Department of Medicaid

30 Day Change Notice
Effective Date: January 1, 2025

NEW PREFERRED DRUGS	
THERAPEUTIC CLASS	**NO PA REQUIRED PREFERRED**
Analgesic Agents: Gout	Colchicine Tab Probenecid/Colchicine
Cardiovascular Agents: Angina, Hypertension and Heart Failure	Candesartan Candesartan/HCTZ Levamlodipine Nebivolol Telmisartan Telmisartan/HCTZ
Cardiovascular Agents: Antiarrhythmics	Amiodarone 100, 400mg
Cardiovascular Agents: Lipotropics	Colesevelam Tab Ezetimibe/Simvastatin Fenofibrate 54, 160mg
Cardiovascular Agents: Pulmonary Arterial Hypertension* LEGACY CATEGORY	Epoprostenol
Central Nervous System (CNS) Agents: Alzheimer's Agents* LEGACY CATEGORY	Donepezil 23mg Tab Memantine ER
Central Nervous System (CNS) Agents: Anticonvulsants Rescue	Libervant
Central Nervous System (CNS) Agents: Antidepressants* LEGACY CATEGORY	Vilazodone
Central Nervous System (CNS) Agents: Attention Deficit Hyperactivity Disorder Agents	Focalin XR
Central Nervous System (CNS) Agents: Atypical Antipsychotics* LEGACY CATEGORY	Olanzapine ODT Rykindo Uzedy
Central Nervous System (CNS) Agents: Parkinson's Agents	Ropinirole ER
Central Nervous System (CNS) Agents: Sedative-Hypnotics, Non-Barbiturate	Belsomra Eszopiclone Ramelteon Temazepam 7.5, 22mg Zolpidem ER
Central Nervous System (CNS) Agents: Skeletal Muscle Relaxants, Non-Benzodiazepine	Baclofen Susp Cyclobenzaprine 7.5mg Metaxalone 800mg Orphenadrine Tizanidine Cap
Dermatologic Agents: Topical Acne Products	Adapalene/Benzoyl Peroxide Azelaic Acid Gel Retin-A Micro Pump 0.04%, 0.1%
Endocrine Agents: Diabetes – Non-Insulin	Kombiglyze XR Onglyza
Endocrine Agents: Estrogenic Agents	Angeliq

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	Climara Divigel Elestrin Minivelle Vivelle-Dot
Endocrine Agents: Osteoporosis – Bone Ossification Enhancers	Raloxifene
Gastrointestinal Agents: Anti-Emetics	Aprepitant TriPac Doxylamine/Pyridoxine Granisetron Tab
Gastrointestinal Agents: Bowel Preparations	Gavilyte-N Sod Sulf-Potass Sulf-Mag Sulf Soln
Gastrointestinal Agents: Crohn's Disease	Mercaptopurine
Gastrointestinal Agents: Proton Pump Inhibitors	Esomeprazole Omeprazole Tab Rabeprazole
Gastrointestinal Agents: Ulcerative Colitis	Mesalamine Enema, Supp
Gastrointestinal Agents: Unspecified GI	Linzess 72, 145, 290mcg
Genitourinary Agents: Benign Prostatic Hyperplasia	Silodosin
Genitourinary Agents: Electrolyte Depleter Agents	Phoslyra Sol
Genitourinary Agents: Urinary Antispasmodics	Fesoterodine Trospium
Infectious Disease Agents: Antibiotics – Cephalosporins	Cephalexin Susp
Infectious Disease Agents: Antibiotics – Inhaled	Tobramycin Inj
Infectious Disease Agents: Antibiotics – Tetracyclines	Doxycycline 20mg Minocycline IR
Infectious Disease Agents: Antibiotics – Antifungals	Clotrimazole Itraconazole Cap Nystatin Voriconazole Susp, Tab
Infectious Disease Agents: Antivirals – HIV* LEGACY CATEGORY	Darunavir 600, 800mg Tab Entecavir Lamivudine Sol Nevirapine Sol Reyataz Powder
Ophthalmic Agents: Antibiotic and Antibiotic-Steroid Combination Drops and Ointments	Tobrex Oint
Ophthalmic Agents: NSAIDs	Nevanac
Respiratory Agents: Antihistamines – Second Generation	Cetirizine Cap Desloratadine Fexofenadine Levocetirizine

Respiratory Agents: Epinephrine Auto-Injectors	Epipen Epipen JR
Respiratory Agents: Inhaled Agents	Brovana Xopenex HFA
Topical Agents: Antifungals	Butenafine
Topical Agents: Corticosteroids	Fluocinolone Acetonide 0.01% Oil Fluocinonide 0.05%
Topical Agents: Immunomodulators	Elidel Tacrolimus

NEW CLINICAL PA REQUIRED PREFERRED DRUGS	
THERAPEUTIC CLASS	**CLINICAL CRITERIA REQUIRED PREFERRED**
Blood Formation, Coagulation, and Thrombosis Agents: Colony Stimulating Factors	Fulphila
Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia A, von Willebrand Disease, and Factor XIII Deficiency* LEGACY CATEGORY	Altuviiio Nuwiq Kit
Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia B* LEGACY CATEGORY	Rebinyn
Cardiovascular Agents: Pulmonary Arterial Hypertension* LEGACY CATEGORY	Bosentan
Gastrointestinal Agents: Anti-Emetics	Dronabinol
Immunomodulator Agents: Systemic Inflammatory Disease	Adalimumab-fkjp (Gen of Hulio) Inflectra (Bio of Remicade) Rinvoq Simlandi (Bio of Humira) Tyenne (Bio of Actemra)
Respiratory Agents: Cystic Fibrosis	Pulmozyme
Respiratory Agents: Hereditary Angioedema	Berinert Icatibant Acetate

NEW STEP THERAPY REQUIRED PREFERRED DRUGS	
THERAPEUTIC CLASS	**STEP THERAPY REQUIRED PREFERRED**
Central Nervous System (CNS) Agents: Anti-Migraine Agents, Acute	Ubrelvy
Central Nervous System (CNS) Agents: Anti-Migraine Agents, Prophylaxis	Emgality 120mg/ml
Central Nervous System (CNS) Agents: Atypical Antipsychotics* LEGACY CATEGORY	Asenapine
Gastrointestinal Agents: Pancreatic Enzymes	Pertzye

NEW NON-PREFERRED DRUGS

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THERAPEUTIC CLASS	PA REQUIRED NON-PREFERRED
Analgesic Agents: NSAIDS	Fenoprofen 600mg Ketoprofen ER Meclofenamate
Analgesic Agents: Opioids	Tramadol 100mg
Blood Formation, Coagulation, and Thrombosis Agents: Colony Stimulating Factors	Ziextenzo
Blood Formation, Coagulation, and Thrombosis Agents: Hematopoietic Agents	Mircera
Cardiovascular Agents: Angina, Hypertension and Heart Failure	Bystolic Entresto Sprinkle Cap Spironolactone Susp
Cardiovascular Agents: Lipotropics	Icosapent Ethyl Cap Pitavastatin
Central Nervous System (CNS) Agents: Anti-Migraine Agents, Acute	Tosymra
Central Nervous System (CNS) Agents: Antidepressants* LEGACY CATEGORY	Caplyta Rexulti
Central Nervous System (CNS) Agents: Attention Deficit Hyperactivity Disorder Agents	Dextroamphetamine Sol
Central Nervous System (CNS) Agents: Multiple Sclerosis* LEGACY CATEGORY	Ocrevus
Central Nervous System (CNS) Agents: Neuropathic Pain	Duloxetine 40mg
Central Nervous System (CNS) Agents: Parkinson's Agents	Amantadine Sol
Central Nervous System (CNS) Agents: Sedative-Hypnotics, Non-Barbiturate	Flurazepam Zolpidem Cap
Central Nervous System (CNS) Agents: Skeletal Muscle Relaxants, Non-Benzodiazepine	Chlorzoxazone 250mg
Dermatologic Agents: Topical Acne Products	Neuac Sodium Sulfacetamide/Sulfur Cream Sodium Sulfacetamide/Sulfur Wash Susp Tretinoin Pump 0.04%, 0.1% ZMA Clear Susp
Endocrine Agents: Androgens	Aveed Testosterone Gel 1.62% Packet
Endocrine Agents: Diabetes – Insulin	Insulin Degludec Novolog 70-30 Novolog U-100
Endocrine Agents: Diabetes – Non-Insulin	Invokamet Invokana Liraglutide Metformin IR 625mg Saxagliptin Saxagliptin/Metformin

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	Sitagliptin/Metformin (Gen of Zituvimet)
Endocrine Agents: Estrogenic Agents	Menest
Endocrine Agents: Growth Hormone	Zomacton
Endocrine Agents: Osteoporosis – Bone Ossification Enhancers	Binosto Evenity Prolia Zoledronic Acid
Gastrointestinal Agents: Anti-Emetics	Aprepitant 125mg Diclegis Emend Ondansetron 16mg
Gastrointestinal Agents: Crohn's Disease	Azathioprine 75, 100mg
Gastrointestinal Agents: Bowel Preparations	Suprep
Gastrointestinal Agents: Ulcerative Colitis	Mesalamine ER Cap 500mg Mesalamine Enema Kit SF Rowasa
Gastrointestinal Agents: Unspecified GI	Amitiza
Genitourinary Agents: Electrolyte Depleter Agents	Fosrenol Powder
Genitoruinary Agents: Urinary Antispasmodics	Toviaz
Hyperkalemia Agents: Potassium Binders	Kionex Susp
Immunomodulator Agents: Systemic Inflammatory Disease	Adalimumab-aaty (Gen of Yuflyma) Adalimumab-ryvk (Gen of Simlandi) Amjevita 10/0.2ml (Bio of Humira) Avsola (Bio of Remicade) Infliximab (Gen of Remicaide) Renflexis (Bio of Remicade)
Infectious Disease Agents: Antibiotics – Cephalosporins	Cephalexin Tab
Infectious Disease Agents: Antibiotics – Inhaled	Tobramycin 300mg/4ml Neb Soln
Infectious Disease Agents: Antibiotics – Macrolides	Clarithromycin ER
Infectious Disease Agents: Antibiotics – Tetracyclines	Minolira
Infectious Disease Agents: Antifungals	Flucytosine
Infectious Disease Agents: Antivirals – HIV* LEGACY CATEGORY	Etravirine Prezista Susp, 75, 150mg Tab Sunlenca Trizivir Vocabria
Ophthalmic Agents: Glaucoma Agents	Betimol Tafluprost
Respiratory Agents: Antihistamines – Second Generation	Loratadine Chewable Fexofenadine/Pseudoephedrine

Respiratory Agents: Hereditary Angioedema	Haegarda Orladeyo Ruconest
Respiratory Agents: Monoclonal Antibodies-Anti-IL/Anti-IgE	Cinqair
Topical Agents: Antifungals	Oxistat
Topical Agents: Antiparasitics	Crotan
Topical Agents: Corticosteroids	Derma-Smoothe/FS Enstilar Fluocinonide 0.1% Texacort Ultravate

THERAPEUTIC CATEGORIES WITH CHANGES IN CRITERIA
Analgesic Agents: Gout
Analgesic Agents: NSAIDS
Analgesic Agents: Opioids
Blood Formation, Coagulation, and Thrombosis Agents: Colony Stimulating Factors
Blood Formation, Coagulation, and Thrombosis Agents: Hematopoietic Agents
Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia A, von Willebrand Disease, and Factor XIII Deficiency* LEGACY CATEGORY
Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia B* LEGACY CATEGORY
Blood Formation, Coagulation, and Thrombosis Agents: Heparin-Related Preparations
Blood Formation, Coagulation, and Thrombosis Agents: Oral Anticoagulants
Cardiovascular Agents: Angina, Hypertension and Heart Failure
Cardiovascular Agents: Lipotropics
Cardiovascular Agents: Pulmonary Arterial Hypertension* LEGACY CATEGORY
Central Nervous System (CNS) Agents: Anti-Migraine Agents, Acute
Central Nervous System (CNS) Agents: Anti-Migraine Agents, Cluster Headache
Central Nervous System (CNS) Agents: Anti-Migraine Agents, Prophylaxis
Central Nervous System (CNS) Agents: Anticonvulsants* LEGACY CATEGORY
Central Nervous System (CNS) Agents: Anticonvulsants Rescue
Central Nervous System (CNS) Agents: Antidepressants* LEGACY CATEGORY
Central Nervous System (CNS) Agents: Attention Deficit Hyperactivity Disorder Agents
Central Nervous System (CNS) Agents: Atypical Antipsychotics* LEGACY CATEGORY
Central Nervous System (CNS) Agents: Fibromyalgia Agents
Central Nervous System (CNS) Agents: Medication Assisted Treatment of Opioid Addiction
Central Nervous System (CNS) Agents: Movement Disorders
Central Nervous System (CNS) Agents: Multiple Sclerosis* LEGACY CATEGORY
Central Nervous System (CNS) Agents: Narcolepsy
Central Nervous System (CNS) Agents: Neuropathic Pain
Central Nervous System (CNS) Agents: Sedative-Hypnotics, Non-Barbiturate
Central Nervous System (CNS) Agents: Skeletal Muscle Relaxants, Non-Benzodiazepine
Dermatologic Agents: Oral Acne Products
Dermatologic Agents: Topical Acne Products

Endocrine Agents: Androgens
Endocrine Agents: Diabetes – Hypoglycemia Treatments
Endocrine Agents: Diabetes – Insulin
Endocrine Agents: Diabetes – Non-Insulin
Endocrine Agents: Endometriosis
Endocrine Agents: Estrogenic Agents
Endocrine Agents: Growth Hormone
Endocrine Agents: Osteoporosis – Bone Ossification Enhancers
Endocrine Agents: Uterine Fibroids
Gastrointestinal Agents: Anti-Emetics
Gastrointestinal Agents: Crohn's Disease
Gastrointestinal Agents: Hepatic Encephalopathy
Gastrointestinal Agents: Irritable Bowel Syndrome (IBS) with Diarrhea
Gastrointestinal Agents: Pancreatic Enzymes
Gastrointestinal Agents: Proton Pump Inhibitors
Gastrointestinal Agents: Ulcerative Colitis
Gastrointestinal Agents: Unspecified GI
Genitourinary Agents: Benign Prostatic Hyperplasia
Genitourinary Agents: Electrolyte Depleter Agents
Hyperkalemia Agents: Potassium Binders
Immunomodulator Agents: Systemic Inflammatory Disease
Infectious Disease Agents: Antibiotics – Cephalosporins
Infectious Disease Agents: Antibiotics – Macrolides
Infectious Disease Agents: Antibiotics – Quinolones
Infectious Disease Agents: Antibiotics – Tetracyclines
Infectious Disease Agents: Antifungals
Infectious Disease Agents: Antivirals – Hepatitis C Agents
Ophthalmic Agents: Antihistamines & Mast Cell Stabilizers
Ophthalmic Agents: NSAIDs
Ophthalmic Agents: Ophthalmic Steroids
Otic Agents: Antibacterial and Antibacterial/Steroid Combinations
Respiratory Agents: Antihistamines – Second Generation
Respiratory Agents: Cystic Fibrosis
Respiratory Agents: Epinephrine Auto-Injectors
Respiratory Agents: Hereditary Angioedema
Respiratory Agents: Inhaled Agents
Respiratory Agents: Leukotriene Receptor Modifiers & Inhibitors
Respiratory Agents: Monoclonal Antibodies-Anti-IL/Anti-IgE
Respiratory Agents: Nasal Preparations
Topical Agents: Antifungals
Topical Agents: Corticosteroids
Topical Agents: Immunomodulators

REVISED THERAPEUTIC CATEGORY CRITERIA	
THERAPEUTIC CLASS	**SUMMARY OF CHANGE**

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<table>
<tr><td>Analgesic Agents:
Gout</td><td><u>LENGTH OF AUTHORIZATIONS:</u> 365 days ~~except 180 days for Familial Mediterranean Fever~~

<u>~~CLINICAL PA CRITERIA:~~</u>
• ~~Must have had an inadequate clinical response with an NSAID and oral corticosteroid within the last 30 days for acute gout diagnosis~~
~~OR~~
• ~~Must have had an inadequate clinical response of at least 30 days with the maximally tolerated xanthine oxidase inhibitor dose for chronic gout diagnosis~~

<u>NON-PREFERRED CRITERIA:</u>
• Must have had an inadequate clinical response of at least <u>30 days</u> with at least <u>one preferred</u> drug in this UPDL category</td></tr>
<tr><td>Analgesic Agents:
NSAIDS</td><td><u>LENGTH OF AUTHORIZATIONS:</u> ~~Dependent upon the table below~~ 365 days

<table><tr><th></th><th>~~Authorization Length~~</th></tr><tr><td>~~H. Pylori Treatment~~</td><td>~~30 days~~</td></tr><tr><td>~~Transdermal/Topical~~</td><td>~~90 days~~</td></tr><tr><td>~~All Other Treatments~~</td><td>~~365 days~~</td></tr></table>
<u>NON-PREFERRED CRITERIA:</u>
• Must have had an inadequate clinical response of at least <u>30 days</u> with at least <u>two preferred</u> drugs in this UPDL category, if indicated for diagnosis</td></tr>
<tr><td>Analgesic Agents:
Opioids</td><td><u>LENGTH OF AUTHORIZATIONS:</u> ~~For the course of therapy, up to 180 days.~~
Initial short-acting and long-acting requests may only be authorized for up to 90 days. For reauthorization, up to 180 days.

<u>BUPRENORPHINE TOPICAL (BUTRANS) CRITERIA:</u>
• For doses greater than 5 mcg/hour must provide documentation of an inadequate clinical response with at least one opioid formulation taken for at least ~~60~~ 30 of the last ~~90~~ 60 days

<u>MORPHINE SULFATE ER (KADIAN, MS CONTIN) & TAPENTADOL ER (NUCYNTA) CRITERIA:</u>
• Unless receiving for cancer pain, palliative care, or end-of-life/hospice care, must provide documentation of an inadequate clinical response with at least <u>one</u> opioid formulation taken for at least ~~60~~ 30 of the last ~~90~~ 60 days

<u>ADDITIONAL SHORT-ACTING OPIOIDS CRITERIA:</u>
• The system defines an “initial request” as having no opioid claims in</td></tr>
</table>

	the previous 90 days
	• **Initial short-acting requests** can be authorized up to 90 days
	  ○ Length of authorization is dependent on indication, previous patient utilization, and requested length of therapy (could be more restrictive)
	  ○ To exceed acute opioid limits, documentation of the following must be provided:
	  ▪ Diagnosis code which must be for somatic type pain
	  ▪ Prescriber attestation that the benefits and risks of opioid therapy have been discussed with patient
	  ○ Exemptions to the additional criteria:
	  ▪ Patients receiving short-acting opioids for active cancer treatment, palliative care, and end-of-life/hospice care, sickle cell, severe burn, traumatic crushing of tissue, amputation, major orthopedic surgery
	  ▪ Prescriber attestation that patient is opioid tolerant (i.e., new to Medicaid or was on higher dose in hospital)
	• **Subsequent short-acting requests** can be authorized up to 180 days
	  ○ Documentation of the following must be provided:
	  ▪ Current treatment plan
	  ▪ Demonstrated adherence to treatment plan through progress notes, including pain and function scores, random urine screenings results reviewed, concerns addressed, and no serious adverse outcomes observed
	  ○ Exemptions to the additional criteria:
	  ▪ Patients receiving short-acting opioids for cancer pain, palliative care, or end-of-life/hospice care
	  ▪ Patients residing in LTC facilities are exempted from urine drug screening requirements
	
	ADDITIONAL LONG-ACTING OPIOIDS CRITERIA:
	• The system defines an "initial long-acting request" as having no opioid claims in the previous 90 days
	• **Initial long-acting requests** can be authorized up to 90 days
	  ○ Documentation of the following must be provided:
	  ▪ Request is a daily dose equivalent of ≤ 80 MED
	  ▪ Inadequate clinical response to both non-opioid pharmacologic and non-pharmacologic treatments
	  ▪ Current use of opioids for ≥ ~~60~~ 30 of the last ~~90~~ 60

<table>
<tr>
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<td>
days
▪ Treatment plan including risk assessment, substance abuse history, concurrent therapies, and requirements for random urine screenings (baseline urine drug tests must be submitted)
▪ Pain and function scores at each visit
▪ Opioid contract required to be in place and submitted with PA form
○ Exemptions to the additional criteria:
▪ Patients receiving long-acting opioids for cancer pain, palliative care, or end-of-life/hospice care
▪ Patients residing in LTC facilities are exempted from urine drug screening and opioid contract requirements

• Subsequent long-acting requests can be authorized up to 180 days
○ Documentation of the following must be provided:
▪ Current treatment plan
▪ Demonstrated adherence to treatment plan through progress notes, including pain and function scores, random urine screenings results reviewed, concerns addressed, and no serious adverse outcomes observed
○ Exemptions to the additional criteria:
▪ Patients receiving long-acting opioids for cancer pain, palliative care, or end-of-life/hospice care
▪ Patients residing in LTC facilities are exempted from urine drug screening and opioid contract requirements
</td>
</tr>
<tr>
<td>Blood Formation, Coagulation, and Thrombosis Agents: Colony Stimulating Factors</td>
<td>
<u>LENGTH OF AUTHORIZATIONS</u>: ~~Dependent upon diagnosis below~~ 30 days or duration of chemotherapy regimen

<table>
<tr><th>~~Diagnosis~~</th><th>~~Authorization Length~~</th></tr>
<tr><td>~~Acute Myeloid Leukemia (AML)~~</td><td>~~14 days or duration of chemotherapy regimen~~</td></tr>
<tr><td>~~Malignancy at risk for febrile neutropenia or undergoing myeloablative chemotherapy prior to allogeneic or autologous bone marrow transplantation~~</td><td>~~14 days or duration of chemotherapy regimen~~</td></tr>
<tr><td>~~Myeloid Engraftment for bone marrow transplant (BMT)~~</td><td>~~30 days~~</td></tr>
<tr><td>~~Severe, chronic neutropenia with absolute neutrophil count (ANC) of less than 500/mm³ and have symptoms associated with neutropenia (e.g., fever, infections, oropharyngeal ulcers).~~</td><td>~~30 days~~</td></tr>
<tr><td>~~Hematopoietic radiation injury syndrome~~</td><td>~~30 days~~</td></tr>
</table>
<u>CLINICAL PA CRITERIA:</u>
• Must provide documentation of diagnosis, patient's weight (for weight-based dosed medications only), and duration of treatment
</td>
</tr>
</table>

<table>
<tr>
<td>Blood Formation, Coagulation, and Thrombosis Agents: Hematopoietic Agents</td>
<td>
<u>LENGTH OF AUTHORIZATIONS</u>: ~~Dependent upon diagnosis below~~ 180 days; except 365 days for patients with chronic renal failure
~~Authorization of epoetin alfa or darbepoetin:~~
<table>
<tr><th>~~Diagnosis~~</th><th>~~Hemoglobin Level~~</th><th>~~Authorization Length~~</th></tr>
<tr><td>~~Anemia due to chronic renal failure, patient on dialysis~~</td><td>~~≤11~~</td><td>~~365 days~~</td></tr>
<tr><td>~~Anemia due to chronic renal failure, patient not on dialysis~~</td><td>~~≤10~~</td><td>~~365 days~~</td></tr>
<tr><td>~~Chemotherapy-induced anemia~~</td><td>~~≤10~~</td><td>~~90 days~~</td></tr>
<tr><td>~~Anemia in myelodysplastic syndrome~~</td><td>~~≤11~~</td><td>~~180 days~~</td></tr>
</table>
~~Authorization of epoetin alfa ONLY:~~
<table>
<tr><th>~~Diagnosis~~</th><th>~~Hemoglobin Level~~</th><th>~~Authorization Length~~</th></tr>
<tr><td>~~Autologous blood donation, patient will require blood transfusions~~</td><td>~~>10 to ≤13~~</td><td>~~30 days~~</td></tr>
<tr><td>~~Anemia of prematurity, age ≤6 months~~</td><td>~~N/A~~</td><td>~~42 days~~</td></tr>
<tr><td>~~Anemia associated with chronic inflammatory disorders (e.g., rheumatoid arthritis)~~</td><td>~~≤11~~</td><td>~~180 days~~</td></tr>
<tr><td>~~Anemia associated with ribavirin combination therapy in hepatitis C infected patient~~</td><td>~~≤11~~</td><td>~~180 days~~</td></tr>
<tr><td>~~Anemia in zidovudine treated HIV infected patients~~</td><td>~~≤11~~</td><td>~~180 days~~</td></tr>
</table>
<u>CLINICAL PA CRITERIA:</u>
• Must provide documentation of baseline hemoglobin level

<u>SUBSEQUENT AUTHORIZATION CRITERIA:</u>
• Provide current hemoglobin lab result
</td>
</tr>
<tr>
<td>Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia A, von Willebrand Disease, and Factor XIII Deficiency* LEGACY CATEGORY</td>
<td>
<u>CLINICAL PA CRITERIA:</u>
• Must provide documentation of patient's body weight (for weight-based dosed medications only)
</td>
</tr>
<tr>
<td>Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia B* LEGACY CATEGORY</td>
<td>
<u>CLINICAL PA CRITERIA:</u>
• Must provide documentation of patient's body weight (for weight-based dosed medications only)
</td>
</tr>
<tr>
<td>Blood Formation, Coagulation, and Thrombosis Agents: Heparin-Related Preparations</td>
<td>
<u>LENGTH OF AUTHORIZATIONS</u>: ~~Dependent upon criteria below~~ 35 days; except 365 days for patients with cancer, pregnancy, or unable to be converted to an oral anticoagulant

<u>~~ADDITIONAL INFORMATION:~~</u>
• ~~For most indications: Guidelines from the American College of Chest Physicians limit duration of therapy in the outpatient setting for most indications to less than 35 days and patients should be transitioned to oral anticoagulant as soon as possible~~
• ~~For requests over 35 days and/or the patient cannot be transitioned to an oral anticoagulant, prescriber must submit additional documentation for reasoning:~~
○ ~~For patients with cancer – authorized up to 180 days~~
</td>
</tr>
</table>

	~~○ For pregnant women – authorized up to 280 days~~ ~~○ For patients unable to take an oral anticoagulant – authorized up to 180 days~~
Blood Formation, Coagulation, and Thrombosis Agents: Oral Anticoagulants	**AR** – ~~All drugs~~ Pradaxa Pellet Pak, Xarelto Susp: a PA is required for patients older than 12 years old
Cardiovascular Agents: Angina, Hypertension and Heart Failure	**ADDITIONAL FINERENONE (KERENDIA) CRITERIA:** • Must be on a maximally tolerated dose of an angiotensin-converting enzyme inhibitor or angiotensin receptor blocker **AND** • Must provide documentation of an inadequate clinical response to a SGLT2 Inhibitor **OR** provide documentation of medical necessity beyond convenience for why the patient cannot try a SGLT2 inhibitor (i.e., chronic kidney disease diagnosis)
Cardiovascular Agents: Lipotropics	**CLINICAL PA CRITERIA:** • Must provide ~~documentation of~~ baseline labs **AND** have ~~documented~~ adherence to 90 days of ~~prescribed~~ preferred lipid lowering medications • Must have had an inadequate clinical response of at least 90 days **AND** unable to reach goal LDL-C (see below) despite treatment with maximally tolerated ~~dose of~~ or high-potency statin ~~and ezetimibe~~ (or a clinical reason that these drugs cannot be utilized) • Must have had an inadequate clinical response of at least 90 days AND unable to reach goal LDL-C (see below) despite treatment with ezetimibe OR documentation that LDL is >25% above goal despite current statin therapy **ADDITIONAL ICOSAPENT ETHYL (VASCEPA) CRITERIA:** • Must provide documentation of baseline labs indicating triglyceride levels ≥500mg/dL after an inadequate clinical response to fibrates, niacin, and diet/exercise • ~~Must provide documentation of discontinuation of drugs known to increase triglyceride levels (i.e., beta blockers, thiazides, and estrogens), if clinically appropriate~~ **ADDITIONAL INFORMATION:** • High potency statins: atorvastatin (Lipitor) 40-80mg & rosuvastatin (Crestor) 20-40mg • LDL goals for Familial Hypercholesterolemia (includes Heterozygous & Homozygous FH): LDL ≤ 100mg/dL for adults or LDL ≤ 110mg/dL for those < 18 years of age • LDL goals for Clinical Atherosclerotic Cardiovascular Disease (ASCVD) not at very high risk: LDL ≤ 70mg/dL • LDL goals for Clinical Atherosclerotic Cardiovascular Disease (ASCVD) at very high risk: LDL ≤ 55mg/dL • Must provide documentation of multiple major ASCVD events or 1 major ASCVD event and multiple high-risk conditions if citing goal LDL ≤ 55mg/dL

Cardiovascular Agents: Pulmonary Arterial Hypertension* LEGACY CATEGORY	**CLINICAL PA CRITERIA:** • Must provide documentation of NYHA Functional Class symptoms for Pulmonary Hypertension ~~and symptoms~~ experienced by patient
Central Nervous System (CNS) Agents: Anti-Migraine Agents, Acute	**STEP THERAPY CRITERIA:** • Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs in this UPDL category **OR** documentation why patient is unable to take product not requiring step therapy **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 14 days with at least one preferred drug and one step therapy drug ~~two preferred drugs~~ in this UPDL category, one of which has the same mechanism of action if available ~~**ADDITIONAL UBROGEPANT (UBRELVY) CRITERIA**~~ • ~~Must have had an inadequate clinical response of at least 14 days with at least one preferred oral CGRP antagonist~~ **ADDITIONAL INFORMATION~~:~~** • Nurtec has a maximum quantity of **8** tablets per month for acute migraines
Central Nervous System (CNS) Agents: Anti-Migraine Agents, Cluster Headache	**ADDITIONAL INFORMATION:** • An inadequate clinical response to verapamil is defined as a titration to at least 480mg daily or maximally tolerated dose based on blood pressure or heart rate and maintained for at least 60 days
Central Nervous System (CNS) Agents: Anti-Migraine Agents, Prophylaxis	**STEP THERAPY CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least ~~three~~ two preferred controller migraine drugs. ○ For patients already established on a serotonergic medication, only ~~two~~ one preferred controller migraine drugs will be required • Must include objective documentation of severity, frequency, type of migraine, and number of headache days per month ~~(preferably a headache diary)~~ • Controller migraine drug classes include beta-blockers, anticonvulsants, serotonin-norepinephrine reuptake inhibitors, or tricyclic antidepressants **ADDITIONAL INFORMATION:** • ~~Controller migraine drug classes include beta-blockers, anticonvulsants, tricyclic antidepressants, or serotonin-norepinephrine reuptake inhibitors~~ • Nurtec has a maximum quantity of **16** tablets per month for migraine prophylaxis

	SUBSEQUENT AUTHORIZATION CRITERIA: • Must provide documentation of patient's clinical response to treatment (~~preferably a headache diary or other~~ Objective documentation of severity, frequency, and number of headache days per month).

Central Nervous System (CNS) Agents: Anticonvulsants* LEGACY CATEGORY	**STIRIPENTOL (DIACOMIT) CRITERIA**
	• Exempt from Legacy rules
	• Must be prescribed by or in consultation with a neurologist
	• Must be concomitantly taking clobazam (Onfi)
	• Must provide documentation of addressed comorbidities and baseline hematologic testing (CBC)
	  ○ Patients with phenylketonuria (PKU) must provide evidence of total daily amount of phenylalanine
	  ○ Prescribers must include management plans for patients with neutrophil counts <1,500 cells/mm^3 or platelet count <150,000/µL
	• Must provide documentation of patient's weight
	  ○ Maximum daily dose does not exceed: 50 mg/kg/day or 3,000mg/day
	• ~~Must provide baseline average number of seizure days per month (measured monthly or quarterly)~~
	
	NON-PREFERRED CRITERIA:
	• Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in this UPDL category
	• ~~Prescriptions submitted form from a prescriber who is credentialed as a neurology specialty with Ohio Medicaid AND for drugs that are used only for seizures, there must have been an inadequate clinical response of at least 30 days with one preferred drug. This provision applies only to the standard tablet/capsule dosage form.~~
	• For prescribers who are credentialed as a neurology specialty with Ohio Medicaid, there must have been an inadequate clinical response of at least 30 days with one preferred anticonvulsant drug in the standard tablet/capsule dosage form.
	
	~~SUBSEQUENT AUTHORIZATION CRITERIA:~~
	• ~~Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring (i.e., documented reduction in average number of seizure days per month [measured monthly or quarterly])~~

Central Nervous System (CNS) Agents: Anticonvulsants Rescue	All products are covered without a PA **~~LENGTH OF AUTHORIZATIONS~~**~~: 365 Days~~ **~~ALL AUTHORIZATIONS:~~** ~~Must be prescribed in accordance with FDA approved labeling~~

	~~**NON-PREFERRED CRITERIA:**~~ • ~~Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)~~ ~~**OR**~~ ○ ~~For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation~~ • ~~Must have had an inadequate clinical response with at least one preferred drug~~ ○ ~~For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)~~ ○ ~~For non-preferred brand names that have preferred generics must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)~~ ~~**SUBSEQUENT AUTHORIZATION CRITERIA:**~~ • ~~Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring~~ AR – Libervant: a PA is required for patients older than 5 years old
Central Nervous System (CNS) Agents: Antidepressants* LEGACY CATEGORY	**LENGTH OF AUTHORIZATIONS:** 365 Days except 14 days with no renewal for Zurzuvae **ADDITIONAL DEXTROMETHORPHAN/BUPROPION (AUVELITY) CRITERIA:** • Must have an inadequate clinical response of at least 30 days with **ALL** of the following: ○ ONE ~~dopamine/norepinephrine~~ norepinephrine/dopamine reuptake inhibitor (~~DNRI~~ NDRI)
Central Nervous System (CNS) Agents: Attention Deficit Hyperactivity Disorder Agents	**STEP THERAPY CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with atomoxetine **OR** at least ~~two~~ one preferred ADHD agent~~s~~.
Central Nervous System (CNS) Agents: Atypical Antipsychotics* LEGACY CATEGORY	~~**ADDITIONAL RISPERIDONE (RYKINDO) CRITERIA:**~~ • ~~Must have had a trial of at least 30 days with one preferred risperidone or paliperidone product~~ ~~**OR**~~ ~~must provide documentation of medical necessity for patient's inability to use preferred risperidone or paliperidone product~~ ~~**ADDITIONAL FLUOXETINE/OLANZAPINE (SYMBYAX) CRITERIA:**~~ • ~~Must provide documentation for patient's inability to use the individual drugs~~
Central Nervous System (CNS) Agents:	**ADDITIONAL INFORMATION**

Fibromyalgia Agents	• Drugs and drug classes include gabapentin, pregabalin, short- and/or long-acting opioids, skeletal muscle relaxants, SNRIs, SSRIs, trazodone, and tricyclic antidepressants • ~~The P&T Committee does not recommend the use of opioids for treatment of fibromyalgia~~
Central Nervous System (CNS) Agents: Medication Assisted Treatment of Opioid Addiction	**~~NON-PREFERRED CRITERIA:~~** • ~~Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs~~
Central Nervous System (CNS) Agents: Movement Disorders	**~~NON-PREFERRED CRITERIA:~~** • ~~Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in this UPDL category~~
Central Nervous System (CNS) Agents: Multiple Sclerosis* LEGACY CATEGORY	**ADDITIONAL OCRELIZUMAB (OCREVUS) CRITERIA:** • Must provide documentation of diagnosis of primary progressive multiple sclerosis **OR** must have had an inadequate clinical response of at least 30 days with at least one preferred drug in this UPDL category **ADDITIONAL SIPONIMOD (MAYZENT) CRITERIA:** • Must provide documentation of CYP2C9 genotype~~, liver function tests (LFTS) complete blood count (CBC), ophthalmic examination, varicella zoster virus antibodies, and electrocardiogram (ECG)~~
Central Nervous System (CNS) Agents: Narcolepsy	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response with at least two preferred drugs - either ~~(1)~~ at least 30 days of armodafinil or ~~ar~~modafinil; **OR** ~~(2)~~ at least 7 days of a preferred methylphenidate or amphetamine drug in this UPDL category
Central Nervous System (CNS) Agents: Neuropathic Pain	**ADDITIONAL GABAPENTIN (GRALISE) AND GABAPENTIN ENCARBIL (HORIZANT) CRITERIA** • Must have had an inadequate clinical response to a preferred gabapentin product
Central Nervous System (CNS) Agents: Sedative-Hypnotics, Non-Barbiturate	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least ~~10~~ 7 days with at least two preferred drugs in this UPDL category **ADDITIONAL INFORMATION** • Non-controlled medications may be authorized if the prescriber indicates the patient has a history of addiction • ~~The P&T Committee does not recommend the use of flurazepam (Dalmane) or triazolam (Halcion)~~
Central Nervous System (CNS) Agents: Skeletal Muscle Relaxants, Non-	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least ~~one~~ two preferred drugs in this UPDL category **~~ADDITIONAL BACLOFEN SOLUTION CRITERIA:~~**

Benzodiazepine	• ~~Must provide documentation of trial with baclofen tablets or justification why a non-solid oral dosage form is indicated~~ **AR** – Fleqsuvy (Baclofen Suspension): a PA is required for patients 12 years and older
Dermatologic Agents: Oral Acne Products	**CLINICAL PA CRITERIA:** • Must have had an inadequate clinical response of at least 90 days with at least one preferred topical **AND** one preferred oral antibiotic for acne • ~~Must be absent of oral tretinoin in the past 56 days~~ • ~~Prescriber attests that patient is registered and meets all of the requirements of the iPLEDGE program~~
Dermatologic Agents: Topical Acne Products	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response ~~of~~ with at least ~~30 days or (90 days for retinoids) of at least three~~ two preferred drugs in this UPDL category. Trials must be 30 days for preferred non-retinoids and 90 days for preferred retinoids.
Endocrine Agents: Androgens	**CLINICAL PA CRITERIA:** • Must provide documentation of baseline lab work to support the need for testosterone supplementation. If baseline testosterone level is within normal limits, provide clinical justification for why replacement therapy is required. **ADDITIONAL TESTOSTERONE ENANTHATE (XYOSTED) CRITERIA:** • Must have a trial and failure of a preferred testosterone cypionate injectable product **OR** • Must provide a clinical rationale why testosterone cypionate injectable product is not appropriate
Endocrine Agents: Diabetes – Hypoglycemia Treatments	**SUBSEQUENT AUTHORIZATION CRITERIA:** • Renewal will be allowed for expired/unused products **WITHOUT** documentation of patient's clinical response to treatment
Endocrine Agents: Diabetes – Insulin	**STEP THERAPY CRITERIA:** • Must have had an inadequate clinical response (defined as the inability to reach target A1C) ~~of~~ after at least 120 days with at least one preferred drug having a similar duration of action in this UPDL category **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response (defined as the inability to reach target A1C) ~~of~~ after at least 120 days with at least two preferred drugs having a similar duration of action in this UPDL category **ADDITIONAL INFORMATION** • An inadequate clinical response is defined as the inability to reach A1C goal after at least 120 days of current regimen with documented adherence and appropriate dose escalation.

	○ Must include a patient specific A1C goal if less than 7% ○ Must include current A1C (within last 6 months) **SUBSEQUENT AUTHORIZATION CRITERIA:** • Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring ○ Must include a patient specific A1C goal if less than 7% ○ Must include current A1C (within last 6 months)
Endocrine Agents: Diabetes – Non-Insulin	~~**ADDITIONAL ORAL AND INJECTABLE COMBINATION DRUGS CRITERIA**~~ ~~• Must have had a trial of at least 120 days with the individual drugs **OR** must provide documentation of medical necessity beyond convenience for patient's inability to use the individual drugs~~ **SUBSEQUENT AUTHORIZATION CRITERIA:** • Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring ~~○ Must document A1C goal per ADA guidelines and A1C trends including current value (within last 6 months).~~
Endocrine Agents: Endometriosis	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 84 days with at least ~~one preferred NSAID, one preferred oral contraceptive, **AND**~~ one preferred step-therapy drug in this UPDL category. **ADDITIONAL INFORMATION:** • A total lifetime duration of therapy of 730 days between Oriahnn and Myfembree or 365 days for Lupron Depot will be authorized
Endocrine Agents: Estrogenic Agents	~~**ADDITIONAL INFORMATION:**~~ ~~• Requests for non-preferred drugs must have an inadequate clinical response with preferred drugs with the same delivery method if available~~
Endocrine Agents: Growth Hormone	**Adult Approvals (18 years of age or older):** • Must be treated and followed by an endocrinologist • Must provide documentation of growth hormone deficiency by means of a negative response to an appropriate stimulation test (clonidine test is not acceptable for adults) ~~• Must provide documentation of baseline evaluation of the following clinical indicators: (1) insulin-like growth factor (IGF-1); (2) fasting lipid profile; (3) BUN; (4) fasting glucose; (5) electrolytic levels; (6) evaluation of any new osteoarthritis and joint pain; (7) bone density test~~ ~~• Must have had other hormonal deficiencies addressed with adequate replacement therapy~~
Endocrine Agents: Osteoporosis – Bone Ossification Enhancers	~~**TERIPARATIDE (FORTEO™)**~~ **CLINICAL PA CRITERIA:** • Must have had an inadequate clinical response of at least 365 days with one bisphosphonate • A total lifetime duration of therapy of 730 days will be authorized between any parathyroid analog

	ADDITIONAL "OTHER BONE RESORPTION SUPPRESSION AND RELATED AGENTS" ~~TYMLOS~~ CRITERIA: • Must have had an inadequate clinical response of at least 365 days with one bisphosphonate • A total lifetime duration of therapy of 730 days will be authorized between any parathyroid analog • A total lifetime duration of therapy of 365 days will be authorized for Evenity
Endocrine Agents: Uterine Fibroids	**~~ALL AUTHORIZATIONS:~~** ~~Must be prescribed in accordance with FDA approved labeling~~ **~~NON-PREFERRED CRITERIA:~~** ~~• Must have had an inadequate clinical response of at least 90 days with at least one preferred drug in this UPDL category.~~ **ADDITIONAL INFORMATION:** • A total lifetime duration of therapy of 730 days between Oriahnn and Myfembree or ~~180~~ 365 days for Lupron Depot will be authorized
Gastrointestinal Agents: Anti-Emetics	**CLINICAL PA CRITERIA:** • Dronabinol is only covered for nausea and vomiting associated with chemotherapy in adult patients who failed at least 3 days with at least one preferred drug in this UPDL category.
Gastrointestinal Agents: Crohn's Disease	~~All products are covered without a PA~~ **LENGTH OF AUTHORIZATIONS**: 365 days **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in this UPDL category.
Gastrointestinal Agents: Hepatic Encephalopathy	**~~RIFAXAMIN (XIFAXAN) CRITERIA:~~** ~~• Must have had an inadequate clinical response of at least 14 days to lactulose to be authorized for monotherapy or add-on therapy~~ **~~NON-PREFERRED CRITERIA:~~** ~~• Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs~~
Gastrointestinal Agents: Irritable Bowel Syndrome (IBS) with Diarrhea	**STEP THERAPY CRITERIA:** • Must have had an inadequate clinical response of at least ~~30~~ 14 days with at least one preferred drug in this UPDL category **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least ~~30~~ 14 days with at least ~~two~~ one preferred drug and one step therapy drug in this UPDL category.
Gastrointestinal Agents: Pancreatic Enzymes	**STEP THERAPY CRITERIA:** • For a diagnosis of Cystic Fibrosis, no trials required • For all other diagnoses, must have had an inadequate clinical response of at least 14 days with at least one preferred drug in this UPDL category

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	NON-PREFERRED CRITERIA: • Must have had an inadequate clinical response of at least 14 days with at least ~~one~~ two preferred drugs in this UPDL category.
Gastrointestinal Agents: Proton Pump Inhibitors	**ADDITIONAL CRITERIA FOR PPI DOSES GREATER THAN ONCE DAILY** • Must have had an inadequate clinical response of at least 30 days of once daily dosing with the requested drug **OR** ~~**AR** – Omeprazole & Pantoprazole Tab/Cap/ODT: a PA is required for patient 21 years and older requesting more than once daily dosing~~
Gastrointestinal Agents: Ulcerative Colitis	**LENGTH OF AUTHORIZATIONS**: 365 Days; except Uceris foam – ~~based on indication~~ 90 days **ADDITIONAL BUDESONIDE (UCERIS) CRITERIA:** • Must have had a documented side effect, allergy, or treatment failure of at least 30 days with ~~topical~~ enema or mesalamine suppository ~~product~~
Gastrointestinal Agents: Unspecified GI	**STEP THERAPY CRITERIA:** • Must have had an inadequate clinical response to at least 14 days with at least two preferred drugs in this UPDL category, if indicated for diagnosis **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 14 days with ~~at least three preferred drugs **AND**~~ one step therapy drug in this UPDL category, if indicated for diagnosis ~~**ADDITIONAL TEDLOGLUTIDE (GATTEX) CRITERIA:**~~ ~~• Must have evidence of specialized parenteral nutritional support~~ ~~• Must have documentation of appropriate lab assessment (bilirubin, alkaline phosphatase, lipase, and amylase) at least 180 days prior to initiation~~
Genitourinary Agents: Benign Prostatic Hyperplasia	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least ~~30~~ 60 days with at least two preferred drugs, with at least one preferred with the same mechanism of action, if available ~~**ADDITIONAL DUTASTERIDE/TAMSULOSIN (JALYN) & FINASTERIDE/TADALAFIL (ENTADFI) CRITERIA**~~ • ~~Must have had a trial of at least 120 days with the individual drugs **OR** must provide documentation of medical necessity beyond convenience for patient's inability to use the individual drugs Must provide documentation for patient's inability to use the individual drugs~~
Genitourinary Agents: Electrolyte Depleter Agents	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least ~~7~~ 14 days with at least two preferred drugs in this UPDL category, one of which must have the same mechanism of action as the requested

	non-preferred drug, if available
Hyperkalemia Agents: Potassium Binders	**NON-PREFERRED CRITERIA:** • ~~Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)~~ **~~OR~~**
Immunomodulator Agents: Systemic Inflammatory Disease	**~~ALL AUTHORIZATIONS:~~** ~~• First line treatment can vary based upon the severity of disease for certain diagnoses. Documentation of the patient's disease state and the criteria used to classify the severity is required.~~ **CLINICAL PA CRITERIA:** ~~• Must have been an inadequate clinical response of at least 90 days with at least two applicable first-line drugs indicated for diagnosis – provide documentation of the trialed drugs, dosages, dates, and durations~~ **ADDITIONAL ATOPIC DERMATITIS CRITERIA:** • Must have at least 10% body surface area (BSA) involvement with an inadequate clinical response of at least 90 days with two of the following: topical corticosteroids or topical calcineurin inhibitors [e.g., Elidel] unless atopic dermatitis is severe and involves >25% BSA **~~ADDITIONAL HIDRADENITIS SUPPURATIVA CRITERIA:~~** ~~• Must provide documentation of Hurley Stage III to be classified as severe disease~~ **~~ADDITIONAL PLAQUE PSORIASIS CRITERIA:~~** ~~• For patients currently receiving phototherapy, initial authorization for preferred drugs requires an inadequate clinical response to at least 90 days of phototherapy~~ • ~~To classify as severe disease patient must present at least two of the following: Psoriasis Area and Severity Index (PASI) score ≥ 11, BSA ≥ 10%, and Static Physician's Global Assessment (sPGA) ≥ 3~~
Infectious Disease Agents: Antibiotics – Cephalosporins	**ADDITIONAL INFORMATION** • Requests may be authorized if: ○ ~~The infection is caused by an organism resistant to **ALL** preferred antibiotics (must provide diagnosis and any culture/sensitivity results)~~ **AR** – Cephalexin Suspension: a PA is required for patients 12 years and older
Infectious Disease Agents: Antibiotics – Macrolides	**ADDITIONAL INFORMATION** • Requests may be authorized if: ○ ~~The infection is caused by an organism resistant to **ALL** preferred antibiotics (must provide diagnosis and any culture/sensitivity results)~~

	AR – Clarithromycin Suspension: a PA is required for patients 12 years and older
Infectious Disease Agents: Antibiotics – Quinolones	**ADDITIONAL INFORMATION** • Requests may be authorized if: o ~~The infection is caused by an organism resistant to **ALL** preferred antibiotics (must provide diagnosis and any culture/sensitivity results)~~ **AR** – Levofloxacin Oral Solution: a PA is required for patients 12 years and older
Infectious Disease Agents: Antibiotics – Tetracyclines	**ADDITIONAL INFORMATION** • Requests may be authorized if: o ~~The infection is caused by an organism resistant to **ALL** preferred antibiotics (must provide diagnosis and any culture/sensitivity results)~~ **AR** – Doxycycline Susp ~~Syrup~~: a PA is required for patients 12 years and older
Infectious Disease Agents: Antifungals	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least ~~7~~ 3 days with at least two preferred drugs, if indicated for the diagnosis in this UPDL category **ADDITIONAL INFORMATION:** • Posaconazole can be approved for aspergillosis treatment and prophylaxis without trials of preferred agents • Requests may be authorized if: o ~~The infection is caused by an organism resistant to **ALL** preferred antifungals (must provide diagnosis and any culture/sensitivity results)~~ **AR** – Voriconazole Susp: a PA is required for patients 12 years and older
Infectious Disease Agents: Antivirals – Hepatitis C Agents	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response defined as not achieving sustained virologic response (SVR) ~~SVR~~ with guideline-recommended preferred drugs in this UPDL category ~~**ADDITIONAL INFORMATION:**~~ • ~~Requests for patients established on current therapy with prior payer (i.e., Commercial, Fee-for-Service, Managed Care Plan, etc) will be authorized with documentation~~ • ~~Requests for regimens including pegylated Interferons must include close monitoring with periodic clinical and laboratory evaluations~~ • ~~Requests for regimens including ribavirin must include documentation of at least two reliable forms of contraception being used during therapy~~

Ophthalmic Agents: Antihistamines & Mast Cell Stabilizers	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least ~~14~~ 7 days with at least two preferred drugs in this UPDL category.
Ophthalmic Agents: NSAIDs	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 3 days with at least ~~one~~ two preferred drugs in this UPDL category.
Ophthalmic Agents: Ophthalmic Steroids	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least ~~14~~ 7 days with at least two preferred drugs in this UPDL category.
Otic Agents: Antibacterial and Antibacterial/ Steroid Combinations	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least ~~7~~ 3 days with at least ~~one~~ two preferred drugs in this UPDL category.
Respiratory Agents: Antihistamines – Second Generation	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least ~~30~~ 7 days with at least two different preferred drugs in this UPDL category. **AR** – Cetirizine Chewable, Loratadine Chewable: a PA is required for patients 6 years and older
Respiratory Agents: Cystic Fibrosis	**CLINICAL PA CRITERIA:** • Must be prescribed by or in consultation with a pulmonologist or infectious disease specialist • Must provide documentation of the specific Cystic Fibrosis Transmembrane Conductance Regular (CFTR) genetic mutation ~~**STEP THERAPY CRITERIA:**~~ • ~~Must have had an inadequate clinical response of at least 30 days with at least one preferred drug in this UPDL category.~~ ~~**SUBSEQUENT AUTHORIZATION CRITERIA:**~~ • ~~Must provide documentation of patient's clinical response to treatment (adherence to treatment demonstrated by claims history **AND** one or more of the following: FEV1, weight gain, sweat chloride, pulmonary exacerbations, etc.) and ongoing safety monitoring~~
Respiratory Agents: Epinephrine Auto-Injectors	**SUBSEQUENT AUTHORIZATION CRITERIA:** • Subsequent reauthorizations for expired, epinephrine auto-injectors are allowable
Respiratory Agents: Hereditary Angioedema	**LENGTH OF AUTHORIZATIONS**: ~~Initial: 90~~ Acute: 30 days; ~~Subsequent:~~ Prophylaxis: 180 Days **CLINICAL PA CRITERIA:** • Acute Treatment ○ Must provide documentation that diagnosis is verified by a C4 level below the lower limit of normal as defined by laboratory testing AND one of the following: ▪ C1 inhibitor (C1-INH) antigenic level below the lower limit of normal as defined by laboratory testing; OR

	▪ C1-INH functional level below the lower limit of normal as defined by laboratory testing • Prophylactic Treatment ○ Must provide documentation that diagnosis is verified by a C4 level below the lower limit of normal as defined by laboratory testing AND one of the following: ▪ C1 inhibitor (C1-INH) antigenic level below the lower limit of normal as defined by laboratory testing; OR ▪ C1-INH functional level below the lower limit of normal as defined by laboratory testing; OR ▪ Presence of a known HAE-causing C1-INH mutation • All indications ○ History of moderate or severe attacks such as airway swelling, severe abdominal pain, facial swelling, nausea and vomiting, or painful facial distortion ~~• Must provide documentation of diagnosis (i.e., C1-INH deficiency or dysfunction (Type I or II HAE)) and whether the drug will be used for prophylaxis or treatment~~ ~~• Must provide documentation of at-home administration~~ **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least ~~60~~ 3 days with at least one preferred acute drug in this UPDL category to request a non-preferred acute drug. • Must have had an inadequate clinical response of at least ~~60~~ 14 days with at least one preferred prophylaxis drug to request a non-preferred prophylaxis drug.
Respiratory Agents: Inhaled Agents	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs ~~within the same class and duration of action~~ in this UPDL category. **ADDITIONAL STEROID-CONTAINING INHALER CRITERIA** • Must have had an inadequate clinical response of at least 14 days with at least one preferred steroid-containing drug ~~• May be authorized if documentation of one of the following is provided:~~ ~~○ Patient is 12 years or younger OR is disabled and is unable to use a preferred inhaler~~ ~~○ Patient has been non-compliant on a preferred inhaler due to taste, dry mouth, or infection~~ ~~○ Patient is clinically unstable, as defined by current guidelines in terms of oral steroid use or patient's current symptomatology~~ **AR** – Budesonide Nebulizer Solution: a PA is required for patients ~~7~~ 13 years and older

Department of Medicaid

30 Day Change Notice
Effective Date: January 1, 2025

Respiratory Agents: Leukotriene Receptor Modifiers & Inhibitors	**STEP THERAPY CRITERIA:** • Must have had an inadequate clinical response of at least ~~90~~ 30 days with at least one preferred drug in this UPDL category. **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least ~~90~~ 30 days with at least two preferred drugs in this UPDL category.
Respiratory Agents: Monoclonal Antibodies-Anti-IL/Anti-IgE	**CLINICAL PA CRITERIA:** • Must be prescribed by or in consultation with an applicable specialist (i.e., allergist/ immunologist, pulmonologist, or otolaryngologist) • For **Asthma** – Must have had uncontrolled asthma symptoms and/or exacerbations despite at least 30 days with: ○ Medium dose preferred ICS/LABA inhaler for 6 years and older **OR** medium dose preferred ICS/LABA inhaler with tiotropium or high dose ICS/LABA inhaler if 12 years and older • For **Chronic Rhinosinusitis with Nasal Polyposis** – Must have had an inadequate clinical response of at least 30 days to at least one oral corticosteroid AND one nasal corticosteroid spray • For **Chronic Urticaria** – Must have had an inadequate clinical response to at least 14 days with at least two different second-generation antihistamines at 4 times standard dose
Respiratory Agents: Nasal Preparations	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least ~~30~~ 14 days with at least two preferred drugs in th~~e same class~~is UPDL category, if available
Topical Agents: Antifungals	**LENGTH OF AUTHORIZATIONS**: ~~Up to 180 days for all agents except~~ 365 days ~~for Jublia~~ **ADDITIONAL EFINACONAZOLE (JUBLIA) CRITERIA:** • Must have had an inadequate clinical response of at least 48 weeks of ciclopirox AND 6 weeks of oral terbinafine (if fingernail) **OR** 12 weeks of oral terbinafine (if toenail) ~~365 days with at least one preferred topical drug **AND** at least 84 days with at least one preferred oral drug indicated for diagnosis~~ **ADDITIONAL INFORMATION** • Requests may be authorized if: ○ The infection is caused by an organism resistant to preferred ~~antibiotics~~ antifungal drugs (note diagnosis and any culture/sensitivity results)
Topical Agents: Corticosteroids	**LENGTH OF AUTHORIZATIONS**: 365 days ~~for low/med potency; 90 days for high/very high potency~~ **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs of similar potency in this UPDL category.

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Topical Agents: Immunomodulators	~~**STEP THERAPY CRITERIA:**~~ • ~~Must have had an inadequate clinical response of at least 30 21 days with at least two topical corticosteroids one preferred agent~~