



NEW PREFERRED DRUGS	
THERAPEUTIC CLASS	NO PA REQUIRED PREFERRED
Cardiovascular Agents: Angina, Hypertension and Heart Failure	bisoprolol 5, 10mg labetalol 100, 200, 300mg spironolactone tab
Cardiovascular Agents: Antiarrhythmics	MULTAQ
Central Nervous System (CNS) Agents: Fibromyalgia Agents	SAVELLA
Central Nervous System (CNS) Agents: Neuropathic Pain	GRALISE HORIZANT
Central Nervous System (CNS) Agents: Skeletal Muscle Relaxants, Non-Benzodiazepine	methocarbamol 500, 750mg
Central Nervous System (CNS) Agents: Restless Legs Syndrome	HORIZANT
Endocrine Agents: Diabetes – Non-Insulin	glimepiride 1, 2, 4mg
Gastrointestinal Agents: Bowel Preparations	MOVIPREP
Gastrointestinal Agents: Crohn's Disease	mercaptopurine tab
Gastrointestinal Agents: Ulcerative Colitis	mesalamine ER cap 500mg PENTASA 250mg
Gastrointestinal Agents: Unspecified GI	polyethylene glycol oral powder bottle
Infectious Disease Agents: Antivirals – HIV* LEGACY CATEGORY	RUKOBIA VIREAD 150, 200mg
Respiratory Agents: Inhaled Agents	arformoterol neb
Topical Agents: Antifungals	tolnaftate cream, powder
Topical Agents: Immunomodulators	pimecrolimus [labeler 68682]

NEW CLINICAL PA REQUIRED PREFERRED DRUGS	
THERAPEUTIC CLASS	CLINICAL CRITERIA REQUIRED PREFERRED
Respiratory Agents: Cystic Fibrosis	ALYFTREK

NEW NON-PREFERRED DRUGS	
THERAPEUTIC CLASS	PA REQUIRED NON-PREFERRED



## Department of Medicaid

**30 Day Change Notice**  
**Effective Date: July 1, 2025**

<b>Analgesic Agents: Opioids</b>	tramadol IR 75mg
<b>Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia A, von Willebrand Disease, and Factor XIII Deficiency* LEGACY CATEGORY</b>	HYMPAVZI
<b>Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia B* LEGACY CATEGORY</b>	HYMPAVZI
<b>Blood Formation, Coagulation, and Thrombosis Agents: Oral Anticoagulants</b>	rivaroxaban tab
<b>Blood Formation, Coagulation, and Thrombosis Agents: Oral Antiplatelet</b>	ticagrelor
<b>Cardiovascular Agents: Angina, Hypertension and Heart Failure</b>	bisoprolol 2.5mg CORLANOR SOLN ivabradine tab labetalol 400mg
<b>Cardiovascular Agents: Antiarrhythmics</b>	quinidine IR, ER
<b>Central Nervous System (CNS) Agents: Alzheimer's Agents* LEGACY CATEGORY</b>	memantine/donepezil cap 14-10, 21-10, 28-10mg
<b>Central Nervous System (CNS) Agents: Anticonvulsants* LEGACY CATEGORY</b>	VIGAFYDE
<b>Central Nervous System (CNS) Agents: Atypical Antipsychotics* LEGACY CATEGORY</b>	EQUETRO ERZOFRI OPIPZA
<b>Central Nervous System (CNS) Agents: Neuropathic Pain</b>	gabapentin ER
<b>Central Nervous System (CNS) Agents: Parkinson's Agents</b>	VYALEV
<b>Central Nervous System (CNS) Agents: Skeletal Muscle Relaxants, Non-Benzodiazepine</b>	methocarbamol 1000mg
<b>Endocrine Agents: Androgens</b>	AZMIRO
<b>Endocrine Agents: Diabetes – Hypoglycemia Treatments</b>	glucagon emerg kit labeler 00378
<b>Endocrine Agents: Diabetes – Non-Insulin</b>	glimepiride 3mg metformin IR 750mg ZITUVIMET XR
<b>Gastrointestinal Agents: Ulcerative Colitis</b>	PENTASA 500mg
<b>Gastrointestinal Agents: Unspecified GI</b>	polyethylene glycol oral powder packet prucalopride
<b>Genitourinary Agents: Electrolyte Depleter Agents</b>	ferric citrate tab
<b>Immunomodulator Agents: Systemic Inflammatory Disease</b>	NEMLUVIO
<b>Infectious Disease Agents: Antibiotics – Cephalosporins</b>	cefaclor ER
<b>Infectious Disease Agents: Antivirals – HIV* LEGACY CATEGORY</b>	EMTRIVA SOLN VIREAD 250, 300mg TAB



<b>Ophthalmic Agents: Glaucoma Agents</b>	BETIMOL 0.25% timolol hemihydrate soln 0.5%
<b>Respiratory Agents: Epinephrine</b>	epinephrine (labeler 00093, 00115) NEFFY
<b>Respiratory Agents: Inhaled Agents</b>	BROVANA umeclidinium/vilanterol
<b>Topical Agents: Antifungals</b>	tolnaftate soln
<b>Topical Agents: Immunomodulators</b>	pimecrolimus [labeler 00591, 68462]

<b>THERAPEUTIC CATEGORIES WITH CHANGES IN CRITERIA</b>	
<b>Analgesic Agents: Gout</b>	
<b>Analgesic Agents: NSAIDS</b>	
<b>Analgesic Agents: Opioids</b>	
<b>Blood Formation, Coagulation, and Thrombosis Agents: Colony Stimulating Factors</b>	
<b>Blood Formation, Coagulation, and Thrombosis Agents: Hematopoietic Agents</b>	
<b>Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia A, von Willebrand Disease, and Factor XIII Deficiency* LEGACY CATEGORY</b>	
<b>Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia B* LEGACY CATEGORY</b>	
<b>Blood Formation, Coagulation, and Thrombosis Agents: Heparin-Related Preparations</b>	
<b>Blood Formation, Coagulation, and Thrombosis Agents: Oral Anticoagulants</b>	
<b>Blood Formation, Coagulation, and Thrombosis Agents: Oral Antiplatelet</b>	
<b>Cardiovascular Agents: Angina, Hypertension and Heart Failure</b>	
<b>Cardiovascular Agents: Antiarrhythmics</b>	
<b>Cardiovascular Agents: Lipotropics</b>	
<b>Cardiovascular Agents: Pulmonary Arterial Hypertension* LEGACY CATEGORY</b>	
<b>Central Nervous System (CNS) Agents: Alzheimer's Agents* LEGACY CATEGORY</b>	
<b>Central Nervous System (CNS) Agents: Anticonvulsants* LEGACY CATEGORY</b>	
<b>Central Nervous System (CNS) Agents: Anticonvulsants Rescue</b>	
<b>Central Nervous System (CNS) Agents: Antidepressants* LEGACY CATEGORY</b>	
<b>Central Nervous System (CNS) Agents: Attention Deficit Hyperactivity Disorder Agents</b>	
<b>Central Nervous System (CNS) Agents: Atypical Antipsychotics* LEGACY CATEGORY</b>	
<b>Central Nervous System (CNS) Agents: Fibromyalgia Agents</b>	
<b>Central Nervous System (CNS) Agents: Medication Assisted Treatment of Opioid Addiction</b>	
<b>Central Nervous System (CNS) Agents: Multiple Sclerosis* LEGACY CATEGORY</b>	
<b>Central Nervous System (CNS) Agents: Narcolepsy</b>	
<b>Central Nervous System (CNS) Agents: Neuropathic Pain</b>	
<b>Central Nervous System (CNS) Agents: Parkinson's Agents</b>	
<b>Central Nervous System (CNS) Agents: Restless Legs Syndrome</b>	
<b>Central Nervous System (CNS) Agents: Sedative-Hypnotics, Non-Barbiturate</b>	
<b>Central Nervous System (CNS) Agents: Skeletal Muscle Relaxants, Non-Benzodiazepine</b>	
<b>Dermatologic Agents: Oral Acne Products</b>	
<b>Dermatologic Agents: Topical Acne Products</b>	
<b>Endocrine Agents: Androgens</b>	
<b>Endocrine Agents: Diabetes – Hypoglycemia Treatments</b>	
<b>Endocrine Agents: Diabetes – Insulin</b>	



Endocrine Agents: Diabetes – Non-Insulin
Endocrine Agents: Endometriosis
Endocrine Agents: Estrogenic Agents
Endocrine Agents: Growth Hormone
Endocrine Agents: Osteoporosis – Bone Ossification Enhancers
Gastrointestinal Agents: Anti-Emetics
Gastrointestinal Agents: Bowel Preparations
Gastrointestinal Agents: Crohn’s Disease
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 Depletter Agents
Genitourinary Agents: Urinary Antispasmodics
Hyperkalemia Agents: Potassium Binders
Immunomodulator Agents: Systemic Inflammatory Disease
Infectious Disease Agents: Antibiotics – Cephalosporins
Infectious Disease Agents: Antibiotics – Inhaled
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
Infectious Disease Agents: Antivirals – Herpes
Infectious Disease Agents: Antivirals – HIV* LEGACY CATEGORY
Ophthalmic Agents: Antibiotic and Antibiotic-Steroid Combination Drops and Ointments
Ophthalmic Agents: Antihistamines & Mast Cell Stabilizers
Ophthalmic Agents: Dry Eye Treatments
Ophthalmic Agents: Glaucoma Agents
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
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
Respiratory Agents: Pulmonary Fibrosis
Topical Agents: Antifungals
Topical Agents: Antiparasitics
Topical Agents: Corticosteroids
Topical Agents: Immunomodulators



REVISED THERAPEUTIC CATEGORY CRITERIA	
THERAPEUTIC CLASS	SUMMARY OF CHANGE
<b>Analgesic Agents: Gout</b>	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"> <li>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 <u>and indicated for diagnosis</u></li> </ul>
<b>Analgesic Agents: NSAIDS</b>	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"> <li>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, <u>if and indicated for diagnosis</u></li> </ul>
<b>Analgesic Agents: Opioids</b>	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"> <li>Must have had an inadequate clinical response of at least <u>7 days</u> of at least <u>two unrelated</u> preferred drugs <u>with different active ingredients</u> of the same duration of action (SHORT-ACTING or LONG-ACTING)</li> </ul> <p><b>AR – All codeine and tramadol containing products: a PA is required for patients younger than 12 years old</b></p>
<b>Blood Formation, Coagulation, and Thrombosis Agents: Colony Stimulating Factors</b>	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"> <li>Must have had an inadequate clinical response of at least <u>14 days</u> with at least <u>one preferred</u> drug in this UPDL category <u>and indicated for diagnosis</u></li> </ul>
<b>Blood Formation, Coagulation, and Thrombosis Agents: Hematopoietic Agents</b>	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"> <li>Must have had an inadequate clinical response of at least <u>14 days</u> with at least <u>one preferred</u> drug in this UPDL category <u>and indicated for diagnosis</u></li> </ul>
<b>Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia A, von Willebrand Disease, and Factor XIII Deficiency* LEGACY CATEGORY</b>	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"> <li>Must have had an inadequate clinical response of at least <u>14 days</u> with at least <u>one preferred</u> drug in this UPDL category <u>and indicated for diagnosis</u></li> </ul> <p><b>ADDITIONAL HYMPAVZI (MARSTACIMAB-HNCQ) CRITERIA</b></p> <ul style="list-style-type: none"> <li>Must have had an inadequate clinical response of at least <u>30 days</u> with <u>HEMLIBRA</u></li> </ul>
<b>Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia B* LEGACY CATEGORY</b>	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"> <li>Must have had an inadequate clinical response of at least <u>14 days</u> with at least <u>one preferred</u> drug in this UPDL category <u>and indicated for diagnosis</u></li> </ul>
<b>Blood Formation, Coagulation, and Thrombosis Agents: Heparin-Related Preparations</b>	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"> <li>Must have had an inadequate clinical response of at least <u>14 days</u> with at least <u>one preferred</u> drug in this UPDL category <u>and indicated for diagnosis</u></li> </ul>



Blood Formation, Coagulation, and Thrombosis Agents: Oral Anticoagulants	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"><li>Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs in this UPDL category and indicated for diagnosis</li></ul>
Blood Formation, Coagulation, and Thrombosis Agents: Oral Antiplatelet	<del>All products are covered without a PA</del> <b>LENGTH OF AUTHORIZATION:</b> 365 days <b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"><li>Must have had an inadequate clinical response of at least 30 days with at least one preferred drug in this UPDL category and indicated for diagnosis</li></ul>
Cardiovascular Agents: Angina, Hypertension and Heart Failure	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"><li>Must have had an inadequate clinical response of at least 30 days of at least two preferred drugs within the same sub-section classification in this UPDL category and indicated for diagnosis with the same mechanism of action, if available and indicated for the same diagnosis in this UPDL category</li></ul>
Cardiovascular Agents: Antiarrhythmics	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"><li>Must have had an inadequate clinical response of at least 30 days with at least one preferred drug in this UPDL category and indicated for diagnosis</li></ul>
Cardiovascular Agents: Lipotropics	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"><li>Must have had an inadequate clinical response of at least 30 days (or 90 days for fibrates) with at least one preferred drug within the same sub-section classification in this UPDL category and indicated for diagnosis in the same drug class</li></ul>
Cardiovascular Agents: Pulmonary Arterial Hypertension* LEGACY CATEGORY	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"><li>Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in this UPDL category and indicated for diagnosis, if available, one of which must be a phosphodiesterase-5 inhibitor</li></ul>
Central Nervous System (CNS) Agents: Alzheimer's Agents* LEGACY CATEGORY	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"><li>Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in this UPDL category and indicated for diagnosis</li></ul>
Central Nervous System (CNS) Agents: Anti-Migraine Agents, Acute	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"><li>Must have had an inadequate clinical response of at least 14 days with at least one preferred drug and one step therapy drug in this UPDL category and indicated for diagnosis, if available one of which has the same mechanism of action if available</li></ul>
Central Nervous System (CNS) Agents: Anti-Migraine Agents, Cluster Headache	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"><li>Must have had an inadequate clinical response of at least 60 days to at least one preferred drug in this UPDL category and indicated for diagnosis</li></ul>
Central Nervous System (CNS)	<b>NON-PREFERRED CRITERIA:</b>



Agents: Anticonvulsants* LEGACY CATEGORY	<ul style="list-style-type: none"><li>• 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 <u>and</u> <u>indicated for diagnosis</u></li><li>• For prescribers who are credentialed as a neurology specialty with Ohio Medicaid, there must have been an inadequate clinical response of at least <u>30 days</u> with <u>one preferred</u> anticonvulsant drug in the standard tablet/capsule dosage form.</li><li>• Prescriptions submitted 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 <u>30 days</u> with <u>one preferred</u> drug. This provision applies only to the standard tablet/capsule dosage form.</li></ul>
Central Nervous System (CNS) Agents: Anticonvulsants Rescue	AR – VALTOCO: a PA is required for patients younger than <u>6 2</u> years old
Central Nervous System (CNS) Agents: Antidepressants* LEGACY CATEGORY	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"><li>• 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 <u>and</u> <u>indicated for diagnosis</u></li></ul>
Central Nervous System (CNS) Agents: Attention Deficit Hyperactivity Disorder Agents	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"><li>• 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 <u>and</u> <u>indicated for diagnosis, if available</u></li></ul>
Central Nervous System (CNS) Agents: Atypical Antipsychotics* LEGACY CATEGORY	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"><li>• 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 <u>and</u> <u>indicated for diagnosis</u></li></ul>
Central Nervous System (CNS) Agents: Fibromyalgia Agents	All products are covered without a PA <b>LENGTH OF AUTHORIZATIONS:</b> <u>365 Days</u> <b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"><li>• Must have had an inadequate clinical response of at least <u>14 days</u> with at least <u>two preferred</u> drugs in different classes (see Additional Information section below)</li></ul> <b>ADDITIONAL INFORMATION</b> <ul style="list-style-type: none"><li>• Drugs and drug classes include gabapentin, pregabalin, short and/or long-acting opioids, skeletal muscle relaxants, SNRIs, SSRIs, trazodone, and tricyclic antidepressants</li></ul>
Central Nervous System (CNS)	<b>BUPRENORPHINE SAFETY EDITS AND DRUG UTILIZATION REVIEW CRITERIA:</b>





# Department of Medicaid

30 Day Change Notice  
Effective Date: July 1, 2025

## Agents: Medication Assisted Treatment of Opioid Addiction

- buprenorphine injection (SUBLOCADE) dosing schedule will be limited to 300mg/30 days

### BUPRENORPHINE INITIAL AUTHORIZATION CRITERIA

Safety edits are in place for dosages over 24mg of buprenorphine equivalents/day Pursuant to Ohio Administrative Code 4731-33-03, dosages exceeding 32mg of buprenorphine equivalents per day will not be approved.

Has prescriber reviewed the OARRS within 7 days prior to the prior authorization request?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diagnosis (not approvable for pain)	ICD-10 Code
Has individual been referred to counseling for addiction treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
If clinically indicated, has individual been offered a referral to counseling for addiction treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the individual been offered a prescription for a naloxone kit?	<input type="checkbox"/> Yes <input type="checkbox"/> No
When is the individual's next appointment to assess induction therapy?	Date:

### BUPRENORPHINE RENEWAL CRITERIA

Please provide the current duration of treatment as of the date of this request	
Please indicate the frequency of prescriber meetings.	
Has individual been actively participating in counseling AND been compliant with all sessions? Date of last counseling	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the dose been reduced in the past 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has there been an evaluation for a dose reduction since the previous PA request? If NO, please provide explanation	<input type="checkbox"/> Yes <input type="checkbox"/> No
Prescriber attests to the continued monitoring for safety and efficacy of the requested medication	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the prescriber reviewed Ohio Automated Rx Reporting System within 7 days prior to the PA request?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If individual is receiving opioids, benzodiazepines, sedative hypnotics, carisoprodol or tramadol, has the physician coordinated with all prescribers of controlled substances and determined treatment should continue?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If YES, has an addiction specialist recommended to continue substance abuse treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Addiction Specialist consulted	Phone Number
Is the individual receiving opioids, benzodiazepines, sedative hypnotics, carisoprodol or tramadol?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Skip this question if answering "No" to the previous question.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the prescriber coordinated care with the prescriber(s) of the above listed substances and evaluated the risks and benefits of the combined use of these medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lab testing requirements met (at least twice per quarter for first year of treatment, once per quarter thereafter)?	<input type="checkbox"/> Yes <input type="checkbox"/> No





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REQUIRED FOR ALL BUPRENORPHINE REQUESTS	
Is the individual pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the individual breastfeeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the individual been explained the difference between an allergic reaction and symptoms of opioid withdrawal?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the patient have an allergy or other contraindication to Naloxone? Please list reactions or reasons for contraindications	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the patient have an allergy to naloxone? If yes, please select appropriate box and provide additional information if needed.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Bronchospasm <input type="checkbox"/> Angioneurotic edema <input type="checkbox"/> Anaphylactic shock <input type="checkbox"/> Hives <input type="checkbox"/> Swelling of face or mouth <input type="checkbox"/> Other: _____
Does the patient have a contraindication to naloxone? If yes, please select appropriate box and provide additional information if needed.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pregnancy <input type="checkbox"/> Breastfeeding <input type="checkbox"/> Moderate to severe hepatic impairment as evidenced by Child-Pugh Class B or C <input type="checkbox"/> Other: _____
Skip this question if the patient has an allergy or contraindication to naloxone	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> Methadone <input type="checkbox"/> Fentanyl <input type="checkbox"/> Extended-release opioids
Is the patient starting buprenorphine induction following use of methadone, fentanyl, or extended-release opioids? If yes, please select appropriate box and provide additional information if needed.*	
*This rationale can only be used for a 30-day authorization.	<input type="checkbox"/> Yes <input type="checkbox"/> N/A
Skip this question if the patient has an allergy or contraindication to naloxone	
Is the patient going to covert from buprenorphine mono-product to buprenorphine-naloxone combination? If yes, please provide additional information if needed.*	
*This rationale can only be used for a one-time 30-day authorization.	
Additional Information	





Central Nervous System (CNS) Agents: Parkinson's Agents	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"><li>Must have had an inadequate clinical response of at least <u>30 days</u> with at least <u>one preferred drug</u> <u>within the same mechanism of action sub-section classification</u> in this UPDL category, <u>if and indicated for diagnosis, if available</u></li></ul>
Central Nervous System (CNS) Agents: Restless Legs Syndrome	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"><li>Must have had an inadequate clinical response of at least <u>30 days</u> with at least <u>one preferred drug</u> in this UPDL category <u>and indicated for diagnosis</u></li></ul>
Central Nervous System (CNS) Agents: Sedative-Hypnotics, Non-Barbiturate	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"><li>Must have had an inadequate clinical response of at least <u>7 days</u> with at least <u>two preferred drugs</u> in this UPDL category <u>and indicated for diagnosis</u></li></ul>
Central Nervous System (CNS) Agents: Skeletal Muscle Relaxants, Non-Benzodiazepine	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"><li>Must have had an inadequate clinical response of at least <u>30 days</u> with at least <u>two preferred drugs</u> in this UPDL category <u>and indicated for diagnosis</u></li></ul>
Dermatologic Agents: Oral Acne Products	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"><li>Must have had an inadequate clinical response of at least <u>90 days</u> with at least <u>two preferred drugs</u> in this UPDL category <u>and indicated for diagnosis</u></li></ul>
Dermatologic Agents: Topical Acne Products	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"><li>Must have had an inadequate clinical response with at least <u>two preferred drugs</u> <u>within the same mechanism of action sub-section classification</u> in this UPDL category. Trials must be 30 days for preferred non-retinoids and 90 days for preferred retinoids.</li></ul>
Endocrine Agents: Androgens	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"><li>Must have had an inadequate clinical response of at least <u>90 days</u> with <u>ALL preferred drugs</u> in this UPDL category <u>and indicated for diagnosis</u></li></ul>
Endocrine Agents: Diabetes – Hypoglycemia Treatments	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"><li>Must have had an inadequate clinical response of at least <u>one preferred drug</u> in this UPDL category <u>and indicated for diagnosis</u> <b>OR</b> the inability of the member and/or caregiver to administer a preferred glucagon product in a timely fashion</li></ul>
Endocrine Agents: Diabetes – Insulin	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"><li>Must have had an inadequate clinical response (defined as the inability to reach target A1C) after at least <u>120 days</u> with at least <u>two preferred drugs</u> having a similar duration of action in this UPDL category <u>and indicated for diagnosis, if available</u></li></ul>
Endocrine Agents: Diabetes – Non-Insulin	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"><li>Must have had an inadequate clinical response of at least <u>120 days</u> with at least <u>three preferred drugs</u> in this UPDL category <u>and indicated for diagnosis, if available</u> <u>if available</u></li></ul>



Endocrine Agents: Endometriosis	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"><li>Must have had an inadequate clinical response of at least <u>84 days</u> with at least <u>one preferred</u> step-therapy drug in this UPDL category <u>and indicated for diagnosis</u></li></ul>
Endocrine Agents: Estrogenic Agents	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"><li>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 <u>within the same route of administration, sub-section classification and if indicated for diagnosis, if available.</u></li></ul>
Endocrine Agents: Growth Hormone	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"><li>Must have had an inadequate clinical response of at least <u>90 days</u> with at least <u>one preferred</u> drug <u>within the same sub-section classification in this UPDL category and indicated for diagnosis of similar duration of action in this UPDL category</u></li></ul>
Endocrine Agents: Osteoporosis – Bone Ossification Enhancers	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"><li>Must have had an inadequate clinical response of at least <u>365 days</u> with at least <u>one preferred</u> drug <u>within the same sub-section classification in this UPDL category and indicated for diagnosis with the same mechanism of action if available</u></li></ul>
Gastrointestinal Agents: Anti- Emetics	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"><li>Must have had an inadequate clinical response of at least <u>3 days</u> with at least <u>one preferred</u> drug in this UPDL category <u>within the same mechanism of action, if sub-section classification and indicated for diagnosis, if available.</u></li></ul>
Gastrointestinal Agents: Bowel Preparations	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"><li>Must have had an inadequate clinical response with at least <u>one preferred</u> drug in this UPDL category <u>and indicated for diagnosis</u></li></ul>
Gastrointestinal Agents: Crohn's Disease	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"><li>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 <u>and indicated for diagnosis</u></li></ul>
Gastrointestinal Agents: Irritable Bowel Syndrome (IBS) with Diarrhea	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"><li>Must have had an inadequate clinical response of at least <u>14 days</u> with at least <u>one preferred</u> drug and one <u>step therapy</u> drug in this UPDL category <u>and indicated for diagnosis</u></li></ul>
Gastrointestinal Agents: Pancreatic Enzymes	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"><li>Must have had an inadequate clinical response of at least <u>14 days</u> with at least <u>two preferred</u> drugs in this UPDL category <u>and indicated for diagnosis</u></li></ul>
Gastrointestinal Agents: Proton Pump Inhibitors	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"><li>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 <u>and indicated for diagnosis</u></li></ul>
Gastrointestinal Agents: Ulcerative Colitis	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"><li>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 <u>within the same route of administration, if sub-section classification and indicated for diagnosis, if available</u></li></ul>



Gastrointestinal Agents: Unspecified GI	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"><li>Must have had an inadequate clinical response of at least 14 days with <u>one step therapy drug</u> this UPDL category <u>and indicated for diagnosis</u>, if indicated for diagnosis</li></ul>
Genitourinary Agents: Benign Prostatic Hyperplasia	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"><li>Must have had an inadequate clinical response of at least 60 days with at least <u>two preferred drugs</u>, with at least <u>one preferred</u> within the same sub-section classification <u>with the same mechanism of action, if available</u> and indicated for diagnosis, if available</li></ul>
Genitourinary Agents: Electrolyte Depleter Agents	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"><li>Must have had an inadequate clinical response of at least 14 days with at least <u>two one preferred step therapy drugs</u> in this UPDL category <u>and indicated for diagnosis, if available</u> <u>in this UPDL category, one of which must have the same mechanism of action as the requested non-preferred drug, if available</u></li></ul>
Genitourinary Agents: Urinary Antispasmodics	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"><li>Must have had an inadequate clinical response of at least 30 days with at least <u>two preferred drugs</u> in this UPDL category <u>and indicated for diagnosis, one of which must be within the same sub-section classification, with different active ingredients within the same mechanism of action, if available</u></li></ul>
Hyperkalemia Agents: Potassium Binders	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"><li>Must have had an inadequate clinical response of at least 30 days with at least <u>one preferred drug</u> in this UPDL category <u>and indicated for diagnosis</u></li></ul>
Immunomodulator Agents: Systemic Inflammatory Disease	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"><li>Must have had an inadequate clinical response of at least 90 days with at least <u>two preferred drugs</u> in this UPDL category that are not biosimilars of the same reference product, <u>if and indicated for diagnosis, if available</u><ul style="list-style-type: none"><li>For non-preferred <u>biosimilars immunomodulators</u>: must provide documentation of inadequate clinical response to its preferred reference product <u>or biosimilar, in this UPDL category, if and indicated for the diagnosis, if available</u></li></ul></li></ul> <b>ADDITIONAL PRURIGO NODULARIS CRITERIA:</b> <ul style="list-style-type: none"><li>Must be prescribed by or in consultation with a specialist (i.e., dermatologist, rheumatologist)</li><li>Must provide documentation of an inadequate clinical response of at least 90 days with a topical steroid</li></ul>
Infectious Disease Agents: Antibiotics – Cephalosporins	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"><li>Must have had an inadequate clinical response of at least 3 days with at least <u>one preferred drug</u> in this UPDL category <u>and indicated for diagnosis</u></li></ul>
Infectious Disease Agents: Antibiotics – Inhaled	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"><li>Must have had an inadequate clinical response of at least 28 days with at least <u>one preferred drug</u> in this UPDL category <u>and indicated</u></li></ul>



	for diagnosis
<b>Infectious Disease Agents: Antibiotics – Macrolides</b>	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"> <li>Must have had an inadequate clinical response of at least 3 days with at least one preferred drug in this UPDL category and indicated for diagnosis</li> </ul>
<b>Infectious Disease Agents: Antibiotics – Quinolones</b>	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"> <li>Must have had an inadequate clinical response of at least 3 days with at least one preferred drug in this UPDL category and indicated for diagnosis</li> </ul>
<b>Infectious Disease Agents: Antibiotics – Tetracyclines</b>	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"> <li>Must have had an inadequate clinical response of at least 3 days with at least one preferred drug for acute infections <b>OR</b> at least 90 days with at least one preferred oral drug for acne in this UPDL category and indicated for diagnosis</li> </ul>
<b>Infectious Disease Agents: Antifungals</b>	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"> <li>Must have had an inadequate clinical response of at least 3 days with at least two preferred drugs, if indicated for the diagnosis in this UPDL category in this UPDL category and indicated for diagnosis</li> </ul>
<b>Infectious Disease Agents: Antivirals – Hepatitis C Agents</b>	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"> <li>Must have had an inadequate clinical response defined as not achieving sustained virologic response (SVR) with guideline-recommended preferred drugs in this UPDL category and indicated for diagnosis</li> </ul>
<b>Infectious Disease Agents: Antivirals – Herpes</b>	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"> <li>Must have had an inadequate clinical response of at least 3 days with at least one preferred drug in this UPDL category and indicated for diagnosis</li> </ul>
<b>Infectious Disease Agents: Antivirals – HIV* LEGACY CATEGORY</b>	<b><del>FOSTEMSAVIR (RUKOBIA) CRITERIA:</del></b> <ul style="list-style-type: none"> <li><del>Must provide documentation of a multidrug-resistant HIV-1 infection</del></li> </ul> <b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"> <li>Must have had an inadequate clinical response of at least 30 days with at least one preferred drug in this UPDL category and indicated for diagnosis. If applicable, the request must address the inability to use the individual components.</li> </ul>
<b>Ophthalmic Agents: Antibiotic and Antibiotic-Steroid Combination Drops and Ointments</b>	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"> <li>Must have had an inadequate clinical response of at least 3 days with at least two preferred drugs in this UPDL category and indicated for diagnosis</li> </ul>
<b>Ophthalmic Agents: Antihistamines &amp; Mast Cell Stabilizers</b>	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"> <li>Must have had an inadequate clinical response of at least 7 days with at least two preferred drugs in this UPDL category and indicated for diagnosis</li> </ul>
<b>Ophthalmic Agents: Dry Eye Treatments</b>	<b>STEP THERAPY CRITERIA:</b> <ul style="list-style-type: none"> <li>Must have had an inadequate clinical response of at least 14 days</li> </ul>



	<p>with at least <u>one</u> preferred drug in this <b>UPDL</b> category in the previous 120 days</p> <p><b>NON-PREFERRED CRITERIA:</b></p> <ul style="list-style-type: none"><li>• Must have had an inadequate clinical response of at least <u>14 days</u> with at least <u>two preferred</u> drugs in this UPDL category <b>and indicated for diagnosis</b></li></ul>
<b>Ophthalmic Agents: Glaucoma Agents</b>	<p><b>STEP THERAPY CRITERIA:</b></p> <ul style="list-style-type: none"><li>• Must have had an inadequate clinical response of at least <u>30 days</u> with at least <u>one preferred</u> drug in the same <b>sub-section classification in this UPDL category and indicated for diagnosis</b>, if available</li></ul> <p><b>NON-PREFERRED CRITERIA:</b></p> <ul style="list-style-type: none"><li>• Must have had an inadequate clinical response of at least <u>30 days</u> with at least <u>two preferred</u> drugs <b>within the same sub-section classification in this UPDL category and indicated for diagnosis in the same class, if available</b></li></ul>
<b>Ophthalmic Agents: NSAIDs</b>	<p><b>NON-PREFERRED CRITERIA:</b></p> <ul style="list-style-type: none"><li>• Must have had an inadequate clinical response of at least <u>3 days</u> with at least <u>two preferred</u> drugs in this UPDL category <b>and indicated for diagnosis</b></li></ul>
<b>Ophthalmic Agents: Ophthalmic Steroids</b>	<p><b>NON-PREFERRED CRITERIA:</b></p> <ul style="list-style-type: none"><li>• Must have had an inadequate clinical response of at least <u>7 days</u> with at least <u>two preferred</u> drugs in this UPDL category <b>and indicated for diagnosis</b></li></ul>
<b>Otic Agents: Antibacterial and Antibacterial/Steroid Combinations</b>	<p><b>NON-PREFERRED CRITERIA:</b></p> <ul style="list-style-type: none"><li>• Must have had an inadequate clinical response of at least <u>3 days</u> with at least <u>two preferred</u> drugs in this UPDL category <b>and indicated for diagnosis</b></li></ul>
<b>Respiratory Agents: Antihistamines – Second Generation</b>	<p><b>NON-PREFERRED CRITERIA:</b></p> <ul style="list-style-type: none"><li>• Must have had an inadequate clinical response of at least <u>7 days</u> with at least <u>two different</u> preferred drugs in this UPDL category <b>and indicated for diagnosis</b>.</li></ul>
<b>Respiratory Agents: Cystic Fibrosis</b>	<p><b>NON-PREFERRED CRITERIA:</b></p> <ul style="list-style-type: none"><li>• 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 <b>and indicated for diagnosis</b></li></ul>
<b>Respiratory Agents: Epinephrine</b>	<p><b>NON-PREFERRED CRITERIA:</b></p> <ul style="list-style-type: none"><li>• Must have had an inadequate clinical response to at least <u>one preferred</u> drug in this UPDL category <b>and indicated for diagnosis</b></li></ul>
<b>Respiratory Agents: Hereditary Angioedema</b>	<p><b>NON-PREFERRED CRITERIA:</b></p> <ul style="list-style-type: none"><li>• Must have had an inadequate clinical response of at least <u>3 days</u> with at least <u>one preferred</u> acute drug in this UPDL category <b>and indicated for diagnosis</b> to request a non-preferred acute drug.</li><li>• Must have had an inadequate clinical response of at least <u>14 days</u> with at least <u>one preferred</u> prophylaxis drug <b>in this UPDL category</b></li></ul>





	and indicated for diagnosis to request a non-preferred prophylaxis drug.
Respiratory Agents: Inhaled Agents	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"><li>Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs in this UPDL category within the same mechanism of action, if sub-section classification and indicated for diagnosis, if available.</li></ul>
Respiratory Agents: Leukotriene Receptor Modifiers & Inhibitors	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"><li>Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in this UPDL category and indicated for diagnosis</li></ul>
Respiratory Agents: Monoclonal Antibodies-Anti- IL/Anti-IgE	<b>CLINICAL PA CRITERIA:</b> <ul style="list-style-type: none"><li>For <b>Chronic Obstructive Pulmonary Disease (COPD)</b>:<ul style="list-style-type: none"><li>The patient must have an eosinophilic count of greater than or equal to 300 cells per mcL within 12 months prior to initiation of therapy <b>AND</b></li><li>The patient has a history of uncontrolled disease, as indicated by greater than or equal to 2 COPD exacerbations or greater than or equal to 1 COPD exacerbation resulting in a hospitalization despite being on standard of care, defined as triple therapy (LAMA+LABA+ICS) for at least 3 months prior to request, and at a stable dose for at least 1 month prior.</li></ul></li></ul> <b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"><li>Must have had an inadequate clinical response of at least 90 days with at least one preferred drug in this UPDL category and indicated for diagnosis</li></ul>
Respiratory Agents: Nasal Preparations	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"><li>Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs in this UPDL category within the same mechanism of action, if sub-section classification and indicated for diagnosis, if available</li></ul>
Respiratory Agents: Pulmonary Fibrosis	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"><li>Must have had an inadequate clinical response of at least 30 days with at least one preferred drug in this UPDL category and indicated for diagnosis</li></ul>
Topical Agents: Antifungals	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"><li>Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs in this UPDL category and indicated for diagnosis, if indicated for diagnosis</li></ul>
Topical Agents: Antiparasitics	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"><li>Must have had an inadequate clinical response of at least 14 days with at least one preferred drug in this UPDL category and indicated for diagnosis</li></ul>



## Department of Medicaid

**30 Day Change Notice**  
**Effective Date: July 1, 2025**

<b>Topical Agents: Corticosteroids</b>	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"><li>• Must have had an inadequate clinical response of at least <u>14 days</u> with at least <u>two preferred</u> drugs <u>within the same sub-section classification</u> in this UPDL category <u>and indicated for diagnosis, if available of similar potency</u></li></ul>
<b>Topical Agents: Immunomodulators</b>	<b>NON-PREFERRED CRITERIA:</b> <ul style="list-style-type: none"><li>• 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 <u>and indicated for diagnosis</u></li></ul>