MC/DEL		DAKLINZA		
	MC/DEL		PEGASYS KIT[1]	MC		EPCLUSA[2]	2. Approvals will require clinical PA. Please see the Hepatitis PA form for criteria	**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/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]	Use PA Form #10700	
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.
	MC		TENOFOVIR	MC		HEPSERA TABS		
				MC		TYZEKA		
				MC		VEMLIDY		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.
RSV PROPHYLAXIS								
RSV PROPHYLAXIS				MC		SYNAGIS[1]	Use PA Form# 30120 1. MaineCare will approve Synagis PA's for start date of 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."	Please see the criteria listed on the Synagis PA form.
MS TREATMENTS								
MULTIPLE SCLEROSIS - INTERFERONS	MC		AVONEX KIT[1]	MC		PLEGRIDY[1]	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.
	MC/DEL		**BETASERON SOLR[1]**	MC/DEL		EXTAVIA		
	MC		REBIF SOLN[1]					
MULTIPLE SCLEROSIS - NON-INTERFERONS	MC		COPAXONE	MC	8	AMPYRA	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.
	MC/DEL		**DALFAMPRIDINE ER**	MC	8	AUBAGIO		
	MC/DEL		**DIMETHYL FUMARATE CAP**	MC	8	BAFIERTAM		
	MC/DEL		**FINGOLIMOD CAP[2]**	MC	8	BRIUMVI		
	MC		KESIMPTA[2,5]	MC/DEL	8	GILENYA		
	MC		TERIFLUNOMIDE TAB[2]	MC/DEL	8	**GLATOPA**		
	MC		TYSABRI[1,2]	MC/DEL	8	**MAVENCLAD[3]**		
				MC/DEL	8	**MAYZENT**		
				MC	8	OCREVUS[2]		
				MC	8	OCREVUS ZUNOVO[2]		
				MC/DEL	8	**PONVORY[2]**		
				MC	8	TASCENSO ODT[2,4]		
				MC	8	TECFIDERA		
				MC	8	VUMERITY		
				MC	8	ZEPOSIA		

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 MC MC/DEL		FIRDAPSE MYOBLOC[1] RUZURGI[3] SKYSONA[4,6] XEOMIN[2]	1. Approval will be limited to Cervical dystonia. 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	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. 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			**GENE** MC ZOLGENSMA[1] **NON-GENE** MC EVRYSDI[1,2] MC 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.	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

							Use PA Form# 20420	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. 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	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
				MC		VYVGART[1]		

				MC		VYVGART HYTRULO[1]	gravis (gMG) in adult patients who are anti-acetylcholine receptor (AChR) antibody positive Use PA Form# 20420	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		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. **DDI:** All preferred steroids will require clinical PA for patients over 60 that are currently on fluoroquinolone therapy.
	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		
	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) 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		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		
				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 MC/DEL		**EVAMIST** **MINIVELLE PATCH**	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	5 8 8 8 **8** 8	**ESTRADIOL PTWK** **DIVIGEL**[1] **CLIMARA PTWK** **ELESTRIN**[1] **MENOSTAR PATCH** **VIVELLE-DOT PTTW**	1. Step order drugs must be used in specified step order. Use PA Form# 20420	Approved for failures on multiple oral estrogen agents after 90 day trials or if unable to swallow any oral medication.
ESTROGENS - TABS	MC/DEL MC/DEL		**ESTRADIOL** **PREMARIN TABS**	MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC		ENJUVIA **ESTRADIOL-NORETHINDRONE** **ESTRACE TABS** ESTRATAB TABS **MENEST TABS** **NORETHINDRON-ETHINYL** ORTHO-EST TABS	Must fail preferred 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.
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		CAMILA TABS	MC/DEL		JOLIVETTE		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.
	MC/DEL		ERRIN	MC/DEL		NORA-BE TABS		
	MC		INCASSIA TAB	MC		ORTHO MICRONOR TABS		
	MC		HEATHER TAB					
	MC/DEL		NORETHINDRONE ACETATE 0.35MG TABS					
	MC/DEL		SLYND				Use PA Form# 20420	
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		ELLA				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		ENCONTRA ONE STEP					
	MC		ECONTRA EZ					
	MC		NEW DAY					
	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. 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.
	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		
	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		
	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.
	MC/DEL		**CAMRESE**					If member experienced adverse reactions, consider using Oral Contraceptives from other groups.
	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					If member experienced adverse reactions, consider using Oral Contraceptives from other groups.
	MC		TRI-LO-MILI TAB					
	MC		TRI-LO-ESTARYLLA TAB					
	MC		TRI-ESTARYLLA					
	MC/DEL		TRI-SPRINTEC TAB					
	MC/DEL		**TRI-LO-SPRINTEC**					
	MC		TRINESSA					**DDI:** Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer.
							Use PA Form# 20420	
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]				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.
			DIABETIC- LANCETS					
			DIABETIC- LANCING DEVICES					
			DIABETIC- LANCING DEVICES					
			DIABETIC- PEN NEEDLES					
			DIABETIC- SYRINGES					
			DIABETIC- TEST STRIPS					
			DIABETIC- METERS					
DIABETES THERAPIES								
DIABETIC - INSULIN	MC/DEL		**FIASP**	MC/DEL		APIDRA	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		HUMALOG KWIKPEN INJ 100/ML	MC/DEL		**ADMELOG**	1. Not to be as a monotherapy. Obtain lab	

	MC		HUMALOG JUNIOR KWIKPEN 100/ML	MC/DEL		**AFREZZA**[1]	monotherapy. Obtain lab values of pulmonary function and recent smoking history	preferred drug(s) exists.
	MC		HUMALOG MIX 75/25	MC		BASAGLAR		
	MC		HUMALOG 50/50 VIAL	MC		HUMALOG KWIKPEN U-200		
	MC		HUMULIN INJ 70/30 KWIKPEN	MC		HUMULIN INJ 50/50		
	MC		HUMULIN INJ 70/30	MC		HUMULIN N INJ U-100	2. For the treatment of patients ≥3 years of age	
	MC		HUMULIN R INJ U-500	MC		HUMULIN R U-100		
	MC		INSULIN ASPART PROT MIX 70-30	MC		INSULIN DEGLUDEC		
	MC		INSULIN ASPART	MC		LYUMJEV		
	MC		INSULIN LISPRO	MC/DEL		**NOVOLIN**		
	MC/DEL		LANTUS SOLN	MC/DEL		**NOVOLOG**		
	MC/DEL		LEVEMIR	MC/DEL		**NOVOLOG MIX**		
				MC/DEL		NOVOLOG MIX 70/30 FLEXPEN		
				MC		RELION		
DIABETIC - PENFILLS	MC		HUMALOG MIX KWIK 50/50	MC		APIDRA OPTICLIK 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 MIX INJ 75/25 KWP	MC/DEL		**NOVOLIN 70/30 PEN**		

	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. 2. 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 (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		
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. 2. 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 (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. **Zituvimet/ Zituvimet XR:** Approvals will require trial of preferred sitagliptin/metformin products or other preferred diabetic agents.
	MC/DEL		**JANUMET XR[1,2]**	MC/DEL		**KAZANO**		
	MC/DEL		**JENTADUETO[1]**	MC		KOMBIGLYZE XR		
				MC/DEL		**OSENI**		
				MC		ZITUVIMET		
				MC		ZITUVIMET XR		
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	Use PA Form #20420 for all others	
				MC		SYMLIN		
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** **MC/DEL** **MC/DEL**		**SYNJARDY** **SYNJARDY XR** **XIGDOU XR**	**MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL**		**GLYXAMBI** **INVOKAMET** **INVOKAMET XR** **SEGLUROMET** **STEGLUJAN** **TRIJARDY XR**	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. Glyxambi /Xigduo XR- Verify prior trials and failures or intolerance of preferred treatments from other diabetic categories Synjardy® XR is not recommended for patients with type 1 DM or for the treatment of diabetic ketoacidosis.
DIABETIC MONITOR	**MC** **MC** **MC** **MC**		ONE TOUCH ULTRA 2 KIT ONE TOUCH ULTRA MINI KIT TRUE METRIX TRUETRACK	**MC** **MC** **MC** **MC** **MC** **MC** **MC** **MC** **MC** **MC**		ACCUCHECK ASCENSIA ASSURE CONTOUR BREEZE Z EXACTECH FREESTYLE INSULINX FREESTYLE LITE SYSTEM KIT ONE TOUCH ULTRA SMART KIT PRECISION XTRA METER PRODIGY	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.
DIABETIC TEST STRIPS	**MC** **MC** **MC**		ONE TOUCH ULTRA[1] TRUE METRIX TRUETRACK	**MC** **MC** **MC** **MC** **MC** **MC** **MC** **MC** **MC** **MC**		ACCUCHECK ASCENSIA ASSURE CONTOUR BREEZE Z EXACTECH FREESTYLE FREESTYLE LITE FREESTYLE INSULINX ONE TOUCH DELICA PRECISION XTRA PRODIGY	1. Only 50 ct & 100 ct package size. 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.
INCRETIN MIMETIC	**MC/DEL** **MC** **MC/DEL**		**RYBELSUS** TRULICITY VICTOZA	**MC/DEL** **MC/DEL** **MC/DEL** **MC** **MC/DEL** **MC/DEL**	5 8 8 8 8 8	**OZEMPIC** **ADLYXIN** BYDUREON BCISE MOUNJARO **SOLIQUA** **XULTOPHY**	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. 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.
DIABETIC - ORAL SULFONYLUREAS	**MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL** **MC/DEL**		**CHLORPROPAMIDE TABS** GLIMEPIRIDE **GLIPIZIDE TABS** **GLIPIZIDE ER TABS** **GLYBURIDE MICRONIZED TABS** **GLYBURIDE TABS**[1] **TOLAZAMIDE TABS** **TOLBUTAMIDE TABS**	**MC/DEL** **MC/DEL** **MC** **MC/DEL** **MC/DEL** **MC/DEL**		**AMARYL TABS** **DIABETA TABS** **GLUCOTROL TABS** **GLUCOTROL XL TBCR** **GLYNASE TABS** **MICRONASE TABS**	Use PA Form# 20420 1. Pa required for members ≥65. Glyburide has a greater risk of severe prolonged hypoglycemia in older adults.	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. **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. **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.

DIABETIC -ORAL BIGUANIDES	MC/DEL MC/DEL		**METFORMIN HCL TABS** METFORMIN ER	MC MC MC MC/DEL		GLUCOPHAGE TABS GLUCOPHAGE XR TB24 FORTAMET METFORMIN ER OSMOTIC	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.
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.	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.

							5. For the treatment of patients ≥ 6 years of age.	
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/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.	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.

							Use PA Form #20420	
CALCIMIMETIC AGENTS								
CALCIMIMETIC AGENTS				MC		PARSABIV	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.
				MC		SENSIPAR		
GROWTH HORMONE								
GROWTH HORMONE	MC/DEL		GENOTROPIN[1]	MC	8	HUMATROPE SOLR	Use PA Form# 10710 1.Clinical PA is required to establish diagnosis and medical necessity. 2. Preferred after single step therapy of short acting growth hormone.	See Growth Hormone PA form for criteria. Step-order will still apply unless clinical contraindication supplied. 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		NORDITROPIN SOLN[1]	MC	8	INCRELEX		
	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**		preferred drug(s) exists.
	MC/DEL			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 acting antispasmodic. 3. For the treatment of patients ≥ 2 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. 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) **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		**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**		
	MC/DEL		**OXYTROL**	MC/DEL	8	TOVIAZ		
	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. 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. Elfabrio and Galfold: For the treatment of adults with confirmed Fabry disease.
				MC		FABRAZYME[2]		
				MC/DEL		GALAFOLD[1]		
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 either

CARDIAC- ERAs				MC		TRYVIO	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. **Tryvio**: In combination with other antihypertensive drugs, is indicated for the treatment of resistant hypertension, to lower blood pressure (BP) in adult patients who are not adequately controlled on other drugs. Resistant HTN is defined as a patient who takes at least 3 different class antihypertensive medications with complementary mechanisms including thiazide, ACE inhibitor, ARB, long-acting calcium channel blocker, with a trial of spironolactone, unless contra-indicated
CARDIAC- SOLUBLE GUANYLATE CYCLASE STIMULATORS				MC/DEL		**VERQUVO**	Use PA Form# 20420	
CARDIAC RISK REDUCTION- SGLT2/GLP-1				MC MC/DEL		INPEFA[1] WEGOVY	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.	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
ANTIANGINALS--Isosorbide Di-nitrate/ Mono-Nitrates	MC/DEL MC/DEL		**ISOSORBIDE MONONITRATE TABS** **ISOSORBIDE MONONITRATE ER**	MC MC MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC		DILATRATE SR CPCR ISORDIL TABS ISORDIL TITRADOSE TABS ISOSORBIDE DINITRATE SUBL **ISOSORBIDE DINITRATE TABS** ISOSORBIDE DINITRATE CR TBCR **ISOSORBIDE DINITRATE ER TBCR** ISOSORBIDE DINITRATE TD TBCR **IMDUR TB24** ISMO TABS MONOKET 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.
NITRO - OINTMENT/CAP/CR	MC/DEL MC/DEL MC MC		**NITROBID OINT** **NITROGLYCERIN CPCR** NITROL OINT NITRO-TIME CPCR				Use PA Form# 20420	
NITRO - PATCHES	MC/DEL MC/DEL	1 1	**NITROGLYCERIN PT24**[1] **NITRO-DUR PT 24 0.8MG**[1]	MC MC/DEL		NITRODISC PT24 **NITRO-DUR 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.
NITRO - SUBLINGUAL/ SPRAY	MC/DEL		**NITROSTAT SUBL**	MC/DEL MC MC		**NITROQUICK SUBL** **NITROLINGUAL SOLN** NITROLINGUAL 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 - NON SELECTIVE	MC/DEL MC		**CARVEDILOL** LEVATOL TABS	MC MC/DEL		ASPRUZYO **BETAPACE TABS**	1. Recommend using BID since its effects do not last 24 hours	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		NADOLOL TABS	MC		BETAPACE AF TABS	24 hours.	preferred drug(s) exists.
	MC/DEL		PINDOLOL TABS	MC		COREG CR[3]	2. Please use other strengths in combination to obtain this dose.	
	MC/DEL		PROPRANOLOL HCL SOLN[1]	MC		COREG TABS		DDI: Concomitant use of Ranolazine products with strong CYP3A inhibitors, including ketoconazole, itraconazole, clarithromycin, nefazodone, nelfinavir, ritonavir, indinavir, and saquinavir, is contraindicated.
	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	3. Dosing limits still apply. Please see dose consolidation list	
	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	Use PA Form# 20420	
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.	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	Use PA Form# 20420	
	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	

				MC		SULAR CR[1]	10MG and 20MG strengths are grandfathered. 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. Use PA Form# 20420	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		
ANTIARRHYTHMICS	MC/DEL		AMIODARONE HCL	MC/DEL		CORDARONE	1. Prescription must be written by Cardiologist. 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:** 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. **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		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		
	MC		QUINAGLUTE	MC/DEL		TAMBOCOR		
	MC/DEL		QUINIDINE GLUCONATE	MC/DEL		TIKOSYN[1]		
	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		
				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**		Per best practices patient should have trialed prior therapy of ACE inhibitor or currently on a diabetic therapy
							Use PA Form# 20420	
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 MC/DEL		**CHOLESTYRAMINE** **COLESTIPOL HCl**	MC/DEL MC/DEL MC MC/DEL		**COLESTID** **PREVALITE** **QUESTRAN** WELCHOL 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.
CHOLESTEROL - FIBRIC ACID DERIVATIVES	MC/DEL MC/DEL MC/DEL		FENOFIBRATE TAB **GEMFIBROZIL TABS** **NIACIN ER**	MC MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC		ANTARA **LOPID** FENOFIBRATE 120mg TAB FENOFIBRATE CAP **FIBRICOR** LIPOFEN **LOFIBRA** **NIASPAN ER** TRICOR TRIGLIDE	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:** Fenofibrate is preferred but will require a prior authorization requests if used concurrent with Warfarin. **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 combination product, any HMG-COA Reductase Inhibitors (statins), or Warfarin.
CHOLESTEROL - HMG COA + ABSORB INHIBITORS MORE POTENT DRUGS/COMBINATIONS	MC/DEL MC/DEL MC MC/DEL		**ATORVASTATIN** **EZETIM/SIMVA TAB** ROSUVASTATIN **SIMVASTATIN**[1]	MC MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL		ATORVALIQ **CRESTOR** **EZALLOR SPRINKLES**[3] **LIPITOR** LIPTRUZET **ZOCOR** **SIMVASTATIN 80MG**[1,2] **VYTORIN**	1. Dosing limits apply, please see dosage consolidation list. 2. Current users grandfathered. 3. For the treatment of patients ≥ 18 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. **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. **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. **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 MC/DEL MC/DEL		**EZETIMIBE TABS** LOVASTATIN TABS[2] PRAVASTATIN[2]	MC MC/DEL MC/DEL MC MC/DEL MC MC MC/DEL MC/DEL MC	8 8 8 8 8 8 8 8 8 8	ALTOPREV TB24 **FLUVASTATIN TAB ER** LESCOL XL TB24 LIVALO MEVACOR TABS NEXLETOL NEXLIZET **PRAVACHOL TABS** PRAVIGARD ZETIA TABS	2. 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. 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. **DDI:** Lescol will now be non-preferred and require prior authorization if it is currently being used in combination with diclofenac. **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. **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. **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 MC		**PRALUENT (LABLER 72733) PEN**[1,2,3,5] REPATHA[1,2,3]	MC MC MC MC		EVKEEZA[1,4] JUXTAPID KYNAMRO[1] LEQVIO	1. Clinical PA required for appropriate diagnosis 2. Quantity limits apply 3. Documented adherence to	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 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. Use PA Form# 20420	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 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.	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.

							Use PA Form# 20420	
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		DOXYLAMINE SUCC-PYRIDOXINE HCL	MC		ANTIVERT 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		MECLIZINE HCL TABS	MC		BARHEMSYS		
	MC		PROMETHAZINE SUPP	MC		BONJESTA		
	MC/DEL		PROMETHAZINE	MC		DICLEGIS		
	MC		TRANSDERM-SCOP PT72	MC		PHENERGAN SOLN		
				MC		PROMETHAZINE 50MG SUPP		
				MC		PROMETHEGAN SUPP		DDI: Concomitant use of MAOIs and Bonjesta® is contraindicated.
				MC		TORECAN TABS		
ANTIEMETIC - 5-HT3 RECEPTOR ANTAGONISTS/ SUBSTANCE P NEUROKININ	MC/DEL		**DRONABINOL CAPS**	MC	8	AKYNZEO[1]	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.
	MC/DEL		GRANISETRON TAB	MC	8	APREPITANT		
	MC/DEL		**ONDANSETRON TAB**	MC	8	ALOXI		
	MC/DEL		**ONDANSETRON ODT TBDP**	MC	8	ANZEMET TABS		
	MC/DEL		**ONDANSETRON SOL**	MC	8	APONVIE[4]		
				MC	8	CESAMET[1]		
				MC	8	CINVANTI[4]		
				MC	8	EMEND[2]		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** **MC/DEL** **MC/DEL**		CLEMASTINE CHLORPHENIRAMINE DIPHENHYDRAMINE				Use PA Form# 20530	
ALLERGY / ASTHMA THERAPIES								
ANAPHYLACTIC DEVICES	**MC/DEL** **MC/DEL** **MC/DEL**		**EPINEPHRINE** **EPIPEN** **EPIPEN JR**	**MC** **MC** **MC**		AUVI- Q NEFFY TWINJECT	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.
ALLERGEN IMMUNOTHERAPY				**MC** **MC** **MC** **MC** **MC**		ODACTRA ORALAIR[1] PALFORZIA RAGWITEK GRASTEK	Use PA Form# 20420 1. See criteria section	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 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. 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		CROMOLYN SODIUM NEBU	MC		CINQAIR[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.
	MC/DEL		DUPIXENT[2,4]	MC		**NUCALA[2]**		
	MC/DEL		**FASENRA[2]**	MC		TEZSPIRE[5]		
	MC/DEL		**FASENRA[2] AUTO INJCT**					
	MC/DEL		XOLAIR[1]					
ANTIASTHMATIC - NASAL STEROIDS	MC/DEL		BUDESONIDE SPRAY	MC	5	BECONASE AQ INHA[1,3]	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 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 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 preferred nasal glucocorticoids, one of which must be fluticasone.
	MC/DEL		**FLUTICASONE SPR[3]**	MC/DEL	8	DYMISTA		
	MC		OLOPATADINE SPRAY	MC/DEL	8	FLONASE SUSP[2,3]		
	MC/DEL		OMNARIS SPR[3]	MC/DEL	8	FLUNISOLIDE SOLN[1,3]		
	MC/DEL		TRIAMCINOLONE NS	MC/DEL	8	NASONEX SUSP		
	MC		QNASL	MC	8	RHINOCORT AERO[2,3]		
				MC/DEL	8	RHINOCORT AQUA SUSP[2,3]		
				MC	8	RYALTRIS[4]		
				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.	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**					

							Use PA Form# 20420	
ANTIASTHMATIC - ADRENERGIC COMBINATIONS	MC MC MC MC MC/DEL MC/DEL MC/DEL		**ADVAIR DISKUS**[1] **ADVAIR HFA**[1] AIRDUO RESPICLICK[2] **BREO ELLIPTA**[1] DULERA FLUTICASONE-SALMETEROL SYMBICORT	MC MC/DEL MC/DEL MC		AIRDUO DIGIHALER[2] **AIRSUPRA** **BREZTRI AEROSPHERE** **TRELEGY ELLIPTA**[1]	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
ANTIASTHMATIC - ADRENERGIC ANTICHOLINERGIC	MC/DEL MC MC/DEL MC/DEL		**ALBUTEROL/IPRATROPIUM NEB. SOLN** **ANORO ELLIPTA** **COMBIVENT RESPIMAT** **STIOLTO**	MC/DEL MC/DEL MC/DEL		**BEVESPI AEROSPHERE**[2,3] **DUAKLIR PRESSAIR** DUONEB SOLN[1]	1. Please use preferred individual ingredients Albuterol and Ipratropium. 2. Dosing limits apply, please see dosing consolidation list. 3. The safety and efficacy of use in children under the age of 18 years have not been established. 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. 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. 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/DEL MC		**ARNUITY ELLIPTA** **ASMANEX TWISTHALER** [3,4] ASMANEX HFA[5] **BUDESONIDE NEB 0.25MG & 0.5MG**[1] **PULMICORT FLEXHALER** [3] QVAR AERS[3]	MC MC/DEL MC MC/DEL MC/DEL	8 8 8 **8** 8	AEROSPAN ALVESCO[3] ARMONAIR DIGIHALER **BUDESONIDE NEB 1MG** **PULMICORT SUSP**	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	
	MC/DEL		**MONTELUKAST SODIUM TAB**	**MC/DEL**	8	**SINGULAIR**[2]	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 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.
				MC		ORKAMBI		
				MC		KALYDECO		
				MC		SYMDEKO		
				MC/DEL		**TRIKAFTA**		

										Use PA Form# 20420	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 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	Ofev- Avoid concomitant use with P-gp and CYPA4 inducers (e.g. carbamazepine, phenytoin, and St. John's wort
	MC		PIRFENIDONE					Esbriet- The concomitant use with strong CYP1A2 inhibitors (e.g. fluvoxamine, enoxacin) is not recommended
							Use PA Form# 20420	
COUGH/COLD								
COUGH/COLD	MC/DEL		**DEXTROMETHORPHAN CAPS**[1]				1. All of cough cold preparations are not covered except these preferred products.	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]				Use PA Form# 20420	
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	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		BISMATROL	MC/DEL		BENTYL TABS	1.Dosing limits apply please refer to Dose Consolidation List	
	MC/DEL		BISMUTH SUBSALICYLATE	MC/DEL		BENTYL SYRP		
	MC/DEL		CALCIUM CARBONATE (ANTACID) CHEW	MC		CUVPOSA		
	MC/DEL		DICYCLOMINE HCL	MC		DARTISLA ODT[2]	2. It is not indicated as monotherapy for treatment of peptic ulcer because effectiveness in peptic ulcer healing has not been established.	
	MC/DEL		GLYCOPYRROLATE TABS	MC		ED-SPAZ		
	MC/DEL		HYOSCYAMINE CAPS & TABS	MC		MYTESI[1]		Preferred products that used to require diag codes still require diag codes unless indicated otherwise.
	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		**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		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 8	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		AMITIZA CALULOSE SYRP CONSTULOSE SYRP ENULOSE SYRP GASTROCROM CONC GENERLAC SYRP LACTULOSE SYRP	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.

	MC/DEL		METOCLOPRAMIDE HCL				Use PA Form# 20420	
GI - INFLAMMATORY BOWEL AGENTS	MC		APRISO	MC/DEL		ASACOL 800MG HD	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		BALSALAZIDE	MC/DEL		AZULFIDINE EN-TABS TBEC		
	MC		MESALAMINE ENMA KIT	MC		AZULFIDINE TABS	1. Current users grandfathered.	
	MC		PENTASA	MC		COLAZAL CAPS		
	MC/DEL		**SULFAZINE EC TBEC**	MC/DEL		DELZICOL	2. Diagnosis required	
	MC/DEL		**SULFASALAZINE TABS**	MC		DIPENTUM CAPS		
				MC		GIAZO		Giazo is only indicated for males, as the safety.efficacy for use in females has not been established.Prior trials of preferred products.
				MC/DEL		LIALDA TABS[1]		
				MC/DEL		**MESALAMINE TAB**		
				MC/DEL		ROWASA ENEM		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		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.	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		BISACODYL	MC		BENEFIBER		
	MC		BISCOLAX SUPP	MC/DEL		CARAFATE	2. For the treatment of carcinoid syndrome diarrhea in combination with somatostatin analog (SSA) therapy in adults inadequately controlled by SSA therapy	
	MC		CINOBAC CAPS	MC/DEL		CLEARLAX POW		
	MC/DEL		CITRATE OF MAGNESIA SOLN	MC/DEL		COLACE CAPS		
	MC/DEL		CITRUCEL	MC		DIOCTO-C SYRP		**Linzess** is preferred for adults as treatment of IBS-Constipation AND treatment of chronic idiopathic constipation in adults.
	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	3. For the treatment of Opioid Induced Constipation(OIC)	
	MC/DEL		DOCUSATE SODIUM	MC/DEL		DULCOLAX SUPP		
	MC/DEL		FIBER LAXATIVE TABS	MC		ENEMEEZ		Trulance should be avoided in pediatric patients less than 18 years of age.
	MC		FLEET	MC		FIBER CON TABS	4. Established users will be grandfathered	
	MC/DEL		GENFIBER POWD	MC/DEL		FIBER-LAX TABS		
	MC/DEL		GLYCERIN	MC/DEL		GAVILYTE-H		**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		HIPREX TABS	MC		GOLYTELY SOLR		
	MC/DEL		KRISTALOSE PACK	MC		IBSRELA		
	MC/DEL		LINZESS	MC		IQIRVO		
	MC		MAALOX	MC/DEL		LINZESS 72mcg[4]		**Livdelzi:** Clinical PA is required 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. Patients who do not have a diagnosis of decompensated cirrhosis.
	MC/DEL		MILK OF MAGNESIA SUSP	MC		LIVDELZI		
	MC		MINERAL OIL OIL	MC		MALTSUPEX		
	MC		MIRALAX BULK POWD (BRAND)	MC		MIRALAX PACKETS		
	MC/DEL		MOVANTIK	MC/DEL		MOTEGRITY		
	MC/DEL		MOVIPREP POWD PACK	MC		OCALIVA[1]		
	MC		NULYTELY SOLR	MC		PEG-ELECTROLYTES SOLR		
	MC		PEG 3350- ELECTROLYTE SOL	MC		PEG 3350 PACKETS		

	MC		PEG 3350 POWDER	MC		PREPOPIK PAK		
	MC/DEL		SENNA	MC		RELISTOR TABS		
	MC/DEL		SENOKOT GRAN	MC/DEL		SENEXON TABS		
	MC/DEL		SENOKOT SYRP	MC/DEL		SENOKOT TABS		
	MC/DEL		SENOKOT CHILDRENS SYRP	MC		SENOKOT S TABS		
	MC		SENOKOT XTRA TABS	MC/DEL		SORBITOL		
	MC/DEL		STOOL SOFTENER CAPS	MC		STOOL SOFTENER PLUS CAPS		
	MC/DEL		SUCRALFATE TABS	MC		SUFLAVE		
	MC/DEL		SUPREP SOL	MC		SUTAB	Use PA Form# 20420	
	MC		TRULANCE[2]	MC/DEL		SYMPROIC[3]		
	MC		UNI-EASE CAPS	MC/DEL		UNI-CENNA TABS		
	MC		URSO FORTE	MC		UNI-EASE PLUS CAPS		
	MC/DEL		URSODIOL	MC		V-R NATURAL SENNA LAXATIV TABS		
				MC		URSO 250		
				MC		XERMELO[4]		
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.	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	Use PA Form# 20420	
	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.	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.
	MC/DEL		CLEOCIN SUPP	MC/DEL		VANDAZOLE		
	MC		CLINDESSE CREA	MC		XACIATO		
	MC/DEL		METRONIDAZOLE VAGINAL GEL[1]					
	MC/DEL		NUVESSA				Use PA Form# 20420	
VAGINAL - ANTI FUNGALS	MC/DEL		CLOTRIMAZOLE CREA	MC		AVC CREA		
	MC/DEL		CLOTRIMAZOLE-3 CREA	MC		CLOTRIMAZOLE 3 DAY CREA	1. Quantity limit: 1/script/2 weeks	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		GYNE-LOTRIMIN CREA	MC		GYNAZOLE-1 CREA		
	MC		MICONAZOLE CREA	MC		GYNE-LOTRIMIN 3 TABS	Use PA Form# 20420	
	MC		MICONAZOLE 3 KIT CREA OTC	MC/DEL		MICONAZOLE 3 COMBO PACK KIT[1]		
	MC/DEL		MICONAZOLE 7 CREA	MC/DEL		MICONAZOLE 3 SUPP		**DDI:** Miconazole will require prior authorization if being used in combination with Warfarin.

	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		**ESTRING RING**	MC/DEL		ESTRACE CREA[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		**PREMARIN CREA**	MC/DEL		VAGIFEM TABS[1]		
VAGINAL - OTHER	MC/DEL		ACID JELLY GEL	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.
	MC		ACI-JEL GEL					
	MC		CERVICAL AMINO ACID CREA					
BENIGN PROSTATIC HYPERPLASIA (BPH)								
BPH	MC/DEL		**DOXAZOSIN MESYLATE TABS**	MC/DEL	5	**FLOMAX CP24**	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.
	MC/DEL		FINASTERIDE[1] 5mg	MC/DEL	8	ALFUZOSIN		
	MC/DEL		TERAZOSIN HCL CAPS	MC	8	AVODART[2,4]		
	MC/DEL		**TAMSULOSIN HCL**	MC/DEL	8	**CARDURA TABS[4]**		
				MC	8	ENTADFI[5,6]		
				MC	8	JALYN[3,4]		
				MC/DEL	8	PROSCAR TABS[4]		
				MC/DEL	8	RAPAFLO[4]		
				MC/DEL	8	UROXATRAL[4]		
ANXIOLYTICS								
ANXIOLYTICS - BENZODIAZEPINES	MC/DEL		ALPRAZOLAM TABS	MC/DEL	8	ALPRAZOLAM ER	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		CHLORDIAZEPOXIDE HCL CAPS	MC/DEL	8	ATIVAN		
	MC/DEL		CLORAZEPATE DIPOTASSIUM TABS	MC	8	LOREEV XR		
	MC/DEL		DIAZEPAM	MC/DEL	8	NIRAVAM		
	MC/DEL		LORAZEPAM	MC/DEL	8	SERAX		
	MC/DEL		OXAZEPAM CAPS	MC/DEL	8	TRANXENE		
				MC/DEL	8	XANAX TABS		
				MC/DEL	9	XANAX XR		
ANXIOLYTICS - MISC.	MC/DEL		BUSPIRONE HCL TABS	MC		BUSPAR TABS	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.
	MC		HYDROXYZINE HCL SOLN	MC		DROPERIDOL SOLN		
	MC		HYDROXYZINE HCL SYRP	MC/DEL		DROPERIDOL SOLN		
	MC/DEL		HYDROXYZINE HCL TABS[1]	MC/DEL		DROPERIDOL SOLN		
	MC/DEL		HYDROXYZINE PAMOATE CAPS					

	MC/DEL		MEPROBAMATE TABS					
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.	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.
	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]		**CYMBALTA:** Fibromyalgia diagnosis- prior use and failure of preferred generics (amitriptyline or cyclobenzaprine) and gabapentin prior to approval.
	MC/DEL		ESCITALOPRAM	MC/DEL	8	DRIZALMA SPRINKLES		DDI: Drizalma Sprinkle avoid the concomitant use of duloxetine with potent CYP1A2 inhibitors (e.g. fluvoxamine, cimetidine, ciprofloxacin, enoxacin).
	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		**DDI:** Fluvoxamine will now be non-preferred and require prior authorization if it is currently being used with glimepiride (Amaryl).
	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		**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.
	MC/DEL		VENLAFAXINE ER CAPS[5]	MC	8	LUVOX TABS		
	MC/DEL		VENLAFAXINE TABS[5]	MC	8	MAPROTILINE HCL TABS		**DDI:** Fluoxetine will require prior authorization if being used in combination with Plavix.
				MC/DEL	8	MIRTAZAPINE ODT		**DDI:** Fluvoxamine will require prior authorization if being used in combination with Plavix.
				MC	8	OLEPTRO		
				MC/DEL	8	PAROXETINE CR[1]		**SAVELLA:** Fibromyalgia diagnosis and trial of a preferred generic amitriptyline, cyclobenzaprine, duloxetine and gabapentin prior to approval.
				MC/DEL	8	PAXIL[1]		
				MC/DEL	8	PAXIL CR[1]		
				MC/DEL	8	PRISTIQ		
				MC	8	PROZAC		Zulresso® is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS) called the Zulresso® REMS.
				MC	8	PROZAC CAPS		
				MC	8	PROZAC WEEKLY CPDR		
				MC/DEL	8	REMERON TABS		**Spravato:** Treatment Resistant Depression
				MC/DEL	8	SARAFEM CAPS		• 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.
				MC/DEL	8	SPRAVATO[8]		
				MC/DEL	8	TRAZODONE HCL 300MG TABS		• 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
				MC/DEL	8	TRINTELLIX		
				MC	8	WELLBUTRIN TABS		• 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
				MC	8	WELLBUTRIN SR TBCR		
				MC	8	WELLBUTRIN XL		**Spravato:** MDD with Suicidal Ideation
				MC/DEL	8	REMERON SOLTAB TBDP		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.
				MC/DEL	8	SAVELLA[4]		
				MC/DEL	8	ZOLOFT		
				MC/DEL	8	ZULRESSO[10]		DDI: Reduce the Zurzuvae® dosage when used with a strong CYP3A4 inhibitor.
				MC	8	ZURZUVAE[12]		
				MC/DEL	8	VENLAFAXINE ER TABS[5]		
				MC/DEL	9	VIIBRYD[6]		
				MC/DEL	9	FLUOXETINE 90mg TABS[6]	Use PA Form# 20420	
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.	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	Use PA Form# 20420	
	MC		SURMONTIL CAPS[1]	MC		VIVACTIL TABS	Use PA Form# 10220 for Brand Name requests	
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.	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]				Use PA Form# 20420	
SEDATIVE/HYPNOTICS - BENZODIAZEPINES	MC/DEL		DORAL TABS[1]	MC		HALCION TABS[1]	1. 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. 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]	Use PA Form# 30110	
	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.	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	1	TRAZODONE	MC/DEL	7	**ESZOPICLONE**		
	MC/DEL	1	ZOLPIDEM [2]				2. Quantity limits will be allowed up to 30/30, but intermittent therapy is recommended.	
				MC/DEL	7	**ZOLPIDEM ER**		
	MC/DEL	2	ZALEPLON [2,3]	MC/DEL	8	AMBIEN CR[1]		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.
				MC/DEL	8	BELSOMRA[1]	3. Only zolpidem trial/failure will be required to obtain Zaleplon.	
				MC	8	DAYVIGO[1]		
				MCDEL	8	EDLUAR		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	8	HETLIOZ		
				MC/DEL	8	INTERMEZZO		
				MC/DEL	8	LUNESTA[1]		
				MC/DEL	8	SONATA CAPS[1]	4. Must fail all preferred products before non-preferred	
				MC/DEL	8	ROZEREM	Use PA Form# 30110	
				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.	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).
	MC		ABILIFY MAINTENA	MC	8	ABILIFY TABS[2]		
	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	COBENFY		
	MC/DEL		**OLANZAPINE**[2,3] **ODT**	MC	8	FANAPT		
	MC/DEL		INVEGA HAFYERA	MC/DEL	8	GEODON		Prescriptions for quetiapine are limited to a maximum daily dose of 800mg.
	MC		INVEGA SUSTENNA	MC	8	INVEGA		
	MC/DEL		INVEGA TRINZA INJ	MC	8	IGALMI		Uzedy: Establish tolerability with oral risperidone prior to initiating Uzedy
	MC/DEL		**LURASIDONE TAB**	MC	8	LATUDA	Use PA form# 20440 for Multiple Antipsychotic requests	
	MC/DEL		**PALIPERIDONE ER**	MC	8	LYBALVI		
							Use PA form# 10130 for non-preferred single therapy atypical requests	**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:
	MC/DEL		PERSERIS	MC	8	NUPLAZID		
	MC		RISPERDAL CONSTA	MC	8	REXULTI		• **schizophrenia**
	MC/DEL		RISPERIDONE ODT	MC	8	RISPERDAL TAB		• **bipolar disorder**
	MC/DEL		RISPERIDONE TAB[2,3]	MC	8	RISPERDAL M TAB[1]		• **agitation related to autism**
	MC/DEL		RISPERIDONE SOLN[2]	MC	8	RISPERDAL SOLN		• **adjunct in major depressice disorder**
	MC		RYKINDO	MC/DEL	8	SAPHRIS[1]		
	MC/DEL		QUETIAPINE[2,3]	MC	8	SECUADO	1. Established users of single therapy atypicals were grandfathered	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.

							grandfathered.	
	MC/DEL		QUETIAPINE XR	MC/DEL	8	SEROQUEL TABS		
	MC		VRAYLAR[4]	MC	8	UZEDY	2. Prior Authorization will be required for preferred medications for members under the age of 5.	
	MC/DEL		**ZIPRASIDONE**[2,3]	MC	8	ZYPREXA TABS		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		ZYPREXA RELPREVV		
				MC	8	ZYPREXA ZYDIS TBDP [1]		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).
				MC/DEL	9	SEROQUEL XR	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	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.
								Cobenfy: Patient must be 18 – 65 years old AND meet criteria for the diagnosis of severe Schizophrenia, defined as PANSS total score of 80 or higher, with at least 4 or more two positive symptom item or 5 or more one positive symptoms item AND Recent history of acute exacerbation of psychotic symptoms necessitating hospitalization in the past two months AND Trial of 2 prior preferred Second Generation Antipsychotics showing minimal response in control of symptoms of schizophrenia (PANSS score less than 20% from baseline) AND Trial of SGA that have yielded side effects of weight gain which has not been responsive to lifestyle & medication augmentation AND Patient must have baseline tests including heart rate, liver enzymes, kidney function tests and bilirubin prior to starting treatment
								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		CLOZAPINE ODT	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.
				MC/DEL		CLOZARIL TABS		
				MC/DEL		VERSACLOZ SUSP		
ANTIPSYCHOTICS - TYPICAL	MC/DEL		CHLORPROMAZINE HCL	MC/DEL		COMPAZINE	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		FLUPHENAZINE DECANOATE	MC/DEL		COMPRO SUPP	If prescribing 2 or more antipsychotics, PA will be required for both drugs, except if one is Clozapine.	
	MC/DEL		FLUPHENAZINE HCL	MC/DEL		FLUPHENAZINE HCL CONC		
	MC		HALDOL	MC		HALDOL DECANOATE		If prescribing 2 or more antipsychotics, PA will be required for both drugs, except if one is Clozapine.
	MC/DEL		HALOPERIDOL	MC/DEL		LOXITANE CAPS		
	MC		HALOPERIDOL DECANOATE SOLN	MC		MELLARIL		
	MC		HALOPERIDOL LACTATE SOLN	MC/DEL		NAVANE CAPS		
	MC/DEL		LOXAPINE SUCCINATE CAPS	MC		PROLIXIN		
	MC/DEL		LOXITANE-C CONC	MC		STELAZINE TABS		
	MC		MOBAN TABS					
	MC/DEL		PERPHENAZINE					
	MC/DEL		PROCHLORPERAZINE					
	MC		SERENTIL					
	MC/DEL		THIORIDAZINE HCL					
	MC/DEL		THIOTHIXENE					
	MC/DEL		TRIFLUOPERAZINE HCL TABS					
LITHIUM								
LITHIUM	MC/DEL		LITHIUM CARBONATE	MC/DEL		ESKALITH CAPS	Use PA Form# 20420	
	MC/DEL		LITHIUM CITRATE SYRP	MC/DEL		ESKALITH CR TBCR		
COMBINATION - PSYCHOTHERAPEUTIC								
PSYCHOTHERPEUTIC COMBINATION				MC/DEL		CHLORDIAZEPOXIDE/AMITRIPT		
				MC/DEL		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[2,4,7] 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.	**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.

							8. For the treatment of patients 6 years of age and older.	
LONG ACTING AMPHETAMINES	MC MC/DEL MC		DEXTROAMPHET SULF CPSR[1,3] **DEXTROAMPHETAMINE ER** DYANAVEL XR SUS	MC/DEL MC MC MC MC		ADZENYS ER[2] ADZENYS XR- ODT ADZENYS XR[3] DEXEDRINE CAP SR[2,3] DYANAVEL XR TAB	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. 3. Dosing limits applly, please see dosing consolidation list. Use PA Form# 20420	DDI: : The concomitant use of Adzenys® XR is contraindicated with monoamine oxidase inhibitors (MAOIs) or within 14 days after discontinuing MAOI treatment.
STIMULANT - METHYLPHENIDATE	MC/DEL MC/DEL MC/DEL MC/DEL		DEXMETHYLPHENIDATE IR TABS METHYLPHENIDATE SOL **METHYLPHENIDATE TAB** METHYLIN TABS[1,2]	MC/DEL MC/DEL MC MC MC/DEL MC/DEL		FOCALIN IR TABS METADATE ER METHYLPHENIDATE HCL CHEW METHYLIN CHEWABLES METHYLIN SOL RITALIN	1. Preferred stimulants will be available without PA if diagnosis of ADHD. Use PA Form# 20420 2. Dosing limits apply, please see dosing consolidation list. Maximum daily doses are as follows: 72mg daily for methylphenidate and 36mg daily for dexmethylphenidate.	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.
STIMULANT - METHYLPHENIDATE - LONG ACTING	MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC MC/DEL		CONCERTA TBCR **DEXMETHYLPHENIDATE CAP ER 50/50** FOCALIN XR METHYLPHENIDATE LA CAPS METHYLPHENIDATE ER CAPS 50/50 METHYLPHENIDATE ER CAPS 40/60 METHYLPHENIDATE CD CAPS 30-70 QUILLICHEW ER[5,1] QUILLIVANT XR SUS[1,5] RITALIN LA[4]	MC MC/DEL MC MC MC MC MC/DEL MC/DEL MC/DEL	5 8 8 8 8 8 8 8 8	METADATE CD CPCR ADHANSIA XR[2,6] APTENSIO XR[2] AZSTARYS[6] COTEMPLA XR[2] COTEMPLA XR ODT[2] DAYTRANA[2,3] JORNAY PM[2,6] METHYLPHENIDATE ER CAPS[2,4]	1. Preferred stimulants will be available without PA if diagnosis of ADHD. 2. Non-preferred products must be used in specified step order. 3.FDA approval currently only for ages 6-16. Limit of one patch daily. Max dose of 30MG daily. 4.Dosing limits applly, please see dosing consolidation list. 5. Quillivant XR and Quillichew ER are only indicated for use in patients 6 years of age and older. 6. For the treatment of patients ≥ 6 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.
STIMULANT - STIMULANT LIKE	MC/DEL		**ATOMOXETINE HCL**	MC/DEL	7	PROVIGIL TABS[3]	1. Failure of both an	Provigil requests require diagnosis of Narcolepsy, ADHD, or Obstructive Sleep Apnea. Previous failures of methylphenidate and amphetamine is required for Narcolepsy and ADHD

	MC/DEL		ARMODAFINIL	MC	7	STRATTERA[1, 2]	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 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. 3. Non-preferred products must be used in specified 4. Please use generic Guanfacine. 5. For patients 7 years of age and older with narcolepsy 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	diagnosis, with additional Strattera trial needed with ADHD diagnosis. Please refer to detailed criteria on Provigil PA form
	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	8	ONYDA XR[6]		Wakix is non-preferred and is indicated for the treatment of excessive daytime sleepiness (EDS) in adults with narcolepsy
				MC/DEL	8	SUNOSI		DDI: Sunosi® is contraindicated with MAO inhibitors or within 14 days after discontinuing the MAO inhibitor.
				MC	8	WAKIX		
				MC	8	XYREM SOL		
								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	8	XYWAV[5]		
				MC/DEL	9	NUVIGIL[3]		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 TABS[3]		
				MC	9	DESOXYN CR[3]		DDI: Concomitant use of Qelbree® with an MAO inhibitor or within 2 weeks after discontinuing an MAO inhibitor is contraindicated
								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. 2. Must fail all preferred products before moving to non-preferred.	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. 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 - Prescribed by or in consultation with a neurologist or geriatrician or geriatric psychiatrist. Diagnosis of Alzheimer's disease defined as: •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		DONEPEZIL HYDROCHLORIDE ODT[1]	MC	6	ARICEPT ODT[2]		
	MC/DEL		EXELON DIS[1]	MC/DEL	7	DONEPEZIL HYDROCHLORIDE TABS 23MG		
	MC/DEL		**GALANTAMINE CAPS[1]**	MC	8	ADLARITY[3]		
	MC/DEL		**GALANTAMINE TAB[1]**	MC/DEL	8	EXELON CAP		
	MC/DEL		MEMANTINE[1]	MC/DEL	8	GALANTAMINE HYDROBROMIDE SOL		

	MC/DEL		RIVASTIGMINE TARTRATE CAPS[1]	MC	8	KISUNLA	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 •Confirmed presence of amyloid pathology and prodromal or mild dementia stage of disease, consistent with Stage 3 and Stage 4 Alzheimer's disease -Testing: •Clinical Dementia Rating (CDR) global score of 0.5 or 1.0 OR •Repeatable Battery for Assessment of Neuropsychological Status (RBANS) delayed memory index score ≤ 85 OR •Mini-Mental State Examination (MMSE) score of 20-30 OR •Montreal Cognitive Assessment (MoCA) score ≤ 22 - Member is age 50 or older - 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) - 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
				MC	8	LEQEMBI[1,2]		
				MC/DEL	8	MEMANTINE HCL SOL		
				MC/DEL	8	NAMENDA		
				MC/DEL	8	NAMENDA XR CAPS		
				MC/DEL	8	NAMZARIC		
				MC	8	RAZADYNE[2]		
				MC	9	COGNEX CAPS[2]	Use PA Form# 20420	
SMOKING CESSATION								
NICOTINE PATCHES / TABLETS	MC/DEL		CHANTIX TAB[1]	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.
	MC/DEL		CHANTIX STARTER PACK					
	MC/DEL		NICOTINE DIS PT24[1]					
	MC/DEL		**VARENICLINE TAB**					
NICOTINE REPLACEMENT - OTHER	MC/DEL		NICOTINE POLACRILEX GUM[1]	MC/DEL	8	NICOTROL INHALER[1,2]	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.
	MC/DEL		NICOTINE LOZENGE MINI	MC/DEL	8	NICOTROL NASAL SPRAY[1,2]		
	MC/DEL		NICOTINE LOZENGE	MC/DEL	8	NICORETTE GUM[1,2]		
				MC	8	NICORETTE LOZENGES		
ALCOHOL DETERRENTS								
ALCOHOL DETERRENTS	MC/DEL		**ACAMPROSATE**	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.
	MC		ANTABUSE TABS					
	MC		DISULFIRAM TABS					
	MC/DEL		NALTREXONE HCL TABS					
MISCELLANEOUS ANALGESICS								
ANALGESICS - MISC.	MC/DEL		ACETAMINOPHEN	MC		AXOCET 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		**ASPIRIN**	MC/DEL		ESGIC-PLUS		
	MC/DEL		ASPRIN/ APAP/ CAFF TAB	MC/DEL		FIORICET TABS		
	MC/DEL		BUTAL/ASA/CAFF	MC		FIORINAL CAPS		
	MC/DEL		BUTALBITAL COMPOUND	MC		FIORTAL CAPS		
	MC/DEL		BUTALBITAL/ACET TABS	MC/DEL		FORTABS TABS		

	MC/DEL		BUTALBITAL/APAP CAPS	MC		PHRENILIN TABS		
	MC/DEL		BUTALBITAL/APAP/CAFFEINE TABS	MC		PHRENILIN FORTE CAPS		
	MC/DEL		**CHOLINE MAGNESIUM TRISALI**	MC		TRILISATE LIQD		
	MC/DEL		**DIFLUNISAL TABS**	MC		TRILISATE TABS		
	MC		EXCEDRIN	MC		ZEBUTAL CAPS		
	MC/DEL		**SALSALATE TABS**	MC		ZORPRIN TBCR		
LONG ACTING NARCOTICS								
NARCOTICS - LONG ACTING	MC/DEL		FENTANYL PATCH[4]	MC	8	ARYMO ER	Use PA Form# 20510	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 & 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:
	MC/DEL		BUTRANS[4]	MC	8	AVINZA	Use PA form #10300 for PAs over the opiate limit	
	MC/DEL		MORPHINE SULFATE ER TB12	MC	8	BELBUCA	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.	
				MC	8	EXALGO		
				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		1.Frequent or persistent early refills of controlled drugs;
				MC/DEL	8	MS CONTIN TB12		2.Multiple instances of early refill overrides due to reports of misplacement, stolen, dropped in toilet or sink, distant travel, etc.;
				MC	8	OPANA ER		3.Breaches of narcotic contracts with any provider;
				MC/DEL	8	ORAMORPH SR TB12		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;
				MC/DEL	8	OXYCONTIN TB12[1]	2. Established users are grandfathered.	5.Failing to take or pass random drug testing;
				MC	8	XARTEMIS ER	3. Oxycodone ER allowed only 2 per day for all strengths except 80 mg,	6.Failing to provide old records regarding prior use of narcotics;
				MC	8	ZOHYDRO ER	where 4 are allowed to	7.Receiving controlled substances from other prescribers that the provider submitting the PA is unaware of
							4. Dosing limits apply. Please see dose consolidation list.	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.
				MC	8	OXYCODONECONC		
				MC/DEL	9	OXYCODONE ER[3,5]	5. Non-preferred products must be used in specific order.	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).
							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.	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.
NARCOTICS - SELECTED	MC/DEL		TRAMADOL HCL TABS	MC/DEL	7	RYZOLT	Use PA Form# 20420	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.
	MC/DEL		TRAMADOL/APAP TABS	MC	8	BUPRENEX SOLN	Use PA form #10300 for PAs over the opiate limit	
				MC/DEL	8	BUTORPHANOL		
				MC	8	NALBUPHINE HCL SOLN	1. Only available if component ingredients are unavailable.	
				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		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. 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		OXYCODONE TAB	MC	8	IBUDONE		
	MC/DEL		OXYCODONE/ACETAMINOPHEN[2,3]	MC/DEL	8	**LEVORPHANOL TARTRATE TAB**		
	MC/DEL		ROXICET	MC/DEL	8	LORCET		
	MC		ROXIPRIN TABS	MC	8	LORTAB		
				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	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		BUPRENORPHINE/NALOXONE TABS[2]	MC		ZUBSOLV	1. Buprenorphine will only be approved for use during pregnancy. 2. See Criteria Section	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.
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.
	MC		SUBLOCADE[1]					

								−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.
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 1. Will only be approved for 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.	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		
	MC		NALOXONE SPRAY OTC	**MC/DEL**		REVIA TABS[1]		
	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. Use PA Form# 20420	
				MC/DEL		VIMOVO[1]		
RHEUMATOID ARTHRITIS								
RHEUMATOID ARTHRITIS	MC/DEL		ACTEMRA VIALS			ADALIMUMAB-AACF	Use PA Form# 20900 1. Dosing limits apply. Please see dose consolidation list. 2. Established users will be grandfathered. 3.Clinical PA is required to establish diagnosis and medical necessity. 4. Verification of age for appropriate indication. 5. Treatment failure or intolerance to other forms of preferred methotrexate	See criteria as listed on Rheumatoid Arthritis PA form. 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. **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.** Jylamvo will require using preferred methotrexate if unable please provide clinical rational as why inappropriate. Zymfentra: In adults for maintenance treatment of: Moderately to severely active ulcerative colitis following treatment with an infliximab product administered intravenously.
	MC/DEL		ACTEMRA SYRINGES	MC		AMJEVITA		
	MC/DEL		**ADALIMUMAB-FKJP**[3]	MC/DEL		**ARAVA**		
	MC		AVSOLA	MC/DEL		CIMZIA		
	MC/DEL		**AZATHIOPRINE**	MC/DEL		**CYLTEZO**		
	MC		**ENBREL**[2]	MC/DEL		ENTYVIO		
	MC		ENBREL SURECLICK[2]	MC		HADLIMA		
	MC		**KINERET SOLN**	MC/DEL		**HULIO**		
	MC/DEL		LEFLUNOMIDE	MC/DEL		**HYDROXYCHLOROQUINE**[2]		
	MC/DEL		METHOTREXATE	MC/DEL		**HYRIMOZ**		
	MC		ORENCIA	MC		IDACIO		
	MC/DEL		**SULFASALAZINE TABS**	MC/DEL		**ILARIS**[1,3,4]		
	MC		SIMLANDI[3]	MC/DEL		INFLECTRA		
	MC		SIMPONI PEN	MC		INFLIXIMAB VIAL		
	MC		SIMPONI AUTOINJECTOR	MC		JYLAMVO		

	MC/DEL		**RINVOQ**[3]	MC/DEL		**KEVZARA**		Moderately to severely active Crohn's disease following treatment with an infliximab product administered intravenously.
	MC		**HUMIRA**[1,2]	MC		OLUMIANT		
	MC/DEL		**XELJANZ**[3,6]	MC		OMVOH	6. See criteria section	
	MC/DEL		**XELJANZ XR**	MC		OTREXUP		
	MC/DEL		**XELJANZ XR SOL**	MC		RASUVO[7]		
				MC		REDITREX		
				MC		**REMICADE**		
				MC/DEL		**RENFLEXIS**		
				MC		SIMLANDI		
				MC		TOFIDENCE		
				MC		VELSIPITY		
				MC		YUFLYMA		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		YUSIMRY		
				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		RIDAURA CAPS	MC/DEL		**ARTHROTEC**[1]	1. The individual components of Arthrotec are 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. The individual components of Arthrotec are available without PA.
	MC		MYOCHRYSINE SOLN				Use PA Form# 20420	
LUPUS-SLE								
LUPUS-SLE				MC		BENLYSTA[1]	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		LUPKYNIS		
				MC		SAPHNELO	1. Approvals will require previous trial of corticosteroids, antimalarials, NSAIDS and immunosuppressives.	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		D.H.E. 45 SOLN	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.
				MC		TRUDHESA		
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	1	MIGRANAL NASAL SPRAY	MC		AMERGE TABS[1,2]	1. All drugs in this category have dosing limits. Please refer to dose consolidation table.	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.
	MC/DEL	1	RELPAX[1]	MC		AXERT TABS[1,2]		
	MC/DEL	1	**RIZATRIPTAN ODT**	MC/DEL		FROVA TABS[1,2]		
	MC/DEL	1	**RIZATRIPTAN TABS**	MC		IMITREX NASAL SPRAY[1]		
	MC/DEL	1	SUMATRIPTAN TABS[1]	MC		IMITREX TABS[1,2]		
	MC/DEL	1	**ZOLMITRIPTAN TAB**[1]	MC/DEL		MAXALT[1,2,3]	2. Must fail all preferred	

	MC/DEL	2	NARATRIPTAN HCl TABS[1]	MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		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]	products before non-preferred. 3.Established users will be grandfathered Use PA Form# 10110	
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 All non-preferred meds must be used in specified order 1. Quantity limit. 5/month 2. Dosing limits apply, please see dose consolidation list. 3. Dosing limits apply per strength as well as a maximum daily dose of 600mg. Please see dose consolidation list. 4. Adjunctive therapy 17 and older. 5. Max dose 2400mg 6. Clinical PA required for appropriate diagnosis 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. 8. For seizures associated with Dravet syndrome in patients 2 years of age and older 9. Adjunctive therapy 12 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. 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). *** SEE CHART AT END OF DOCUMENT 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. All non-preferred meds must be used in specified order. Please use Drug-Drug Interaction PA form #10400 for this combination. Epidiolex Criteria for Lennox-Gastaut syndrome (LGS) and Dravet: a trial of two drugs (clobazam, levetiracetam, valproate derivatives, lamotrigine, topiramate, rufinamide, or felbamate). **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. 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		CARBAMAZEPINE	MC	8	BANZEL		
	MC		CARBAMAZEPINE ER CAP	MC	8	CARBAMAZEPINE SUS		
	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		
	MC		DEPAKOTE SPRINKLES CPSP	MC	8	ELEPSIA XR[9]		
	MC/DEL		DIAZEPAM GEL[1]	MC	8	EPRONTIA SOLN[10]		
	MC/DEL		DILANTIN	MC/DEL	8	FELBATOL		
	MC/DEL		DIVALPROEX SODIUM	MC/DEL	8	FELBATOL SUS		
	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		
	MC/DEL		GABAPENTIN[2] CAP	MC/DEL	8	KEPPRA TABS		
	MC/DEL		GABAPENTIN[2] TAB	MC/DEL	8	KEPPRA SOLN		
	MC/DEL		GABAPENTIN SOL	MC/DEL	8	KLONOPIN TABS		
	MC/DEL		GABITRIL TABS	MC	8	LAMICTAL IR		
	MC/DEL		**LACOSAMIDE SOL**	MC	8	LAMICTAL ODT		
	MC/DEL		**LACOSAMIDE TAB**	MC	8	LAMICTAL XR		
	MC		LAMICTAL CHEW	MC/DEL	8	**LEVETIRACETAM INJ**		
	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]		
	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		
	MC/DEL		LYRICA[3]	MC/DEL	8	OXCARBAZEPINE SUS		
	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		
	MC/DEL		PHENYTOIN	MC/DEL	8	PREGABALIN (ORAL) SOL		
	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.	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		TOPIRAMATE SPRINKLE IR CAPS	MC	8	SYMPAZAN		
	MC/DEL		TRILEPTAL SUS	MC/DEL	8	TEGRETOL TAB		
	MC/DEL		VALPROIC ACID TABS	MC/DEL	8	TIAGABINE		Motpoly XR: pediatric patient weight must be > 50kg and requires multiple preferred medication trials including generic lacosamide
	MC/DEL		VALPROIC ACID SOL	MC	8	TOPAMAX		
	MC		VALTOCO[2]	MC/DEL	8	TOPIRAMATE ER CAPS		
	MC/DEL		ZONISAMIDE	MC	8	TOPAMAX SPRINKLE ER CAPS[2]		**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	8	TOPAMAX SPRINKLE IR CAPS[2]		
				MC/DEL	8	TOPIRAMATE SPRINKLE ER CAPS[2]		
				MC	8	TROKENDI[2,6]		
				MC	8	VIGAFYDE		**Vigafyde:** Indicated as monotherapy for the treatment of infantile spasms in pediatric patients 1 month to 2 years of age for whom the potential benefits outweigh the potential risk of vision loss.
				MC/DEL	8	VIMPAT[4]		
				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		
							SEE ANTICONVULSANT INDICATION CHART AT THE END OF THIS DOCUMENT	
						BIPOLAR DISORDER: STEP ORDER	M= Monotherapy	
					M ~ A		A= Adjunctive	
					4 ~ 4	LAMICTAL	9= No Evidence	
					4 ~ 4	LITHIUM	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	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)		
					4 ~ 4	LITHIUM	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	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 MC/DEL MC MC MC MC MC/DEL MC/DEL MC MC MC MC		**APOKYN** AZILECT[2] **CARBIDOPA/LEVODOPA RAPDIS** CREXONT[4] 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. 4. Approvals will require trials of preferred medications including extended-release levodopa/carbidopa tablets 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		**BACLOFEN TABS** **CHLORZOXAZONE TABS**	MC/DEL MC/DEL	7 8	**ORPHENADRINE CITRATE** **CARISOPRODOL 350MG 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

	MC/DEL		**CYCLOBENZAPRINE HCL 5mg & 10mg TABS**	MC/DEL	8	AMRIX		potential drug interaction between another drug and the prererred 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		LIORESAL INTRATHECAL KIT	MC/DEL	8	DANTRIUM CAPS		
	MC/DEL		**METHOCARBAMOL TABS**	MC	8	FLEQSUVY		
	MC/DEL		**TIZANIDINE HCL TABS**	MC	8	LIORESAL TABS		
				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		
				MC/DEL	8	**ZANAFLEX TABS**		**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	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		CARISOPRODOL/ASPIRIN TABS	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.
				MC/DEL		CARISOPRODOL/ASPIRIN/CODE		
				MC		NORGESIC TABS		
				MC/DEL		ORPHENADRINE COMPOUND		
				MC/DEL		ORPHENADRINE/ASA/CAFF		
				MC		ORPHENGESIC		
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.	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		YORVIPATH[1]		
							Use PA Form# 20420	
VITAMINS								
VITAMINS	MC		CYANOCOBALAMIN SOLN	MC		AQUASOL E 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. Certain drugs require specific diagnoses for approval.
	MC		FERIVA CAP	MC		AQUAVIT-E SOLN	**Please refer to OTC list for covered products.**	
	MC		FERIVAFA CAP	MC		DHT SOLN		
	MC/DEL		FOLIC ACID TABS	MC		FUSION PLUS CAP		
	MC/DEL		MEPHYTON TABS			HEMOCYTE PLU CAP		
				MC			Click here for the OTC List	
	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					**Please refer to OTC list for covered products.**
	MC/DEL		VITAMIN B-12					**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.
	MC		VITAMIN B-6 TABS					
	MC/DEL		VITAMIN C					
	MC/DEL		VITAMIN E CAPS					Preferred products that used to require diag codes still require diag codes unless indicated otherwise.
	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	Preferred products require dialysis/renal failure diagnosis.

	MC/DEL		**ROCALTROL**	MC/DEL		**DOXERCALCIF CAP**	(renal failure) required.	
	MC/DEL		**VITAMIN D2**[2]	MC/DEL		**DOXERCALCIF INJ**	2. Only specific NDCs available	
	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)		Rayaldee requires clinical PA to verify stage 3 or 4 CKD.
				MC		RAYALDEE		
				MC		ZEMPLAR INJ		
				MC		ZEMPLAR CAPS	Use PA Form# 20420	
EMZYMES								
POMPE DISEASE AGENTS				MC		NEXVIAZYME[1]		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.
				MC		LUMIZYME		
				MC		OPFOLDA	1. For patients 1 year of age and older with late-onset Pompe disease (lysosomal acid alpha-glucosidase [GAA] deficiency).	
				MC		POMBILITI		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).
							Use PA Form# 20420	
MISC MULTI-VITAMINS								
VITAMINS - MISC.	MC		CENTRUM TABS	MC		ADEKS	1. Diag codes are no longer required on prenatal vitamins.	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		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	**Please refer to OTC list.**	
	MC/DEL		CHEWABLE MULTIVIT/FL CHEW	MC		CENTRUM PERFORMANCE TABS		**Please refer to OTC list.**
	MC		COD LIVER OIL CAPS	MC		CENTRUM SILVER TABS	Use PA Form# 20420	
				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	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	**Please refer to OTC list.**	
	MC		CALCIQUID SYRP	MC/DEL		**CALCIUM 600-D TABS**		
	MC		CALCITRATE/VITAMIN D TABS	MC		CALCIUM/VITAMIN D TABS		
	MC/DEL		CALCIUM	MC		CALTRATE 600 PLUS/VIT D TABS	Click here for the OTC List	
	MC/DEL		CALCIUM CARBONATE	MC		CALTRATE PLUS TABS		**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.
	MC/DEL		CALCIUM CITRATE TABS	MC		CHROMAGEN		
	MC/DEL		CALCIUM GLUCONATE TABS	MC		CITRACAL PLUS TABS		
	MC/DEL		CALCIUM LACTATE TABS	MC		CONTRIN CAPS		**Please refer to OTC list.**
	MC		CALCIUM/MAGNESIUM TABS	MC		FEOGEN FORTE CAPS		
	MC/DEL		**CALCIUM/VITAMIN D TABS**	MC		FEROCON CAPS		Preferred products that used to require diag codes still require diag codes unless indicated otherwise.
	MC		CALTRATE 600 TABS	MC/DEL		FERREX 150 CAPS		
	MC/DEL		CHEWABLE CALCIUM CHEW	MC		FERRO-SEQUELS TBCR		
	MC		CITRACAL TABS	MC		FE-TINIC CAPS		
	MC		CITRACAL + D TABS	MC		FE-TINIC 150 FORTE CAPS		
	MC		CITRUS CALCIUM TABS	MC/DEL		FLUOR-A-DAY SOLN		
	MC		CITRUS CALCIUM 1500 + D TABS	MC		HEMOCYTE TABS		
	MC		EFFERVESCENT POTASSIUM TBEF	MC/DEL		K-DUR TBCR		
	MC/DEL		FEOSTAT CHEW	MC		KLOR-CON PACK		
	MC		FERATAB TABS	MC		K-LYTE		
	MC/DEL		FER-GEN-SOL SOLN	MC/DEL		K-PHOS TABS NEUTRAL		
	MC		FER-IRON SOLN	MC		K-TABS TBCR		
	MC		FERRONATE TABS	MC		K-VESCENT PACK		
	MC/DEL		FERROUS SULFATE	MC		MICRO-K 10 MEG CPCR		
	MC/DEL		FLUOR-A-DAY CHEW	MC		NU-IRON 150 CAPS		
	MC		FLUORIDE CHEW	MC/DEL		**OYSTER SHELL CALCIUM/VITA TABS**		
	MC		FLUORIDE SODIUM CHEW	MC/DEL		POLY-IRON 150 CAPS		
	MC		FLUORITAB CHEW	MC/DEL		POLYSACCHARIDE IRON CAPS		
	MC		HM CALCIUM TABS	MC/DEL		POTASSIUM BICARB/CHLORIDE		
	MC		K+ POTASSIUM PACK	MC/DEL		POTASSIUM CHLORIDE 10MEQ CAPS		
	MC		KAON ELIX	MC/DEL		POTASSIUM CHLORIDE 8MEQ CAPS		
	MC		KAON-CL-10 TBCR	MC		TUMS 500 CHEW		
	MC		KCL 0.075%/D5W/NACL 0.2% SOLN	MC		VIACTIV CHEW		
	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		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	

				MC		LOVAZA[1,2]	& SGA Form	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	
NIEMANN-PICK DISEASE AGENTS								
NIEMANN-PICK DISEASE AGENTS				MC		AQNEURSA[1]	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.
				MC		MIPLYFFA[1]	Use PA Form# 20420	
ANTICOAGULANTS / PLATELET AGENTS								
ANTICOAGULANTS	MC		COUMADIN TABS	MC		ARIXTRA SOLN	1. Enoxaparin therapy durations greater than 7	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		ENOXAPARIN[1]	MC/DEL		FONDAPARINUX		

	MC		ELIQUIS	MC/DEL		FRAGMIN INJ	days every 30 days require PA	preferred drug(s) exists. Exceeding days supply limits for LMWH class requires PA.
	MC		ELIQUIS STARTER PACK	MC/DEL		FRAGMIN VIAL	2. Use other strengths available to obtain desired dose.	
	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	3. Diagnosis required	**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]	4. For the treatment of patients aged 3 months to less than 12 years of age.	**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					**DDI:** Rifampin will require prior authorization if being used in combination with Savaysa
	MC/DEL		JANTOVEN					
	MC/DEL		**WARFARIN SODIUM TABS**					
	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.	Non-preferred will only be approved if other preferred products are unavailable.
	MC		ALPHANINE SD	MC		ADVATE[1,2,5]		
	MC/DEL		ALPROLIX VIAL	MC		ALTUVIIIO[4]		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:
	MC/DEL		BEBULIN VIAL	MC/DEL		AFSTYLA	2. Advate may be available with PA in cases of large volume dosing in patients with poor venous access.	· Currently use factor IX prophylaxis therapy, or
	MC/DEL		BENEFIX SOLR	MC/DEL		BEQVEZ		· Have current or historical life-threatening hemorrhage, or
	MC/DEL		HELIXATE FS KIT	MC/DEL		ESPEROCT		· Have repeated, serious spontaneous bleeding episodes, and,
	MC		HEMLIBRA	MC/DEL		ELOCTATE		· Do not have neutralizing antibodies to adeno-associated virus serotype Rh74var (AAVRh74var) capsid as detected by an FDA- approved test.
	MC		HEMOFIL - M	MC/DEL		HEMGENIX		
	MC		HUMATE-P SOLR	MC/DEL		IDELVION		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.
	MC/DEL		IXINITY VIAL	MC/DEL		KOGENATE FS[5]		
	MC/DEL		JIVI[3]	MC		RECOMBINATE VIAL[5]	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.	
	MC		KOATE-DVI	MC		ROCTAVIAN[4]		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.
	MC		KONYNE - 80	MC		SEVENFACT		
	MC/DEL		KOVALTRY					
	MC/DEL		REBINYN					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 5
	MC		MONARC - M					Inclusion:
	MC		MONOCLATE - P					Severe factor VIII deficiency (less than 1% native factor VIII).
	MC		MONONINE					Exclusion Criteria:
	MC/DEL		NOVOEIGHT				4. Clinical PA required for appropriate diagnosis.	Antibodies to the virus AAV5
	MC		NOVOSEVEN SOLR					Factor VIII inhibitors (or history of)
	MC		NUWIQ				5. Established users will be grandfathered	Known significant fibrosis of cirrhosis of the liver, or unexplained elevated LFTs
	MC/DEL		PROFILNINE					History of inadequate compliance with prophylaxis, or regular bleeds despite adequate prophylaxis
	MC		RECOMBINATE SOLR					Conditions in which high-dose steroids are contraindicated.
	MC		REFACTO					-Inability to abstain from alcohol for one year
	MC/DEL		RIXUBIS VIAL					Plan to impregnate a partner within 6 months of infusion
	MC		WILATE INJ					-Hypersensitivity to mannitol
	MC/DEL		XYNTHA					-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	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		ASPIRIN-DIPYRIDAMOLE ER CPMP 12HR	MC/DEL	8	BRILINTA 60mg		
	MC/DEL		BRILINTA 90mg	MC	8	DURLAZA	Use PA form# 20420 for other requests	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.
	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	1. Dosing limits apply,	

				MC/DEL	8	**ZONTIVITY**	please see dose consolidation list.	**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.
PLATELET AGGR. INHIBITORS / COMBO'S - MISC.	MC/DEL MC/DEL		**CILOSTAZOL** PENTOXIFYLLINE ER TBCR	MC/DEL MC/DEL MC/DEL MC MC		**AGRYLIN CAPS** **ANAGRELIDE CAPS** **PLETAL TABS** TRENTAL TBCR YOSPRALA	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.
HEMATOLOGICALS								
MONOCLONAL ANTIBODY				MC MC/DEL MC MC/DEL MC MC MC/DEL MC MC		EMPAVELI ENSPRYNG FABHALTA GAMIFANT PIASKY SOLIRIS ULTOMIRIS UPLIZNA VOYDEYA	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).
IMMUNE GLOBULIN	MC MC/DEL MC MC MC/DEL MC/DEL MC		BIVIGAM[1] CUTAQUIG[1] GAMUNEX-C GAMMAGARD S-D[1] HIZENTRA[1] PANZYGA[1] PRIVIGEN[1]	MC MC MC/DEL MC MC/DEL MC MC/DEL		ALYGLO ASCENIV[2] CUVITRU GAMMAPLEX INJ HYQVIA OCTAGAM INJ[1] XEMBIFY	Use PA Form# 20420 1. Clinical PA required 2. For the treatment of patients between 12 to 17 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. **Alyglo** is indicated for treatment of primary humoral immunodeficiency in adults ages 17 or older. 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).
HEREDITARY ANGIOEDEMA	MC MC MC MC/DEL MC/DEL MC MC/DEL		**PROPHYLAXIS** CINRYZE[1] HAEGARDA[1] ORLADEYO[1,2] TAKHZYRO[1] **TREATMENT** BERINERT KIT[1] FIRAZYR[1] RUCONEST VIAL[1]			**PROPHYLAXIS** **TREATMENT** KALBITOR VIAL	1. Clinical PA is required to establish diagnosis and medical necessity. 2. For the treatment of patients ≥ 12 years of age. Use PA Form# 20420	Haegarda is indicated for routine prophylaxis to prevent Hereditary Angioedema (HAE) attacks in adolescent and adult patients
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 MC 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 NEOSPORIN OINT OCUSULF-10 SOLN OCUTRICIN SOLN POLYTRIM DROPS SULFACETAMIDE SODIUM DROPS SULFACETAMIDE SODIUM 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		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	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 MC/DEL MC/DEL MC/DEL		CILOXAN OINT CIPROFLOXACIN SOL 0.3% OFLOXACIN QUIXIN SOLN	MC/DEL MC/DEL MC		BESIVANCE CILOXAN SOLN OCUFLOX 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.
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 MC/DEL MC MC MC/DEL MC MC MC MC MC MC MC		ARTIFICIAL TEARS OINT ARTIFICIAL TEARS SOLN CELLUVISC SOLN EYE LUBRICANT OINT GENTEAL LIQUITEARS SOLN MAJOR TEARS SOLN PURALUBE OINT PURALUBE TEARS SOLN REFRESH SOLN OP REFRESH PLUS SOLN[1] REFRESH PM OINT	MC/DEL MC MC MC MC/DEL MC/DEL MC MC MC MC/DEL MC/DEL MC MC MC MC/DEL MC/DEL MC MC/DEL MC		ARTIFICIAL TEARS SOLN OP BION TEARS SOLN DRY EYES OINT DURATEARS OINT HYPO TEARS ISOPTO TEARS SOLN LACRI-LUBE LUBRIFRESH P.M. OINT MURINE SOLN MUROCEL SOLN NATURE'S TEARS SOLN REFRESH SOLN REFRESH TEARS SOLN[1] TEARGEN SOLN TEARISOL SOLN TEARS NATURALE TEARS PURE SOLN TEARS RENEWED OINT THERATEARS SOLN V-R ARTIFICIAL TEARS SOLN	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.
OP. - BETA - BLOCKERS	MC/DEL MC/DEL MC/DEL MC/DEL		**BETOPTIC-S SUSP** **CARTEOLOL HCL SOLN** **LEVOBUNOLOL HCL SOLN** METIPRANOLOL SOLN	MC MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL MC/DEL		BETAGAN SOLN **BETAXOLOL HCL SOLN** ISTALOL **OCUPRESS SOLN** OPTIPRANOLOL SOLN **TIMOPTIC SOLN** TIMOLOL DROP **TIMOLOL SOL-GEL** **TIMOPTIC-XE SOLG**	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.
OP. - ANTI-INFLAMMATORY / STEROIDS OPHTH.	MC MC/DEL MC/DEL MC/DEL		AK-SPORE HC OINT ALREX SUSP DEXAMETH SOD PHOS SOLN FLUOROMETHOLONE SUSP	MC MC MC MC		AK-TROL SUSP BAC/POLY/NEOMY/HC OINT BLEPHAMIDE S.O.P. OINT BLEPHAMIDE 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		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. Use PA Form# 20420	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]		
				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		
	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.	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]	2. For the short-term (up to two weeks) treatment of the signs and symptoms of dry eye disease.	
				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.	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	2. Dosing limits allowing one	

	MC/DEL		EVOCLIN	MC/DEL		ALTRENO	package per month. Please refer to Dose Consolidation List.	
	MC		ISOTRETINOIN	MC		AMZEEQ[6]		
	MC		METRONIDAZOLE CREA[2]	MC		ARAZLO LOTION[6]	3. Only available if component ingredients are unavailable.	
	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]	4. Dosing limits apply, please see dosing consolidation list.	
	MC		TRETINOIN CREA[1,2]	MC/DEL		BENZAGEL-10 GEL		
				MC/DEL		BENZAMYCIN GEL		
				MC/DEL		BENZAMYCINPAK PACK	5. Not approved for use in children <12 years of age	
				MC		BENZEFOAM		
				MC		BENZOYL PEROXIDE		
				MC		BREVOXYL		
				MC		CABTREO GEL[5]	6. For the treatment of patients ≥ 9 years of age.	
				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	Use PA Form# 10220 for Brand Name requests	
				MC		DESQUAM-X		
				MC		DIFFERIN 0.3% GEL	Use PA Form# 20420 for all other requests	
				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		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	PIMECROLIMUS CRE (AUTH GENERIC LABELER 68682 Oceanside Pharmaceuticals)	MC		EBGLYSS[2,3]	1.Avoid live vaccines if treated with Dupixent	
	MC/DEL	1	PROTOPIC OINT				2. Clinical PA required.	

	MC/DEL	1	TACROLIMUS OINT				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	
	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.
				MC		ZNP BAR		
				MC		ZORYVE FOAM		

								Zoryve Foam: For the treatment of seborrheic dermatitis in adult and pediatric patients 9 years of age and older.
TOPICAL - ANTIVIRALS				MC/DEL MC/DEL MC MC		**ACYCLOVIR OINT** DENAVIR CREA[1, 3] YCANTH ZOVIRAX OINT[1,2]	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 topical treatment of molluscum contagiosum in adult and pediatric patients 2 years of age and older. Use PA Form# 20420	
TOPICAL - ANTINEOPLASTICS	MC		EFUDEX	MC/DEL MC/DEL MC MC/DEL		CARAC CREA FLUOROURACIL SOLARAZE GEL ZYCLARA	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 - BURN PRODUCTS	MC MC/DEL MC MC MC/DEL		FURACIN CREA SILVER SULFADIAZINE CREA SSD AF CREA SSD CREA THERMAZENE 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.
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 MC/DEL MC MC MC		DERMA-SMOOTHE- FS BODY HYDROCORTISONE CREA HYDROCORTISONE LOTN HYDROCORTISONE LOTN TEXACORT SOLN	MC/DEL MC MC MC/DEL MC/DEL MC MC		ACLOVATE ANUSOL HC-1 OINT DESONATE GEL **FLUOCINOLONE ACETONIDE** **FLUOCINOLONE** HALOG HYDROCORTISONE POWD		
			MEDIUM POTENCY	MC		LIDA MANTLE HC CREA		
	MC/DEL MC MC MC MC MC MC		DESOXIMETASONE 0.05% CREA/GEL FLUTICASONE PROPIONATE CREA/OINT HYDROCORTISONE BUTYRATE HYDROCORTISONE OINT HYDROCORTISONE VALERATE MOMETASONE FUROATE OINT TRIAMCINOLONE ACETONIDE .025-.1%	MC MC/DEL MC/DEL MC MC MC/DEL MC MC/DEL MC/DEL MC/DEL MC		PROCTOCORT CREA VERDESO **MEDIUM POTENCY** **BESER LOTION[3]** CLODERM CREA CORDRAN CUTIVATE CREA / OINT CUTIVATE LOTN DERMATOP 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"		
			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 require PA for users over 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		CAPSAICIN CREA	MC/DEL		EMLA CREA		
	MC/DEL		CAPSAICIN PATCH	MC		LIDA MANTLE CREA		

	MC/DEL		**DIBUCAINE OINT**	MC		PONTOCAINE SOLN	years of age.	
	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.	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	3. For the treatment of adults with moderate-to-severe plaque psoriasis who are candidates for systemic therapy or phototherapy. 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	
				MC/DEL		SPEVIGO		
				MC		SILIQ		
				MC		STELARA		
				MC		TREMFYA		
				MC		YUFLYMA		
				MC		YUSIMRY		
ALTERNATIVE MEDICINES								
ALTERNATIVE MEDICINES	MC		DIMETHYL SULFOXIDE SOLN	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.
	MC		MELATONIN					
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.	
	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]		

							Use PA Form# 20420	
ANTINEOPLASTIC AGENTS - TYROSINE KINASE INHIBITORS				MC MC/DEL MC		SPRYCEL[1] TYKERB[2] GLEEVEC[1]	Use PA Form# 20420 1. Verification of diagnosis is required. 2. PA required to confirm FDA approved indication and to monitor for potential drug-drug interactions.	
ANTINEOPLASTICS-MISCELLANEOUS	MC MC/DEL MC/DEL		AMIFOSTINE MERCAPTOPURINE **OXALIPLATIN**	MC MC/DEL MC/DEL MC MC/DEL MC/DEL		DOCEFREZ ELOXATIN ETHYOL LEUPROLIDE PURINETHOL ZOLINZA	Use PA Form# 20420	
ANTINEOPLASTICS- MONOCLONAL ANTIBODIES	MC/DEL		TRAZIMERA	MC/DEL MC/DEL MC.DEL MC MC MC/DEL		ENHERTU HERCEPTIN HERZUMA KANJINTI OGIVRI ONTRUZANT	 Use PA Form# 20420	
CANCER								
CANCER	MC MC/DEL MC MC MC/DEL MC MC/DEL MC		ALIMTA ANASTROZOLE TABS ERBITUX **IMATINIB MESYLATE** LETROZOLE RUXIENCE VIDAZA ZIRABEV	MC MC MC MC/DEL MC MC MC/DEL MC MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC MC MC MC/DEL MC MC MC MC MC/DEL MC MC/DEL MC/DEL MC/DEL MC		ABECMA AKEEGA ALECENSA ALIQOPA[3] ALUNBRIG[1] ALYMSYS ARIMIDEX AUGTYRO AYVAKIT AVASTIN BALVERSA BAVENCIO[1,8] BENDEKA[3] BESPONSA[3] BESREMI[1] BLENREP BOSULIF BRAFTOVI[1] BREYANZI BRUKINSA CABOMETYX[3] CAMCEVI CALQUENCE[3] COMETRIQ[3,4,5] COTELLIC COPIKTRA DARZALEX[3] DAURISMO ELREXFIO EMPLICITI(IV)[8] EPKINLY	1. PA required to confirm appropriate diagnosis and testing. 2. Avoid CYP3A drug drug interaction. 3. Clinical PA required for appropriate diagnosis 4. Re-approval will require documentation of response without disease progression and tolerance to treatment 5. Dosing limits apply, please see dosage consolidation list. 6. Max daily dose of 300mg. 7. Monitor liver enzymes periodically and stop treatment upon Grade 3 or higher elevation of liver enzymes approved indication 8. For patients ≥ 12 years of age 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.	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 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/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		LAZCLUZE	
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		TECELRA
MC		TECENTRIQ[1]
MC		TECENTRIQ HYBREZA
MC		TEPMETKO
MC		TEVIMBRA
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		VORANIGO		
				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 2.Clinical PA is 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. **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. **Myhibbin:** For the prophylaxis of organ rejection, in adult and pediatric recipients 3 months of age and older of allogeneic kidney, heart, or liver transplants, in combination with other immunosuppressants. **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		MYHIBBIN[2]		
	MC/DEL		RAPAMUNE	MC/DEL		NEORAL CAP		
	MC/DEL		SANDIMMUNE	MC		PROGRAF CAPS		
	MC/DEL		**TACROLIMUS CAPS**	MC		REZUROCK[1]		
				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.