Louisiana Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)

http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf

- The PDL is a list of over 100 therapeutic classes reviewed by the Pharmaceutical & Therapeutics (P&T) committee. There are medications and/or classes of medications that are not reviewed by the committee. Unless there is a clinical pre-authorization requirement for the entire class (as noted on the last page of the PDL) these medications will continue to be covered without prior authorization. **Examples: spironolactone, hydrochlorothiazide, amoxicillin suspension**
- There is a mandatory generic substitution **unless** the brand is preferred, and the generic is non-preferred. When the brand is preferred and the generic is non-preferred, no special notations are required by the prescriber and the pharmacist enters "**9**" in the DAW field 408-D8.
- When the brand is non-preferred and the prescriber has determined it to be medically necessary, *"Brand medically necessary"* or *"Brand necessary"* must be written on the prescription in the prescriber's handwriting and the pharmacist enters "**1**" in the DAW field 408-D8. For more information, please refer to the following policy: **https://www.lamedicaid.com/provweb1/Providermanuals/manuals/PHARMACY/PHARMACY.pdf**
- To locate any medication on this list, you may use the keyboard shortcut **CTRL + F** to search.
- New medications that enter the marketplace in classes reviewed by P&T committee will be considered non-preferred requiring prior authorization until the next P&T committee meeting. Please refer to the following criteria: **New Drugs Introduced into the Market / Non-Preferred**
- The PDL is arranged by therapeutic class with an item number and may contain a subset of medications under each therapeutic class.
- Medications listed as non-preferred are available through the prior authorization process. Each Managed Care Organization (MCO) and Fee for Service (FFS) have their own prior authorization departments.
- Any statement highlighted and underlined in blue is a hyperlink to go directly to forms and/or clinical criteria for medications with an explanation of the purpose and the requirements. **Example: Request Form**
- There is a list of abbreviations at the top of each page to define the letters listed by certain medications. **Example: DD – Drug Interactions**
- There are additional agents that have Point-of-Sale (POS) requirements listed at the end of the PDL document. Words underlined and highlighted in blue are hyperlinks to the criteria/request form. **Example: Xolair® (Omalizumab) CL, DX**
- For medications that require a diagnosis code at the pharmacy, please refer to the following link and click ICD-10-CM Diagnosis Code Policy Chart: **http://ldh.la.gov/index.cfm/page/1328**
- If your request is denied, medical reconsideration may be requested by the prescriber on the **Request for Reconsideration** form.
- Links to Diabetic Supply Lists for MCOs are found on Page 50 of this document (Click **HERE** to go to MCO Diabetic Supply Links on Page 50).
- This PDL/NPDL applies only to medications dispensed in the outpatient retail pharmacy.

LA Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL) Effective Date: July 1, 2019

AG – Authorized Generic	**DR** – Concurrent Prescriptions Must Be Written by Same Prescriber	**PU** – Prior Use of Other Medication is Required
AL – Age Limits	**DS** – Maximum Days' Supply Allowed	**QL** – Quantity Limits
BH – Behavioral Health Clinical Authorization Required for Children Younger Than 6 Years Old	**DT** – Duration of Therapy Limit	**RX** – Specific Prescription Requirements
BY – Diagnosis Codes Bypass Some Requirements	**DX** – Diagnosis Code Requirements	**TD** – Therapeutic Duplication
CL – More Detailed Clinical Information Required for Authorization	**ER** – Early Refill **NOT** Allowed	**UN** – Drug Use Not Warranted (Needs Appropriate Diagnosis)
CU – Concurrent Use with Opioids or Benzodiazepines is Restricted	**MD** – Maximum Dose Limits	**X** – Prescriber Must Have 'X' DEA Number
DD – Drug-Drug Interactions	**PR** – Enrollment in a Physician-Supervised Program Required	**YQ** – Yearly Quantity Limits

Descriptive Therapeutic Class	Drugs on PDL	POS Edits	Drugs on NPDL which Require Prior Authorization (PA)	POS Edits
ACNE AGENTS, TOPICAL (1)	Clindamycin Phosphate Gel	**CL**	Adapalene (Plixda™)	**CL**
*Request Form	Clindamycin Phosphate Medicated Swab	**CL**	Adapalene Cream (Generic; Differin®)	**CL**
*Criteria	Clindamycin Phosphate Solution	**CL**	Adapalene Gel (Generic; AG)	**CL**
	Erythromycin Gel	**CL**	Adapalene Gel Pump (Generic; AG; Differin®)	**CL**
	Erythromycin Solution	**CL**	Adapalene Lotion (Differin®)	**CL**
			Adapalene Solution	**CL**
			Adapalene/Benzoyl Peroxide (Generic; Epiduo®)	**CL**
			Adapalene/Benzoyl Peroxide with Pump (Epiduo Forte® Gel)	**CL**
			Azelaic Acid (Azelex®)	**CL**
			Benzoyl Peroxide Gel	**CL**
			Clindamycin Phosphate (Cleocin-T® Gel)	**CL**
			Clindamycin Phosphate (AG; Clindagel®)	**CL**
			Clindamycin Phosphate (Evoclin®)	**CL**
			Clindamycin Phosphate /Benzoyl Peroxide w/Pump (AG; Acanya®)	**CL**
			Clindamycin Phosphate Foam	**CL**
			Clindamycin Phosphate Lotion (Generic; Cleocin-T®)	**CL**
			Clindamycin Phosphate/Benzoyl Peroxide (Generic; BenzaClin®)	**CL**
			Clindamycin Phosphate/Benzoyl Peroxide (Generic; Duac®)	**CL**
			Clindamycin Phosphate/Benzoyl Peroxide Pump (Onexton®)	**CL**
			Clindamycin/Benzoyl Peroxide with Pump (Generic; BenzaClin®)	**CL**
			Clindamycin Phosphate/Skin Cleanser 19 (Clindacin® Pac Kit)	**CL**
			Clindamycin/Benzoyl/Emollient Combo 94 (NeuAc® Kit)	**CL**
			Clindamycin/Tretinoin (Generic; AG; Ziana®)	**CL**
			Dapsone Gel (Generic; AG; Aczone®)	**CL**
			Dapsone Gel with Pump (Aczone®)	**CL**
			Erythromycin Gel (AG)	**CL**
			Erythromycin Medicated Swab	**CL**
			Erythromycin/Benzoyl Peroxide (Generic; Benzamycin®)	**CL**
			Sulfacetamide Cleanser	**CL**
			Sulfacetamide Sodium (Ovace® Plus Cream ER)	**CL**
			Sulfacetamide Sodium (Ovace® Plus Cleanser ER)	**CL**
			Sulfacetamide Sodium (Ovace® Plus Foam)	**CL**
			Sulfacetamide Sodium (Ovace® Plus Lotion)	**CL**

AG – Authorized Generic	**DR** – Concurrent Prescriptions Must Be Written by Same Prescriber	**PU** – Prior Use of Other Medication is Required
AL – Age Limits	**DS** – Maximum Days' Supply Allowed	**QL** – Quantity Limits
BH – Behavioral Health Clinical Authorization Required for Children Younger Than 6 Years Old	**DT** – Duration of Therapy Limit	**RX** – Specific Prescription Requirements
BY – Diagnosis Codes Bypass Some Requirements	**DX** – Diagnosis Code Requirements	**TD** – Therapeutic Duplication
CL – More Detailed Clinical Information Required for Authorization	**ER** – Early Refill **NOT** Allowed	**UN** – Drug Use Not Warranted (Needs Appropriate Diagnosis)
CU – Concurrent Use with Opioids or Benzodiazepines is Restricted	**MD** – Maximum Dose Limits	**X** – Prescriber Must Have 'X' DEA Number
DD – Drug-Drug Interactions	**PR** – Enrollment in a Physician-Supervised Program Required	**YQ** – Yearly Quantity Limits

Descriptive Therapeutic Class	Drugs on PDL	POS Edits	Drugs on NPDL which Require Prior Authorization (PA)	POS Edits
ACNE AGENTS, TOPICAL (1) Continued	(preferred agents listed on page 1)		Sulfacetamide Sodium (Ovace® Plus Wash)	**CL**
			Sulfacetamide Sodium (Ovace® Wash)	**CL**
			Sulfacetamide Sodium Cleanser ER	**CL**
			Sulfacetamide Sodium Shampoo	**CL**
			Sulfacetamide Sodium/Sulfur (Avar® LS Cleanser)	**CL**
			Sulfacetamide Sodium/Sulfur (Avar® LS Medicated Pads)	**CL**
			Sulfacetamide Sodium/Sulfur (Avar® Medicated Pads)	**CL**
			Sulfacetamide Sodium/Sulfur (Avar-e®)	**CL**
			Sulfacetamide Sodium/Sulfur (BP 10-1®)	**CL**
			Sulfacetamide Sodium/Sulfur	**CL**
			Sulfacetamide Sodium/Sulfur Cleanser (Avar®)	**CL**
			Sulfacetamide Sodium/Sulfur Cleanser	**CL**
			Sulfacetamide Sodium/Sulfur Cleanser Kit	**CL**
			Sulfacetamide Sodium/Sulfur Cream	**CL**
			Sulfacetamide Sodium/Sulfur Foam (Avar®)	**CL**
			Sulfacetamide Sodium/Sulfur Foam (SSS 10-5®)	**CL**
			Sulfacetamide Sodium/Sulfur Lotion	**CL**
			Sulfacetamide Sodium/Sulfur Medicated Pads	**CL**
			Sulfacetamide Sodium/Sulfur Sunscreen	**CL**
			Sulfacetamide Suspension	**CL**
			Sulfacetamide/Sulfur Suspension	**CL**
			Sulfacetamide/Sulfur/Cleanser 23 (Sumaxin® CP Kit)	**CL**
			Sulfacetamide/Sulfur/Urea Cleanser	**CL**
			Tazarotene (Fabior®)	**CL**
			Tazarotene Cream (Generic; AG; Tazorac®)	**CL**
			Tazarotene Gel (Tazorac®)	**CL**
			Tretinoin (Altreno®)	**CL**
			Tretinoin Cream (Generic; Avita®; Retin-A®)	**CL**
			Tretinoin Gel (Generic; Atralin®)	**CL**
			Tretinoin Gel (Generic Avita, Generic Retin-A®; Retin-A®)	**CL**
			Tretinoin 0.06% Pump (Retin-A® Micro)	**CL**
			Tretinoin 0.04% & 0.1% Gel; Pump (Generic; AG; Retin-A® Micro)	**CL**
			Tretinoin 0.08% Pump (Retin-A® Micro)	**CL**

AG – Authorized Generic	**DR** – Concurrent Prescriptions Must Be Written by Same Prescriber	**PU** – Prior Use of Other Medication is Required
AL – Age Limits	**DS** – Maximum Days' Supply Allowed	**QL** – Quantity Limits
BH – Behavioral Health Clinical Authorization Required for Children Younger Than 6 Years Old	**DT** – Duration of Therapy Limit	**RX** – Specific Prescription Requirements
BY – Diagnosis Codes Bypass Some Requirements	**DX** – Diagnosis Code Requirements	**TD** – Therapeutic Duplication
CL – More Detailed Clinical Information Required for Authorization	**ER** – Early Refill **NOT** Allowed	**UN** – Drug Use Not Warranted (Needs Appropriate Diagnosis)
CU – Concurrent Use with Opioids or Benzodiazepines is Restricted	**MD** – Maximum Dose Limits	**X** – Prescriber Must Have 'X' DEA Number
DD – Drug-Drug Interactions	**PR** – Enrollment in a Physician-Supervised Program Required	**YQ** – Yearly Quantity Limits

Descriptive Therapeutic Class	Drugs on PDL	POS Edits	Drugs on NPDL which Require Prior Authorization (PA)	POS Edits
ACNE AGENTS, TOPICAL (1) Continued	(preferred agents listed on page 1)		Tretinoin (Tretin-X®)	**CL**
			Tretinoin/Emollient 9/Skin Cleanser 1 (Tretin-X® Combo Pack)	**CL**
ADD/ADHD (2)	Amphetamine Salt Combo ER (Generic; AG for Adderall XR®)	**BH, DX, TD**	Amphetamine ER Suspension (Adzenys ER®)	**BH, DX, TD**
Stimulants and Related Agents	Amphetamine Salt Combo Tablet (Generic Adderall®)	**BH, DX, TD**	Amphetamine ODT (Adzenys XR ODT®)	**BH, DX, TD**
*Request Form	Atomoxetine Capsule (Generic; AG for Strattera®)	**BH, DX, TD**	Amphetamine Salt Combo ER (Adderall XR®)	**BH, DX, TD**
*Stimulants and Related Agents Criteria with Diagnosis Code Chart	Dexmethylphenidate ER Capsule (Focalin XR®)	**BH, DX, TD**	Amphetamine Suspension (Dyanavel XR®)	**BH, DX, TD**
	Dexmethylphenidate Tablet (Generic; AG for Focalin®)	**BH, DX, TD**	Amphetamine Tablet (Evekeo®)	**BH, DX, TD**
	Dextroamphetamine Solution (ProCentra®)	**BH, DX, TD**	Amphetamine/Dextroamphetamine XR Capsule (Mydayis®)	**BH, DX, TD**
	Dextroamphetamine Tablet (Generic)	**BH, DX, TD**	Armodafinil Tablet (Generic; AG; Nuvigil®)	**AL, CU, DX, TD**
	Guanfacine ER Tablet (Generic)	**BH, DX, TD**	Atomoxetine Capsule (Strattera®)	**BH, DX, TD**
	Lisdexamfetamine Capsule, Chewable Tablet (Vyvanse®)	**BH, DX, TD**	Clonidine ER Tablet (Generic; Kapvay®)	**BH, DX, TD**
	Methylphenidate ER Capsule (Aptensio XR®)	**BH, DX, TD**	Dexmethylphenidate ER Capsule (Generic; AG for Focalin XR®)	**BH, DX, TD**
	Methylphenidate ER Capsule (Generic; AG for Metadate CD®)	**BH, DX, TD**	Dexmethylphenidate Tablet (Focalin®)	**BH, DX, TD**
	Methylphenidate ER Capsule (Generic Ritalin LA®)	**BH, DX, TD**	Dextroamphetamine IR Tablet (Zenzedi®)	**BH, DX, TD**
	Methylphenidate ER Chewable (QuilliChew ER®)	**BH, DX, TD**	Dextroamphetamine Solution (Generic ProCentra®)	**BH, DX, TD**
	Methylphenidate ER Suspension (Quillivant XR®)	**BH, DX, TD**	Dextroamphetamine Sulfate ER (Generic; Dexedrine® Spansule®)	**BH, DX, TD**
	Methylphenidate ER Tablet (Generic; AG for Concerta®)	**BH, DX, TD**	Guanfacine ER Tablet (Intuniv®)	**BH, DX, TD**
	Methylphenidate IR Tablet (Generic)	**BH, DX, TD**	Methamphetamine Tablet (Generic; Desoxyn®)	**BH, DX, TD**
	Modafinil Tablet (Generic)	**AL, CU, DX, TD**	Methylphenidate ER Capsule (Ritalin LA®)	**BH, DX, TD**
			Methylphenidate ER Tablet (Concerta®)	**BH, DX, TD**
			Methylphenidate ER Tablet (Generic Metadate ER)	**BH, DX, TD**
			Methylphenidate ER Tablet 72mg (Generic)	**BH, DX, TD**
			Methylphenidate IR Chew Tablet (Generic)	**BH, DX, TD**
			Methylphenidate IR Tablet (Ritalin®)	**BH, DX, TD**
			Methylphenidate Patch (Daytrana®)	**BH, DX, TD**
			Methylphenidate Solution (Generic; AG; Methylin®)	**BH, DX, TD**
			Methylphenidate XR ODT (Cotempla XR ODT®)	**BH, DX, TD**
			Modafinil Tablet (Provigil®)	**AL, CU, DX, TD**

AG – Authorized Generic	**DR** – Concurrent Prescriptions Must Be Written by Same Prescriber	**PU** – Prior Use of Other Medication is Required
AL – Age Limits	**DS** – Maximum Days' Supply Allowed	**QL** – Quantity Limits
BH – Behavioral Health Clinical Authorization Required for Children Younger Than 6 Years Old	**DT** – Duration of Therapy Limit	**RX** – Specific Prescription Requirements
BY – Diagnosis Codes Bypass Some Requirements	**DX** – Diagnosis Code Requirements	**TD** – Therapeutic Duplication
CL – More Detailed Clinical Information Required for Authorization	**ER** – Early Refill **NOT** Allowed	**UN** – Drug Use Not Warranted (Needs Appropriate Diagnosis)
CU – Concurrent Use with Opioids or Benzodiazepines is Restricted	**MD** – Maximum Dose Limits	**X** – Prescriber Must Have 'X' DEA Number
DD – Drug-Drug Interactions	**PR** – Enrollment in a Physician-Supervised Program Required	**YQ** – Yearly Quantity Limits

Descriptive Therapeutic Class	Drugs on PDL	POS Edits	Drugs on NPDL which Require Prior Authorization (PA)	POS Edits
ALLERGY (3)	Cetirizine Tablet OTC (Generic)	**TD**	Acrivastin/Pseudoephedrine (Semprex-D®)	**TD**
Antihistamines – Minimally Sedating	Cetirizine Solution OTC/Rx (1mg/ml) (Generic)	**TD**	Cetirizine Chewable Tablet OTC (Generic)	**TD**
*Request Form	Levocetirizine Tablet (Generic)	**TD**	Cetirizine 5mg/5ml Solution OTC (Generic)	**TD**
*Criteria	Loratadine Solution OTC; Tablet OTC; ODT OTC (Generic)	**TD**	Cetirizine-D Tablet OTC (Generic)	**TD**
			Desloratadine Tablet (Generic; Clarinex®)	**TD**
			Desloratadine ODT (Generic)	**TD**
			Desloratadine Syrup (Clarinex®)	**TD**
			Desloratadine/Pseudoephedrine (Clarinex-D 12-Hour®)	**TD**
			Fexofenadine Suspension OTC (Generic; Allegra Allergy®)	**TD**
			Fexofenadine 60mg & 180mg OTC (Generic; Allegra Allergy®)	**TD**
			Fexofenadine/Pseudoephedrine 12-hour OTC (Generic)	**TD**
			Fexofenadine/Pseudoephedrine 24-hour OTC (Allegra-D®)	**TD**
			Levocetirizine Solution (Generic)	**TD**
			Loratadine Capsule OTC, Chewable Tablet OTC (Generic)	**TD**
			Loratadine-D 12-hour OTC (Generic)	**TD**
			Loratadine-D 24-hour OTC (Generic)	**TD**
ALLERGY (3)	Azelastine (Generic Astelin®)		Azelastine (Astepro®)	
Rhinitis Agents, Nasal	Azelastine (Generic; AG for Astepro®)		Azelastine/Fluticasone (Dymista®)	
*Request Form	Fluticasone Propionate Nasal Spray (Generic)		Beclomethasone (Beconase AQ®; Qnasl 40®; Qnasl 80®)	
*Criteria	Ipratropium Bromide Nasal Spray (Generic)		Ciclesonide (Omnaris®; Zetonna®)	
			Flunisolide Nasal Spray (Generic)	
			Fluticasone Propionate (Xhance®)	
			Mometasone (Generic; AG; Nasonex®)	
			Mometasone Furoate Implant (Sinuva™)	
			Olopatadine (Generic; AG; Patanase®)	

AG – Authorized Generic	**DR** – Concurrent Prescriptions Must Be Written by Same Prescriber	**PU** – Prior Use of Other Medication is Required
AL – Age Limits	**DS** – Maximum Days' Supply Allowed	**QL** – Quantity Limits
BH – Behavioral Health Clinical Authorization Required for Children Younger Than 6 Years Old	**DT** – Duration of Therapy Limit	**RX** – Specific Prescription Requirements
BY – Diagnosis Codes Bypass Some Requirements	**DX** – Diagnosis Code Requirements	**TD** – Therapeutic Duplication
CL – More Detailed Clinical Information Required for Authorization	**ER** – Early Refill **NOT** Allowed	**UN** – Drug Use Not Warranted (Needs Appropriate Diagnosis)
CU – Concurrent Use with Opioids or Benzodiazepines is Restricted	**MD** – Maximum Dose Limits	**X** – Prescriber Must Have 'X' DEA Number
DD – Drug-Drug Interactions	**PR** – Enrollment in a Physician-Supervised Program Required	**YQ** – Yearly Quantity Limits

Descriptive Therapeutic Class	Drugs on PDL	POS Edits	Drugs on NPDL which Require Prior Authorization (PA)	POS Edits
ALZHEIMER'S AGENTS (4)	Donepezil ODT (Generic)		Donepezil (Aricept®)	
Cholinesterase Inhibitors	Donepezil Tablet (Generic)		Donepezil 23mg (Generic; Aricept® 23mg)	
*Request Form	Memantine Tablet (Generic; AG)		Donepezil/Memantine ER Capsule; Dose Pack (Namzaric®)	
*Criteria	Rivastigmine Transdermal (Generic)		Galantamine ER Capsule; Solution; Tablet (Generic)	
			Memantine Capsule ER (Generic; Namenda XR®)	
			Memantine Solution (Generic)	
			Memantine Tablet (Namenda®)	
			Memantine Titration Pack (AG for Namenda®)	
			Rivastigmine Capsule (Generic)	
			Rivastigmine Transdermal (AG; Exelon®)	
ANDROGENIC AGENTS (5)	Testosterone Transdermal System (Androderm®)	**CL**	Testosterone Gel (AG; Testim®)	**CL**
*Request Form	Testosterone Gel; Gel Packet; Gel Pump (AG Vogelxo®)	**CL**	Testosterone Gel (AG for Fortesta®)	**CL**
*Androgenic Agents Criteria	Testosterone Gel (Generic Vogelxo®)	**CL**	Testosterone Gel Packet (Generic; AG; Androgel®)	**CL**
			Testosterone Gel Pump (Generic Axiron®)	**CL**
			Testosterone Gel Pump (Generic; AG; Androgel®)	**CL**
			Testosterone Gel Pump (Vogelxo®)	**CL**
			Testosterone Gel Pump (Generic; Fortesta®)	**CL**
ANTIPSYCHOTIC AGENTS (6)	**ORAL AGENTS**		**ORAL AGENTS**	
Antipsychotic Oral Agents	Amitriptyline/Perphenazine (Generic)	**BH, DX, TD**	Aripiprazole ODT, Solution (Generic)	**BH, DX, MD, TD**
*Request Form	Aripiprazole Tablet (Generic)	**BH, DX, MD, TD**	Aripiprazole Tablet (Abilify®)	**BH, DX, MD, TD**
*Antipsychotics Criteria with Diagnosis Code Chart	Chlorpromazine Tablet (Generic)	**BH, DX, TD**	Aripiprazole Tablet with Sensor (Abilify® Mycite®)	
	Clozapine Tablet (Generic)	**BH, DX, MD, TD**	Asenapine Sublingual Tablet (Saphris®)	**BH, DX, MD, TD**
	Fluphenazine Tablet (Generic)	**BH, DX, TD**	Brexpiprazole Tablet (Rexulti®)	**BH, DX, MD, TD**
*Nuplazid Criteria	Haloperidol Tablet (Generic)	**BH, DX, TD**	Cariprazine Capsule (Vraylar®) **(plus QL for therapy pack)**	**BH, DX, MD, TD**
	Haloperidol Lactate Concentrate (Generic)	**BH, DX, TD**	Clozapine ODT (Generic; AG; Fazaclo®)	**BH, DX, MD, TD**
	Loxapine Capsule (Generic)	**BH, DX, TD**	Clozapine Suspension (Versacloz®)	**BH, DX, MD, TD**
	Olanzapine Tablet, ODT (Generic)	**BH, DX, MD, TD**	Clozapine Tablet (Clozaril®)	**BH, DX, MD, TD**
	Perphenazine Tablet (Generic)	**BH, DX, TD**	Fluphenazine Elixir/Solution (Generic)	**BH, DX, TD**
	Pimozide Tablet (Generic)	**BH, DX, TD**	Iloperidone Tablet (Fanapt®)	**BH, DX, MD, TD**
	Quetiapine ER Tablet (Generic; AG)	**BH, DX, MD, TD**	Loxapine Inhalation (Adasuve®)	**BH, DX, TD**
	Quetiapine Tablet (Generic)	**BH, DX, MD, TD**	Lurasidone Tablet (Latuda®)	**BH, DX, MD, TD**

AG – Authorized Generic	**DR** – Concurrent Prescriptions Must Be Written by Same Prescriber	**PU** – Prior Use of Other Medication is Required
AL – Age Limits	**DS** – Maximum Days' Supply Allowed	**QL** – Quantity Limits
BH – Behavioral Health Clinical Authorization Required for Children Younger Than 6 Years Old	**DT** – Duration of Therapy Limit	**RX** – Specific Prescription Requirements
BY – Diagnosis Codes Bypass Some Requirements	**DX** – Diagnosis Code Requirements	**TD** – Therapeutic Duplication
CL – More Detailed Clinical Information Required for Authorization	**ER** – Early Refill **NOT** Allowed	**UN** – Drug Use Not Warranted (Needs Appropriate Diagnosis)
CU – Concurrent Use with Opioids or Benzodiazepines is Restricted	**MD** – Maximum Dose Limits	**X** – Prescriber Must Have 'X' DEA Number
DD – Drug-Drug Interactions	**PR** – Enrollment in a Physician-Supervised Program Required	**YQ** – Yearly Quantity Limits

Descriptive Therapeutic Class	Drugs on PDL	POS Edits	Drugs on NPDL which Require Prior Authorization (PA)	POS Edits
ANTIPSYCHOTIC AGENTS (6)	Risperidone Solution, Tablet (Generic)	**BH, DX, MD, TD**	Olanzapine Tablet, ODT (Zyprexa®; Zyprexa Zydis®)	**BH, DX, MD, TD**
Antipsychotic Oral Agents Continued	Thioridazine Tablet (Generic)	**BH, DX, TD**	Olanzapine/Fluoxetine (Generic; Symbyax®)	**BH, DX, MD, TD**
	Thiothixene Capsule (Generic)	**BH, DX, TD**	Paliperidone ER Tablet (Generic; AG; Invega®)	**BH, DX, MD, TD**
	Trifluoperazine Tablet (Generic)	**BH, DX, TD**	Pimavanserin Capsule, Tablet (Nuplazid®)	**CL, DX, QL, TD**
	Ziprasidone Capsule (Generic)	**BH, DX, MD, TD**	Pimozide Tablet (Orap®)	**BH, DX, TD**
			Quetiapine Tablet, ER Tablet (Seroquel®, Seroquel XR®)	**BH, DX, MD, TD**
			Risperidone ODT (Generic)	**BH, DX, MD, TD**
			Risperidone Solution, Tablet (Risperdal®)	**BH, DX, MD, TD**
			Ziprasidone Capsule (Geodon®)	**BH, DX, MD, TD**
ANTIPSYCHOTIC AGENTS (6)	**INJECTABLE AGENTS**		**INJECTABLE AGENTS**	
Antipsychotic Injectable Agents	Aripiprazole Lauroxil (Aristada®)	**AL, BH, DX, MD, PU, QL, TD**	Haloperidol Decanoate; Lactate (Haldol®)	**BH, DX, TD**
*Request Form *Antipsychotics Criteria with Diagnosis Code Chart	Aripiprazole Lauroxil (Aristada Initio®)	**BH, DX, MD, QL, TD**	Olanzapine Solution (Generic; Zyprexa®)	**BH, DX, TD**
	Aripiprazole Suspension ER (Abilify Maintena®)	**BH, DX, TD**	Olanzapine Suspension (Zyprexa Relprevv®)	**BH, DX, TD**
	Fluphenazine Decanoate (Generic)	**BH, DX, TD**	Risperidone ER Suspension (Subcutaneous) (Perseris®)	**BH, DX, MD, QL, TD**
	Haloperidol Decanoate (Generic)	**BH, DX, TD**		
	Haloperidol Lactate (Generic)	**BH, DX, TD**		
	Paliperidone (Invega Sustenna®)	**BH, DX, TD**		
	Paliperidone (Invega Trinza®)	**AL, BH, DX, MD, PU, QL, TD**		
	Risperidone ER Suspension (Intramuscular) (Risperdal Consta®)	**BH, DX, TD**		
	Ziprasidone (Geodon®)	**BH, DX, TD**		

AG – Authorized Generic	**DR** – Concurrent Prescriptions Must Be Written by Same Prescriber	**PU** – Prior Use of Other Medication is Required
AL – Age Limits	**DS** – Maximum Days' Supply Allowed	**QL** – Quantity Limits
BH – Behavioral Health Clinical Authorization Required for Children Younger Than 6 Years Old	**DT** – Duration of Therapy Limit	**RX** – Specific Prescription Requirements
BY – Diagnosis Codes Bypass Some Requirements	**DX** – Diagnosis Code Requirements	**TD** – Therapeutic Duplication
CL – More Detailed Clinical Information Required for Authorization	**ER** – Early Refill **NOT** Allowed	**UN** – Drug Use Not Warranted (Needs Appropriate Diagnosis)
CU – Concurrent Use with Opioids or Benzodiazepines is Restricted	**MD** – Maximum Dose Limits	**X** – Prescriber Must Have 'X' DEA Number
DD – Drug-Drug Interactions	**PR** – Enrollment in a Physician-Supervised Program Required	**YQ** – Yearly Quantity Limits

Descriptive Therapeutic Class	Drugs on PDL	POS Edits	Drugs on NPDL which Require Prior Authorization (PA)	POS Edits
ANTIVIRALS, ORAL (7)	Acyclovir Capsule; Suspension; Tablet (Generic)		Acyclovir Suspension; Tablet (Zovirax®)	
*Request Form	Famciclovir Tablet (Generic)		Baloxavir Marboxil (Xofluza®)	
*Criteria	Oseltamivir Capsule (Tamiflu®)		Oseltamivir Capsule (Generic)	
	Oseltamivir Suspension (Generic)		Oseltamivir Suspension (Tamiflu®)	
	Valacyclovir Tablet (Generic)		Rimantadine Tablet (Generic)	
			Valacyclovir Tablet (Valtrex®)	
			Zanamivir Inhalation Powder (Relenza® Diskhaler®)	
ANXIOLYTICS (8)	Alprazolam Tablet (Generic)	**BH, CU, QL, TD**	Alprazolam ER Tablet (Generic; Xanax XR®)	**AL, CU, DX, QL, TD**
*Request Form	Buspirone Tablet (Generic)	**BH, CU, TD**	Alprazolam Intensol Concentrate (Generic)	**BH, CU, TD**
*Criteria	Lorazepam Tablet (Generic)	**BH, BY, CU, QL, TD**	Alprazolam ODT (Generic)	**AL, CU, DX, TD**
			Alprazolam Tablet (Xanax®)	**BH, CU, QL, TD**
*Age Limits (AL), Diagnosis Code Requirement (DX), Quantity Limits (QL) & Diagnosis Codes That Bypass Quantity Limits or Behavioral Health Authorization Requirements (BY)			Chlordiazepoxide Capsule (Generic)	**BH, CU, QL, TD**
			Clorazepate Dipotassium Tablet (Generic; Tranxene T-Tab®)	**BH, BY, CU, QL, TD**
			Diazepam Injection Vial; Syringe (Generic)	**BH, BY, CU, TD**
			Diazepam Intensol Concentrate (Generic)	**BH, BY, CU, TD**
			Diazepam Solution (Generic)	**BH, BY, CU, TD**
			Diazepam Tablet (Generic)	**BH, BY, CU, QL, TD**
			Lorazepam Intensol Concentrate (Generic)	**BH, CU, TD**
			Lorazepam Tablet (Ativan®)	**BH, BY, CU, QL, TD**
			Meprobamate (Generic)	**CU, TD**
			Oxazepam (Generic)	**BH, CU, QL, TD**

AG – Authorized Generic	**DR** – Concurrent Prescriptions Must Be Written by Same Prescriber	**PU** – Prior Use of Other Medication is Required
AL – Age Limits	**DS** – Maximum Days' Supply Allowed	**QL** – Quantity Limits
BH – Behavioral Health Clinical Authorization Required for Children Younger Than 6 Years Old	**DT** – Duration of Therapy Limit	**RX** – Specific Prescription Requirements
BY – Diagnosis Codes Bypass Some Requirements	**DX** – Diagnosis Code Requirements	**TD** – Therapeutic Duplication
CL – More Detailed Clinical Information Required for Authorization	**ER** – Early Refill **NOT** Allowed	**UN** – Drug Use Not Warranted (Needs Appropriate Diagnosis)
CU – Concurrent Use with Opioids or Benzodiazepines is Restricted	**MD** – Maximum Dose Limits	**X** – Prescriber Must Have 'X' DEA Number
DD – Drug-Drug Interactions	**PR** – Enrollment in a Physician-Supervised Program Required	**YQ** – Yearly Quantity Limits

Descriptive Therapeutic Class	Drugs on PDL	POS Edits	Drugs on NPDL which Require Prior Authorization (PA)	POS Edits
ASTHMA/COPD (9)	**INHALATION**		**INHALATION**	
Bronchodilator, Anticholinergics (COPD) Inhalation	Albuterol Sulfate/Ipratropium (Combivent Respimat®)		Aclidinium Bromide Inhalation Powder (Tudorza Pressair®)	
	Albuterol Sulfate/Ipratropium Nebulizer Solution (Generic)		Glycopyrrolate (Seebri Neohaler®)	
*Request Form	Glycopyrrolate/Formoterol Inhalation (Bevespi Aerosphere®)		Glycopyrrolate Inhalation Solution (Lonhala Magnair®)	
*Criteria	Ipratropium Inhalation Aerosol MDI (Atrovent HFA®)		Indacaterol/Glycopyrrolate (Utibron Neohaler®)	
	Ipratropium Nebulizer Solution (Generic)		Revefenacin Inhalation Solution (Yupelri®)	
	Tiotropium Inhalation Powder (Spiriva® Handihaler®)		Tiotropium Bromide Inhalation Spray (Spiriva Respimat®)	
	Tiotropium/Olodaterol (Stiolto Respimat®)		Umeclidinium Inhalation Powder (Incruse Ellipta®)	
			Umeclidinium/Vilanterol Inhalation Powder (Anoro Ellipta®)	
ASTHMA/COPD (9)	**ORAL**		**ORAL**	
Bronchodilator, Anticholinergics (COPD) Oral	**NONE**		Roflumilast (Daliresp®)	**CL**
*Request Form *Daliresp Criteria				
ASTHMA/COPD (9)	**INHALATION**		**INHALATION**	
Bronchodilator, Beta-Adrenergic Inhalation Agents	Albuterol Sulfate Nebulizer 0.63mg/3ml, 1.25mg/3ml, 2.5mg/3ml (Generic)		Albuterol Sulfate MDI (Ventolin HFA®)	**YQ, BY, TD**
*Request Form	Albuterol Sulfate Nebulizer Solution 100mg/20ml (Generic)		Albuterol Sulfate Inhalation Powder (ProAir RespiClick®)	**YQ, BY, TD**
*Criteria	Albuterol Sulfate Nebulizer Solution 2.5 mg/0.5ml (Generic)		Arformoterol Inhalation Solution (Brovana®)	
*Yearly Quantity Limits (YQ)	Albuterol Sulfate MDI (ProAir HFA®; Proventil HFA®)	**YQ, BY, TD**	Formoterol Inhalation Solution (Perforomist®)	
*Diagnosis Codes That Bypass YQ (BY)	Salmeterol Xinafoate (Serevent Diskus®)		Indacaterol Inhalation Powder (Arcapta Neohaler®)	
			Levalbuterol Nebulizer Solution; Solution Concentrate (Generic; Xopenex®)	
			Levalbuterol MDI (AG; Xopenex HFA®)	**YQ, BY, TD**
			Olodaterol (Striverdi Respimat®)	
ASTHMA/COPD (9)	**ORAL**		**ORAL**	
Bronchodilator, Beta-Adrenergic Oral Agents	Albuterol Sulfate Syrup (Generic)		Albuterol Sulfate ER Tablet (Generic)	
	Terbutaline Sulfate Tablet (Generic)		Albuterol Sulfate Tablet (Generic)	
*Request Form			Metaproterenol Sulfate Syrup; Tablet (Generic)	
*Criteria				

AG – Authorized Generic	**DR** – Concurrent Prescriptions Must Be Written by Same Prescriber	**PU** – Prior Use of Other Medication is Required
AL – Age Limits	**DS** – Maximum Days' Supply Allowed	**QL** – Quantity Limits
BH – Behavioral Health Clinical Authorization Required for Children Younger Than 6 Years Old	**DT** – Duration of Therapy Limit	**RX** – Specific Prescription Requirements
BY – Diagnosis Codes Bypass Some Requirements	**DX** – Diagnosis Code Requirements	**TD** – Therapeutic Duplication
CL – More Detailed Clinical Information Required for Authorization	**ER** – Early Refill **NOT** Allowed	**UN** – Drug Use Not Warranted (Needs Appropriate Diagnosis)
CU – Concurrent Use with Opioids or Benzodiazepines is Restricted	**MD** – Maximum Dose Limits	**X** – Prescriber Must Have 'X' DEA Number
DD – Drug-Drug Interactions	**PR** – Enrollment in a Physician-Supervised Program Required	**YQ** – Yearly Quantity Limits

Descriptive Therapeutic Class	Drugs on PDL	POS Edits	Drugs on NPDL which Require Prior Authorization (PA)	POS Edits
ASTHMA/COPD (9)	Budesonide Respules 0.25mg; 0.5mg; 1mg (Generic)		Beclomethasone HFA; Breath-Actuated HFA (QVAR®, QVAR® RediHaler®)	
Glucocorticoids, Inhalation	Budesonide/Formoterol MDI (Symbicort®)		Budesonide DPI (Pulmicort Flexhaler®)	
*Request Form	Fluticasone MDI (Flovent® HFA)		Budesonide Respules 0.25mg; 0.5mg; 1mg (Pulmicort Respules®)	
*Criteria	Fluticasone/Salmeterol DPI (Advair Diskus®)		Ciclesonide MDI (Alvesco®)	
	Mometasone Inhalation Powder (Asmanex® Twisthaler®)		Fluticasone Furoate Inhalation Powder (Arnuity Ellipta®)	
	Mometasone/Formoterol MDI (Dulera®)		Fluticasone Propionate Inhalation Powder (ArmonAir RespiClick®)	
			Fluticasone Propionate Inhalation Powder (Flovent Diskus®)	
			Fluticasone/Salmeterol MDI (Advair HFA®)	
			Fluticasone/Salmeterol Inhalation Powder (AG; Airduo RespiClick®)	
			Fluticasone/Vilanterol Inhalation Powder (Breo Ellipta®)	
			Fluticasone/Umeclidinium/Vilanterol Inhalation Powder (Trelegy Ellipta®)	
			Mometasone Furoate MDI (Asmanex HFA®)	
ASTHMA/COPD (9)	Montelukast Chewable Tablet; Tablet (Generic)		Montelukast Chewable Tablet; Tablet (Singulair®)	
Leukotriene Modifiers			Montelukast Granules (Generic; Singulair®)	
*Request Form			Zafirlukast Tablet (Generic; Accolate®)	
*Criteria			Zileuton ER Tablet (Generic; Zyflo CR®)	
			Zileuton Tablet (Zyflo®)	
COLONY STIMULATING FACTORS (10)	Filgrastim Syringe; Vial (Neupogen®)	**CL**	Filgrastim-aafi (Nivestym®)	**CL**
	Pegfilgrastim-cbqv (Udenyca®)	**CL**	Filgrastim-sndz (Zarxio®)	**CL**
*Request Form	Pegfilgrastim-jmdb (Fulphila®)	**CL**	Pegfilgrastim Kit; Syringe (Neulasta®)	**CL**
*Criteria	Tbo-Filgrastim (Granix®)	**CL**	Sargramostim (Leukine®)	**CL**
CYSTIC FIBROSIS, ORAL (11)	**NONE**		Ivacaftor Packet (Kalydeco®)	**CL, DX**
*Request Form			Ivacaftor Tablet (Kalydeco®)	**CL, DX**
*Kalydeco			Lumacaftor/Ivacaftor Packet (Orkambi®)	**CL, DX**
*Orkambi Criteria			Lumacaftor/Ivacaftor Tablet (Orkambi®)	**CL, DX**
*Symdeko Criteria			Tezacaftor/Ivacaftor (Symdeko®)	**CL**

AG – Authorized Generic	**DR** – Concurrent Prescriptions Must Be Written by Same Prescriber	**PU** – Prior Use of Other Medication is Required
AL – Age Limits	**DS** – Maximum Days' Supply Allowed	**QL** – Quantity Limits
BH – Behavioral Health Clinical Authorization Required for Children Younger Than 6 Years Old	**DT** – Duration of Therapy Limit	**RX** – Specific Prescription Requirements
BY – Diagnosis Codes Bypass Some Requirements	**DX** – Diagnosis Code Requirements	**TD** – Therapeutic Duplication
CL – More Detailed Clinical Information Required for Authorization	**ER** – Early Refill **NOT** Allowed	**UN** – Drug Use Not Warranted (Needs Appropriate Diagnosis)
CU – Concurrent Use with Opioids or Benzodiazepines is Restricted	**MD** – Maximum Dose Limits	**X** – Prescriber Must Have 'X' DEA Number
DD – Drug-Drug Interactions	**PR** – Enrollment in a Physician-Supervised Program Required	**YQ** – Yearly Quantity Limits

Descriptive Therapeutic Class	Drugs on PDL	POS Edits	Drugs on NPDL which Require Prior Authorization (PA)	POS Edits
DEPRESSION (12)	Bupropion HCl IR (Generic)	**BH**	Bupropion HBr ER (Aplenzin®)	**BH**
Antidepressants, Other	Bupropion HCl SR (Generic)	**BH**	Bupropion HCl ER (Forfivo XL®; Wellbutrin XL®)	**BH**
*Request Form	Bupropion HCl XL (Generic)	**BH**	Bupropion HCl SR (Wellbutrin SR®)	**BH**
*Criteria	Mirtazapine ODT (Generic)	**BH**	Desvenlafaxine ER (AG; Khedezla®)	**BH**
	Mirtazapine Tablet (Generic)	**BH**	Desvenlafaxine ER (Generic)	**BH**
	Trazodone (Generic)	**BH**	Desvenlafaxine Fumarate ER (Generic)	**BH**
	Venlafaxine ER Capsule (Generic)	**BH**	Desvenlafaxine Succinate ER Tablet (Generic; AG; Pristiq®)	**BH**
	Venlafaxine IR Tablet (Generic)	**BH**	Isocarboxazid (Marplan®)	**BH**
			Levomilnacipran (Fetzima®)	**BH**
			Mirtazapine Tablet; ODT (Remeron®; Remeron ODT®)	**BH**
			Nefazodone Tablet (Generic)	**BH**
			Phenelzine (Generic; Nardil®)	**BH**
			Selegiline Patch (Emsam®)	**BH**
			Tranylcypromine Sulfate (Generic; Parnate®)	**BH**
			Venlafaxine ER Capsule (Effexor XR®)	**BH**
			Venlafaxine ER Tablet (Generic; AG)	**BH**
			Vilazodone (Viibryd®; Viibryd® Dose Pack)	**BH**
			Vortioxetine (Trintellix®)	**BH**
DEPRESSION (12)	Citalopram Solution; Tablet (Generic)	**BH, TD**	Citalopram Tablet (Celexa®)	**BH, TD**
Selective Serotonin Reuptake Inhibitors (SSRIs)	Escitalopram Tablet (Generic)	**BH, TD**	Escitalopram Solution (Generic)	**BH, TD**
	Fluoxetine Capsule; Solution (Generic)	**BH, TD**	Escitalopram Tablet (Lexapro®)	**BH, TD**
*Request Form	Fluvoxamine Maleate Tablet (Generic)	**BH, TD**	Fluoxetine 60 mg Tablet (Generic)	**BH, TD**
*Criteria	Paroxetine Tablet (Generic)	**BH, TD**	Fluoxetine Capsule (Prozac®)	**BH, TD**
	Sertraline Concentrate; Tablet (Generic)	**BH, TD**	Fluoxetine Tablet (Generic; Sarafem®)	**BH, TD**
Brisdelle Acceptable Diagnosis Codes Moderate to Severe Vasomotor Symptoms Associated with Menopause **E28.310, E89.41, N95.1**			Fluoxetine Delayed Release Capsule (Generic)	**BH, TD**
			Fluvoxamine Maleate ER (Generic)	**BH, TD**
			Paroxetine ER Tablet (Generic; Paxil CR®)	**BH, TD**
			Paroxetine HCl Suspension; Tablet (Paxil®)	**BH, TD**
			Paroxetine Mesylate (Generic; AG; Brisdelle®)	**BH, DX, TD**
			Paroxetine Mesylate (Pexeva®)	**BH, TD**
			Sertraline Tablet (Zoloft®)	**BH, TD**

AG – Authorized Generic	**DR** – Concurrent Prescriptions Must Be Written by Same Prescriber	**PU** – Prior Use of Other Medication is Required
AL – Age Limits	**DS** – Maximum Days' Supply Allowed	**QL** – Quantity Limits
BH – Behavioral Health Clinical Authorization Required for Children Younger Than 6 Years Old	**DT** – Duration of Therapy Limit	**RX** – Specific Prescription Requirements
BY – Diagnosis Codes Bypass Some Requirements	**DX** – Diagnosis Code Requirements	**TD** – Therapeutic Duplication
CL – More Detailed Clinical Information Required for Authorization	**ER** – Early Refill **NOT** Allowed	**UN** – Drug Use Not Warranted (Needs Appropriate Diagnosis)
CU – Concurrent Use with Opioids or Benzodiazepines is Restricted	**MD** – Maximum Dose Limits	**X** – Prescriber Must Have 'X' DEA Number
DD – Drug-Drug Interactions	**PR** – Enrollment in a Physician-Supervised Program Required	**YQ** – Yearly Quantity Limits

Descriptive Therapeutic Class	Drugs on PDL	POS Edits	Drugs on NPDL which Require Prior Authorization (PA)	POS Edits
DERMATOLOGY (13)	Mupirocin Ointment (Generic)		Gentamicin Sulfate Cream; Ointment (Generic)	
Antibiotics, Topical			Mupirocin Cream (Generic)	
*Request Form			Mupirocin Ointment (Centany®)	
*Criteria			Mupirocin Ointment (Centany® Kit)	
DERMATOLOGY (13)	Clotrimazole Rx Cream; Solution (Generic)		Butenafine Cream (Mentax®)	
Antifungals - Topical	Clotrimazole/Betamethasone Cream (Generic)		Ciclopirox Cream; Gel; Solution; Suspension (Generic)	
*Request Form	Ketoconazole Cream (Generic)		Ciclopirox Shampoo (Generic; Loprox®)	
*Criteria	Ketoconazole Shampoo Rx only (Generic)		Ciclopirox Solution Kit (Generic)	
	Nystatin Cream; Ointment; Topical Powder (Generic)		Ciclopirox/Skin Cleanser No. 40 (Loprox® Kit)	
	Nystatin/Triamcinolone Cream		Ciclopirox Solution (Penlac®)	
			Clotrimazole/Betamethasone Lotion (Generic)	
			Clotrimazole/Betamethasone Cream (Lotrisone®)	
			Clotrimazole/Betamethasone/Zinc Oxide (DermacinRx® TherazolePak™)	
			Econazole Cream (Generic)	
			Efinaconazole Solution (Jublia®)	
			Ketoconazole Foam (Generic; AG; Extina®)	
			Luliconazole Cream (AG; Luzu®)	
			Miconazole/Zinc Oxide/White Petrolatum (AG; Vusion®)	
			Naftifine Cream (Generic; Naftin®)	
			Naftifine Gel (Naftin®)	
			Nystatin/Triamcinolone Ointment (Generic)	
			Oxiconazole Lotion; Cream (Oxistat®)	
			Oxiconazole Cream (Generic)	
			Salicylic Acid/Benzoic Acid (Bensal HP®)	
			Sertaconazole (Ertaczo®)	
			Sulconazole Cream; Solution (Exelderm®)	
			Tavaborole Solution (Kerydin®)	

AG – Authorized Generic	**DR** – Concurrent Prescriptions Must Be Written by Same Prescriber	**PU** – Prior Use of Other Medication is Required
AL – Age Limits	**DS** – Maximum Days' Supply Allowed	**QL** – Quantity Limits
BH – Behavioral Health Clinical Authorization Required for Children Younger Than 6 Years Old	**DT** – Duration of Therapy Limit	**RX** – Specific Prescription Requirements
BY – Diagnosis Codes Bypass Some Requirements	**DX** – Diagnosis Code Requirements	**TD** – Therapeutic Duplication
CL – More Detailed Clinical Information Required for Authorization	**ER** – Early Refill **NOT** Allowed	**UN** – Drug Use Not Warranted (Needs Appropriate Diagnosis)
CU – Concurrent Use with Opioids or Benzodiazepines is Restricted	**MD** – Maximum Dose Limits	**X** – Prescriber Must Have 'X' DEA Number
DD – Drug-Drug Interactions	**PR** – Enrollment in a Physician-Supervised Program Required	**YQ** – Yearly Quantity Limits

Descriptive Therapeutic Class	Drugs on PDL	POS Edits	Drugs on NPDL which Require Prior Authorization (PA)	POS Edits
DERMATOLOGY (13)	Permethrin Cream (Generic)		Crotamiton Cream; Lotion (Eurax®)	
Antiparasitic Agents, Topical	Ivermectin Lotion (Sklice®)		Crotamiton Lotion (Crotan®)	
*Request Form	Spinosad Suspension (Natroba®)		Lindane Shampoo (Generic)	
*Criteria			Malathion Lotion (Generic; Ovide®)	
			Permethrin Cream (Elimite®)	
			Spinosad Suspension (Generic)	
DERMATOLOGY (13)	Acitretin Capsule (Generic; AG)		Acitretin Capsule (Soriatane®)	
Antipsoriatics, Oral			Methoxsalen Rapid (Generic)	
*Request Form				
*Criteria				
DERMATOLOGY (13)	Calcipotriene Cream; Solution (Generic)		Calcipotriene Cream (Dovonex®)	
Antipsoriatics, Topical			Calcipotriene Foam (Sorilux®)	
*Request Form			Calcipotriene Ointment (Generic; Calcitrene®)	
*Criteria			Calcipotriene/Betamethasone Dipropionate Foam (Enstilar®)	
			Calcipotriene/Betamethasone Dipropionate Ointment (Generic; AG; Taclonex®)	
			Calcipotriene/Betamethasone Dipropionate Suspension (Taclonex Scalp®)	
			Calcitriol Ointment (Generic; Vectical®)	
DERMATOLOGY (13)	Acyclovir Ointment (Generic)		Acyclovir Cream (Generic; Zovirax®)	
Antiviral Agents, Topical			Acyclovir Ointment (Zovirax®)	
*Request Form			Acyclovir/Hydrocortisone (Xerese®)	
*Criteria			Penciclovir Cream (Denavir®)	

AG – Authorized Generic	**DR** – Concurrent Prescriptions Must Be Written by Same Prescriber	**PU** – Prior Use of Other Medication is Required
AL – Age Limits	**DS** – Maximum Days' Supply Allowed	**QL** – Quantity Limits
BH – Behavioral Health Clinical Authorization Required for Children Younger Than 6 Years Old	**DT** – Duration of Therapy Limit	**RX** – Specific Prescription Requirements
BY – Diagnosis Codes Bypass Some Requirements	**DX** – Diagnosis Code Requirements	**TD** – Therapeutic Duplication
CL – More Detailed Clinical Information Required for Authorization	**ER** – Early Refill **NOT** Allowed	**UN** – Drug Use Not Warranted (Needs Appropriate Diagnosis)
CU – Concurrent Use with Opioids or Benzodiazepines is Restricted	**MD** – Maximum Dose Limits	**X** – Prescriber Must Have 'X' DEA Number
DD – Drug-Drug Interactions	**PR** – Enrollment in a Physician-Supervised Program Required	**YQ** – Yearly Quantity Limits

Descriptive Therapeutic Class	Drugs on PDL	POS Edits	Drugs on NPDL which Require Prior Authorization (PA)	POS Edits
DERMATOLOGY (13)	Pimecrolimus Cream (Elidel®)		Crisaborole Topical Ointment (Eucrisa®)	
Atopic Dermatitis Immunomodulators			Dupilumab Injection (Dupixent®)	
			Tacrolimus Ointment (Generic; AG; Protopic®)	
*Request Form				
*Criteria				
DERMATOLOGY (13)	Ammonium Lactate Cream; Lotion (Generic)		Emollient Combination No. 10 (Biafine® Emulsion)	
Emollients			Emollient Combination No. 43 (Promiseb®)	
*Request Form			Emollient Combination No. 43 / Skin Cleanser No. 27 (Promiseb Complete®)	
*Criteria			Hyaluronic Acid/Grape Seed Extract/Vitamin C & E (Atopiclair®)	
DERMATOLOGY (13)	Imiquimod 5% Cream Packet (Generic)	**DX**	Imiquimod 5% Cream Packet (Aldara®)	**DX**
Immunomodulators, Topical			Imiquimod (Zyclara®)	**DX**
*Request Form			Podofilox (Generic)	
*Criteria			Sinecatechins (Veregen®)	
*Diagnosis Code Required				
DERMATOLOGY (13)	Fluocinolone Acetonide 0.01% Oil (Derma-Smoothe-FS®)		Alclometasone Dipropionate Cream; Ointment (Generic)	
Steroids, Topical	Hydrocortisone Cream; Lotion; Ointment (Generic)		Desonide Cream; Lotion; Ointment (Generic)	
Low Potency			Desonide Gel (Desonate®)	
*Request Form			Fluocinolone Acetonide 0.01% Oil (Generic)	
*Criteria			Fluocinolone Acetonide Shampoo (Capex®)	
			Hydrocortisone Acetate Cream (Micort-HC®)	
			Hydrocortisone Base Cream; Lotion (Ala-Cort®; Ala-Scalp®)	
			Hydrocortisone Solution (Texacort®)	
			Hydrocortisone/Skin Cleanser No. 25 (Aqua Glycolic HC®)	
			Hydrocortisone/Skin Cleanser No. 35 (Dermasorb HC®)	

AG – Authorized Generic	**DR** – Concurrent Prescriptions Must Be Written by Same Prescriber	**PU** – Prior Use of Other Medication is Required
AL – Age Limits	**DS** – Maximum Days' Supply Allowed	**QL** – Quantity Limits
BH – Behavioral Health Clinical Authorization Required for Children Younger Than 6 Years Old	**DT** – Duration of Therapy Limit	**RX** – Specific Prescription Requirements
BY – Diagnosis Codes Bypass Some Requirements	**DX** – Diagnosis Code Requirements	**TD** – Therapeutic Duplication
CL – More Detailed Clinical Information Required for Authorization	**ER** – Early Refill **NOT** Allowed	**UN** – Drug Use Not Warranted (Needs Appropriate Diagnosis)
CU – Concurrent Use with Opioids or Benzodiazepines is Restricted	**MD** – Maximum Dose Limits	**X** – Prescriber Must Have 'X' DEA Number
DD – Drug-Drug Interactions	**PR** – Enrollment in a Physician-Supervised Program Required	**YQ** – Yearly Quantity Limits

Descriptive Therapeutic Class	Drugs on PDL	POS Edits	Drugs on NPDL which Require Prior Authorization (PA)	POS Edits
DERMATOLOGY (13)	Fluticasone Propionate Cream; Ointment (Generic)		Betamethasone Valerate Foam (Generic; Luxiq®)	
Steroids, Topical	Mometasone Furoate Cream; Ointment; Solution (Generic)		Clocortolone Pivalate Cream (AG; Cloderm®)	
Medium Potency			Fluocinolone Acetonide Cream; Ointment; Solution (Generic)	
*Request Form			Fluocinolone Acetonide Ointment; Solution (Synalar®)	
*Criteria			Fluocinolone Acetonide/Emollient CMB No. 65 Cream Kit; Ointment Kit (Synalar®)	
			Fluocinolone Acetonide/Skin Cleanser No. 28 (Synalar® TS Kit)	
			Flurandrenolide Cream, Ointment (Generic)	
			Flurandrenolide Lotion (Generic; AG)	
			Flurandrenolide Tape (Cordran Tape®)	
			Fluticasone Propionate Lotion (Generic)	
			Hydrocortisone Butyrate Cream; Lotion; Solution (Generic; AG)	
			Hydrocortisone Butyrate Ointment (Generic)	
			Hydrocortisone Butyrate/Emollient (Generic; AG)	
			Hydrocortisone Probutate Cream (Pandel®)	
			Hydrocortisone Valerate Cream; Ointment (Generic)	
			Mometasone Furoate Cream; Ointment (Elocon®)	
			Prednicarbate Cream; Ointment (Generic)	
DERMATOLOGY (13)	Betamethasone Dipropionate/Propylene Glycol Cream (Generic)		Amcinonide Cream; Lotion (Generic)	
Steroids, Topical	Betamethasone Valerate Cream; Lotion; Ointment (Generic)		Betamethasone Dipropionate Cream; Gel; Lotion; Ointment (Generic)	
High Potency	Triamcinolone Acetonide Cream; Lotion; Ointment (Generic)		Betamethasone Dipropionate Spray (Sernivo®)	
*Request Form			Betamethasone Dipropionate/Propylene Glycol Lotion (Generic)	
*Criteria			Betamethasone Dipropionate/Propylene Glycol Ointment (Generic; Diprolene®)	
			Desoximetasone Cream; Gel	
			Desoximetasone Ointment; Spray (Generic; Topicort®)	
			Diflorasone Diacetate Cream; Ointment (Generic)	
			Fluocinonide Cream 0.05%; Cream 0.1%; Gel; Solution; Ointment (Generic)	
			Fluocinonide Cream 0.1% (Vanos®)	
			Halcinonide Cream; Ointment (Halog®)	

AG – Authorized Generic	**DR** – Concurrent Prescriptions Must Be Written by Same Prescriber	**PU** – Prior Use of Other Medication is Required
AL – Age Limits	**DS** – Maximum Days' Supply Allowed	**QL** – Quantity Limits
BH – Behavioral Health Clinical Authorization Required for Children Younger Than 6 Years Old	**DT** – Duration of Therapy Limit	**RX** – Specific Prescription Requirements
BY – Diagnosis Codes Bypass Some Requirements	**DX** – Diagnosis Code Requirements	**TD** – Therapeutic Duplication
CL – More Detailed Clinical Information Required for Authorization	**ER** – Early Refill **NOT** Allowed	**UN** – Drug Use Not Warranted (Needs Appropriate Diagnosis)
CU – Concurrent Use with Opioids or Benzodiazepines is Restricted	**MD** – Maximum Dose Limits	**X** – Prescriber Must Have 'X' DEA Number
DD – Drug-Drug Interactions	**PR** – Enrollment in a Physician-Supervised Program Required	**YQ** – Yearly Quantity Limits

Descriptive Therapeutic Class	Drugs on PDL	POS Edits	Drugs on NPDL which Require Prior Authorization (PA)	POS Edits
DERMATOLOGY (13)	(preferred agents listed on page 14)		Triamcinolone Acetonide Aerosol (Generic; Kenalog Aerosol®)	
Steroids, Topical			Triamcinolone Acetonide Ointment (Trianex®)	
High Potency Continued			Triamcinolone Acetonide/Dimethicone Ointment Kit (Ellzia Pak™)	
			Triamcinolone Acetonide/Dimethicone Ointment/Cream Kit (Generic)	
			Triamcinolone/Emollient Combination No. 86 (Dermasorb TA®)	
DERMATOLOGY (13)	Clobetasol Propionate Cream; Emollient; Gel; Ointment; Solution		Clobetasol Propionate Foam (Generic; Olux®)	
Steroids, Topical	Halobetasol Propionate Cream; Ointment (Generic)		Clobetasol Propionate Lotion; Shampoo (Generic; Clobex®)	
Very High Potency			Clobetasol Propionate Spray (Generic; AG; Clobex®)	
*Request Form			Clobetasol/Skin Cleanser No. 28 (Clodan® Kit)	
*Criteria			Diflorasone Diacetate (Apexicon E®)	
			Halobetasol Propionate Foam (Lexette™)	
			Halobetasol Propionate Lotion (Bryhali®; Ultravate®)	
			Halobetasol Propionate/Lactic Acid Cream; Ointment (Ultravate® X)	
DIABETES (14)	Acarbose (Generic)		Acarbose (Precose®)	
Alpha-Glucosidase Inhibitors			Miglitol (Generic; Glyset®)	
*Request Form				
*Criteria				

AG – Authorized Generic	**DR** – Concurrent Prescriptions Must Be Written by Same Prescriber	**PU** – Prior Use of Other Medication is Required
AL – Age Limits	**DS** – Maximum Days' Supply Allowed	**QL** – Quantity Limits
BH – Behavioral Health Clinical Authorization Required for Children Younger Than 6 Years Old	**DT** – Duration of Therapy Limit	**RX** – Specific Prescription Requirements
BY – Diagnosis Codes Bypass Some Requirements	**DX** – Diagnosis Code Requirements	**TD** – Therapeutic Duplication
CL – More Detailed Clinical Information Required for Authorization	**ER** – Early Refill **NOT** Allowed	**UN** – Drug Use Not Warranted (Needs Appropriate Diagnosis)
CU – Concurrent Use with Opioids or Benzodiazepines is Restricted	**MD** – Maximum Dose Limits	**X** – Prescriber Must Have 'X' DEA Number
DD – Drug-Drug Interactions	**PR** – Enrollment in a Physician-Supervised Program Required	**YQ** – Yearly Quantity Limits

Descriptive Therapeutic Class	Drugs on PDL	POS Edits	Drugs on NPDL which Require Prior Authorization (PA)	POS Edits
DIABETES (14)	Exenatide ER Subcutaneous; Pen-Injector (Bydureon®)	**MD, PU**	Albiglutide (Tanzeum®) **Discontinued**	
Hypoglycemics	Exenatide Solution Pens (Byetta®)	**MD, PU**	Alogliptin (AG; Nesina®)	**MD, PU**
Incretin Mimetics/Enhancers	Linagliptin Tablet (Tradjenta®)	**PU**	Alogliptin/Metformin (AG; Kazano®)	**MD, PU**
*Request Form	Linagliptin/Empagliflozin (Glyxambi®) **(See SGLT2 Criteria)**	**MD, PU**	Alogliptin/Pioglitazone (AG; Oseni®)	**MD, PU**
*Incretin Mimetic/Enhancer Criteria	Linagliptin/Metformin (Jentadueto®)	**MD, PU**	Dulaglutide Pen (Trulicity®)	**MD, PU**
*SGLT2 Criteria	Liraglutide (Victoza®)	**MD, PU**	Exenatide ER Auto-Injector (Bydureon BCise®)	**MD, PU**
*Insulins & Related Agents Criteria	Sitagliptin Tablet (Januvia®)	**MD, PU**	Linagliptin/Metformin Tablet ER (Jentadueto XR®)	**MD, PU**
	Sitagliptin/Metformin Tablet (Janumet®)	**MD, PU**	Liraglutide/Insulin Degludec (Xultophy®) **(See Insulins & Related)**	
	Sitagliptin/Metformin Tablet ER (Janumet XR®)	**MD, PU**	Lixisenatide (Adlyxin®)	**MD, PU**
			Lixisenatide/ Insulin Glargine (Soliqua®) **(See Insulins & Related)**	
			Pramlintide Pens (SymlinPen®)	**MD, PU**
			Saxagliptin (Onglyza®)	**MD, PU**
			Saxagliptin/Dapagliflozin (Qtern®) **(See SGLT2 Criteria)**	**PU**
			Saxagliptin/Metformin ER (Kombiglyze XR®)	**MD, PU**
			Semaglutide Pen (Ozempic®)	**MD, PU**
			Sitagliptin/Ertugliflozin (Steglujan®) **(See SGLT2 Criteria)**	**PU**
DIABETES (14)	Insulin Aspart Cartridge; Pen; Vial (Novolog®)		Insulin Aspart Pen (Fiasp® FlexTouch®)	
Hypoglycemics	Insulin Aspart/Insulin Aspart Protamine Pens; Vial (Novolog Mix 70/30®)		Insulin Aspart Vial (Fiasp®)	
Insulins & Related Agents	Insulin Detemir Pens; Vial (Levemir®)		Insulin Degludec 100 U/ml (Tresiba® FlexTouch®)	
*Request Form	Insulin Glargine Pen (Lantus® SoloStar®)		Insulin Degludec 200 U/ml (Tresiba® FlexTouch®)	
*Criteria	Insulin Glargine Vial (Lantus®)		Insulin Degludec Vial (Tresiba®)	
	Insulin Human Vial OTC (Humulin® N; Humulin® R)		Insulin Glargine (Toujeo Solostar Pen®)	
	Insulin Human Regular 500 units/ml Vial (Humulin® R U-500)		Insulin Glargine 300 units/mL (Toujeo Max Solostar Pen®)	
	Insulin Isophane (NPH)/Insulin Regular Vial OTC (Humulin® 70/30)		Insulin Glargine U-100 (Basaglar® KwikPen®)	
	Insulin Lispro Pen; Vial (Humalog®)		Insulin Glulisine Pens (Apidra® SoloStar®)	
	Insulin Lispro/Protamine Lispro Pen; Vial (Humalog Mix®)		Insulin Glulisine Vials (Apidra®)	
			Insulin Human Inhalation Powder Cartridge (Afrezza®)	
			Insulin Human Pen OTC (Humulin® N)	
			Insulin Human Regular 500 U/ml Pen (Humulin® R U-500)	

AG – Authorized Generic	**DR** – Concurrent Prescriptions Must Be Written by Same Prescriber	**PU** – Prior Use of Other Medication is Required
AL – Age Limits	**DS** – Maximum Days' Supply Allowed	**QL** – Quantity Limits
BH – Behavioral Health Clinical Authorization Required for Children Younger Than 6 Years Old	**DT** – Duration of Therapy Limit	**RX** – Specific Prescription Requirements
BY – Diagnosis Codes Bypass Some Requirements	**DX** – Diagnosis Code Requirements	**TD** – Therapeutic Duplication
CL – More Detailed Clinical Information Required for Authorization	**ER** – Early Refill **NOT** Allowed	**UN** – Drug Use Not Warranted (Needs Appropriate Diagnosis)
CU – Concurrent Use with Opioids or Benzodiazepines is Restricted	**MD** – Maximum Dose Limits	**X** – Prescriber Must Have 'X' DEA Number
DD – Drug-Drug Interactions	**PR** – Enrollment in a Physician-Supervised Program Required	**YQ** – Yearly Quantity Limits

Descriptive Therapeutic Class	Drugs on PDL	POS Edits	Drugs on NPDL which Require Prior Authorization (PA)	POS Edits
DIABETES (14)	(preferred agents listed on page 16)		Insulin Human Vial OTC (Novolin®)	
Hypoglycemics			Insulin Isophane (NPH) Insulin Regular Pen OTC (Novolin® 70/30)	
Insulins & Related Agents Continued			Insulin Isophane (NPH) Insulin Regular Vial OTC (Novolin® 70/30)	
			Insulin Isophane (NPH) -Insulin Regular Pen OTC (Humulin® 70/30)	
			Insulin Lispro (Humalog® Jr KwikPen)	
			Insulin Lispro 200 U/ml Pen (Humalog®)	
			Insulin Lispro Cartridge (Humalog®)	
			Insulin Lispro Pen (Admelog® SoloStar®)	
			Insulin Lispro Vial (Admelog®)	
DIABETES (14)	Nateglinide (Generic)		Nateglinide (Starlix®)	
Hypoglycemics	Repaglinide (Generic)		Repaglinide (Prandin®)	
Meglitinides			Repaglinide/Metformin (Generic)	
*Request Form				
*Criteria				
DIABETES (14)	Canagliflozin (Invokana®)	**PU**	Canagliflozin/Metformin (Invokamet®)	**PU**
Hypoglycemics	Empagliflozin (Jardiance®)	**PU**	Canagliflozin/Metformin ER (Invokamet® XR)	**PU**
Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors			Dapagliflozin (Farxiga®)	**PU**
			Dapagliflozin/Metformin ER Tablet (Xigduo® XR)	**PU**
*Request Form			Empagliflozin/Metformin (Synjardy®)	**PU**
*Criteria			Empagliflozin/Metformin ER (Synjardy® XR)	**PU**
			Ertugliflozin (Steglatro®)	**PU**
			Ertugliflozin/Metformin (Segluromet®)	**PU**
DIABETES (14)	Glimepiride (Generic)		Chlorpropamide (Generic)	
Hypoglycemics	Glipizide (Generic)		Glimepiride (Amaryl®)	
Sulfonylureas	Glipizide ER (Generic)		Glipizide (Glucotrol®)	
*Request Form	Glyburide (Generic)		Glipizide ER (Glucotrol® XL)	
*Criteria	Glyburide Micronized (Generic)		Tolazamide (Generic)	
			Tolbutamide (Generic)	

AG – Authorized Generic	**DR** – Concurrent Prescriptions Must Be Written by Same Prescriber	**PU** – Prior Use of Other Medication is Required
AL – Age Limits	**DS** – Maximum Days' Supply Allowed	**QL** – Quantity Limits
BH – Behavioral Health Clinical Authorization Required for Children Younger Than 6 Years Old	**DT** – Duration of Therapy Limit	**RX** – Specific Prescription Requirements
BY – Diagnosis Codes Bypass Some Requirements	**DX** – Diagnosis Code Requirements	**TD** – Therapeutic Duplication
CL – More Detailed Clinical Information Required for Authorization	**ER** – Early Refill **NOT** Allowed	**UN** – Drug Use Not Warranted (Needs Appropriate Diagnosis)
CU – Concurrent Use with Opioids or Benzodiazepines is Restricted	**MD** – Maximum Dose Limits	**X** – Prescriber Must Have 'X' DEA Number
DD – Drug-Drug Interactions	**PR** – Enrollment in a Physician-Supervised Program Required	**YQ** – Yearly Quantity Limits

Descriptive Therapeutic Class	Drugs on PDL	POS Edits	Drugs on NPDL which Require Prior Authorization (PA)	POS Edits
DIABETES (14)	Pioglitazone (Generic)		Pioglitazone (Actos®)	
Hypoglycemics			Pioglitazone/Glimepiride (AG for Duetact®)	
Thiazolidinediones (TZDs)			Pioglitazone/Metformin (Generic Actoplus Met®)	
*Request Form			Pioglitazone/Metformin ER (Actoplus Met XR®)	
*Criteria			Rosiglitazone (Avandia®)	
DIABETES (14)	Glipizide-Metformin (Generic)		Metformin (Glucophage®)	
Metformins	Glyburide-Metformin (Generic)		Metformin ER (Generic; Fortamet™)	
*Request Form	Metformin (Generic)		Metformin ER (Generic; Glumetza™)	
*Criteria	Metformin ER (Generic Glucophage XR®)		Metformin Oral Solution (Riomet™)	
			Metformin ER (Glucophage XR®)	
DIGESTIVE DISORDERS (15)	Meclizine Tablet (Generic)		Aprepitant Capsule (Generic; Emend®)	
Antiemetic/Antivertigo Agents	Metoclopramide Vial (Generic)		Aprepitant Pack (Generic; Emend Pack®)	
*Request Form	Metoclopramide Tablet; Solution (Generic)		Aprepitant (Emend® Powder Packet)	
*Criteria	Ondansetron Tablet; ODT Tablet; Solution (Generic)		Aprepitant Injectable Emulsion (Cinvanti®)	
	Ondansetron Vial (Generic)		Dimenhydrinate Injection (Generic)	
*Authorization Required When Prochlorperazine (an antipsychotic) is Used For Children Under 6 (BH)	Prochlorperazine Oral (Generic)	**BH, BY, DX, TD**	Dolasetron Oral (Anzemet®)	
	Promethazine Ampule; Vial (Generic)		Doxylamine/Pyridoxine Tablet (Diclegis®, Bonjesta®)	
	Promethazine Tablet; Syrup (Generic)		Dronabinol Oral (Marinol®; Generic)	
*Prochlorperazine Use in Children, Diagnosis Requirements (DX), & Diagnosis Codes that Bypass (BY) BH Authorization Requirement for Children Under 6	Promethazine Rectal 12.5, 25mg (Generic)		Dronabinol Oral Solution (Syndros®)	
	Scopolamine Transdermal (Generic)		Fosaprepitant Dimeglumine Injection (Emend®)	
			Fosnetupitant/Palonosetron (Akynzeo®) (Intravenous)	
			Granisetron Oral; IV (Generic)	
			Granisetron ER Injection (Sustol®)	
			Granisetron Transdermal (Sancuso®)	
			Metoclopramide Tablet (Reglan®)	
			Metoclopramide Oral ODT (Generic)	

AG – Authorized Generic	**DR** – Concurrent Prescriptions Must Be Written by Same Prescriber	**PU** – Prior Use of Other Medication is Required
AL – Age Limits	**DS** – Maximum Days' Supply Allowed	**QL** – Quantity Limits
BH – Behavioral Health Clinical Authorization Required for Children Younger Than 6 Years Old	**DT** – Duration of Therapy Limit	**RX** – Specific Prescription Requirements
BY – Diagnosis Codes Bypass Some Requirements	**DX** – Diagnosis Code Requirements	**TD** – Therapeutic Duplication
CL – More Detailed Clinical Information Required for Authorization	**ER** – Early Refill **NOT** Allowed	**UN** – Drug Use Not Warranted (Needs Appropriate Diagnosis)
CU – Concurrent Use with Opioids or Benzodiazepines is Restricted	**MD** – Maximum Dose Limits	**X** – Prescriber Must Have 'X' DEA Number
DD – Drug-Drug Interactions	**PR** – Enrollment in a Physician-Supervised Program Required	**YQ** – Yearly Quantity Limits

Descriptive Therapeutic Class	Drugs on PDL	POS Edits	Drugs on NPDL which Require Prior Authorization (PA)	POS Edits
DIGESTIVE DISORDERS (15)	(preferred agents listed on page 18)		Metoclopramide Syringe (Generic)	
Antiemetic/Antivertigo Agents Continued			Nabilone (Cesamet®)	
			Netupitant/Palonosetron HCl Capsule (Akynzeo®)	
			Ondansetron Ampule (Generic)	
			Ondansetron Syringe (Generic)	
			Ondansetron Tablet; ODT; Solution (Zofran®)	
			Ondansetron Oral Film (Zuplenz®)	
			Palonosetron Injection (Generic; AG; Aloxi®)	
			Prochlorperazine Rectal (Generic; Compro®)	
			Prochlorperazine Injection (Generic)	**BH, BY, DX, TD**
			Promethazine Ampule; Vial (Phenergan®)	
			Promethazine Rectal 50 mg (Generic)	
			Rolapitant Tablet (Varubi®)	
			Scopolamine Transdermal (Transderm-Scop®)	
			Trimethobenzamide IM Injection (Tigan®)	
			Trimethobenzamide Oral (Generic)	
DIGESTIVE DISORDERS (15)	Ursodiol Tablet (Generic)		Chenodiol Tablet (Chenodal®)	
Bile Acid Salts			Cholic Acid Capsule (Cholbam®)	
*Request Form			Obeticholic Acid Tablet (Ocaliva®)	
*Criteria			Ursodiol 300 mg Capsule (Generic; Actigall®)	
			Ursodiol (URSO 250®; URSO Forte®)	
DIGESTIVE DISORDERS (15)	Famotidine Tablet (Generic)	**BY, DT**	Cimetidine Solution; Tablet (Generic)	**BY, DT**
Histamine II Receptor Blockers	Ranitidine Syrup; Tablet (Generic)	**BY, DT**	Famotidine Suspension (Generic; Pepcid®)	**BY, DT**
*Request Form			Famotidine Tablet (Pepcid®)	**BY, DT**
*H2 Antagonists Criteria with Duration of Therapy Limits (DT)			Nizatidine Capsule; Solution (Generic)	**BY, DT**
			Ranitidine Capsule (Generic)	**BY, DT**
*Diagnosis Codes That Bypass DT (BY)			Ranitidine Tablet (Zantac 25®)	**BY, DT**

AG – Authorized Generic	**DR** – Concurrent Prescriptions Must Be Written by Same Prescriber	**PU** – Prior Use of Other Medication is Required
AL – Age Limits	**DS** – Maximum Days' Supply Allowed	**QL** – Quantity Limits
BH – Behavioral Health Clinical Authorization Required for Children Younger Than 6 Years Old	**DT** – Duration of Therapy Limit	**RX** – Specific Prescription Requirements
BY – Diagnosis Codes Bypass Some Requirements	**DX** – Diagnosis Code Requirements	**TD** – Therapeutic Duplication
CL – More Detailed Clinical Information Required for Authorization	**ER** – Early Refill **NOT** Allowed	**UN** – Drug Use Not Warranted (Needs Appropriate Diagnosis)
CU – Concurrent Use with Opioids or Benzodiazepines is Restricted	**MD** – Maximum Dose Limits	**X** – Prescriber Must Have 'X' DEA Number
DD – Drug-Drug Interactions	**PR** – Enrollment in a Physician-Supervised Program Required	**YQ** – Yearly Quantity Limits

Descriptive Therapeutic Class	Drugs on PDL	POS Edits	Drugs on NPDL which Require Prior Authorization (PA)	POS Edits
DIGESTIVE DISORDERS (15)	Pancrelipase (Creon®)		Pancrelipase (Pancreaze®)	
Pancreatic Enzymes	Pancrelipase (Zenpep®)		Pancrelipase (Pertzye®)	
*Request Form			Pancrelipase (Viokace®)	
*Criteria				
DIGESTIVE DISORDERS (15)	Lansoprazole Capsule (Generic)	**BY, DT, TD**	Dexlansoprazole (Dexilant®)	**BY, DT, TD**
Proton Pump Inhibitors	Omeprazole Rx (Generic)	**BY, DT, TD**	Esomeprazole Capsule (Generic; AG; Nexium®)	**BY, DT, TD**
*Request Form	Pantoprazole (Generic)	**BY, DT, TD**	Esomeprazole Kit	**BY, DT, TD**
	Pantoprazole Suspension (Protonix®)		Esomeprazole Suspension (Nexium®)	**BY, DT, TD**
*Criteria with Duration of Therapy Limits (DT) and Diagnosis Codes That Bypass DT (BY)			Esomeprazole Strontium (Generic)	**BY, DT, TD**
			Lansoprazole Capsule (Prevacid®)	**BY, DT, TD**
			Lansoprazole Disintegrating Tablet (Generic; Prevacid® SoluTab®)	**BY, DT, TD**
			Omeprazole Granules for Suspension (Prilosec®)	**BY, DT, TD**
			Omeprazole/Sodium Bicarbonate Rx (Generic; Zegerid®)	**BY, DT, TD**
			Pantoprazole (Protonix®)	**BY, DT, TD**
			Rabeprazole Capsule Sprinkle (AcipHex® Sprinkle™)	**BY, DT, TD**
			Rabeprazole Tablet (Generic; AcipHex®)	**BY, DT, TD**
DIGESTIVE DISORDERS (15)	Balsalazide (Generic)		Balsalazide Capsule (Colazal®)	
Ulcerative Colitis Agents	Mesalamine ER (Apriso®)		Balsalazide Tablet (Giazo®)	
*Request Form	Mesalamine Rectal (Generic)		Budesonide DR Tablet; Rectal Foam (Uceris®)	
*Criteria	Sulfasalazine (Generic)		Budesonide DR Tablet (Generic; AG for Uceris®)	
	Sulfasalazine DR (Generic)		Mesalamine DR (Generic; Asacol HD®)	
			Mesalamine DR Capsule (Delzicol®)	
			Mesalamine Enema (Rowasa®)	
			Mesalamine Kit (Generic)	
			Mesalamine DR Tablet MMX® (Generic; AG; Lialda®)	
			Mesalamine ER Capsule (Pentasa®)	
			Mesalamine Suppositories (Generic; AG; Canasa®)	
			Olsalazine Capsule (Dipentum®)	
			Sulfasalazine DR Tablet (Azulfidine EN-Tabs®)	
			Sulfasalazine Tablet (Azulfidine®)	

AG – Authorized Generic	**DR** – Concurrent Prescriptions Must Be Written by Same Prescriber	**PU** – Prior Use of Other Medication is Required
AL – Age Limits	**DS** – Maximum Days' Supply Allowed	**QL** – Quantity Limits
BH – Behavioral Health Clinical Authorization Required for Children Younger Than 6 Years Old	**DT** – Duration of Therapy Limit	**RX** – Specific Prescription Requirements
BY – Diagnosis Codes Bypass Some Requirements	**DX** – Diagnosis Code Requirements	**TD** – Therapeutic Duplication
CL – More Detailed Clinical Information Required for Authorization	**ER** – Early Refill **NOT** Allowed	**UN** – Drug Use Not Warranted (Needs Appropriate Diagnosis)
CU – Concurrent Use with Opioids or Benzodiazepines is Restricted	**MD** – Maximum Dose Limits	**X** – Prescriber Must Have 'X' DEA Number
DD – Drug-Drug Interactions	**PR** – Enrollment in a Physician-Supervised Program Required	**YQ** – Yearly Quantity Limits

Descriptive Therapeutic Class	Drugs on PDL	POS Edits	Drugs on NPDL which Require Prior Authorization (PA)	POS Edits
EPINEPHRINE, SELF-INJECTED (16)	Epinephrine 0.3mg (AG for EpiPen®)	**QL**	Epinephrine 0.3mg (EpiPen®)	**QL**
*Request Form	Epinephrine 0.15mg (AG for EpiPen Jr®)	**QL**	Epinephrine 0.15mg (EpiPen Jr®)	**QL**
*Criteria			Epinephrine 0.15 Mg (AG for Adrenaclick®)	**QL**
			Epinephrine 0.3 Mg (AG for Adrenaclick®)	**QL**
GI MOTILITY, CHRONIC (17)	Linaclotide Capsule (Linzess®)		Alosetron Tablet (Generic; AG; Lotronex®)	
*Request Form	Lubiprostone Capsule (Amitiza®)		Eluxadoline Tablet (Viberzi®)	
*Criteria	Naloxegol Tablet (Movantik®)		Methylnaltrexone Syringe; Tablet; Vial (Relistor®)	
			Naldemedine (Symproic®)	
			Plecanatide (Trulance®)	
			Prucalopride (Motegrity®)	
GLUCOCORTICOIDS, ORAL (18)	Budesonide Delayed Release Capsules (Generic for Entocort EC®)		Budesonide Delayed Release Capsules (Entocort EC®)	
*Request Form	Dexamethasone Tablet		Cortisone Acetate Tablet	
*Criteria	Hydrocortisone Tablet		Deflazacort Suspension; Tablet (Emflaza®)	
	Methylprednisolone Tablet Dose Pack		Dexamethasone (DexPak®; TaperDex®)	
	Prednisolone Sodium Phosphate Oral Solution (Generic) 5mg/5ml; 15mg/5ml; 25mg/5ml		Dexamethasone Elixir; Intensol Concentrate; Solution; Tablet Dose Pack	
	Prednisolone Solution		Hydrocortisone Tablet (Cortef®)	
	Prednisone Tablet		Methylprednisolone Therapy Pack; Tablet (Medrol®)	
			Methylprednisolone 4mg; 8mg; 16mg; 32mg Tablet	
			Prednisone Delayed Release Tablet (Rayos®)	
			Prednisone Intensol Concentrate; Solution; Tablet Dose Pack	
			Prednisolone Solution; Tablet; Tablet Dose Pack (Millipred®)	
			Prednisolone Sodium Phosphate 10mg/5ml (Generic Millipred®)	
			Prednisolone Sodium Phosphate 20mg/5ml (Generic Veripred®)	
			Prednisolone Sodium Phosphate ODT (Generic; AG; Orapred ODT®)	

AG – Authorized Generic	**DR** – Concurrent Prescriptions Must Be Written by Same Prescriber	**PU** – Prior Use of Other Medication is Required
AL – Age Limits	**DS** – Maximum Days' Supply Allowed	**QL** – Quantity Limits
BH – Behavioral Health Clinical Authorization Required for Children Younger Than 6 Years Old	**DT** – Duration of Therapy Limit	**RX** – Specific Prescription Requirements
BY – Diagnosis Codes Bypass Some Requirements	**DX** – Diagnosis Code Requirements	**TD** – Therapeutic Duplication
CL – More Detailed Clinical Information Required for Authorization	**ER** – Early Refill **NOT** Allowed	**UN** – Drug Use Not Warranted (Needs Appropriate Diagnosis)
CU – Concurrent Use with Opioids or Benzodiazepines is Restricted	**MD** – Maximum Dose Limits	**X** – Prescriber Must Have 'X' DEA Number
DD – Drug-Drug Interactions	**PR** – Enrollment in a Physician-Supervised Program Required	**YQ** – Yearly Quantity Limits

Descriptive Therapeutic Class	Drugs on PDL	POS Edits	Drugs on NPDL which Require Prior Authorization (PA)	POS Edits
GOUT AGENTS (19)	Allopurinol Tablet (Generic)		Colchicine Capsule (Mitigare®)	
Antihyperuricemics	Colchicine Capsule (AG)		Colchicine Tablet (AG; Colcrys®)	
*Request Form	Probenecid Tablet (Generic)		Febuxostat Tablet (Uloric®)	
*Criteria	Probenecid/Colchicine Tablet (Generic)		Pegloticase (Krystexxa®) (Intravenous)	
GROWTH DEFICIENCY (20)	Somatropin Cartridge; Syringe (Genotropin®)	**CL, DX**	Somatropin Cartridge; Vial (Humatrope®)	**CL, DX**
Growth Hormones	Somatropin Pen (Norditropin® FlexPro®)	**CL, DX**	Somatropin Pen (Nutropin AQ® NuSpin®)	**CL, DX**
*Request Form			Somatropin Cartridge; Vial (Omnitrope®)	**CL, DX**
*Criteria			Somatropin Cartridge; Vial (Saizen®)	**CL, DX**
			Somatropin Vial (Serostim®)	**CL, DX**
			Somatropin Vial (Zomacton®)	**CL, DX**
			Somatropin Vial (Zorbtive®)	**CL, DX**
H. PYLORI TREATMENT (21)	**NONE**		Bismuth Subcitrate Potassium/Metronidazole/Tetracycline (Pylera®)	
*Request Form			Lansoprazole/Amoxicillin/ Clarithromycin (Generic Prevpac®)	
*Criteria			Omeprazole/Clarithromycin/Amoxicillin (Omeclamox-Pak®)	
HEART DISEASE, HYPERLIPIDEMIA (22)	Apixaban Tablet; Dose Pack (Eliquis®)	**QL**	Dalteparin Syringe (Fragmin®)	**QL**
	Dabigatran (Pradaxa®)	**QL**	Dalteparin Vial (Fragmin®)	**DS, QL**
Anticoagulants	Enoxaparin Syringe (Generic; AG for Lovenox®)	**DS, QL**	Edoxaban Tablet (Savaysa®)	**QL**
*Request Form	Enoxaparin Vial (AG for Lovenox®)	**DS**	Enoxaparin Vial (Lovenox®)	**DS**
*Criteria	Rivaroxaban (Xarelto®; Xarelto® Starter Pack)	**QL**	Enoxaparin Syringe (Lovenox®)	**DS, QL**
	Warfarin (Generic)		Fondaparinux (Generic; Arixtra®)	**DS, QL**
			Warfarin (Coumadin®)	

AG – Authorized Generic	**DR** – Concurrent Prescriptions Must Be Written by Same Prescriber	**PU** – Prior Use of Other Medication is Required
AL – Age Limits	**DS** – Maximum Days' Supply Allowed	**QL** – Quantity Limits
BH – Behavioral Health Clinical Authorization Required for Children Younger Than 6 Years Old	**DT** – Duration of Therapy Limit	**RX** – Specific Prescription Requirements
BY – Diagnosis Codes Bypass Some Requirements	**DX** – Diagnosis Code Requirements	**TD** – Therapeutic Duplication
CL – More Detailed Clinical Information Required for Authorization	**ER** – Early Refill **NOT** Allowed	**UN** – Drug Use Not Warranted (Needs Appropriate Diagnosis)
CU – Concurrent Use with Opioids or Benzodiazepines is Restricted	**MD** – Maximum Dose Limits	**X** – Prescriber Must Have 'X' DEA Number
DD – Drug-Drug Interactions	**PR** – Enrollment in a Physician-Supervised Program Required	**YQ** – Yearly Quantity Limits

Descriptive Therapeutic Class	Drugs on PDL	POS Edits	Drugs on NPDL which Require Prior Authorization (PA)	POS Edits
HEART DISEASE, HYPERLIPIDEMIA (22)	Clopidogrel (Generic)		Aspirin/Dipyridamole ER Capsule (Generic; AG; Aggrenox®)	
	Dipyridamole (Generic)		Aspirin/Omeprazole DR Tablet (Yosprala®)	
Anticoagulants	Prasugrel (Generic)		Clopidogrel (Plavix®)	
Platelet Aggregation Inhibitors	Ticagrelor (Brilinta®)		Prasugrel (Effient®)	
*Request Form			Vorapaxar Tablet (Zontivity®)	
*Criteria				
HEART DISEASE, HYPERLIPIDEMIA (22)	Benazepril (Generic)	**TD**	Aliskiren (Tekturna®)	**TD**
	Enalapril (Generic)	**TD**	Aliskiren/HCTZ (Tekturna HCT®)	**TD**
Hypertension	Enalapril/HCTZ (Generic)	**TD**	Azilsartan Medoxomil (Edarbi®)	**TD**
ACE Inhibitors & Direct Renin Inhibitors	Fosinopril/HCTZ (Generic)	**TD**	Azilsartan/Chlorthalidone (Edarbyclor®)	**TD**
*Request Form	Irbesartan (Generic)	**TD**	Benazepril/HCTZ (Generic)	**TD**
*Criteria	Irbesartan/HCTZ (Generic)	**TD**	Candesartan (Generic; AG; Atacand®)	**TD**
	Lisinopril (Generic)	**TD**	Candesartan/HCTZ (Generic; AG; Atacand HCT®)	**TD**
	Lisinopril/HCTZ (Generic)	**TD**	Captopril (Generic)	**TD**
	Losartan (Generic)	**TD**	Captopril/HCTZ (Generic)	**TD**
	Losartan/HCTZ (Generic)	**TD**	Enalapril for Solution (Epaned®)	**TD**
	Olmesartan (Generic; AG for Benicar®)	**TD**	Enalapril (Vasotec®)	**TD**
	Quinapril (Generic)	**TD**	Eprosartan (Generic)	**TD**
	Ramipril (Generic)	**TD**	Fosinopril (Generic)	**TD**
	Sacubitril/Valsartan (Entresto®)		Irbesartan (Avapro®)	**TD**
	Valsartan (Generic)	**TD**	Irbesartan/HCTZ (Avalide®)	**TD**
	Valsartan/HCTZ (Generic)	**TD**	Lisinopril Solution (Qbrelis®)	**TD**
			Lisinopril (Zestril®; Prinivil®)	**TD**
			Lisinopril/HCTZ (Zestoretic®)	**TD**
			Losartan (Cozaar®)	**TD**
			Losartan/HCTZ (Hyzaar®)	**TD**
			Moexipril (Generic)	**TD**
			Moexipril/HCTZ (Generic)	**TD**

AG – Authorized Generic	**DR** – Concurrent Prescriptions Must Be Written by Same Prescriber	**PU** – Prior Use of Other Medication is Required
AL – Age Limits	**DS** – Maximum Days' Supply Allowed	**QL** – Quantity Limits
BH – Behavioral Health Clinical Authorization Required for Children Younger Than 6 Years Old	**DT** – Duration of Therapy Limit	**RX** – Specific Prescription Requirements
BY – Diagnosis Codes Bypass Some Requirements	**DX** – Diagnosis Code Requirements	**TD** – Therapeutic Duplication
CL – More Detailed Clinical Information Required for Authorization	**ER** – Early Refill **NOT** Allowed	**UN** – Drug Use Not Warranted (Needs Appropriate Diagnosis)
CU – Concurrent Use with Opioids or Benzodiazepines is Restricted	**MD** – Maximum Dose Limits	**X** – Prescriber Must Have 'X' DEA Number
DD – Drug-Drug Interactions	**PR** – Enrollment in a Physician-Supervised Program Required	**YQ** – Yearly Quantity Limits

Descriptive Therapeutic Class	Drugs on PDL	POS Edits	Drugs on NPDL which Require Prior Authorization (PA)	POS Edits
HEART DISEASE, HYPERLIPIDEMIA (22)	(preferred agents listed on page 23)		Olmesartan (Benicar®)	**TD**
			Olmesartan/HCTZ (Generic; AG; Benicar HCT®)	**TD**
Hypertension			Perindopril (Generic)	**TD**
ACE Inhibitors & Direct Renin Inhibitors Continued			Quinapril (Accupril®)	**TD**
			Quinapril/HCTZ (Generic)	**TD**
			Ramipril (Altace®)	**TD**
			Telmisartan (Generic; AG; Micardis®)	**TD**
			Telmisartan/HCTZ (Generic; AG; Micardis HCT®)	**TD**
			Trandolapril (Generic)	**TD**
			Valsartan (Diovan®)	**TD**
			Valsartan/HCTZ (Diovan HCT®)	**TD**
HEART DISEASE, HYPERLIPIDEMIA (22)	Amlodipine/Benazepril (Generic)	**TD**	Amlodipine/Benazepril (Lotrel®)	**TD**
	Amlodipine/Valsartan (Generic; AG for Exforge®)	**TD**	Amlodipine/Olmesartan (Generic; AG; Azor®)	**TD**
Hypertension	Amlodipine/Valsartan/HCTZ (Generic Exforge HCT®)	**TD**	Amlodipine/Olmesartan/HCTZ (Generic, AG; Tribenzor®)	**PU, TD**
Angiotensin Modulators/Calcium Channel Blockers Combinations			Amlodipine/Perindopril (Prestalia®)	**TD**
			Amlodipine/Telmisartan (Generic Twnysta®)	**TD**
*Request Form			Amlodipine/Valsartan (Exforge®)	**TD**
*Criteria			Amlodipine/Valsartan/HCTZ (Exforge HCT®)	**PU, TD**
			Nebivolol/Valsartan (Byvalson®)	**TD**
			Trandolapril/Verapamil (AG; Tarka®)	**TD**
HEART DISEASE, HYPERLIPIDEMIA (22)	Atenolol (Generic)	**TD**	Atenolol (Tenormin®)	**TD**
	Acebutolol (Generic)	**TD**	Atenolol/Chlorthalidone (Tenoretic®)	**TD**
Hypertension	Atenolol/Chlorthalidone (Generic)	**TD**	Bisoprolol/HCTZ (Ziac®)	**TD**
Beta Blocker Agents	Betaxolol (Generic)	**TD**	Carvedilol (Coreg®)	**TD**
*Request Form	Bisoprolol (Generic)	**TD**	Carvedilol ER (Generic; Coreg CR®)	**TD**
*Criteria	Bisoprolol/HCTZ (Generic)	**TD**	Metoprolol/HCTZ (Generic)	**TD**
	Carvedilol (Generic)	**TD**	Metoprolol Succinate (Kapspargo®)	**TD**
	Labetalol (Generic)	**TD**	Metoprolol Tartrate ER (Toprol XL®)	**TD**
	Metoprolol Tartrate (Generic)	**TD**	Metoprolol Tartrate (Lopressor®)	**TD**

AG – Authorized Generic	**DR** – Concurrent Prescriptions Must Be Written by Same Prescriber	**PU** – Prior Use of Other Medication is Required
AL – Age Limits	**DS** – Maximum Days' Supply Allowed	**QL** – Quantity Limits
BH – Behavioral Health Clinical Authorization Required for Children Younger Than 6 Years Old	**DT** – Duration of Therapy Limit	**RX** – Specific Prescription Requirements
BY – Diagnosis Codes Bypass Some Requirements	**DX** – Diagnosis Code Requirements	**TD** – Therapeutic Duplication
CL – More Detailed Clinical Information Required for Authorization	**ER** – Early Refill **NOT** Allowed	**UN** – Drug Use Not Warranted (Needs Appropriate Diagnosis)
CU – Concurrent Use with Opioids or Benzodiazepines is Restricted	**MD** – Maximum Dose Limits	**X** – Prescriber Must Have 'X' DEA Number
DD – Drug-Drug Interactions	**PR** – Enrollment in a Physician-Supervised Program Required	**YQ** – Yearly Quantity Limits

Descriptive Therapeutic Class	Drugs on PDL	POS Edits	Drugs on NPDL which Require Prior Authorization (PA)	POS Edits
HEART DISEASE, HYPERLIPIDEMIA (22)	Metoprolol Succinate ER (Generic)	**TD**	Nadolol (Generic; Corgard®)	**TD**
	Propranolol ER (Generic; AG)	**TD**	Nadolol/Bendroflumethiazide (Generic)	**TD**
Hypertension	Propranolol Tablet; Solution (Generic)	**TD**	Nebivolol (Bystolic®)	**TD**
Beta Blocker Agents Continued	Sotalol (Generic)	**TD**	Pindolol (Generic)	**TD**
			Propranolol (Hemangeol®)	**TD**
			Propranolol ER Capsule (Innopran XL®; Inderal XL®)	**TD**
			Propranolol LA (Inderal LA®)	**TD**
			Propanolol/HCTZ (Generic)	**TD**
			Sotalol (Betapace® AF)	**TD**
			Sotalol Solution (Sotylize®)	**TD**
			Timolol Maleate (Generic)	**TD**
HEART DISEASE, HYPERLIPIDEMIA (22)	Amlodipine Tablet (Generic)	**TD**	Amlodipine (Norvasc®)	**TD**
	Diltiazem ER Capsule (Generic)	**TD**	Diltiazem CD (Cardizem CD®; Cardizem CD® 360mg)	**TD**
Hypertension	Diltiazem IR Tablet (Generic)	**TD**	Diltiazem LA Tablet (AG; Cardizem LA®; Matzim LA®)	**TD**
Calcium Channel Blockers	Felodipine ER (Generic)	**TD**	Diltiazem (Tiazac® 420mg)	**TD**
*Request Form	Nifedipine ER Tablet (Generic)	**TD**	Isradipine (Generic)	**TD**
*Criteria	Verapamil ER Tablet (Generic)	**TD**	Nicardipine (Generic)	**TD**
	Verapamil ER PM (Generic)	**TD**	Nifedipine ER (Adalat CC®; Procardia XL®)	**TD**
	Verapamil IR Tablet (Generic)	**TD**	Nifedipine IR Capsule (Generic; Procardia®)	**TD**
			Nimodipine Capsule (Generic)	**TD**
			Nimodipine Solution (Nymalize®)	**TD**
			Nisoldipine (Generic)	**TD**
			Verapamil 360mg Capsule (Generic)	**TD**
			Verapamil Capsule (Verelan®)	**TD**
			Verapamil ER PM (Verelan PM®)	**TD**
			Verapamil ER Capsule (Generic)	**TD**
			Verapamil ER Tablet (Calan® SR)	**TD**

AG – Authorized Generic	**DR** – Concurrent Prescriptions Must Be Written by Same Prescriber	**PU** – Prior Use of Other Medication is Required
AL – Age Limits	**DS** – Maximum Days' Supply Allowed	**QL** – Quantity Limits
BH – Behavioral Health Clinical Authorization Required for Children Younger Than 6 Years Old	**DT** – Duration of Therapy Limit	**RX** – Specific Prescription Requirements
BY – Diagnosis Codes Bypass Some Requirements	**DX** – Diagnosis Code Requirements	**TD** – Therapeutic Duplication
CL – More Detailed Clinical Information Required for Authorization	**ER** – Early Refill **NOT** Allowed	**UN** – Drug Use Not Warranted (Needs Appropriate Diagnosis)
CU – Concurrent Use with Opioids or Benzodiazepines is Restricted	**MD** – Maximum Dose Limits	**X** – Prescriber Must Have 'X' DEA Number
DD – Drug-Drug Interactions	**PR** – Enrollment in a Physician-Supervised Program Required	**YQ** – Yearly Quantity Limits

Descriptive Therapeutic Class	Drugs on PDL	POS Edits	Drugs on NPDL which Require Prior Authorization (PA)	POS Edits
HEART DISEASE, HYPERLIPIDEMIA (22)	Cholestyramine/Sucrose (Generic Questran®)		Alirocumab Subcutaneous Pen (Praluent®)	**CL**
	Colestipol Granules; Tablet (Generic)		Cholestyramine (Questran®)	
Lipotropics, Other	Ezetimibe (Generic)		Cholestyramine/Aspartame (Generic)	
*Request Form	Fenofibrate Nanocrystalized Tablet (Generic; AG for Tricor® 48mg & 145mg)		Colesevelam Powder Pack; Tablet (Generic; AG; Welchol®)	
*Criteria	Gemfibrozil (Generic)		Colestipol Granules (Colestid®)	
	Niacin ER (Generic)		Evolocumab Auto-Injector; Cartridge; Prefilled Syringe (Repatha® SureClick®; Repatha® Pushtronex®; Repatha®)	**CL**
Criteria relative to Mipomersen Sodium (Kynamro®) is no longer applicable, as this agent is not listed on the July 2019 PDL/NPDL			Ezetimibe (Zetia®)	
			Fenofibrate Capsule Micronized (Generic; AG; Antara®)	
			Fenofibrate Capsule (Generic; Lipofen®)	
			Fenofibrate Tablet (Generic; AG; Fenoglide®)	
			Fenofibrate Capsule Micronized; Tablet (Generic Lofibra®)	
			Fenofibrate Tablet Nanocrystallized Tablet (Tricor®)	
			Fenofibrate Tablet Nanocrystallized Tablet (AG; Triglide®)	
			Fenofibric Acid Tablet (Generic Fibricor®)	
			Fenofibric Acid Choline Capsule (Generic; AG; Trilipix®)	
			Gemfibrozil (Lopid®)	
			Icosapent Ethyl (Vascepa®)	
			Lomitapide (Juxtapid®)	**CL**
			Niacin ER (Niaspan®)	
			Omega-3-acid Ethyl Esters (Generic; Lovaza®)	
HEART DISEASE, HYPERLIPIDEMIA (22)	Atorvastatin (Generic)		Amlodipine/Atorvastatin (Generic; Caduet®)	**TD**
	Lovastatin (Generic)		Atorvastatin (Lipitor®)	
Statins & Statin Combination Agents	Pravastatin (Generic)		Ezetimibe/Simvastatin (Generic; Vytorin®)	
*Request Form	Rosuvastatin (Generic)		Fluvastatin (Generic)	
*Criteria	Simvastatin (Generic)		Fluvastatin ER (Generic; AG; Lescol XL®)	
			Lovastatin ER (Altoprev®)	
			Pitavastatin (Livalo®; Zypitamag®)	
			Pravastatin (Pravachol®)	
			Rosuvastatin (Crestor®)	
			Simvastatin (Zocor®)	

AG – Authorized Generic	**DR** – Concurrent Prescriptions Must Be Written by Same Prescriber	**PU** – Prior Use of Other Medication is Required
AL – Age Limits	**DS** – Maximum Days' Supply Allowed	**QL** – Quantity Limits
BH – Behavioral Health Clinical Authorization Required for Children Younger Than 6 Years Old	**DT** – Duration of Therapy Limit	**RX** – Specific Prescription Requirements
BY – Diagnosis Codes Bypass Some Requirements	**DX** – Diagnosis Code Requirements	**TD** – Therapeutic Duplication
CL – More Detailed Clinical Information Required for Authorization	**ER** – Early Refill **NOT** Allowed	**UN** – Drug Use Not Warranted (Needs Appropriate Diagnosis)
CU – Concurrent Use with Opioids or Benzodiazepines is Restricted	**MD** – Maximum Dose Limits	**X** – Prescriber Must Have 'X' DEA Number
DD – Drug-Drug Interactions	**PR** – Enrollment in a Physician-Supervised Program Required	**YQ** – Yearly Quantity Limits

Descriptive Therapeutic Class	Drugs on PDL	POS Edits	Drugs on NPDL which Require Prior Authorization (PA)	POS Edits
HEART DISEASE, HYPERLIPIDEMIA (22)	Ambrisentan Tablet (Letairis®)	**DX**	Bosentan Suspension (Tracleer®)	**DX**
	Bosentan Tablet (Tracleer®)	**DX**	Iloprost Inhalation Solution (Ventavis®)	**DX**
Pulmonary Arterial Hypertension (PAH)	Sildenafil Tablet (Generic for Revatio®)	**DD, DX**	Macitentan Tablet (Opsumit®)	**DX**
*Request Form			Riociguat Tablet (Adempas®)	**DX**
*Criteria			Selexipag Tablet; Dose Pack (Uptravi®)	**DX**
*Diagnosis Code Required			Sildenafil Tablet; Oral Suspension (Revatio®)	**DD, DX**
			Tadalafil Tablet (Generic; Adcirca®)	**DD, DX**
			Treprostinil Inhalation Solution (Tyvaso®)	**DX**
			Treprostinil ER Tablet (Orenitram ER®)	**DX**
HEART DISEASE, HYPERLIPIDEMIA (22)	Clonidine Patch (Catapres-TTS®)	**BH, BY, DX**	Clonidine Tablet (Catapres®)	**BH, BY, DX**
	Clonidine Tablet (Generic)	**BH, BY, DX**	Clonidine Patch (Generic)	**BH, BY, DX**
Sympatholytics	Guanfacine Tablet (Generic)	**BH, BY, DX**	Methyldopa/Hydrochlorothiazide Tablet (Generic)	
*Request Form	Methyldopa Tablet (Generic)		Methyldopate HCl (Intravenous)	
*Criteria				
*ADHD Use of Clonidine and Guanfacine Under 21 Y/O				
*DX Under 21 Y/O, BH & BY				
HEART DISEASE, HYPERLIPIDEMIA (22)	Isosorbide Dinitrate Tablet (Generic)		Isosorbide Dinitrate Tablet (Isordil®)	
	Isosorbide Mononitrate Tablet (Generic)		Isosorbide Dinitrate ER Capsule (Dilatrate-SR®)	
Vasodilators, Coronary	Isosorbide Mononitrate SR Tablet (Generic)		Isosorbide Dinitrate/Hydralazine Tablet (BiDil®)	
*Request Form	Nitroglycerin Sublingual Tablet (Generic; AG)		Nitroglycerin ER Capsule (Generic)	
*Criteria	Nitroglycerin Transdermal Ointment (Nitro-Bid®)		Nitroglycerin Spray (Generic; Nitrolingual®; NitroMist®)	
	Nitroglycerin Transdermal Patch (Generic)		Nitroglycerin Transdermal Patch (Nitro-Dur®)	
			Nitroglycerin Sublingual Tablet (Nitrostat®)	
			Nitroglycerin Sublingual Packet (GoNitro®)	
HEMATOLOGIC AGENTS, HEMATOPOIETIC AGENTS (23)	Epoetin Alfa (Procrit®)		Darbepoetin Syringe; Vial (Aranesp®)	
	Epoetin Alfa-epbx (Retacrit®)		Epoetin alfa (Epogen®)	
Erythropoietins			Methoxy Polyethylene Glycol-Epoetin Beta (Mircera®)	
*Request Form				
*Criteria				

AG – Authorized Generic	**DR** – Concurrent Prescriptions Must Be Written by Same Prescriber	**PU** – Prior Use of Other Medication is Required
AL – Age Limits	**DS** – Maximum Days' Supply Allowed	**QL** – Quantity Limits
BH – Behavioral Health Clinical Authorization Required for Children Younger Than 6 Years Old	**DT** – Duration of Therapy Limit	**RX** – Specific Prescription Requirements
BY – Diagnosis Codes Bypass Some Requirements	**DX** – Diagnosis Code Requirements	**TD** – Therapeutic Duplication
CL – More Detailed Clinical Information Required for Authorization	**ER** – Early Refill **NOT** Allowed	**UN** – Drug Use Not Warranted (Needs Appropriate Diagnosis)
CU – Concurrent Use with Opioids or Benzodiazepines is Restricted	**MD** – Maximum Dose Limits	**X** – Prescriber Must Have 'X' DEA Number
DD – Drug-Drug Interactions	**PR** – Enrollment in a Physician-Supervised Program Required	**YQ** – Yearly Quantity Limits

Descriptive Therapeutic Class	Drugs on PDL	POS Edits	Drugs on NPDL which Require Prior Authorization (PA)	POS Edits
HEMODIALYSIS (24)	Calcium Acetate Capsule (Generic)		Calcium Acetate Tablet (Generic)	
Phosphate Binders	Sevelamer HCl Tablet (RenaGel®)		Calcium Acetate Solution (Phoslyra®)	
*Request Form			Calcium Carbonate/Magnesium Carbonate/FA (MagneBind 400 Rx®	
*Criteria			Ferric Citrate Tablet (Auryxia®)	
			Lanthanum Carbonate Chew Tablet (Generic; Fosrenol®)	
			Lanthanum Carbonate Powder Pack (Fosrenol®)	
			Sevelamer Carbonate Tablet (Generic; AG; Renvela®)	
			Sevelamer Carbonate Powder Pack (Generic; Renvela®)	
			Sevelamer HCl Tablet (Generic; AG for RenaGel®)	
			Sucroferric Oxyhydroxide (Velphoro®)	
HEMOPHILIA TREATMENT (25)	Factor IX (Mononine® Kit)		Anti-Inhibitor Coagulant Complex (Feiba NF®)	
*Request Form	Factor IX Complex (PCC) 3-Factor (Profilnine® SD)		Emicizumab-kxwh (Hemlibra®)	
*Criteria	Factor IX Human Recombinant (BeneFIX® Kit)		Factor IX Complex (PCC) 3-Factor (Bebulin®)	
	Factor VIIa, Recombinant (Novoseven® RT)		Factor IX Human (AlphaNine SD®)	
	Factor VIII, B-Domain-Deleted (Xyntha® Kit)		Factor IX Human Recomb, GlycoPEGylated (Rebinyn®)	
	Factor VIII, B-Domain-Deleted (Xyntha® Solofuse Syringe Kit®)		Factor IX Human Recombinant (Ixinity®)	
	Factor VIII, B-Domain-Truncated (Novoeight®)		Factor IX Recombinant (Rixubis®)	
	Factor VIII, Full-Length (Advate®)		Factor IX Recombinant, Albumin Fusion (Idelvion®)	
	Factor VIII, HEK B-Domain-Deleted (Nuwiq®)		Factor IX Recombinant, Fc Fusion Protein (Alprolix®)	
	Factor VIII, Human (Monoclate-P® Kit)		Factor VIII (Helixate FS®)	
	Factor VIII, Recombinant (Recombinate®)		Factor VIII (Kogenate FS®)	
	Factor VIIIVWF (Alphanate®)		Factor VIII (Kovaltry®)	
	Factor VIII/VWF (Humate-P® Kit)		Factor VIII, Full-Length PEGylated (Adynovate®)	
	Factor VIII/VWF (Wilate®)		Factor VIII, Human (Hemofil-M®)	
	Factor X (Coagadex®)		Factor VIII, Human Kit; Vial (Koate DVI®)	
	Factor XIII Concentrate, Human (Corifact® Kit)		Factor VIII, Recombinant Porcine (Obizur®)	
			Factor VIII, Recombinant, Fc Fusion (Eloctate®)	
			Factor VIII, Recombinant, PEGylated-aucl (Jivi®)	
			Factor VIII, Single-Chain, B-Domain Truncated (Afstyla®)	
			Factor XIII A-Subunit, Recombinant (Tretten®)	
			Von Willebrand Factor, Recombinant (Vonvendi®)	

AG – Authorized Generic	**DR** – Concurrent Prescriptions Must Be Written by Same Prescriber	**PU** – Prior Use of Other Medication is Required
AL – Age Limits	**DS** – Maximum Days' Supply Allowed	**QL** – Quantity Limits
BH – Behavioral Health Clinical Authorization Required for Children Younger Than 6 Years Old	**DT** – Duration of Therapy Limit	**RX** – Specific Prescription Requirements
BY – Diagnosis Codes Bypass Some Requirements	**DX** – Diagnosis Code Requirements	**TD** – Therapeutic Duplication
CL – More Detailed Clinical Information Required for Authorization	**ER** – Early Refill **NOT** Allowed	**UN** – Drug Use Not Warranted (Needs Appropriate Diagnosis)
CU – Concurrent Use with Opioids or Benzodiazepines is Restricted	**MD** – Maximum Dose Limits	**X** – Prescriber Must Have 'X' DEA Number
DD – Drug-Drug Interactions	**PR** – Enrollment in a Physician-Supervised Program Required	**YQ** – Yearly Quantity Limits

Descriptive Therapeutic Class	Drugs on PDL	POS Edits	Drugs on NPDL which Require Prior Authorization (PA)	POS Edits
IMMUNOSUPPRESSIVES, ORAL (26)	Azathioprine Tablet (Generic)		Azathioprine (Azasan®; Imuran®)	
*Request Form	Cyclosporine Capsule - MODIFIED (Generic)		Cyclosporine Capsule (Generic; Sandimmune®)	
*Criteria	Mycophenolate Mofetil Capsule; Tablet (Generic)		Cyclosporine Softgel; Solution - MODIFIED (Generic; Neoral®)	
	Tacrolimus Capsule (Generic)		Cyclosporine Solution (Sandimmune®)	
			Everolimus (Zortress®)	
			Mycophenolate Mofetil Capsule; Tablet; Suspension (CellCept®)	
			Mycophenolate Mofetil Suspension (Generic)	
			Mycophenolate Sodium as Mycophenolic Acid (Generic; Myfortic®)	
			Sirolimus Solution (Generic; Rapamune®)	
			Sirolimus Tablet (Generic; AG; Rapamune®)	
			Tacrolimus Packet; Tablet (Prograf®)	
			Tacrolimus ER Capsule (Astagraf® XL)	
			Tacrolimus ER Tablet (Envarsus® XR)	
INFECTIOUS DISORDERS (27)	Amoxicillin/Clavulanate Suspension; Tablet (Generic)		Amoxicillin/Clavulanate ER (Generic; Augmentin XR®)	
Antibiotics	Cefadroxil Capsule (Generic)		Amoxicillin/Clavulanate Chewable Tablet (Generic)	
Cephalosporin and Related Antibiotics	Cefdinir Capsule; Suspension (Generic)		Amoxicillin/Clavulanate Suspension (Augmentin® 125mg, 250mg)	
*Request Form	Cefprozil Suspension; Tablet (Generic)		Cefaclor Capsule; Suspension (Generic)	
*Criteria	Cefuroxime Tablet (Generic)		Cefaclor ER Tablet (Generic)	
	Cephalexin Capsule; Suspension; (Generic)		Cefadroxil Suspension; Tablet (Generic)	
			Cefixime Capsule; Chewable Tablet (Suprax®)	
			Cefixime Suspension (Generic; Suprax®)	
			Cephalexin Capsule (Daxbia®)	
			Cephalexin Capsule (Keflex®)	
			Cephalexin Tablet (Generic)	
			Cefpodoxime Proxetil Suspension; Tablet (Generic)	

AG – Authorized Generic	**DR** – Concurrent Prescriptions Must Be Written by Same Prescriber	**PU** – Prior Use of Other Medication is Required
AL – Age Limits	**DS** – Maximum Days' Supply Allowed	**QL** – Quantity Limits
BH – Behavioral Health Clinical Authorization Required for Children Younger Than 6 Years Old	**DT** – Duration of Therapy Limit	**RX** – Specific Prescription Requirements
BY – Diagnosis Codes Bypass Some Requirements	**DX** – Diagnosis Code Requirements	**TD** – Therapeutic Duplication
CL – More Detailed Clinical Information Required for Authorization	**ER** – Early Refill **NOT** Allowed	**UN** – Drug Use Not Warranted (Needs Appropriate Diagnosis)
CU – Concurrent Use with Opioids or Benzodiazepines is Restricted	**MD** – Maximum Dose Limits	**X** – Prescriber Must Have 'X' DEA Number
DD – Drug-Drug Interactions	**PR** – Enrollment in a Physician-Supervised Program Required	**YQ** – Yearly Quantity Limits

Descriptive Therapeutic Class	Drugs on PDL	POS Edits	Drugs on NPDL which Require Prior Authorization (PA)	POS Edits
INFECTIOUS DISORDERS (27)	Ciprofloxacin Tablet (Generic)		Ciprofloxacin Suspension (Generic; Cipro®)	
Antibiotics	Levofloxacin Tablet (Generic)		Ciprofloxacin Tablet (Cipro®)	
Fluoroquinolones			Ciprofloxacin ER Tablet (Generic)	
*Request Form			Delafloxacin (Baxdela®)	
*Criteria			Levofloxacin Solution (Generic)	
			Levofloxacin Tablet (Levaquin®)	
			Moxifloxacin (Generic; AG; Avelox®)	
			Ofloxacin (Generic)	
INFECTIOUS DISORDERS (27)	Metronidazole Tablet (Generic)		Fidaxomicin (Dificid®)	
Antibiotics	Neomycin Tablet (Generic)		Metronidazole Capsule (Generic; Flagyl®)	
Gastrointestinal Antibiotics	Vancomycin HCl Capsule (Generic; AG for Vancocin®)		Metronidazole Tablet (Flagyl®)	
*Request Form	Vancomycin Solution (Firvanq ®)		Nitazoxanide Suspension (Alinia®)	
*Criteria			Paromomycin (Generic)	
			Rifaximin (Xifaxan®)	
			Secnidazole (Solosec™)	
			Tinidazole (Generic; Tindamax®)	
			Vancomycin HCl (Vancocin®)	
INFECTIOUS DISORDERS (27)	Tobramycin Solution (Bethkis®)	**DX**	Amikacin Inhalation Suspension (Arikayce®)	
Antibiotics	Tobramycin Pak (AG for Kitabis Pak®)	**DX**	Aztreonam Solution (Cayston®)	**DX**
Inhaled Antibiotics			Tobramycin Solution (Generic; AG; Tobi®)	**DX**
*Request Form			Tobramycin (Tobi Podhaler®)	**DX**
*Criteria			Tobramycin Inhalation Solution Pak (Kitabis Pak®)	**DX**
*Diagnosis Code Required				
INFECTIOUS DISORDERS (27)	Clindamycin Capsule (Generic)		Clindamycin Capsule (Cleocin®)	
Antibiotics	Clindamycin Palmitate Solution (Generic)		Clindamycin Palmitate Solution (Cleocin®)	
Lincosamides			Clindamycin Phosphate Piggyback Injection (Generic)	
*Request Form			Clindamycin Phosphate Injection Vial (Generic; Cleocin®)	
*Criteria			Clindamycin in 0.9% Sodium Chloride Piggyback Intravenous	
			Lincomycin HCl Injection (Generic; Lincocin®)	

AG – Authorized Generic	**DR** – Concurrent Prescriptions Must Be Written by Same Prescriber	**PU** – Prior Use of Other Medication is Required
AL – Age Limits	**DS** – Maximum Days' Supply Allowed	**QL** – Quantity Limits
BH – Behavioral Health Clinical Authorization Required for Children Younger Than 6 Years Old	**DT** – Duration of Therapy Limit	**RX** – Specific Prescription Requirements
BY – Diagnosis Codes Bypass Some Requirements	**DX** – Diagnosis Code Requirements	**TD** – Therapeutic Duplication
CL – More Detailed Clinical Information Required for Authorization	**ER** – Early Refill **NOT** Allowed	**UN** – Drug Use Not Warranted (Needs Appropriate Diagnosis)
CU – Concurrent Use with Opioids or Benzodiazepines is Restricted	**MD** – Maximum Dose Limits	**X** – Prescriber Must Have 'X' DEA Number
DD – Drug-Drug Interactions	**PR** – Enrollment in a Physician-Supervised Program Required	**YQ** – Yearly Quantity Limits

Descriptive Therapeutic Class	Drugs on PDL	POS Edits	Drugs on NPDL which Require Prior Authorization (PA)	POS Edits
INFECTIOUS DISORDERS (27)	Azithromycin Packet; Suspension; Tablet (Generic)		Azithromycin Packet; Suspension; Tablet (Zithromax®)	
Antibiotics	Clarithromycin Tablet (Generic)		Clarithromycin ER (Generic)	
Macrolides - Ketolides	Erythromycin Base DR Capsule (Generic)		Clarithromycin Suspension (Generic)	
*Request Form			Erythromycin Base Tablet (Generic)	
*Criteria			Erythromycin Ethyl Succinate Suspension (AG; E.E.S. ® 200; EryPed® 200)	
			Erythromycin Ethyl Succinate Suspension (EryPed® 400)	
			Erythromycin Ethyl Succinate Tablet (E.E.S. ® 400)	
			Erythromycin Stearate (Erythrocin®)	
			Erythromycin Tablet (Ery-Tab®)	
INFECTIOUS DISORDERS (27)	Nitrofurantoin Macrocrystals Capsule (Generic)		Nitrofurantoin Suspension (Generic; Furadantin®)	
Antibiotics	Nitrofurantoin Monohydrate Macrocrystals Capsule (Generic)		Nitrofurantoin Macrocrystals Capsule (Macrodantin®)	
Nitrofuran Derivatives			Nitrofurantoin Monohydrate Macrocrystals Capsule (Macrobid®)	
*Request Form				
*Criteria				
INFECTIOUS DISORDERS (27)	Linezolid Tablet (Generic; AG for Zyvox®)	**CL**	Linezolid Injection (Generic; AG; Zyvox®)	**CL**
Antibiotics			Linezolid Suspension (Generic; AG; Zyvox®)	**CL**
Oxazolidinones			Linezolid Tablet (Zyvox®)	**CL**
*Request Form			Tedizolid IV; Tablet (Sivextro®)	**CL**
*Sivextro Criteria				
*Zyvox Criteria				
INFECTIOUS DISORDERS (27)	**NONE**		Quinupristin/Dalfopristin Vial (Synercid®)	
Antibiotics				
Streptogramins				
*Request Form				
*Criteria				

AG – Authorized Generic	**DR** – Concurrent Prescriptions Must Be Written by Same Prescriber	**PU** – Prior Use of Other Medication is Required
AL – Age Limits	**DS** – Maximum Days' Supply Allowed	**QL** – Quantity Limits
BH – Behavioral Health Clinical Authorization Required for Children Younger Than 6 Years Old	**DT** – Duration of Therapy Limit	**RX** – Specific Prescription Requirements
BY – Diagnosis Codes Bypass Some Requirements	**DX** – Diagnosis Code Requirements	**TD** – Therapeutic Duplication
CL – More Detailed Clinical Information Required for Authorization	**ER** – Early Refill **NOT** Allowed	**UN** – Drug Use Not Warranted (Needs Appropriate Diagnosis)
CU – Concurrent Use with Opioids or Benzodiazepines is Restricted	**MD** – Maximum Dose Limits	**X** – Prescriber Must Have 'X' DEA Number
DD – Drug-Drug Interactions	**PR** – Enrollment in a Physician-Supervised Program Required	**YQ** – Yearly Quantity Limits

Descriptive Therapeutic Class	Drugs on PDL	POS Edits	Drugs on NPDL which Require Prior Authorization (PA)	POS Edits
INFECTIOUS DISORDERS (27)	Doxycycline Hyclate Tablet (Generic)		Demeclocycline (Generic)	
Antibiotics	Doxycycline Hyclate Capsule (Generic; AG)		Doxycycline Calcium Suspension; Syrup (Vibramycin®)	
Tetracyclines	Doxycycline Monohydrate 50mg, 100 mg Capsule (Generic)		Doxycycline Hyclate DR Tablet (Doryx® MPC)	
*Request Form	Doxycycline Monohydrate Tablet (Generic)		Doxycycline Hyclate DR Tablet (Generic Doryx®)	
*Criteria	Minocycline Capsule (Generic)		Doxycycline Hyclate Capsule/Skin Cleanser (Morgidox® Kit)	
			Doxycycline Monohydrate 40mg DR Capsule (AG; Oracea®)	
			Doxycycline Monohydrate Capsule 75mg (Generic)	
			Doxycycline Monohydrate Capsule 150 mg (Generic)	
			Doxycycline Monohydrate Suspension (Generic)	
			Minocycline ER Capsule (Generic; Ximino®)	
			Minocycline Tablet (Generic)	
			Omadacycline Tosylate (Nuzyra®)	
			Tetracycline Capsule	
INFECTIOUS DISORDERS (27)	Clindamycin Vaginal Cream (Generic)		Clindamycin Vaginal Cream (Cleocin®)	
Antibiotics	Clindamycin Vaginal Cream (Clindesse®)		Clindamycin Vaginal Ovules (Cleocin®)	
Vaginal	Metronidazole Vaginal Gel (Generic)		Metronidazole Vaginal Gel (MetroGel-Vaginal®; Vandazole®)	
*Request Form	Metronidazole Vaginal Gel (Nuvessa®)			
*Criteria				
INFECTIOUS DISORDERS (27)	Clotrimazole Troches (Generic)		Fluconazole Tablet; Suspension (Diflucan®)	
Antifungals	Fluconazole Tablet; Suspension (Generic)		Flucytosine (Generic; Ancobon®)	
Antifungals, Oral	Griseofulvin Suspension (Generic)		Griseofulvin Tablet (Generic)	
*Request Form	Nystatin Tablet; Suspension (Generic)		Griseofulvin Ultramicrosize Tablet (Generic)	
*Criteria	Terbinafine Tablet (Generic)		Isavuconazonium (Cresemba®)	
			Itraconazole Capsule; Solution (Generic; Sporanox®)	
			Itraconazole Tablet (Onmel®)	
			Itraconazole Capsule (Tolsura®)	
			Ketoconazole (Generic)	
			Miconazole Buccal Tablet (Oravig®)	
			Posaconazole Tablet; Suspension (Noxafil®)	
			Voriconazole Tablet (Generic)	
			Voriconazole Suspension (Generic; Vfend®)	

AG – Authorized Generic	**DR** – Concurrent Prescriptions Must Be Written by Same Prescriber	**PU** – Prior Use of Other Medication is Required
AL – Age Limits	**DS** – Maximum Days' Supply Allowed	**QL** – Quantity Limits
BH – Behavioral Health Clinical Authorization Required for Children Younger Than 6 Years Old	**DT** – Duration of Therapy Limit	**RX** – Specific Prescription Requirements
BY – Diagnosis Codes Bypass Some Requirements	**DX** – Diagnosis Code Requirements	**TD** – Therapeutic Duplication
CL – More Detailed Clinical Information Required for Authorization	**ER** – Early Refill **NOT** Allowed	**UN** – Drug Use Not Warranted (Needs Appropriate Diagnosis)
CU – Concurrent Use with Opioids or Benzodiazepines is Restricted	**MD** – Maximum Dose Limits	**X** – Prescriber Must Have 'X' DEA Number
DD – Drug-Drug Interactions	**PR** – Enrollment in a Physician-Supervised Program Required	**YQ** – Yearly Quantity Limits

Descriptive Therapeutic Class	Drugs on PDL	POS Edits	Drugs on NPDL which Require Prior Authorization (PA)	POS Edits
INFECTIOUS DISORDERS (27)	Glecaprevir/Pibrentasvir (Mavyret®)	**AL, CL, DX, ER, QL, TD**	Daclatasvir Tablet (Daklinza®)	**AL, CL, DT, DX, ER, QL, TD**
Hepatitis C Agents	Sofosbuvir/Velpatasvir (Epclusa®)	**AL, CL, DT, DX, ER, QL, TD**	Elbasvir/Grazoprevir (Zepatier®)	**AL, CL, DT, DX, ER, QL, TD**
Direct Acting Antiviral Agents	Sofosbuvir/Velpatasvir/Voxilaprevir (Vosevi®)	**CL**	Ledipasvir/Sofosbuvir Tablet (AG; Harvoni®)	**AL, CL, DT, DX, ER, QL, TD**
*Hepatitis C DAA Criteria, Request Form, Worksheet and Patient Treatment Agreement			Ombitasvir/Paritaprevir/Ritonavir (Technivie®) **Discontinued**	**AL, CL, DT, DX, ER, QL, TD**
			Ombitasvir/Paritaprevir/Ritonavir/Dasabuvir (Viekira Pak®)	**AL, CL, DT, DX, ER, QL, TD**
			Sofosbuvir (Sovaldi®)	**AL, CL, DT, DX, ER, QL, TD**
			Sofosbuvir/Velpatasvir (AG for Epclusa®)	**AL, CL, DT, DX, ER, QL, TD**
INFECTIOUS DISORDERS (27)	Peginterferon alfa 2a Proclick; Syringe; Vial (Pegasys®)	**DX**	Peginterferon alfa 2b Kit (Peg-Intron®)	**DX**
Hepatitis C Agents	Ribavirin Tablet (Generic)	**DX**	Ribavirin Capsule (Generic)	**DX**
Not Direct Acting Antiviral Agents			Ribavirin Tablet (Ribasphere® 400mg, 600mg; Ribasphere Ribapak®; Moderiba® Dose Pack)	**DX**
*Request Form			Ribavirin Solution (Rebetol®)	**DX**
*Criteria				
*Diagnosis Code Required				
MULTIPLE SCLEROSIS (28)	Fingolimod Capsule (Gilenya®)	**CL**	Alemtuzumab Vial (Lemtrada®)	**CL**
Multiple Sclerosis Agents	Glatiramer Acetate 20mg/ml (Copaxone®)	**CL**	Dalfampridine ER Tablet (Generic; AG; Ampyra®)	**CL**
Immunomodulatory Agents	Interferon β-1a Pen, Syringe (Avonex®)	**CL**	Dimethyl Fumarate Capsule (Tecfidera®)	**CL**
*Request Form	Interferon β-1a Auto-Injector (Rebif® Rebidose®)	**CL**	Glatiramer Acetate 20mg/ml (Generic; Glatopa®)	**CL**
*Criteria	Interferon β-1a Auto-Injector (Rebif® Rebidose® Titration Pack)	**CL**	Glatiramer Acetate 40mg/ml (Generic; Copaxone®; Glatopa®)	**CL**
	Interferon β-1a Syringe (Rebif®)	**CL**	Interferon β-1b Kit; Vial (Extavia®)	**CL**
Tysabri Acceptable Diagnosis Codes Multiple Sclerosis – G35 Crohn's – K50*	Interferon β-1b Kit (Betaseron®)	**CL**	Natalizumab Vial (Tysabri®)	**DX**
			Ocrelizumab Injection (Ocrevus®)	**CL**
			Peginterferon β -1a Pen; Syringe; Starter Pack (Plegridy®)	**CL**
			Teriflunomide Tablet (Aubagio®)	**CL**

AG – Authorized Generic	**DR** – Concurrent Prescriptions Must Be Written by Same Prescriber	**PU** – Prior Use of Other Medication is Required
AL – Age Limits	**DS** – Maximum Days' Supply Allowed	**QL** – Quantity Limits
BH – Behavioral Health Clinical Authorization Required for Children Younger Than 6 Years Old	**DT** – Duration of Therapy Limit	**RX** – Specific Prescription Requirements
BY – Diagnosis Codes Bypass Some Requirements	**DX** – Diagnosis Code Requirements	**TD** – Therapeutic Duplication
CL – More Detailed Clinical Information Required for Authorization	**ER** – Early Refill **NOT** Allowed	**UN** – Drug Use Not Warranted (Needs Appropriate Diagnosis)
CU – Concurrent Use with Opioids or Benzodiazepines is Restricted	**MD** – Maximum Dose Limits	**X** – Prescriber Must Have 'X' DEA Number
DD – Drug-Drug Interactions	**PR** – Enrollment in a Physician-Supervised Program Required	**YQ** – Yearly Quantity Limits

Descriptive Therapeutic Class	Drugs on PDL	POS Edits	Drugs on NPDL which Require Prior Authorization (PA)	POS Edits
ONCOLOGY (29)	Anastrozole (Generic)		Abemaciclib (Verzenio®)	
Oral – Breast	Capecitabine (Xeloda®)		Anastrozole (Arimidex®)	
*Request Form	Cyclophosphamide (Generic)		Capecitabine (Generic)	
*Criteria	Exemestane (Generic)		Exemestane (Aromasin®)	
	Letrozole (Generic)		Fulvestrant (Faslodex®)	
	Palbociclib (Ibrance®)		Lapatinib Ditosylate (Tykerb®)	
	Tamoxifen Citrate (Generic)		Letrozole (Femara®)	
			Neratinib Maleate (Nerlynx®)	
			Ribociclib Succinate (Kisqali®)	
			Ribociclib Succinate/Letrozole (Kisqali/Femara Kit®)	
			Toremifene Citrate (Fareston®)	
ONCOLOGY (29)	Busulfan (Myleran®)		Acalabrutinib (Calquence®)	
Oral – Hematologic	Chlorambucil (Leukeran®)		Bosutinib (Bosulif®)	
*Request Form	Dasatinib (Sprycel®)		Enasidenib Mesylate (Idhifa®)	
*Criteria	Hydroxyurea (Generic)		Hydroxyurea (Hydrea®)	
*Diagnosis Codes for Selected Agents (DX)	Ibrutinib Capsule; Tablet (Imbruvica®)		Idelalisib (Zydelig®)	
	Imatinib Mesylate (Gleevec®)		Imatinib Mesylate (Generic)	
	Lenalidomide (Revlimid®)	**DX**	Ivosidenib (Tibsovo®)	
	Melphalan (Generic)		Ixazomib Citrate (Ninlaro®)	
	Mercaptopurine (Generic)		Melphalan (Alkeran®)	
	Nilotinib HCl (Tasigna®)		Mercaptopurine (Purixan®)	
	Procarbazine HCl (Matulane®)		Midostaurin (Rydapt®)	
	Ruxolitinib Phosphate (Jakafi®)		Panobinostat Lactate (Farydak®)	
	Tretinoin (Generic)		Pomalidomide (Pomalyst®)	**DX**
			Ponatinib HCl (Iclusig®)	
			Thalidomide (Thalomid®)	
			Thioguanine (Tabloid®)	
			Venetoclax Tablet; Therapy Pack (Venclexta®)	
			Vorinostat (Zolinza®)	

AG – Authorized Generic	**DR** – Concurrent Prescriptions Must Be Written by Same Prescriber	**PU** – Prior Use of Other Medication is Required
AL – Age Limits	**DS** – Maximum Days' Supply Allowed	**QL** – Quantity Limits
BH – Behavioral Health Clinical Authorization Required for Children Younger Than 6 Years Old	**DT** – Duration of Therapy Limit	**RX** – Specific Prescription Requirements
BY – Diagnosis Codes Bypass Some Requirements	**DX** – Diagnosis Code Requirements	**TD** – Therapeutic Duplication
CL – More Detailed Clinical Information Required for Authorization	**ER** – Early Refill **NOT** Allowed	**UN** – Drug Use Not Warranted (Needs Appropriate Diagnosis)
CU – Concurrent Use with Opioids or Benzodiazepines is Restricted	**MD** – Maximum Dose Limits	**X** – Prescriber Must Have 'X' DEA Number
DD – Drug-Drug Interactions	**PR** – Enrollment in a Physician-Supervised Program Required	**YQ** – Yearly Quantity Limits

Descriptive Therapeutic Class	Drugs on PDL	POS Edits	Drugs on NPDL which Require Prior Authorization (PA)	POS Edits
ONCOLOGY (29)	Afatinib Dimaleate (Gilotrif®)		Brigatinib (Alunbrig®)	
Oral – Lung	Alectinib HCl (Alecensa®)		Ceritinib (Zykadia®)	
*Request Form	Crizotinib (Xalkori®)			
*Criteria	Erlotinib HCl (Tarceva®)			
	Gefitinib (Iressa®)			
	Osimertinib Mesylate (Tagrisso®)			
	Topotecan HCl (Hycamtin®)			
ONCOLOGY (29)	Temozolomide (Generic; AG)		Altretamine (Hexalen®)	
Oral – Other	Vandetanib (Caprelsa®)		Cabozantinib S-Malate (Cometriq®)	
*Request Form			Niraparib Tosylate (Zejula®)	
*Criteria			Olaparib (Lynparza®)	
			Regorafenib (Stivarga®)	
			Rucaparib Camsylate (Rubraca®)	
			Temozolomide (Temodar®)	
			Trifluridine/Tipiracil HCl (Lonsurf®)	
ONCOLOGY (29)	Bicalutamide (Generic)		Abiraterone Acetate (Zytiga®)	
Oral – Prostate	Flutamide (Generic)		Abiraterone Acetate, Submicronized (Yonsa®)	
*Request Form			Apalutamide (Erleada®)	
*Criteria			Bicalutamide (Casodex®)	
			Enzalutamide (Xtandi®)	
			Estramustine Phosphate Sodium (Emcyt®)	
			Nilutamide (Generic)	
ONCOLOGY (29)	Axitinib (Inlyta®)		Cabozantinib S-Malate (Cabometyx®)	
Oral - Renal Cell	Lenvatinib Mesylate (Lenvima®)		Everolimus (Afinitor®, Afinitor Disperz®)	
*Request Form	Pazopanib HCl (Votrient®)			
*Criteria	Sorafenib Tosylate (Nexavar®)			
	Sunitinib Malate (Sutent®)			

AG – Authorized Generic	**DR** – Concurrent Prescriptions Must Be Written by Same Prescriber	**PU** – Prior Use of Other Medication is Required
AL – Age Limits	**DS** – Maximum Days' Supply Allowed	**QL** – Quantity Limits
BH – Behavioral Health Clinical Authorization Required for Children Younger Than 6 Years Old	**DT** – Duration of Therapy Limit	**RX** – Specific Prescription Requirements
BY – Diagnosis Codes Bypass Some Requirements	**DX** – Diagnosis Code Requirements	**TD** – Therapeutic Duplication
CL – More Detailed Clinical Information Required for Authorization	**ER** – Early Refill **NOT** Allowed	**UN** – Drug Use Not Warranted (Needs Appropriate Diagnosis)
CU – Concurrent Use with Opioids or Benzodiazepines is Restricted	**MD** – Maximum Dose Limits	**X** – Prescriber Must Have 'X' DEA Number
DD – Drug-Drug Interactions	**PR** – Enrollment in a Physician-Supervised Program Required	**YQ** – Yearly Quantity Limits

Descriptive Therapeutic Class	Drugs on PDL	POS Edits	Drugs on NPDL which Require Prior Authorization (PA)	POS Edits
ONCOLOGY (29)	Cobimetinib Fumarate (Cotellic®)		Encorafenib (Braftovi®)	
Oral – Skin	Dabrafenib Mesylate (Tafinlar®)		Binimetinib (Mektovi®)	
*Request Form	Sonidegib Phosphate (Odomzo®)			
*Criteria	Trametinib Dimethyl Sulfoxide (Mekinist®)			
	Vemurafenib (Zelboraf®)			
	Vismodegib (Erivedge®)			
OPHTHALMIC DISORDERS (30)	Cromolyn Sodium Solution (Generic)		Alcaftadine Solution (Lastacaft®)	
Allergic Conjunctivitis	Loteprednol Suspension (Alrex®)		Azelastine HCl Solution (Generic)	
*Request Form	Olopatadine HCl Solution (Generic; AG for Patanol®)		Bepotastine Solution (Bepreve®)	
*Criteria	Olopatadine HCl Solution (Pazeo®)		Emedastine Difumarate Solution (Emadine®)	
			Epinastine Solution (Generic)	
			Lodoxamide Tromethamine Solution (Alomide®)	
			Nedocromil Sodium Solution (Alocril®)	
			Olopatadine HCl Solution (Generic; AG; Pataday®)	
			Olopatadine HCl Solution (Patanol®)	
OPHTHALMIC DISORDERS (30)	Bacitracin/Polymyxin B Sulfate Ointment (Generic)		Azithromycin Solution (AzaSite®)	
Antibiotics	Ciprofloxacin Solution Ophthalmic (Generic)		Bacitracin Ointment (Generic)	
*Request Form	Erythromycin Base Ointment (Generic)		Besifloxacin Suspension (Besivance®)	
*Criteria	Gentamicin Sulfate Ointment; Solution (Generic)		Ciprofloxacin Ointment; Solution (Ciloxan®)	
	Moxifloxacin Solution (Moxeza®)		Gatifloxacin Solution (Generic; Zymaxid®)	
	Neomycin/Polymyxin B/Gramicidin Solution (Generic)		Levofloxacin Solution (Generic)	
	Ofloxacin Solution Ophthalmic (Generic)		Moxifloxacin Solution (Generic; AG; Vigamox®)	
	Polymyxin B Sulfate/Trimethoprim (Generic)		Natamycin Suspension (Natacyn®)	
	Sulfacetamide Sodium Solution (Generic)		Neomycin/Polymyxin B/Bacitracin Ointment (Generic)	
	Tobramycin Solution (Generic)		Ofloxacin Solution (Ocuflox®)	
			Polymyxin B Sulfate/Trimethoprim Solution (Polytrim®)	
			Sulfacetamide Sodium Ointment (Generic)	
			Sulfacetamide Sodium Solution (Bleph-10®)	
			Tobramycin Solution; Ointment (Tobrex®)	

AG – Authorized Generic	**DR** – Concurrent Prescriptions Must Be Written by Same Prescriber	**PU** – Prior Use of Other Medication is Required
AL – Age Limits	**DS** – Maximum Days' Supply Allowed	**QL** – Quantity Limits
BH – Behavioral Health Clinical Authorization Required for Children Younger Than 6 Years Old	**DT** – Duration of Therapy Limit	**RX** – Specific Prescription Requirements
BY – Diagnosis Codes Bypass Some Requirements	**DX** – Diagnosis Code Requirements	**TD** – Therapeutic Duplication
CL – More Detailed Clinical Information Required for Authorization	**ER** – Early Refill **NOT** Allowed	**UN** – Drug Use Not Warranted (Needs Appropriate Diagnosis)
CU – Concurrent Use with Opioids or Benzodiazepines is Restricted	**MD** – Maximum Dose Limits	**X** – Prescriber Must Have 'X' DEA Number
DD – Drug-Drug Interactions	**PR** – Enrollment in a Physician-Supervised Program Required	**YQ** – Yearly Quantity Limits

Descriptive Therapeutic Class	Drugs on PDL	POS Edits	Drugs on NPDL which Require Prior Authorization (PA)	POS Edits
OPHTHALMIC DISORDERS (30)	Neomycin/Polymyxin B/Dexamethasone Suspension; Ointment		Gentamicin/Prednisolone Ointment; Suspension (Pred-G®)	
Antibiotic-Steroid Combinations	Sulfacetamide/Prednisolone Solution (Generic)		Neomycin/Bacitracin/Polymyxin B/Hydrocortisone Ointment	
*Request Form	Tobramycin/Dexamethasone Ointment; Suspension (Tobradex®)		Neomycin/Polymyxin B/Dexamethasone Suspension (Maxitrol®)	
*Criteria			Neomycin/Polymyxin B/Dexamethasone Ointment (Maxitrol®)	
			Neomycin/Polymyxin B/Hydrocortisone Suspension (Generic)	
			Sulfacetamide/Prednisolone Ointment (Blephamide S.O.P.®)	
			Sulfacetamide/Prednisolone Solution (Blephamide®)	
			Tobramycin/Dexamethasone Susp. (Generic; AG)	
			Tobramycin/Dexamethasone ST (Tobradex ST®)	
			Tobramycin/Loteprednol Suspension (Zylet®)	
OPHTHALMIC DISORDERS (30)	Dexamethasone Sodium Phosphate (Generic)		Bromfenac Sodium 0.07% Solution (Prolensa®)	
Anti-Inflammatories	Diclofenac Sodium Solution (Generic)		Bromfenac Sodium 0.075% Solution (BromSite®)	
*Request Form	Difluprednate Emulsion (Durezol®)		Bromfenac Sodium 0.09% Solution (Generic)	
*Criteria	Fluorometholone 0.1% Suspension (Generic)		Dexamethasone Intraocular Implant (Ozurdex®)	
	Flurbiprofen Sodium Solution (Generic)		Dexamethasone Suspension (Maxidex®)	
	Ketorolac Tromethamine LS Solution 0.4%; Solution 0.5%		Fluocinolone Acetonide Intraocular Implant (Iluvien®; Retisert®)	
	Nepafenac 0.3% Suspension (Ilevro®)		Fluorometholone 0.1% Ointment (FML S.O.P.®)	
	Prednisolone Acetate 1% Suspension (Generic)		Fluorometholone 0.1% Suspension (FML®)	
			Fluorometholone 0.25% Suspension (FML Forte®)	
			Fluorometholone Acetate 0.1% Suspension (Flarex®)	
			Ketorolac Tromethamine 0.4% Solution (Acular LS®)	
			Ketorolac Tromethamine 0.5% Solution (Acular®)	
			Ketorolac Tromethamine PF Solution 0.45% (Acuvail®)	
			Loteprednol Suspension; Gel; Ointment (Lotemax®)	
			Loteprednol Etabonate 1% Ophthalmic Suspension (Inveltys®)	
			Nepafenac 0.1% Suspension (Nevanac®)	
			Prednisolone Acetate 0.12% Solution (Pred Mild®)	
			Prednisolone Acetate 1% Suspension (Pred Forte®)	
			Prednisolone Sodium Phosphate (Generic)	
			Triamcinolone Acetonide Suspension (Triesence®)	

AG – Authorized Generic	**DR** – Concurrent Prescriptions Must Be Written by Same Prescriber	**PU** – Prior Use of Other Medication is Required
AL – Age Limits	**DS** – Maximum Days' Supply Allowed	**QL** – Quantity Limits
BH – Behavioral Health Clinical Authorization Required for Children Younger Than 6 Years Old	**DT** – Duration of Therapy Limit	**RX** – Specific Prescription Requirements
BY – Diagnosis Codes Bypass Some Requirements	**DX** – Diagnosis Code Requirements	**TD** – Therapeutic Duplication
CL – More Detailed Clinical Information Required for Authorization	**ER** – Early Refill **NOT** Allowed	**UN** – Drug Use Not Warranted (Needs Appropriate Diagnosis)
CU – Concurrent Use with Opioids or Benzodiazepines is Restricted	**MD** – Maximum Dose Limits	**X** – Prescriber Must Have 'X' DEA Number
DD – Drug-Drug Interactions	**PR** – Enrollment in a Physician-Supervised Program Required	**YQ** – Yearly Quantity Limits

Descriptive Therapeutic Class	Drugs on PDL	POS Edits	Drugs on NPDL which Require Prior Authorization (PA)	POS Edits
OPHTHALMIC DISORDERS (30)	Cyclosporine (Restasis®; Restasis® Multidose™)		Cyclosporine 0.09% Ophthalmic Solution (Cequa®)	
Anti-Inflammatory/Immunomodulators			Lifitegrast (Xiidra®)	
*Request Form				
*Criteria				
OPHTHALMIC DISORDERS (30)	Brimonidine 0.15% Solution (Alphagan P® 0.15%)		Apraclonidine Solution (Generic; Iopidine®)	
Glaucoma Agents	Brimonidine 0.2% Solution (Generic)		Betaxolol 0.25% Suspension (Betoptic S®)	
Intraocular Pressure (IOP) Reducers	Brimonidine/Brinzolamide Suspension (Simbrinza®)		Betaxolol 0.5% Solution (Generic)	
*Request Form	Brimonidine/Timolol Solution (Combigan®)		Bimatoprost Solution (Generic; Lumigan®)	
*Criteria	Carteolol Solution (Generic)		Brimonidine 0.1% Solution (Alphagan P® 0.1%)	
	Dorzolamide Solution (Generic)		Brimonidine P 0.15% Solution (Generic)	
	Dorzolamide/Timolol Solution (Generic)		Brinzolamide Suspension (Azopt®)	
	Latanoprost 2.5ml Solution (Generic)		Dorzolamide Solution (Trusopt®)	
	Levobunolol Solution (Generic)		Dorzolamide/Timolol Solution (Cosopt®)	
	Netarsudil Mesylate (Rhopressa®)		Dorzolamide/Timolol/PF Solution (Generic; Cosopt PF®)	
	Pilocarpine HCl Solution (Generic)		Echothiophate Iodide (Phospholine Iodide®)	
	Timolol Maleate Solution; Gel-Forming Solution		Latanoprost Emulsion (Xelpros®)	
	Travoprost (Travatan Z®)		Latanoprost Solution (Xalatan®)	
			Latanoprostene Bunod Solution (Vyzulta®)	
			Tafluprost Solution (Zioptan®)	
			Timolol Maleate LA Solution (Generic; AG; Istalol®)	
			Timolol Maleate Solution (Timoptic® Ocudose®)	

AG – Authorized Generic	**DR** – Concurrent Prescriptions Must Be Written by Same Prescriber	**PU** – Prior Use of Other Medication is Required
AL – Age Limits	**DS** – Maximum Days' Supply Allowed	**QL** – Quantity Limits
BH – Behavioral Health Clinical Authorization Required for Children Younger Than 6 Years Old	**DT** – Duration of Therapy Limit	**RX** – Specific Prescription Requirements
BY – Diagnosis Codes Bypass Some Requirements	**DX** – Diagnosis Code Requirements	**TD** – Therapeutic Duplication
CL – More Detailed Clinical Information Required for Authorization	**ER** – Early Refill **NOT** Allowed	**UN** – Drug Use Not Warranted (Needs Appropriate Diagnosis)
CU – Concurrent Use with Opioids or Benzodiazepines is Restricted	**MD** – Maximum Dose Limits	**X** – Prescriber Must Have 'X' DEA Number
DD – Drug-Drug Interactions	**PR** – Enrollment in a Physician-Supervised Program Required	**YQ** – Yearly Quantity Limits

Descriptive Therapeutic Class	Drugs on PDL	POS Edits	Drugs on NPDL which Require Prior Authorization (PA)	POS Edits
OPIATE DEPENDENCE AGENTS (31)	Buprenorphine/Naloxone Sublingual Film (Suboxone®)	**Al, DX, MD, QL, TD, X**	Buprenorphine Sublingual Tablet (Generic)	**AL, DX, MD, TD, X**
*Request Form	Naloxone Nasal Spray (Narcan®)	**QL**	Buprenorphine Injection (Sublocade®)	**AL, DX, QL, TD, X**
*Criteria, Quantity Limits, Diagnosis Codes, and Concurrent Meds	Naloxone Syringe; Vial (Generic)	**QL**	Buprenorphine Implant (Probuphine®)	**AL, DX, QL, TD, X**
	Naltrexone Tablet (Generic)		Buprenorphine/Naloxone Film Buccal Film (Bunavail®)	**AL, DX, MD, QL, TD, X**
			Buprenorphine/Naloxone Sublingual Film	**Al, DX, MD, QL, TD, X**
			Buprenorphine/Naloxone Sublingual Tablet (Generic)	**AL, DX, MD, QL, TD, X**
			Buprenorphine/Naloxone Sublingual Tablet (Zubsolv®)	**AL, DX, MD, QL, TD, X**
			Lofexidine (Lucemyra®)	
			Naltrexone Extended-Release Injectable Suspension (Vivitrol®)	**AL, DD, DX, QL**
OSTEOPOROSIS (32)	Alendronate Tablet (Generic)		Abaloparatide (Tymlos®)	
Bone Resorption Suppression Agents	Calcitonin-Salmon Nasal (Generic)		Alendronate Effervescent Tablet (Binosto®)	
*Request Form			Alendronate Tablet (Fosamax®)	
*Criteria			Alendronate Solution (Generic)	
			Alendronate/Vitamin D (Fosamax Plus D®)	
			Denosumab (Prolia®)	
			Etidronate Disodium (Generic)	
			Ibandronate Sodium Tablet (Generic; Boniva®)	
			Raloxifene (Generic; Evista®)	
			Risedronate (Generic; AG; Actonel®)	
			Risedronate DR (AG; Atelvia®)	
			Teriparatide Subcutaneous (Forteo®)	

AG – Authorized Generic	**DR** – Concurrent Prescriptions Must Be Written by Same Prescriber	**PU** – Prior Use of Other Medication is Required
AL – Age Limits	**DS** – Maximum Days' Supply Allowed	**QL** – Quantity Limits
BH – Behavioral Health Clinical Authorization Required for Children Younger Than 6 Years Old	**DT** – Duration of Therapy Limit	**RX** – Specific Prescription Requirements
BY – Diagnosis Codes Bypass Some Requirements	**DX** – Diagnosis Code Requirements	**TD** – Therapeutic Duplication
CL – More Detailed Clinical Information Required for Authorization	**ER** – Early Refill **NOT** Allowed	**UN** – Drug Use Not Warranted (Needs Appropriate Diagnosis)
CU – Concurrent Use with Opioids or Benzodiazepines is Restricted	**MD** – Maximum Dose Limits	**X** – Prescriber Must Have 'X' DEA Number
DD – Drug-Drug Interactions	**PR** – Enrollment in a Physician-Supervised Program Required	**YQ** – Yearly Quantity Limits

Descriptive Therapeutic Class	Drugs on PDL	POS Edits	Drugs on NPDL which Require Prior Authorization (PA)	POS Edits
OTIC AGENTS (33)	Ciprofloxacin Otic (Generic)		Ciprofloxacin Otic (Otiprio®)	
Antibiotics	Ciprofloxacin/Dexamethasone (Ciprodex®)		Ciprofloxacin/Fluocinolone Acetonide (Otovel®)	
*Request Form	Neomycin/Polymyxin B/Hydrocortisone Solution; Suspension		Ciprofloxacin/Hydrocortisone (Cipro HC Otic®)	
*Criteria			Neomycin/Colistin/Thonzonium/Hydrocortisone (Coly-Mycin S®)	
			Ofloxacin Otic (Generic)	
OTIC AGENTS (33)	Acetic Acid (Generic)		**NONE**	
Anti-Infectives and Anesthetics	Acetic Acid/Hydrocortisone (Generic)			
*Request Form				
*Criteria				
PAIN MANAGEMENT (34)	Galcanezumab-gnlm Pen (Emgality®)	**CL**	Erenumab-aooe (Aimovig®)	**CL**
Antimigraine Agents	Galcanezumab-gnlm Syringe (Emgality®)	**CL**	Fremanezumab-vfrm Subcutaneous (Ajovy®)	**CL**
CGRP Antagonists				
*Request Form				
*Criteria				
PAIN MANAGEMENT (34)	**NONE**		Diclofenac Potassium Oral Packet (Cambia®)	
Antimigraine Agents			Dihydroergotamine Mesylate Injection (Generic)	
Ergotamines			Dihydroergotamine Mesylate Nasal (Generic; Migranal®)	
*Request Form			Ergotamine Tartrate Sublingual (Ergomar®)	
*Criteria			Ergotamine Tartrate/Caffeine Tablet (Cafergot®)	
			Ergotamine Tartrate/Caffeine Rectal (Migergot®)	
PAIN MANAGEMENT (34)	Rizatriptan ODT, Tablet (Generic)	**DX, QL**	Almotriptan Tablet (Generic)	**DX, QL**
Antimigraine Agents	Sumatriptan Nasal (Generic)	**DX**	Eletriptan Tablet (Generic; AG; Relpax®)	**DX, QL**
Triptans	Sumatriptan Vial (Generic)	**DX**	Frovatriptan (Generic; Frova®)	**DX, QL**
*Request Form	Sumatriptan Tablet (Generic)	**DX, QL**	Naratriptan (Generic; Amerge®)	**DX, QL**
*Criteria	Sumatriptan Disp Syringe (Generic)	**DX**	Rizatriptan Tablet (Maxalt®; Maxalt MLT®)	**DX, QL**
*Diagnosis Requirement (DX) for Younger than 18 Y/O, Quantity Limits (QL)			Sumatriptan Auto-Injector (Zembrace SymTouch®)	**DX**
			Sumatriptan Jet-Injector (Sumavel DosePro®)	**DX**

AG – Authorized Generic	**DR** – Concurrent Prescriptions Must Be Written by Same Prescriber	**PU** – Prior Use of Other Medication is Required
AL – Age Limits	**DS** – Maximum Days' Supply Allowed	**QL** – Quantity Limits
BH – Behavioral Health Clinical Authorization Required for Children Younger Than 6 Years Old	**DT** – Duration of Therapy Limit	**RX** – Specific Prescription Requirements
BY – Diagnosis Codes Bypass Some Requirements	**DX** – Diagnosis Code Requirements	**TD** – Therapeutic Duplication
CL – More Detailed Clinical Information Required for Authorization	**ER** – Early Refill **NOT** Allowed	**UN** – Drug Use Not Warranted (Needs Appropriate Diagnosis)
CU – Concurrent Use with Opioids or Benzodiazepines is Restricted	**MD** – Maximum Dose Limits	**X** – Prescriber Must Have 'X' DEA Number
DD – Drug-Drug Interactions	**PR** – Enrollment in a Physician-Supervised Program Required	**YQ** – Yearly Quantity Limits

Descriptive Therapeutic Class	Drugs on PDL	POS Edits	Drugs on NPDL which Require Prior Authorization (PA)	POS Edits
PAIN MANAGEMENT (34)	(preferred agents listed on page 40)		Sumatriptan Kit (Generic; AG [by SUN] for Imitrex®)	**DX**
Antimigraine Agents			Sumatriptan Nasal (Onzetra Xsail®)	**DX, QL**
Triptans Continued			Sumatriptan Nasal (Imitrex®)	**DX**
			Sumatriptan Tablet (Imitrex®)	**DX, QL**
			Sumatriptan Kit, Vial (Imitrex ®)	**DX**
			Sumatriptan/Naproxen (Generic; Treximet®)	**DX, QL**
			Sumatriptan/Menthol/Camphor (Migranow Kit®)	**DX**
			Zolmitriptan Tablet (Generic; AG; Zomig®)	**DX, QL**
			Zolmitriptan ODT (Generic; AG; Zomig ZMT®)	**DX, QL**
			Zolmitriptan Nasal (Zomig®)	**DX**
PAIN MANAGEMENT (34)	Adalimumab Pen Kit; Syringe Kit (Humira®)	**CL, DX**	Abatacept Injection Clickject; Syringe; Vial (Orencia®)	**CL**
Cytokine and CAM Antagonists	Secukinumab Pen; Syringe (Cosentyx®)	**CL**	Anakinra Syringe (Kineret®)	**CL**
*Request Form			Apremilast Tablet (Otezla®)	**CL**
*Criteria			Baricitinib Tablet (Olumiant®)	**CL**
*Diagnosis Codes for Selected Agents (DX)			Brodalumab Syringe (Siliq®)	**CL**
			Canakinumab/PF Vial (Ilaris®)	**CL**
			Certolizumab Pegol Kit; Syringe Kit (Cimzia®)	**CL, DX**
			Etanercept Kit; Mini Cartridge; Pen; Syringe (Enbrel®)	**CL, DX**
			Golimumab Pen; Syringe; Vial (Simponi®; Simponi Aria®)	**CL, DX**
			Guselkumab Syringe (Tremfya®)	**CL**
			Infliximab Vial (Remicade®)	**CL, DX**
			Infliximab-abda (Renflexis®)	**CL, DX**
			Infliximab-dyyb (Inflectra®)	**CL, DX**
			Ixekizumab Syringe; Autoinjector (Taltz®)	**CL**
			Rilonacept (Arcalyst®)	**CL**
			Sarilumab Pen; Syringe (Kevzara®)	**CL**
			Tildrakizumab-asmn Syringe (Ilumya®)	**CL**
			Tocilizumab Syringe; Vial (Actemra®)	**CL**
			Tofacitinib Tablet (Xeljanz®)	**CL**
			Tofacitinib ER Tablet (Xeljanz® XR)	**CL**
			Ustekinumab Syringe; Vial (Stelara®)	**CL, DX**
			Vedolizumab (Entyvio®)	**CL**

AG – Authorized Generic	**DR** – Concurrent Prescriptions Must Be Written by Same Prescriber	**PU** – Prior Use of Other Medication is Required
AL – Age Limits	**DS** – Maximum Days' Supply Allowed	**QL** – Quantity Limits
BH – Behavioral Health Clinical Authorization Required for Children Younger Than 6 Years Old	**DT** – Duration of Therapy Limit	**RX** – Specific Prescription Requirements
BY – Diagnosis Codes Bypass Some Requirements	**DX** – Diagnosis Code Requirements	**TD** – Therapeutic Duplication
CL – More Detailed Clinical Information Required for Authorization	**ER** – Early Refill **NOT** Allowed	**UN** – Drug Use Not Warranted (Needs Appropriate Diagnosis)
CU – Concurrent Use with Opioids or Benzodiazepines is Restricted	**MD** – Maximum Dose Limits	**X** – Prescriber Must Have 'X' DEA Number
DD – Drug-Drug Interactions	**PR** – Enrollment in a Physician-Supervised Program Required	**YQ** – Yearly Quantity Limits

Descriptive Therapeutic Class	Drugs on PDL	POS Edits	Drugs on NPDL which Require Prior Authorization (PA)	POS Edits
PAIN MANAGEMENT (34)	Acetaminophen w/Codeine Elixir (Generic)	**AL, CU, TD**	Acetaminophen w/Codeine (Tylenol #3®; Tylenol #4®)	**AL, CU, QL, TD**
Narcotic Analgesics - Short-Acting	Acetaminophen w/Codeine Tablet (Generic)	**AL, CU, QL, TD**	Benzhydrocodone/Acetaminophen (Apadaz®)	
*Request Form *Criteria, Age Limits, Diagnosis Requirements, Maximum Daily Dose, Quantity Limits, & Diagnosis Codes That Bypass MOST Narcotic Quantity Limits *Quantity Limits, Maximum Morphine Milligram Equivalent (MME), & Criteria for Override	Hydrocodone/Acetaminophen Tablet (Generic)	**CU, QL, TD**	Butalbital/Caffeine/APAP w/ Codeine (Generic)	**AL, CU, TD**
	Hydrocodone/Acetaminophen Solution (Generic)	**CU, TD**	Butalbital Compound with Codeine (Generic; Fiorinal w/ Codeine®)	**AL, CU, TD**
	Hydromorphone Tablet (Generic)	**CU, QL, TD**	Butorphanol Tartrate Nasal (Generic)	**CU, TD**
	Morphine IR Tablet (Generic)	**CU, QL, TD**	Carisoprodol Compound-Codeine (Generic)	**AL, CU, QL, TD**
	Morphine Sulfate Oral Syringe	**CU, TD**	Capital w/Codeine	**AL, CU, QL, TD**
	Oxycodone Tablet (Generic)	**CU, QL, TD**	Codeine Tablet (Generic)	**AL, CU, TD**
	Oxycodone/Acetaminophen Tablet (Generic)	**CU, QL, TD**	Dihydrocodeine Bitartrate/Acetaminophen/Caffeine (Generic)	**CU, TD**
	Tramadol (Generic)	**AL, CU, MD, QL, TD**	Fentanyl Buccal (Generic; Fentora®)	**CU, DX, QL, TD**
	Tramadol/Acetaminophen (Generic)	**AL, CU, MD, QL, TD**	Fentanyl Nasal Solution (Lazanda®)	**AL, CU, DX, TD**
			Fentanyl Sublingual (Abstral®)	**CU, DX, QL, TD**
			Fentanyl Sublingual Spray (Subsys®)	**AL, CU, DX, TD**
			Hydrocodone/Acetaminophen Solution (Lortab®)	**CU, TD**
			Hydrocodone/Acetaminophen Tablet (Lortab®; Norco®)	**CU, QL, TD**
			Hydrocodone/Ibuprofen (Ibudone®; Generic)	**CU, QL, TD**
			Hydromorphone Liquid (Dilaudid®)	**CU, TD**
			Hydromorphone Tablet (Dilaudid®)	**CU, QL, TD**
			Hydromorphone Suppositories; Liquid (Generic)	**CU, TD**
			Levorphanol Tablet (Generic)	**CU, TD**
			Meperidine Solution (Generic)	**CU, TD**
			Meperidine Tablet (Generic)	**CU, QL, TD**
			Morphine Oral Solution Concentrate (Generic)	**CU, TD**
			Morphine Solution (Generic)	**CU, TD**
			Morphine Suppositories (Generic)	**CU, TD**
			Oxycodone Capsule (Generic)	**CU, QL, TD**
			Oxycodone Tablet (Roxybond®)	**CU, QL, TD**
			Oxycodone HCl Tablet (Oxaydo® Abuse-Deterrent)	**CU, QL, TD**
			Oxycodone Tablet (Roxicodone®)	**CU, QL, TD**
			Oxycodone Oral Solution Concentrate (Generic)	**CU, TD**
			Oxycodone Oral Syringe (Generic)	**CU, TD**

AG – Authorized Generic	**DR** – Concurrent Prescriptions Must Be Written by Same Prescriber	**PU** – Prior Use of Other Medication is Required
AL – Age Limits	**DS** – Maximum Days' Supply Allowed	**QL** – Quantity Limits
BH – Behavioral Health Clinical Authorization Required for Children Younger Than 6 Years Old	**DT** – Duration of Therapy Limit	**RX** – Specific Prescription Requirements
BY – Diagnosis Codes Bypass Some Requirements	**DX** – Diagnosis Code Requirements	**TD** – Therapeutic Duplication
CL – More Detailed Clinical Information Required for Authorization	**ER** – Early Refill **NOT** Allowed	**UN** – Drug Use Not Warranted (Needs Appropriate Diagnosis)
CU – Concurrent Use with Opioids or Benzodiazepines is Restricted	**MD** – Maximum Dose Limits	**X** – Prescriber Must Have 'X' DEA Number
DD – Drug-Drug Interactions	**PR** – Enrollment in a Physician-Supervised Program Required	**YQ** – Yearly Quantity Limits

Descriptive Therapeutic Class	Drugs on PDL	POS Edits	Drugs on NPDL which Require Prior Authorization (PA)	POS Edits
PAIN MANAGEMENT (34)	(preferred agents listed on page 42)		Oxycodone Solution (Generic)	**CU, TD**
Narcotic Analgesics - Short-Acting Continued			Oxycodone/Acetaminophen Tablet (Nalocet®; Percocet®; Primlev®)	**CU, QL, TD**
			Oxycodone/Aspirin (Generic)	**CU, QL, TD**
			Oxycodone/Ibuprofen (Generic)	**CU, QL, TD**
			Oxymorphone IR Tablet (Generic; Opana®)	**CU, QL, TD**
			Pentazocine/Naloxone (Generic)	**CU, TD**
			Tapentadol (Nucynta®)	**CU, MD, QL, TD**
			Tramadol (Ultram®)	**AL, CU, MD, QL, TD**
			Tramadol/Acetaminophen (Ultracet®)	**AL, CU, MD, QL, TD**
PAIN MANAGEMENT (34)	Fentanyl Transdermal (12mcg, 25mcg, 50mcg, 75mcg, 100mcg)	**CU, PU, QL, TD**	Buprenorphine Buccal Film (Belbuca®)	**CU, DX, MD, PU, QL, TD**
Narcotic Analgesics - Long-Acting	Morphine Sulfate ER Tablet (Generic)	**CU, PU, QL, TD**	Buprenorphine Transdermal (Generic, AG; Butrans®)	**CU, DX, MD, PU, QL, TD**
*Request Form	Morphine Sulfate/Naltrexone HCl ER Capsule (Embeda®)	**CU, PU, QL, TD**	Fentanyl Transdermal (Duragesic®)	**CU, PU, QL, TD**
			Fentanyl Transdermal (Generic 37.5mcg, 62.5mcg, 87.5mcg)	**CU, PU, QL, TD**
*Criteria, Age Limits, Diagnosis Requirements, Maximum Daily Dose, Quantity Limits (QL) & Diagnosis Codes That Bypass **MOST** Narcotic QL			Hydrocodone Bitartrate ER Capsule (Zohydro ER®)	**CU, PU, QL, TD**
			Hydrocodone Bitartrate ER Tablet (Hysingla ER®)	**CU, PU, QL, TD**
			Hydromorphone ER Tablet (Generic; AG; Exalgo®)	**CU, PU, QL, TD**
			Methadone Oral Concentrate; Oral Solution	**CL, CU, PU, TD**
*Quantity Limits, Maximum Morphine Milligram Equivalent (MME), & Criteria for Override			Methadone Soluble Tablet	**CL, CU, PU, QL, TD**
			Methadone Tablet (Generic; Dolophine®)	**CL, CU, PU, QL, TD**
*Methadone Clinical Criteria			Morphine Sulfate ER Capsule (Generic Avinza®)	**CU, MD, PU, QL, TD**
			Morphine Sulfate ER Capsule (Generic Kadian; Kadian®)	**CU, MD, PU, QL, TD**
			Morphine Sulfate ER Tablet (MS Contin®, Arymo ER®, MorphaBond ER®)	**CU, PU, QL, TD**
			Oxycodone ER Tablet (AG; OxyContin®)	**CU, PU, QL, TD**

AG – Authorized Generic	**DR** – Concurrent Prescriptions Must Be Written by Same Prescriber	**PU** – Prior Use of Other Medication is Required
AL – Age Limits	**DS** – Maximum Days' Supply Allowed	**QL** – Quantity Limits
BH – Behavioral Health Clinical Authorization Required for Children Younger Than 6 Years Old	**DT** – Duration of Therapy Limit	**RX** – Specific Prescription Requirements
BY – Diagnosis Codes Bypass Some Requirements	**DX** – Diagnosis Code Requirements	**TD** – Therapeutic Duplication
CL – More Detailed Clinical Information Required for Authorization	**ER** – Early Refill **NOT** Allowed	**UN** – Drug Use Not Warranted (Needs Appropriate Diagnosis)
CU – Concurrent Use with Opioids or Benzodiazepines is Restricted	**MD** – Maximum Dose Limits	**X** – Prescriber Must Have 'X' DEA Number
DD – Drug-Drug Interactions	**PR** – Enrollment in a Physician-Supervised Program Required	**YQ** – Yearly Quantity Limits

Descriptive Therapeutic Class	Drugs on PDL	POS Edits	Drugs on NPDL which Require Prior Authorization (PA)	POS Edits
PAIN MANAGEMENT (34)	(preferred agents listed on page 43)		Oxycodone Myristate (Xtampza® ER)	**CU, PU, QL, TD**
Narcotic Analgesics - Long-Acting Continued			Oxymorphone ER (Generic Opana ER®)	**CU, PU, QL, TD**
			Tapentadol Extended Release (Nucynta ER®)	**CU, MD, PU, QL, TD**
			Tramadol ER Capsule (AG; Conzip®)	**AL, CU, MD, PU, QL, TD**
			Tramadol ER Tablet (Generic Ultram ER®, Generic Ryzolt®)	**AL, CU, MD, PU, QL, TD**
PAIN MANAGEMENT (34)	Duloxetine Capsule (Generic)	**BH**	Capsaicin/Skin Cleanser (Qutenza Kit®)	
Neuropathic Pain	Gabapentin Capsule; Solution; Tablet (Generic)		Duloxetine Capsule (Cymbalta®; Generic for Irenka®)	**BH**
*Request Form	Lidocaine Patch (Generic; AG)	**QL**	Gabapentin Capsule; Solution; Tablet (Neurontin®)	
*Criteria			Gabapentin Enacarbil Tablet (Horizant®)	
*Criteria to Override Quantity Limit (QL) For Lidocaine Patch			Gabapentin ER Tablet (Gralise®)	
			Lidocaine Patch (Lidoderm®)	**QL**
*Duloxetine Use (BH) in Children Younger Than 6 Years Old Requires Clinical Authorization (see bottom of page 2)			Lidocaine Topical System (Ztlido®)	
			Lidocaine/Emollient Combo No. 102 (DermacinRx® PHN Pak™)	
			Milnacipran (Savella®; Savella Titration Pack®)	
			Pregabalin Capsule; Solution (Lyrica®)	
			Pregabalin ER Tablet (Lyrica CR®)	
PAIN MANAGEMENT (34)	Diclofenac Sodium Tablet (Generic)	**TD**	Celecoxib (Generic; AG; Celebrex®)	**DX, TD, UN**
Non-Steroidal Anti-Inflammatory Drugs (NSAIDS)	Diclofenac Sodium Transdermal Gel (Voltaren®)	**TD**	Diclofenac Epolamine Patch (Flector®)	**TD**
	Diclofenac SR (Generic)	**TD**	Diclofenac Potassium Capsule (Zipsor®)	**TD**
*Request Form	Ibuprofen Suspension Rx; Tablet Rx (Generic)	**TD**	Diclofenac Potassium Tablet (Generic)	**TD**
*Criteria	Indomethacin Capsule (Generic)	**TD**	Diclofenac Sodium Topical Solution (Generic; Pennsaid®)	**TD**
	Ketorolac Tablet (Generic)	**QL, DS, TD**	Diclofenac Sodium Transdermal Gel (Generic)	**TD**
	Meloxicam Tablet (Generic)		Diclofenac Sodium/Isopropyl Alcohol (Vopac MDS Kit)	**TD**
Ketorolac Quantity Limit – 20; Maximum 5-Day Supply (Point-of-Sale Override May Be Available)	Nabumetone Tablet (Generic)		Diclofenac Submicronized Capsule (Zorvolex®)	**TD**
	Naproxen EC DR (Generic)		Diclofenac/Capsicum Oleoresin Kit	**TD**
	Naproxen Suspension; Tablet (Generic)		Diclofenac/Misoprostol Tablet (Generic; Arthrotec®)	**TD**
	Sulindac Tablet (Generic)		Diflunisal Tablet (Generic)	**TD**

AG – Authorized Generic	**DR** – Concurrent Prescriptions Must Be Written by Same Prescriber	**PU** – Prior Use of Other Medication is Required
AL – Age Limits	**DS** – Maximum Days' Supply Allowed	**QL** – Quantity Limits
BH – Behavioral Health Clinical Authorization Required for Children Younger Than 6 Years Old	**DT** – Duration of Therapy Limit	**RX** – Specific Prescription Requirements
BY – Diagnosis Codes Bypass Some Requirements	**DX** – Diagnosis Code Requirements	**TD** – Therapeutic Duplication
CL – More Detailed Clinical Information Required for Authorization	**ER** – Early Refill **NOT** Allowed	**UN** – Drug Use Not Warranted (Needs Appropriate Diagnosis)
CU – Concurrent Use with Opioids or Benzodiazepines is Restricted	**MD** – Maximum Dose Limits	**X** – Prescriber Must Have 'X' DEA Number
DD – Drug-Drug Interactions	**PR** – Enrollment in a Physician-Supervised Program Required	**YQ** – Yearly Quantity Limits

Descriptive Therapeutic Class	Drugs on PDL	POS Edits	Drugs on NPDL which Require Prior Authorization (PA)	POS Edits
PAIN MANAGEMENT (34)	(preferred agents listed on page 44)		Etodolac Tablet; Capsule; SR Tablet (Generic)	**TD**
Non-Steroidal Anti-Inflammatory Drugs (NSAIDS) Continued			Fenoprofen Capsule (Generic; AG; Nalfon®)	**TD**
			Flurbiprofen Tablet (Generic)	**TD**
			Ibuprofen/Famotidine Tablet (Duexis®)	**TD**
			Indomethacin ER Capsule (Generic)	**TD**
			Indomethacin Submicronized Capsule (Tivorbex®)	**TD**
			Indomethacin Suppository; Suspension (Indocin®)	**TD**
			Ketoprofen Capsule (Generic)	**TD**
			Ketoprofen ER Capsule (Generic)	**TD**
			Ketorolac Nasal Spray (Sprix®)	**TD**
			Meclofenamate Sodium Capsule (Generic)	**TD**
			Mefenamic Acid (Generic)	**TD**
			Meloxicam, Submicronized (Vivlodex®)	**TD**
			Meloxicam Tablet (Mobic®)	**TD**
			Naproxen CR (Generic; AG)	**TD**
			Naproxen Sodium (Generic; Naprelan®)	**TD**
			Naproxen/Esomeprazole Tablet (Vimovo®)	**TD**
			Oxaprozin Tablet (Generic)	**TD**
			Piroxicam Capsule (Generic; Feldene®)	**TD**
			Tolmetin Capsule; Tablet (Generic)	**TD**
PAIN MANAGEMENT (34)	Baclofen (Generic)		Carisoprodol Compound	**QL**
Skeletal Muscle Relaxants	Chlorzoxazone (Generic)		Carisoprodol Tablet 250mg & 350mg (Generic; Soma®)	**QL**
*Request Form	Cyclobenzaprine (Generic)		Chlorzoxazone (Lorzone®)	
*Criteria	Methocarbamol (Generic)		Cyclobenzaprine ER (Amrix®)	
*Quantity Limits for Carisoprodol Products (QL) (see bottom of page 3)	Tizanidine Tablet (Generic)		Dantrolene Sodium (Generic; AG; Dantrium®)	
			Metaxalone (Generic; Skelaxin®)	
			Methocarbamol (Robaxin®)	
			Orphenadrine ER Tablet (Generic)	
			Tizanidine Capsule (Generic; Zanaflex®)	
			Tizanidine Tablet (Zanaflex®)	

AG – Authorized Generic	**DR** – Concurrent Prescriptions Must Be Written by Same Prescriber	**PU** – Prior Use of Other Medication is Required
AL – Age Limits	**DS** – Maximum Days' Supply Allowed	**QL** – Quantity Limits
BH – Behavioral Health Clinical Authorization Required for Children Younger Than 6 Years Old	**DT** – Duration of Therapy Limit	**RX** – Specific Prescription Requirements
BY – Diagnosis Codes Bypass Some Requirements	**DX** – Diagnosis Code Requirements	**TD** – Therapeutic Duplication
CL – More Detailed Clinical Information Required for Authorization	**ER** – Early Refill **NOT** Allowed	**UN** – Drug Use Not Warranted (Needs Appropriate Diagnosis)
CU – Concurrent Use with Opioids or Benzodiazepines is Restricted	**MD** – Maximum Dose Limits	**X** – Prescriber Must Have 'X' DEA Number
DD – Drug-Drug Interactions	**PR** – Enrollment in a Physician-Supervised Program Required	**YQ** – Yearly Quantity Limits

Descriptive Therapeutic Class	Drugs on PDL	POS Edits	Drugs on NPDL which Require Prior Authorization (PA)	POS Edits
PARKINSON'S (35)	Amantadine Capsule; Syrup (Generic)		Amantadine Hydrochloride ER Capsule (Gocovri®)	
Antiparkinson Agents	Benztropine Tablet (Generic)		Amantadine Hydrochloride ER Tablet (Osmolex ER®)	
Anticholinergic and Other	Carbidopa/Levodopa ER Tablet (Generic)		Amantadine Tablet (Generic)	
*Request Form	Carbidopa/Levodopa Tablet (Generic)		Bromocriptine Capsule; Tablet (Generic)	
*Criteria	Carbidopa/Levodopa/Entacapone Tablet (Generic)		Carbidopa Tablet (Generic; Lodosyn®)	
	Pramipexole Tablet (Generic)		Carbidopa/Levodopa Enteral Suspension (Duopa®)	
	Ropinirole Tablet (Generic)		Carbidopa/Levodopa ER Capsule (Rytary®)	
	Selegiline Capsule, Tablet (Generic)		Carbidopa/Levodopa ER Tablet (Sinemet CR®)	
	Trihexyphenidyl Elixir, Tablet (Generic)		Carbidopa/Levodopa ODT (Generic)	
			Carbidopa/Levodopa Tablet (Sinemet®)	
			Carbidopa/Levodopa/Entacapone Tablet (Stalevo®)	
			Entacapone Tablet (Generic)	
			Pramipexole (Mirapex®)	
			Pramipexole ER (Generic; Mirapex ER®)	
			Rasagiline (Generic; Azilect®)	
			Ropinirole (Requip®)	
			Ropinirole ER (Generic; Requip XL®)	
			Rotigotine Patch (Neupro®)	
			Safinamide Tablet (Xadago®)	
			Selegiline (Zelapar®)	
			Tolcapone Tablet (Generic)	
PEDIATRIC MULTIVITAMINS (36)	Pediatric MVI No. 16 With FL Chewable		Pediatric MVI A, C, D3 No. 21 With FL Drop (Tri-Vitamin with FL)	
*Request Form	Pediatric MVI No. 17 With FL Chewable (Generic)		Pediatric MVI No. 47 With FL & Fe Chewable (Escavite™)	
*Criteria	Pediatric MVI A, C, D3 No. 21 With FL Drop (Generic)		Pediatric MVI No. 85 With FL Chewable (Floriva™)	
	Pediatric MVI No. 2 With FL Drop (Generic)		Pediatric MVI No. 78 With FL & Fe Chewable (Escavite™ D)	
	Pediatric MVI No. 82 With FL Drop (Generic)		Pediatric MVI No. 86 With FL & Fe Drop (Escavite® LQ)	
	Pediatric MVI No. 45 With FL & Fe Drop (Generic)		Pediatric MVI No. 130 With FL Drop (Floriva Plus™)	
	Pediatric MVI No. 75 With FL & Fe Drop (Generic)		Pediatric MVI No. 142 With FL & Fe Chewable (Quflora™ FE)	
			Pediatric MVI No. 151 With FL & Fe Drop (Quflora™ FE)	
			Pediatric MVI No. 84 With FL 0.5 mg/ml Drop (Quflora™)	

AG – Authorized Generic	**DR** – Concurrent Prescriptions Must Be Written by Same Prescriber	**PU** – Prior Use of Other Medication is Required
AL – Age Limits	**DS** – Maximum Days' Supply Allowed	**QL** – Quantity Limits
BH – Behavioral Health Clinical Authorization Required for Children Younger Than 6 Years Old	**DT** – Duration of Therapy Limit	**RX** – Specific Prescription Requirements
BY – Diagnosis Codes Bypass Some Requirements	**DX** – Diagnosis Code Requirements	**TD** – Therapeutic Duplication
CL – More Detailed Clinical Information Required for Authorization	**ER** – Early Refill **NOT** Allowed	**UN** – Drug Use Not Warranted (Needs Appropriate Diagnosis)
CU – Concurrent Use with Opioids or Benzodiazepines is Restricted	**MD** – Maximum Dose Limits	**X** – Prescriber Must Have 'X' DEA Number
DD – Drug-Drug Interactions	**PR** – Enrollment in a Physician-Supervised Program Required	**YQ** – Yearly Quantity Limits

Descriptive Therapeutic Class	Drugs on PDL	POS Edits	Drugs on NPDL which Require Prior Authorization (PA)	POS Edits
PEDIATRIC MULTIVITAMINS (36) Continued	(preferred agents listed on page 46)		Pediatric MVI No. 63 With FL Chewable (Quflora™)	
			Pediatric MVI No. 83 With FL 0.25 mg/ml Drop (Quflora™)	
			Pediatric MVI No. 37 With FL Drop (Poly-Vi-Flor®)	
			Pediatric MVI A, C, D3 No. 38 with FL Drop (Tri-Vi-Flor®)	
			Pediatric MVI No. 37 With FL & Fe Drop (Poly-Vi-Flor® Fe)	
			Pediatric MVI No. 33 With FL Chewable (Poly-Vi-Flor®)	
			Pediatric MVI No. 33 With FL & Fe Chewable (Poly-Vi-Flor® Fe)	
PITUITARY SUPPRESSIVE AGENTS (37)	Goserelin Acetate (Zoladex®)	**DX**	Histrelin Implant Kit (Supprelin LA®)	**DX**
	Leuprolide Acetate Subcutaneous (Generic)	**DX**	Histrelin Kit (Vantas®)	**DX**
*Request Form	Leuprolide Acetate (Lupron Depot®)	**DX**	Leuprolide Acetate (Lupron Depot-Ped®)	**DX**
*Criteria	Leuprolide Acetate (Lupron Depot Kit®)	**DX**	Leuprolide Acetate Subcutaneous Kit (Eligard®)	**DX**
*Diagnosis Code Required	Leuprolide Acetate (Lupron Depot-Ped Kit®)	**DX**	Triptorelin Pamoate (Trelstar®; Trelstar LA®)	**DX**
	Leuprolide Acetate Susp/Norethindrone Tablet (Lupaneta Pack®)	**DX**	Triptorelin Pamoate (Triptodur®)	**DX**
	Nafarelin Acetate Nasal Solution (Synarel®)	**DX**		
PROGESTATIONAL AGENTS (38)	Hydroxyprogesterone Caproate MDV; SDV; Auto Injector (Makena®)	**DX**	Hydroxyprogesterone Caproate (Generic by ANI; Generic by Mylan) – **NOT** indicated for pre-term labor	
	Hydroxyprogesterone Caproate Vial (Generic; AG)		Medroxyprogesterone Acetate (Depo-Provera® 400mg/ml)	
*Request Form	Medroxyprogesterone Acetate Tablet (Generic)		Medroxyprogesterone Acetate Tablet (Provera®)	
*Progestational Agents Criteria	Norethindrone Acetate Tablet (Generic)		Norethindrone Acetate Tablet (Aygestin®)	
	Progesterone Capsule (Generic)		Progesterone Injection (Generic)	
			Progesterone, Micronized, Oral (Prometrium®)	
			Progesterone, Micronized, Vaginal (Crinone®)	
PROSTATE (39)	Alfuzosin (Generic)		Doxazosin (Cardura®)	
Benign Prostatic Hyperplasia Treatment (BPH)	Doxazosin (Generic)		Doxazosin ER (Cardura XL®)	
	Dutasteride (Generic)		Dutasteride (Avodart®)	
*Request Form	Finasteride (Generic)		Dutasteride/Tamsulosin (Generic; Jalyn®)	
*Criteria	Tamsulosin (Generic)		Finasteride (Proscar®)	
	Terazosin (Generic)		Silodosin (Generic; Rapaflo®)	
			Tamsulosin (Flomax®)	

AG – Authorized Generic	**DR** – Concurrent Prescriptions Must Be Written by Same Prescriber	**PU** – Prior Use of Other Medication is Required
AL – Age Limits	**DS** – Maximum Days' Supply Allowed	**QL** – Quantity Limits
BH – Behavioral Health Clinical Authorization Required for Children Younger Than 6 Years Old	**DT** – Duration of Therapy Limit	**RX** – Specific Prescription Requirements
BY – Diagnosis Codes Bypass Some Requirements	**DX** – Diagnosis Code Requirements	**TD** – Therapeutic Duplication
CL – More Detailed Clinical Information Required for Authorization	**ER** – Early Refill **NOT** Allowed	**UN** – Drug Use Not Warranted (Needs Appropriate Diagnosis)
CU – Concurrent Use with Opioids or Benzodiazepines is Restricted	**MD** – Maximum Dose Limits	**X** – Prescriber Must Have 'X' DEA Number
DD – Drug-Drug Interactions	**PR** – Enrollment in a Physician-Supervised Program Required	**YQ** – Yearly Quantity Limits

Descriptive Therapeutic Class	Drugs on PDL	POS Edits	Drugs on NPDL which Require Prior Authorization (PA)	POS Edits
SEDATIVE/HYPNOTICS (40)	Temazepam Capsule 15mg; 30mg (Generic)	**MD, TD**	Doxepin Tablet (Silenor®)	**BH, MD, TD**
*Request Form	Triazolam Tablet (Generic)	**MD, TD**	Estazolam Tablet (Generic)	**MD, TD**
*Criteria	Zolpidem Tablet (Generic)	**MD, TD**	Eszopiclone Tablet (Generic; Lunesta®)	**MD, TD**
*Maximum Dose Limits Selected Agents (MD)			Flurazepam Capsule (Generic)	**MD, TD**
*Hetlioz Criteria			Ramelteon Tablet (Rozerem®)	**MD, TD**
*Doxepin Use (BH) in Children Younger Than 6 Years Old Requires Clinical Authorization (see bottom of page 2)			Suvorexant Tablet (Belsomra®)	**MD, TD**
			Tasimelteon Capsule (Hetlioz®)	**CL, MD, TD**
			Temazepam Capsule (Restoril®)	**MD, TD**
			Temazepam 7.5mg, 22.5mg (Generic)	**MD, TD**
			Triazolam Tablet (Halcion®)	**MD, TD**
			Zaleplon Capsule (Generic; Sonata®)	**MD, TD**
			Zolpidem Tartrate ER Tablet (Generic; Ambien CR®)	**MD, TD**
			Zolpidem Tartrate Oral Spray (Zolpimist®)	**MD, TD**
			Zolpidem Tartrate Sublingual (Generic; Edluar®; Intermezzo®)	**MD, TD**
			Zolpidem Tartrate Tablet (Ambien®)	**MD, TD**
SINUS NODE INHIBITORS (41)	**NONE**		Ivabradine (Corlanor®)	**CL**
*Request Form				
*Corlanor Criteria				
SMOKING CESSATION PRODUCTS (42)	Bupropion SR Tablet (Generic)		Bupropion ER Tablet (Zyban®)	
	Nicotine Buccal Gum OTC (Generic)	**RX, PR**	Nicotine Buccal Gum OTC (Nicorette®)	**RX, PR**
*Request Form	Nicotine Buccal Lozenges OTC (Generic)		Nicotine Buccal Lozenges OTC (Nicorette®)	
*Criteria	Nicotine Patch OTC (Generic)	**RX, PR**	Nicotine Inhaler (Nicotrol Inhaler®)	
	Varenicline (Chantix®; Chantix Dose Pack®)		Nicotine Nasal Spray (Nicotrol Nasal Spray®)	**RX, PR**
			Nicotine Patch OTC (Nicoderm CQ®)	**RX, PR**

AG – Authorized Generic	**DR** – Concurrent Prescriptions Must Be Written by Same Prescriber	**PU** – Prior Use of Other Medication is Required
AL – Age Limits	**DS** – Maximum Days' Supply Allowed	**QL** – Quantity Limits
BH – Behavioral Health Clinical Authorization Required for Children Younger Than 6 Years Old	**DT** – Duration of Therapy Limit	**RX** – Specific Prescription Requirements
BY – Diagnosis Codes Bypass Some Requirements	**DX** – Diagnosis Code Requirements	**TD** – Therapeutic Duplication
CL – More Detailed Clinical Information Required for Authorization	**ER** – Early Refill **NOT** Allowed	**UN** – Drug Use Not Warranted (Needs Appropriate Diagnosis)
CU – Concurrent Use with Opioids or Benzodiazepines is Restricted	**MD** – Maximum Dose Limits	**X** – Prescriber Must Have 'X' DEA Number
DD – Drug-Drug Interactions	**PR** – Enrollment in a Physician-Supervised Program Required	**YQ** – Yearly Quantity Limits

Descriptive Therapeutic Class	Drugs on PDL	POS Edits	Drugs on NPDL which Require Prior Authorization (PA)	POS Edits
UROLOGY INCONTINENCE (43)	Fesoterodine Fumarate ER (Toviaz®)		Darifenacin ER (Generic; AG; Enablex®)	
Bladder Relaxant Preparations	Oxybutynin Syrup; Tablet (Generic)		Flavoxate (Generic)	
*Request Form	Oxybutynin ER (Generic; AG)		Mirabegron ER Tablet (Myrbetriq®)	
*Criteria	Solifenacin (VESIcare®)		Oxybutynin ER (Ditropan XL®)	
			Oxybutynin Gel Pump; Transdermal (Gelnique®)	
			Oxybutynin Transdermal (Oxytrol® Rx)	
			Tolterodine (Generic; Detrol®)	
			Tolterodine ER (Generic; AG; Detrol LA®)	
			Trospium (Generic)	
			Trospium ER (Generic)	
UTERINE DISORDER TREATMENTS (44)	Elagolix Tablet (Orilissa®)	**CL**	**NONE**	
*Request Form				
*Orilissa Criteria				

ADDITIONAL AGENTS THAT HAVE POINT-OF-SALE (POS) REQUIREMENT(S)

Click Here for Behavioral Health Agents Listed Below for Children Younger Than Six (BH)

Click Here for Agents Listed Below with POS Requirements

Acetaminophen	POS	Equetro® (Carbamazepine)	BH	Remodulin® (Treprostinil Sodium) **INJECTION**	POS
Actimmune® (Interferon Gamma-1b)	POS	Exjade®, Jadenu® (Deferasirox)	POS	Soliris® (Eculizumab)	POS
Alferon N® (Interferon Alfa-N3)	POS	Exondys 51® (Eteplirsen)	CL, DX	Spinraza® (Nusinersen)	CL, DX
Allergen Extracts (Grastek® [Timothy Grass]; Oralair® [Mixed Grass]; Ragwitek® [Short Ragweed]	POS	Fasenra® (Benralizumab)	CL	Sylatron® (Peginterferon alfa-2b)	POS
Amitriptyline	BH, TD	First-Progesterone VGS® (Vaginal Progesterone)	POS	Synagis (Palivizumab) / Synagis Request for Reconsideration	AL, CL, DT, ER, QL
Amitriptyline/Chlordiazepoxide	BH	Flolan® (Epoprostenol Sodium)	POS	Testosterone Cypionate; Testosterone Enanthate	CL
Amoxapine	BH, TD	Fycompa® (Perampanel)	POS	Testosterone (Aveed®; Striant®; Testopel®)	CL
Aspirin	POS	Imipramine	BH, TD	Tosymra (Sumatriptan) – 6 units/30 days DX for Under 18 y/o G43.0*, G43.1*, G43.7*	DX, QL
Austedo® (Deutetrabenazine)	CL	Ingrezza® (Valbenazine)	CL	Trimipramine	BH, TD
Beyaz® (Drospirenone/Ethinyl Estradiol/ Levomefolate Calcium)	POS	Intron-A® (Interferon Alfa-2B Recombinant)	POS	Veletri® (Epoprostenol)	POS
Botox® (OnabotulinumtoxinA)	DX, QL	Isotretinoin	POS	Xenazine® (Tetrabenazine)	CL
Carafate® (Sucralfate)	POS	Lithium	BH	Xenical® (Orlistat)	DX, QL
Chlordiazepoxide/Clidinium	BH	Lorazepam Injectable	BY	Xeomin® (IncobotulinumtoxinA)	DX, QL
Chlorpromazine Injectable	BH	Maprotiline	BH	Xolair® (Omalizumab)	CL, DX
Cialis® (Tadalafil) 2.5mg, 5mg	POS	Methyltestosterone (Android®)	CL	Xyrem® (Sodium Oxybate)	CL, TD
Cinqair® (Reslizumab)	CL	Mosquito Repellant to Decrease Zika Virus Exposure Risk FFS Notice MCO Notice	AL, DX, QL		
Clomipramine	BH, TD	Myobloc® (RimabotulinumtoxinB)	DX		
Clonazepam Tablet	BH, BY, QL	Nexplanon® (Etonogestrel)	POS		
Daraprim® (Pyrimethamine)	CL	Nortriptyline	BH, TD	**DIABETIC SUPPLY LIST LINKS BY PLAN**	
Desipramine	BH, TD	Nucala® (Mepolizumab)	CL	AETNA	
Doral® (Quazepam)	MD	Proleukin® (Aldesleukin)	POS	AMERIHEALTH CARITAS LA	
Doxepin (10mg-150mg)	BH, TD	Protriptyline	BH, TD	HEALTHY BLUE	
Dysport® (AbobotulinumtoxinA)	DX	Pulmozyme® (Dornase Alfa)	POS	LOUISIANA HEALTHCARE CONNECTIONS	
				UNITEDHEALTHCARE	