Ohio Medicaid

Pharmacy Benefit Management Program

Unified Preferred Drug List

Medicaid Fee-for-Service and Managed Care Plans

Effective January 1, 2020

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Therapeutic Drug Categories Page

Analgesic Agents: NSAIDs

ANALGESIC AGENTS: NON-GASTROPROTECTIVE NSAIDS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
DICLOFENAC SODIUM (generic of Voltaren®) DICLOFENAC POTASSIUM (generic of Cataflam®) ETODOLAC (generic of Lodine, Lodine XL) IBUPROFEN Tablets and Susp (generic of Motrin®) INDOMETHACIN (generic of Indocin®) KETOROLAC MECLOFENAMATE SODIUM MEFENAMIC ACID (generic of Ponstel®) MELOXICAM (generic of Mobic®) NABUMETONE NAPROXEN NAPROXEN SUSP (no PA age <12) OXAPROZIN (generic of Daypro®) PIROXICAM (generic of Feldene®) SULINDAC	FENOPROFEN KETOPROFEN NAPRELAN (naproxen) NAPROXEN CR, DR NAPROXEN SUSP (PA required age ≥12) QMIIZ ODTTM (meloxicam) TIVORBEX® (indomethacin) TOLMETIN VIVLODEX TM (meloxicam) ZORVOLEX® (diclofenac)

ANALGESIC AGENTS: GASTROPROTECTIVE NSAIDS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
CELECOXIB (generic for Celebrex®) (no PA required for age 60 or older)	CELECOXIB (generic for Celebrex®) (PA required for under age 60) DICLOFENAC/MISOPROSTOL (generic of Arthrotec®) DUEXIS® (ibuprofen/famotidine) VIMOVO® (naproxen/esomeprazole)

ANALGESIC AGENTS: NSAIDS TRANSDERMAL/TOPICAL

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
DICLOFENAC 1% (generic of VOLTAREN® gel)	DICLOFENAC 1.3% patch (generic of FLECTOR® patch) DICLOFENAC 1.5% topical solution (generic of Pennsaid®) PENNSAID® 2% solution (diclofenac sodium)

Analgesic Agents: Gout

ANALGESIC AGENTS: GOUT – Agents to Reduce Hyperuricemia

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
ALLOPURINOL (generic of Zyloprim®) PROBENECID (generic for Benemid®) PROBENECID-COLCHICINE	DUZALLO® (lesinurad and allopurinol) ULORIC® (febuxostat) ZURAMPIC® (lesinurad)

ANALGESIC AGENTS: GOUT – Analgesic Agents

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
COLCHICINE tablets (generic of Colcrys®) COLCHICINE capsules (generic of Mitigare®)	

ANALGESIC AGENTS: GOUT – Agents to Reduce Hyperuricemia

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
ALLOPURINOL (generic of Zyloprim®) PROBENECID (generic for Benemid®) PROBENECID-COLCHICINE	DUZALLO® (lesinurad and allopurinol) ULORIC® (febuxostat) ZURAMPIC® (lesinurad)

ANALGESIC AGENTS: GOUT – Analgesic Agents*

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
COLCHICINE tablets (generic of Colcrys®) COLCHICINE capsules (generic of Mitigare®)	

- Colchicine quantity limit 6/claim for acute gout, 60/30 days for chronic gout after trial on xanthine oxidase inhibitor, 120/30 days for FMF

Analgesic Agents: Opioids

ANALGESIC AGENTS: OPIOIDS – Long-Acting Oral
ALL LONG-ACTING OPIOIDS REQUIRE CLINICAL PRIOR AUTHORIZATION

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
Extended Release Buprenorphine Products	
	BELBUCA™ (Buprenorphine buccal film)
Extended Release Hydrocodone Products	
	HYSINGLA ER® (hydrocodone) ZOHYDRO ER® (hydrocodone)
Extended Release Morphine Products	
MORPHINE SULFATE ER tablet (generic of MS Contin®)	ARYMO™ (morphine ER) EMBEDA® (morphine sulfate/ naltrexone) MORPHABONDTM ER (morphine ER) MORPHINE SULFATE ER capsule (generic of Avinza®, Kadian®)
Extended Release Oxycodone Products	
	OXYCODONE ER (generic of Oxycontin®) OXYCONTIN® (oxycodone) XARTEMIS XR® (oxycodone/ acetaminophen) XTAMPZA® ER (oxycodone)
Extended Release Tramadol Products	
	CONZIP® (tramadol) TRAMADOL ER (generic of Ryzolt ER®, Ultram ER®)
Extended Release Oxymorphone Products	
	OXYMORPHONE HCL ER tablets (generic of Opana® ER non-abuse-deterrent)
Extended Release Hydromorphone Products	
	HYDROMORPHONE ER (generic of Exalgo® ER)
Extended Release Tapentadol Products	
	NUCYNTA® ER (tapentadol)
Methadone Products	
	METHADONE tablet (generic of Dolophine®) METHADONE HCL oral concentrate 10mg/ml METHADONE HCL SOLN 5mg/5ml, 10mg/5ml METHADONE INTENSOL® 10mg/ml

ANALGESIC AGENTS: OPIOIDS – Long-Acting Oral
ALL LONG-ACTING OPIOIDS REQUIRE CLINICAL PRIOR AUTHORIZATION

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
Extended Release Buprenorphine Products	
	BELBUCA™ (Buprenorphine buccal film)
Extended Release Hydrocodone Products	
	HYSINGLA ER® (hydrocodone) ZOHYDRO ER® (hydrocodone)
Extended Release Morphine Products	

MORPHINE SULFATE ER tablet (generic of MS Contin®)	ARYMO™ (morphine ER) EMBEDA® (morphine sulfate/ naltrexone) MORPHABONDTM ER (morphine ER) MORPHINE SULFATE ER capsule (generic of Avinza®, Kadian®)
Extended Release Oxycodone Products	
	OXYCODONE ER (generic of Oxycontin®) OXYCONTIN® (oxycodone) XARTEMIS XR® (oxycodone/ acetaminophen) XTAMPZA® ER (oxycodone)
Extended Release Tramadol Products	
	CONZIP® (tramadol) TRAMADOL ER (generic of Ryzolt ER®, Ultram ER®)
Extended Release Oxymorphone Products	
	OXYMORPHONE HCL ER tablets (generic of Opana® ER non-abuse-deterrent)
Extended Release Hydromorphone Products	
	HYDROMORPHONE ER (generic of Exalgo® ER)
Extended Release Tapentadol Products	
	NUCYNTA® ER (tapentadol)
Methadone Products	
	METHADONE tablet (generic of Dolophine®) METHADONE HCL oral concentrate 10mg/ml METHADONE HCL SOLN 5mg/5ml, 10mg/5ml METHADONE INTENSOL® 10mg/ml

ANALGESIC AGENTS: OPIOIDS – Long-Acting Oral
ALL LONG-ACTING OPIOIDS REQUIRE CLINICAL PRIOR AUTHORIZATION

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
Extended Release Buprenorphine Products	
	BELBUCA™ (Buprenorphine buccal film)
Extended Release Hydrocodone Products	
	HYSINGLA ER® (hydrocodone) ZOHYDRO ER® (hydrocodone)
Extended Release Morphine Products	
MORPHINE SULFATE ER tablet (generic of MS Contin®)	ARYMO™ (morphine ER) EMBEDA® (morphine sulfate/ naltrexone) MORPHABONDTM ER (morphine ER) MORPHINE SULFATE ER capsule (generic of Avinza®, Kadian®)
Extended Release Oxycodone Products	
	OXYCODONE ER (generic of Oxycontin®) OXYCONTIN® (oxycodone) XARTEMIS XR® (oxycodone/ acetaminophen) XTAMPZA® ER (oxycodone)
Extended Release Tramadol Products	
	CONZIP® (tramadol) TRAMADOL ER (generic of Ryzolt ER®, Ultram ER®)
Extended Release Oxymorphone Products	
	OXYMORPHONE HCL ER tablets (generic of Opana® ER non-abuse-deterrent)
Extended Release Hydromorphone Products	
	HYDROMORPHONE ER (generic of Exalgo® ER)
Extended Release Tapentadol Products	
	NUCYNTA® ER (tapentadol)
Methadone Products	
	METHADONE tablet (generic of Dolophine®) METHADONE HCL oral concentrate 10mg/ml METHADONE HCL SOLN 5mg/5ml, 10mg/5ml METHADONE INTENSOL® 10mg/ml

ANALGESIC AGENTS: OPIOIDS – Long-Acting Transdermal

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
BUTRANS® patch (buprenorphine)	BUPRENORPHINE patch (generic for Butrans®) FENTANYL PATCH (generic of Duragesic®) FENTANYL patch 37.5mg/hr, 62.5mg/hr, 87.5mg/hr

ANALGESIC AGENTS: OPIOIDS – SHORT-ACTING ORAL SINGLE-ENTITY

Note: Effective July 1, 2018, patients with short acting opioid therapy are limited to 30 MED per prescription and a maximum of 7 days per prescription. Prior authorization will be required to exceed these limits**.**

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
Codeine Products	
CODEINE SULFATE tablet	
Hydromorphone Products	
HYDROMORPHONE HCL tablet (generic of Dilaudid®)	
Levorphanol Products	
	LEVORPHANOL TABLETS (generic of Levo-Dromoran)
Meperidine Products	
	MEPERIDINE tablet (generic of Demerol®)
Morphine Products	
MORPHINE SULFATE: immediate-release tablets (generic of MSIR®)	
Oxycodone Products	
ROXICODONE® tablets (oxycodone) OXYCODONE HCL capsules, tablets (generic of M-Oxy®, OxyIR®)	OXECTA® (oxycodone)
Oxymorphone Products	
	OXYMORPHONE HCL tablets (generic of Opana®)
Tapentadol Products	
	NUCYNTA® (tapentadol)

ANALGESIC AGENTS: OPIOIDS – Short-Acting Combination and tramadol

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
Codeine Combinations	
ACETAMINOPHEN w/CODEINE TABLETS (generic of Tylenol® #2, #3, #4)	
Dihydrocodeine Combinations	
	DIHYDROCODEINE/ASPIRIN/CAFFEINE (generic of Synalgos-DC®)
Hydrocodone Combinations	
HYDROCODONE/ACETAMINOPHEN tablets containing 325mg acetaminophen (generic of Lorcet, Lortab, Norco)	BENZHYDROCODONE & ACETAMINOPHEN (generic for APADAZTM) HYDROCODONE/ IBUPROFEN (generic of Ibudone®, Vicoprofen®) HYDROCODONE/ACETAMINOPHEN tablets containing 300mg acetaminophen (generic of Vicodin®, Xodol®)
Oxycodone Combinations	
OXYCODONE W/ ACETAMINOPHEN tablets (generic of Percocet®)	OXYCODONE W/ IBUPROFEN (generic of Combunox®) PRIMLEV® (oxycodone/ acetaminophen)
Pentazocine Combinations	
Not advocated for use	PENTAZOCINE/NALOXONE (generic of Talwin NX®)
Tramadol	
TRAMADOL (generic of Ultram®) TRAMADOL/ACETAMINOPHEN (generic of Ultracet®)	
Carisoprodol Combinations	
	CARISOPRODOL/ASPIRIN/CODEINE (generic of Soma Compound w/Codeine®)

ANALGESIC AGENTS: OPIOIDS –Liquids Immediate-Release (Single Entity)

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
HYDROMORPHONE 1mg/ml liquid (generic of Dilaudid-5®) MORPHINE SULFATE solution: 10 mg/5ml, 20mg/5ml, 20mg/ml (generic of MSIR Soln®, Roxanol Soln®) OXYCODONE oral solution 5mg/5ml, concentrate 20mg/1ml (generic of Oxydose®, Roxicodone Intensol®)	MEPERIDINE HCL SYRUP 50 mg/5ml (generic of Demerol Oral Syrup®)

ANALGESIC AGENTS: OPIOIDS – Liquids and Oral Syrup Immediate-Release (Combination)

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
ACETAMINOPHEN w/CODEINE ORAL SOLN 120mg-12mg/5ml (generic of Tylenol w/Codeine Elixir®) HYDROCODONE BITARTRATE w/ ACETAMINOPHEN ELIXIR 2.5mg-167mg/5ml, 2.5mg-108mg/5ml (generic of Hycet®, Lortab Elixir®) LORTAB® 10mg-300mg/15ml (hydrocodone/ acetaminophen) ROXICET® ORAL SOLN (5mg Oxycodone-325mg APAP/5ml)	CAPITAL w/CODEINE® suspension 12mg codeine-120mg APAP/5ml ZAMICET® 10mg-325mg/15ml (hydrocodone/ acetaminophen)

ANALGESIC AGENTS: OPIOIDS – Nasal Inhalers

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
BUTORPHANOL TARTRATE NS (generic of Stadol NS®)	

ANALGESIC AGENTS: OPIOIDS – Transmucosal System *

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
	ABSTRAL® (fentanyl) FENTANYL CITRATE (generic of Actiq®) FENTORA® (fentanyl) SUBSYS® (fentanyl)

Blood Formation, Coagulation, and Thrombosis Agents: Hematopoietic Agents

BLOOD AGENTS: HEMATOPOIETIC AGENTS

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
EPOGEN® (epoetin alfa) RETACRIT® (epoetin alfa-epbx)	ARANESP® (darbepoetin alfa) MIRCERA® (methoxy polyethylene glycol-epoetin beta) PROCRIT® (epoetin alfa)

Blood Formation, Coagulation, and Thrombosis Agents: Colony Stimulating Factors

BLOOD AGENTS: HEMATOPOIETIC AGENTS-COLONY STIMULATING FACTORS

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
GRANIX® (tbo-filgrastim) UDENYCA® (pegfilgrastim-cbqv)	FULPHILATM (pegfilgrastim-jmdb) LEUKINE® (sargramostim) NEULASTA® (pegfilgrastim) NEUPOGEN® (filgrastim) NIVESTYMTM (filgrastim) ZARXIO® (filgrastim-sndz)

Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia Factors

BLOOD AGENTS: FACTOR VII CONCENTRATE

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
NOVOSEVEN (factor VIIa recombinant)	

BLOOD AGENTS: FACTOR VIII

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
ADVATE® (factor VIII recombinant) AFSTYLA® (factor VIII recombinant) HEMOFIL M® (factor VIII human) KOATE® (factor VIII human) KOGENATE FS® (factor VIII recombinant) MONOCLATE-P® (factor VIII human) NOVOEIGHT® (factor VIII recombinant) NUWIQ® (factor VIII recombinant) RECOMBINATE® (factor VIII recombinant) XYNTHA® (factor VIII recombinant)	ADYNOVATE® (factor VIII recombinant) † ELOCTATE® (factor VIII recombinant, fc fusion protein) † JIVI® (factor VIII recombinant, pegylated-aucl) † KOVALTRY® (factor VIII recombinant) OBIZUR® (factor VIII recombinant, porcine sequence)

†Denotes long half-life factor

BLOOD AGENTS: FACTOR IX

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
ALPHANINE SD® (factor IX human) ALPROLIX® (factor IX recombinant) † BENEFIX® (factor IX recombinant) IXINITY® (factor IX recombinant) MONONINE® (factor IX human) PROFILNINE® (factor IX complex human) RIXUBIS® (factor IX recombinant)	IDELVION® (factor IX recombinant)† REBINYN® (factor IX recombinant)†

†Denotes long half-life factor

BLOOD AGENTS: ANTI-INHIBITOR COAGULATION COMPLEX

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
FEIBA® (anti-inhibitor coagulant complex)	

BLOOD AGENTS: VON WILLEBRAND FACTOR

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
WILATE® (factor VIII/Von Willebrand factor human)	VONVENDI® (Von Willebrand factor recombinant)

BLOOD AGENTS: VON WILLEBRAND FACTOR/FACTOR VIII

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
ALPHANATE® (factor VIII/Von Willebrand factor human) HUMATE-P® (factor VIII/Von Willebrand factor human)	

MONOCLONAL MODIFIED IMMUNOGLOBULIN G4 ANTIBODY

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-REFERRED"
HEMLIBRA® (emicizumab-kxwh)	

Blood Formation, Coagulation, and Thrombosis Agents: Heparin-Related Preparations

BLOOD AGENTS: HEPARIN-RELATED PREPARATIONS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
ENOXAPARIN (generic of Lovenox®)	FONDAPARINUX (generic of Arixtra®) FRAGMIN® (dalteparin)

Blood Formation, Coagulation, and Thrombosis Agents: Oral Anticoagulants

BLOOD AGENTS: ORAL ANTICOAGULANTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
ELIQUIS® (apixaban) PRADAXA® (dabigatran) WARFARIN (generic of Coumadin®) XARELTO® (rivaroxaban) *	SAVAYSA® (edoxaban)

- Note: Duration limit of 35 days applies to Xarelto 10mg tablets, see Heparin-Related Preparations for details; XARELTO® 2.5mg requires concurrent use of aspirin which may be verified via a point-of-sale check

BLOOD AGENTS: PLATELET AGGREGATION INHIBITORS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
ASPIRIN BRILINTA® (ticagrelor) CLOPIDOGREL (generic of Plavix®) PRASUGREL (generic of Effient®)	YOSPRALA™ (aspirin/omeprazole) ZONTIVITY® (vorapaxar sulfate)

Cardiovascular Agents: Angina, Hypertension & Heart Failure

CHRONIC STABLE ANGINA

NO PA REQUIRED "PREFERRED"	PA REQUIRED "PREFERRED"
Generic beta blockers Generic calcium channel blockers Generic nitrates	RANOLAZINE (generic of Ranexa®)

ACE INHIBITORS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
BENAZEPRIL (generic of Lotensin®) CAPTOPRIL (generic of Capoten®) ENALAPRIL (generic of Vasotec®) EPANED® (enalapril oral solution) FOSINOPRIL (generic of Monopril®) LISINOPRIL (generic of Zestril®, Prinivil®) MOEXIPRIL (generic of Univasc®) PERINDOPRIL ERBUMINE (generic of Aceon®) QUINAPRIL (generic of Accupril®) RAMIPRIL (generic of Altace®) TRANDOLAPRIL (generic of Mavik®)	QBRELIS™ (lisinopril oral solution)

ACE INHIBITORS/CCB COMBINATION

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
AMLODIPINE/BENAZEPRIL (generic of Lotrel®) VERAPAMIL/TRANDOLAPRIL (generic of Tarka®)	PRESTALIA® (perindopril-amlodipine tablet)

ACE INHIBITORS/DIURETIC COMBINATION

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
BENAZEPRIL/HCTZ (generic of Lotensin HCT®) CAPTOPRIL/HCTZ (generic of Capozide®) ENALAPRIL/HCTZ (generic of Vaseretic®) FOSINOPRIL/HCTZ (generic of Monopril HCT®) LISINOPRIL/HCTZ (generic of Zestoretic®, Prinzide®) MOEXIPRIL/HCTZ (generic of Uniretic®) QUINAPRIL/HCTZ (generic of Accuretic®)	

ALDOSTERONE ANTAGONIST

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
SPIRONOLACTONE (generic of Aldactone®)	CAROSPIR® SUSP (spironolactone suspension)

ALPHA-BETA BLOCKERS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
CARVEDILOL (generic of Coreg®) LABETALOL (generic of Trandate®)	CARVEDILOL ER (generic of COREG CRTh)

ANGIOTENSIN II RECEPTOR ANTAGONISTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
IRBESARTAN (generic of Avapro®) LOSARTAN (generic of Cozaar®) VALSARTAN (generic of Diovan®)	CANDESARTAN (generic of Atacand®) EDARBI® (azilsartan) EPROSARTAN (generic of Teveten®) OLMESARTAN (generic of Benicar®) TELMISARTAN (generic of Micardis®)

ANGIOTENSIN II RECEPTOR ANTAGONISTS/ DIURETIC COMBINATION

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
IRBESARTAN-HCTZ (generic of Avalide®) LOSARTAN-HCTZ (generic of Hyzaar®) VALSARTAN/HCTZ (generic of Diovan HCT®)	CANDESARTAN/HCTZ (generic of Atacand HCT®) EDARBYCLOR™ (azilsartan/ chlorthalidone) OLMESARTAN/HCTZ (generic of Benicar HCT®) TELMISARTAN/HCTZ (generic of Micardis HCT®) TEVETEN HCT® (eprosartan/HCTZ)

ANGIOTENSIN II RECEPTOR ANTAGONISTS/ BETA BLOCKERS COMBINATION

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
Trial of Preferred Beta blocker and a preferred angiotesnsin II receptor antagonist	BYVALSONTM (nebivolol/valsartan)

ANGIOTENSIN II RECEPTOR ANTAGONISTS/ CALCIUM CHANNEL BLOCKER COMBINATION

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
AMLODIPINE/OLMESARTAN (generic of Azor®) AMLODIPINE/ TELMISARTAN (generic of Twynsta®) AMLODIPINE/VALSARTAN (generic of Exforge®)	

ANGIOTENSIN II RECEPTOR ANTAGONISTS/ CALCIUM CHANNEL BLOCKER/DIURETIC COMBINATION

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
AMLODIPINE/ VALSARTAN /HCTZ (generic of Exforge® HCT)	OLMESARAN/AMLODIPINE/ HCTZ (generic of Tribenzor®)

ANGIOTENSIN II RECEPTOR ANTAGONIST/ NEPRILYSIN INHIBITOR COMBINATION

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
ENTRESTOTM (valsartan/sacubitril)	

BETA BLOCKERS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
ACEBUTOLOL (generic of Sectral®) ATENOLOL (generic of Tenormin®) BETAXOLOL (generic of Kerlone®) BISOPROLOL FUMARATE (generic of Zebeta®) METOPROLOL SUCCINATE (generic of Toprol XL®) METOPROLOL TARTRATE (generic of Lopressor®) NADOLOL (generic of Corgard®) PINDOLOL (generic of Visken®) PROPRANOLOL (generic of Inderal®) PROPRANOLOL ER (generic of Inderal LA®) SOTALOL (generic of Betapace®) SOTALOL AF (generic of Betapace AF·) TIMOLOL (generic of Blocadren®)	BYSTOLIC® (nebivolol) INNOPRAN XL® (propranolol) KAPSPARGO SPRINKLE™ (metoprolol succinate) LEVATOL® (penbutolol) SOTYLIZE· oral solution (sotalol solution)

BETA-BLOCKERS/DIURETIC COMBINATION

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
ATENOLOL/CHLORTHALIDONE (generic of Tenoretic®) BISOPROLOL/HCTZ (generic of Ziac®) DUTOPROL® (metoprolol succinate/HCTZ) METOPROLOL/HCTZ (generic of Lopressor HCT·) NADOLOL/BENDROFLUMETHIAZIDE (generic of Corzide®) PROPRANOLOL/HCTZ (generic of Inderide®)	

CALCIUM CHANNEL BLOCKERS- DIHYDROPYRIDINE

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
AMLODIPINE (generic of Norvasc®) FELODIPINE (generic of Plendil®) NICARDIPINE (generic of Cardene®) NIFEDIPINE ER (generic of Procardia XL·, Adalat CC®) NIFEDIPINE IMMEDIATE RELEASE (generic of Procardia·)	ISRADIPINE (generic of Dynacirc·) NIMODIPINE (generic of Nimotop®)* NYMALIZE oral solution (nimodipine solution)* NISOLDIPINE (generic of Sular·)

* Note: nimodipine only approvable for 21 days after subarachnoid hemorrhage.

CALCIUM CHANNEL BLOCKERS- NON-DIHYDROPYRIDINE

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
DILTIAZEM (generic of Cardizem·) DILTIAZEM ER (generic of Cardizem CD· q24h, Tiazac·) DILTIAZEM SR (generic of Cardizem SR· q12h) VERAPAMIL (Generic of Calan·) VERAPAMIL SR/ER (Generic of Calan SR·, Isoptin SR·, Verelan·)	DILTIAZEM 24H ER tablet (generic of Cardizem LA®) VERAPAMIL ER PM (generic of Verelan PM·)

DIRECT RENIN INHIBITORS* and combinations

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
Trial of any one preferred anti-hypertensive agent	ALISKIREN (generic Tekturna®) TEKTURNA HCT® (aliskiren/HCTZ)

HYPERPOLARIZATION-ACTIVATED CYCLE NUCLEOTIDE-GATED CHANNEL INBITOR*

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
	CORLANOR· (ivabradine)

Cardiovascular Agents: Antiarrhythmics

CARDIOVASCULAR AGENTS: ANTIARRHYTHMICS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
AMIODARONE (generic of Cordarone®) 200mg DISOPYRAMIDE PHOSPHATE IR (generic of Norpace®) DISOPYRAMIDE PHOSPHATE ER (generic of Norpace® CR) FLECAINIDE (generic of Tambocor®) MEXILITINE PROPAFENONE (generic of Rythmol®) PROPAFENONE ER (generic of Rythmol SR®) QUINIDINE GLUCONATE ER QUINIDINE SULFATE QUINIDINE SULFATE ER TIKOSYN® (dofetilide)	AMIODARONE 100mg, 400mg MULTAQ® (dronedarone)

Cardiovascular Agents: Lipotropics

CARDIOVASCULAR AGENTS: LIPOTROPICS – BILE ACID SEQUESTRANTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
CHOLESTYRAMINE LIGHT POWDER (generic of Questran Light®) CHOLESTYRAMINE POWDER (generic of Questran®) COLESTIPOL tablets (generic of Colestid® tablets) PREVALITE® POWDER (cholestyramine)	COLESTIPOL granules (generic of Colestid® granules) WELCHOL® packets (colesevelam) WELCHOL® tablets (colesevelam)

CARDIOVASCULAR AGENTS: LIPOTROPICS - STATINS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
ATORVASTATIN (generic of Lipitor®) LOVASTATIN (generic of Mevacor®) PRAVASTATIN (generic of Pravachol®) ROSUVASTATIN (generic of Crestor®) SIMVASTATIN (generic of Zocor®)	ALTOPREV® (lovastatin) EZALLORTM SPRINKLE (rosuvastatin) FLUVASTATIN (generic of Lescol®, Lescol XL®) LIVALO® (pitavastatin) ZYPITAMAGTM (pitavastatin)

CARDIOVASCULAR AGENTS: LIPOTROPICS - FIBRIC ACID DERIVATIVES

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
GEMFIBROZIL (generic of Lopid®) FENOFIBRATE TABLETS (generic of Tricor®)	ANTARA® (fenofibrate) FENOFIBRATE CAPSULES (generic of Lipofen®) FENOFIBRIC ACID (generic of Trilipix®) LOFIBRA® (fenofibrate) TRIGLIDE® (fenofibrate)

CARDIOVASCULAR AGENTS: LIPOTROPICS - NICOTINIC ACID DERIVATIVES

NO PA REQUIRED PREFERRED"	PA REQUIRED "NON-PREFERRED"
NIACIN NIASPAN® (niacin)	NIACIN ER (generic of Niaspan®)

CARDIOVASCULAR AGENTS: LIPOTROPICS - OMEGA-3 POLYUNSATURATED FATTY ACIDS

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
OMEGA 3-ACID ETHYL ESTERS (generic of Lovaza®)	VASCEPA® (icosapent ethyl)

CARDIOVASCULAR AGENTS: LIPOTROPICS - SELECTIVE CHOLESTEROL ABSORPTION INHIBITORS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
EZETIMIBE (generic of ZETIA®)	SIMVASTATIN/EZETIMIBE (generic for Vytorin®)

CARDIOVASCULAR AGENTS: LIPOTROPIC/HYPERTENSION COMBINATION

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
Inability to utilize agents separately	AMLODIPINE/ATORVASTATIN (generic of Caduet®)

CARDIOVASCULAR AGENTS: LIPOTROPICS PCSK9 INHIBITORS

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
	PRALUENT® (alirocumab) REPATHA™ (evolocumab)

Cardiovascular Agents: Pulmonary Arterial Hypertension

CARDIOVASCULAR AGENTS: PULMONARY ARTERIAL HYPERTENSION, Phosphodiesterase-5 Inhibitor, Oral

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
REVATIO® oral solution (sildenafil) (no PA for age under 6) SILDENAFIL (generic of Revatio®) TADALAFIL (generic for Adcirca®)	REVATIO® oral solution (sildenafil) (PA required for age over 6)

CARDIOVASCULAR AGENTS: PULMONARY ARTERIAL HYPERTENSION, Endothelin Receptor Antagonist, Oral

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
AMBRISENTAN (generic for Letairis®) TRACLEER® (bosentan)	OPSUMIT® (macitentan) TRACLEER® Susp (bosentan)

CARDIOVASCULAR AGENTS: PULMONARY ARTERIAL HYPERTENSION, Prostacyclin Analog, Oral

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
	ORENITRAM® (treprostinil diolamine)

CARDIOVASCULAR AGENTS: PULMONARY ARTERIAL HYPERTENSION, Prostacyclin Receptor Agonist, Oral

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
	UPTRAVI® (selexipag)

CARDIOVASCULAR AGENTS: PULMONARY ARTERIAL HYPERTENSION, Guanylate Cyclase Stimulators, Oral

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
	ADEMPAS® (riociguat)

CARDIOVASCULAR AGENTS: PULMONARY ARTERIAL HYPERTENSION, Prostacyclin Analog, Inhaled

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
	TYVASO® (treprostinil) VENTAVIS® (iloprost)

CARDIOVASCULAR AGENTS: PULMONARY ARTERIAL HYPERTENSION Prostacyclin Analog, Intravenous

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
	EPOPROSTENOL (generic of Flolan®) REMODULIN® (treprostinil sodium) VELETRI® (epoprostenol)

Central Nervous System (CNS) Agents: Alzheimer's Agents

CNS AGENTS: ALZHEIMER'S AGENTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
DONEPEZIL 5mg, 10mg (generic of Aricept®) GALANTAMINE (generic of Razadyne) GALANTAMINE 4mg/ml solution (generic of Razadyne™) GALANTAMINE ER (generic of Razadyne ER) MEMANTINE tablets (generic of Namenda) RIVASTIGMINE capsules (generic of Exelon®)	DONEPEZIL ODT (generic of Aricept® ODT) DONEPEZIL 23mg (generic of Aricept® 23mg) MEMANTINE 10mg/5ml solution (generic of Namenda®) NAMENDA XR® (memantine ER) NAMZARIC® (memantine ER/donepezil) RIVASTIGMINE patch (generic of Exelon® patch)

Central Nervous System (CNS) Agents: Anti-Migraine Agents

CNS AGENTS: ANTI-MIGRAINE AGENTS – SEROTONIN 5-HT1 RECEPTOR AGONISTS –"Fast" Onset

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
RIZATRIPTAN tablets (generic of Maxalt®) RIZATRIPTAN ODT (generic of Maxalt-MLT®) SUMATRIPTAN tablets, nasal spray, injection (generic of Imitrex®)	ALMOTRIPTAN (generic of Axert®) ONZETRA™ XSAIL™ (sumatriptan) ELETRIPTAN (generic of Relpax®) SUMAVEL DOSEPRO® (sumatriptan) ZOLMITRIPTAN (generic of Zomig®) ZOLMITRIPTAN ODT (generic of Zomig ZMT®) ZOMIG® NASAL SPRAY (zolmitriptan) ZECUITY® (sumatriptan)

CNS AGENTS: ANTI-MIGRAINE AGENTS – SEROTONIN 5-HT1 RECEPTOR AGONISTS - "Slow" Onset

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
NARATRIPTAN (generic of Amerge®)	FROVA® (frovatriptan)

CNS AGENTS: ANTI-MIGRAINE AGENTS – SEROTONIN 5-HT1 RECEPTOR AGONIST/NSAID COMBINATION

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
	TREXIMET® (sumatriptan/naproxen)

CNS AGENTS: ANTI-MIGRAINE AGENTS – CALCITONIN GENE-RELATED PEPTIDE RECEPTOR ANTAGONIST

NO PA REQUIRED "PREFERRED" (Trails of at least 3 controller medications)	PA REQUIRED "NON-PREFERRED"
Cardiovascular Agents: Beta-blockers CNS Agents: Anticonvulsant CNS Agents: Tricyclic antidepressants CNS Agents: Serotonin-norepinephrine	AIMOVIGTM (erenumab-aooe)† EMGALITYTM (galcanezumab) AJOVYTM (fremanezumab-vfrm)*

†Initial Dose is limited to 70mg once monthly; may request dose increase if 70mg fails to provide adequate relief over two consecutive months.

* 675mg doses (quarterly administration) will not be authorized until patient has demonstrated efficacy of medication for at least 90 days

Central Nervous System (CNS) Agents: Anticonvulsants

ANTICONVULSANTS: CARBAMAZEPINE DERIVATIVES

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
CARBAMAZEPINE IR tablet, chewable, oral suspension (generic of Tegretol®) CARBAMAZEPINE 12-hour ER capsule, tablet (generic of Carbatrol®, Tegretol XR®) OXCARBAZEPINE tablet, suspension (generic of Trileptal®)	OXTELLAR® XR (oxcarbazepine)

ANTICONVULSANTS: FIRST GENERATION

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
CLONAZEPAM tablet (generic of Klonopin®) DIAZEPAM rectal gel (generic of Diastat®) DIVALPROEX (generic of Depakote®) DIVALPROEX ER (generic of Depakote® ER) ETHOSUXAMIDE (generic of Zarontin®) PHENOBARBITAL PHENYTOIN (generic of Dilantin®) PRIMIDONE (generic of Mysoline®) VALPROIC ACID (generic of Depakene®)	CELONTIN® (methsuximide) CLONAZEPAM ODT (generic of Klonopin® wafer) CLOBAZAM (generic for Onfi®) PEGANONE® (ethotoin) STAVZOR® (valproic acid delayed-release) SYMPAZANTM (clobazam film)

ANTICONVULSANTS: SECOND GENERATION

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
GABAPENTIN (generic of Neurontin®) LAMOTRIGINE IR tablet, chewable tablet (generic of Lamictal®) LEVETIRACETAM IR tablet, solution (generic of Keppra®) PREGABALIN (generic for Lyrica®) SABRIL® powder (no PA for age < 2) TOPIRAMATE tablet (generic of Topamax®) ZONISAMIDE (generic of Zonegran®)	FYCOMPA® (perampanel)	BANZEL® (rufinamide) BRIVIACT® (brivaracetam) FELBAMATE (generic of Felbatol®) LAMICTAL® ODT (lamotrigine) LAMOTRIGINE ER tablet (generic of Lamictal® XR) LEVETIRACETAM ER tablet (generic of Keppra® XR) QUDEXY XR® (topiramate ER) SABRIL® powder (PA required for age > 2) SABRIL® tablet (vigabatrin) SPRITAM® (levetiracetam tablet for suspension) SUBVENITE (lamotrigine) TIAGABINE (generic of Gabitril®) TOPIRAMATE ER TOPIRAMATE sprinkle cap (generic of Topamax® sprinkle cap) TROKENDI XR® (topiramate)

ANTICONVULSANTS: THIRD GENERATION

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
Alternative Anticonvulsant	VIMPAT® (lacosamide)	APTIOM® (esliscarbazepine acetate)

ANTICONVULSANTS: CANNABINOID

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
EPIDIOLEX® (cannabidiol)	

ANTICONVULSANTS: STIRIPENTOL

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
DIACOMIT® (stiripentol)	

Central Nervous System (CNS) Agents: Antidepressants

ANTIDEPRESSANTS: SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRI)

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
CITALOPRAM solution (generic of Celexa®) CITALOPRAM tablets (generic of Celexa®) ESCITALOPRAM (generic of Lexapro®) FLUOXETINE HCL capsules, tablets (generic of Prozac®) FLUOXETINE HCL solution (generic of Prozac®) FLUVOXAMINE MALEATE (generic of Luvox®) PAROXETINE HCL (generic of Paxil®) SERTRALINE (generic of Zoloft®) SERTRALINE oral concentrate (generic of Zoloft®)	BRISDELLE® (paroxetine mesylate) FLUOXETINE ER (generic of Prozac Weekly®) FLUVOXAMINE ER (generic of Luvox CR®) PAROXETINE ER (generic of Paxil CR®) PEXEVA® (paroxetine mesylate)

ANTIDEPRESSANTS: SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITORS (SNRI)

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
DULOXETINE 20mg, 30mg, 60mg (generic of Cymbalta®) VENLAFAXINE (generic of Effexor®) VENLAFAXINE ER capsule (generic of Effexor XR®)	DESVENLAFAXINE ER (generic of Khedezla ER®) DESVENLAFAXINE ER tablet DESVENLAFAXINE FUMARATE DULOXETINE 40mg (generic of Irenka®) FETZIMA® (levomilnacipran) PRISTIQ® (desvenlafaxine) VENLAFAXINE ER tablet

ANTIDEPRESSANTS: NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIBITORS (NDRI)

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
BUPROPION HCL (generic of Wellbutrin®) BUPROPION SR (generic of Wellbutrin SR®) BUPROPION XL (generic of Wellbutrin XL®)	APLENZIN™ (bupropion) FORFIVO XL® (bupropion)

ANTIDEPRESSANTS: ALPHA-2 RECEPTOR ANTAGONISTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
MIRTAZAPINE (generic of Remeron®) MIRTAZAPINE rapid dissolve (generic of Remeron® Sol-Tab)	

ANTIDEPRESSANTS: MONOAMINE OXIDASE INHIBITORS (MAOI)

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
TRANYLCYPROMINE (generic of Parnate®)	EMSAM® patches (selegiline) MARPLAN® (isocarboxazid) PHENELZINE (generic of NARDIL®)

ANTIDEPRESSANTS: Serotonin-2 Antagonist/Reuptake Inhibitors (SARI)

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
TRAZODONE 50mg, 100mg, 150mg NEFAZODONE	OLEPTRO ER® (trazodone) TRAZODONE 300mg

ANTIDEPRESSANTS: SSRI - SEROTONIN PARTIAL AGONIST

NO PA REQUIRED "PREFERRED GENERIC"	PA REQUIRED "NON-PREFERRED"
	TRINTELLIX® (vortioxetine) VIIBRYD® (vilazodone)

Central Nervous System (CNS) Agents: Atypical Antipsychotics

ANTIPSYCHOTICS, SECOND GENERATION, ORAL

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
ARIPIPRAZOLE tablet (generic of Abilify®) OLANZAPINE (generic of Zyprexa®) CLOZAPINE (generic of Clozaril®) QUETIAPINE (generic of Seroquel®) RISPERIDONE (generic of Risperdal®) ZIPRASIDONE (generic of Geodon®)	LATUDA® (lurasidone) QUETIAPINE ER (generic of Seroquel XR®) FANAPT® (iloperidone) SAPHRIS® (asenapine)	ABILIFY DISCMELT® (aripiprazole) ABILIFY MYCITE® (aripiprazole with IEM) ARIPIPRAZOLE solution (generic of Abilify®) CLOZAPINE RAPID DIS(generic of Clozaril®) FAZACLO® (clozapine) OLANZAPINE ODT (generic of Zyprexa® Zydis) PALIPERIDONE (generic of INVEGA®) REXULTI® (brexpiprazole) VERSACLOZ® (clozapine oral suspension) VRAYLAR™ (cariprazine capsule)

ANTIPSYCHOTICS, SECOND GENERATION, AGENTS FOR PARKISON'S PSYCHOSIS

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
		NUPLAZID™ (pimavanserin)

ANTIPSYCHOTICS, SECOND GENERATION and SSRI COMBINATION

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
	A trial of no less than fourteen days each of at least two preferred second generation oral antipsychotics or step therapy products	FLUOXETINE/OLANZAPINE (generic of Symbyax®)

ANTIPSYCHOTICS, SECOND GENERATION, LONG-ACTING INJECTABLES +

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
ABILIFY MAINTENA® (aripiprazole) ARISTADA™ (aripiprazole lauroxil) ARISTADA™ Initio (aripiprazole lauroxil) INVEGA SUSTENNA® (paliperidone) INVEGA TRINZA® (paliperidone) PERSERISTM (risperidone) RISPERDAL CONSTA® (risperidone) ZYPREXA RELPREVV® (olanzapine)	

+ Long-Acting Injectable Antipsychotics may be billed by the pharmacy if they are not dispensed directly to the patient. If not administered by the pharmacist, the drug must be released only to the administering provider or administering provider's staff, following all regulations for a Prescription Pick-Up Station as described by the Ohio Board of Pharmacy.

Central Nervous System (CNS) Agents: Attention Deficit Hyperactivity Disorder Agents

CNS AGENTS: ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS – SHORT ACTING

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
AMPHETAMINE SALTS (generic of Adderall®) DEXMETHYLPHENIDATE (generic of Focalin®) DEXTROAMPHETAMINE (generic of Dexedrine®) METHYLPHENIDATE tablets (generic of Ritalin®)	DEXTROAMPHETAMINE solution (generic of Procentra®) EVEKEO® (amphetamine sulfate) EVEKEO ODTTM (amphetamine sulfate ODT) METHAMPHETAMINE (generic of Desoxyn®) METHYLPHENIDATE solution, chewable tablets (generic of Methylin®) ZENZEDI® (dextroamphetamine sulfate)

CNS AGENTS: ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS – LONG ACTING, SOLID DOSAGE FORMS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
ATOMOXETINE (generic of Strattera®) APTENSIO XR™ (methylphenidate) DEXMETHYLPHENIDATE ER (generic of Focalin XR®) DEXTROAMPHETAMINE-AMPHETAMINE XR (generic of Adderall XR®) DEXTROAMPHETAMINE SA (generic of Dexedrine® spansule) GUANFACINE ER (generic of Intuniv®) METHYLPHENIDATE ER (generic of Metadate® ER, Methylin® ER, Ritalin SR®) METHYLPHENIDATE ER (generic of Concerta®) [Labeler 10147] METHYLPHENIDATE LA (generic of Metadate® CD, Ritalin® LA) VYVANSE® (lisdexamfetamine)	CLONIDINE ER (generic of Kapvay®) JORNAY PM™ (methylphenidate ER) METHYLPHENIDATE ER (generic of Concerta®) [All other Labelers] MYDAYIS™ (amphetamine-dextroamphetamine ER)

CNS AGENTS: ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS – LONG ACTING, NON-SOLID DOSAGE FORMS

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
QUILLICHEWTM ER (methylphenidate tablet, chewable, extended release) (no PA for age 12 or under) VYVANSE® chewable (lisdexamfetamine) †	ADZENYSTM XR-ODT, Susp (amphetamine tablet, ODT) COTEMPLA XR-ODTTM (methylphenidate, ODT) DAYTRANA® (methylphenidate) DYANAVELTM XR (amphetamine ER oral suspension) QUILLICHEWTM ER (methylphenidate tablet, chewable, extended release) (PA required for age over 12) QUILLIVANT XR® suspension (methylphenidate)

Central Nervous System (CNS) Agents: Fibromyalgia Agents

CNS AGENTS: FIBROMYALGIA AGENTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
PREGABALIN (generic for Lyrica®)	SAVELLA® (milnacipran)

Central Nervous System (CNS) Agents: Medication Assisted Treatment of Opioid Addiction

CENTRAL NERVOUS SYSTEM AGENTS: MEDICATION ASSISTED TREATMENT OF OPIOID ADDICTION*

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
BUNAVAIL® buccal film (buprenorphine/naloxone) BUPRENORPHINE/NALOXONE SL tablets and films SUBOXONE® SL film (buprenorphine/naloxone) ZUBSOLV® SL tablets (buprenorphine/naloxone)	BUPRENORPHINE SL tablets (generic of Subutex®)†

†Use restricted to pregnancy or breastfeeding; or contraindication to preferred products.
*Dosing limits apply.

CENTRAL NERVOUS SYSTEM AGENTS: MEDICATION ASSISTED TREATMENT OF OPIOID ADDICTION LONG-ACTING INJECTABLES +

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
VIVITROL® (naltrexone)	

+ Vivitrol may be billed by the pharmacy if it is not dispensed directly to the patient. If not administered by the pharmacist, the drug must be released only to the administering provider or administering provider's staff, following all regulations for a Prescription Pick-Up Station as described by the Ohio Board of Pharmacy.

SUBCUTANEOUS BUPRENORPHINE INJECTION * +

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
SUBLOCADE™ (buprenorphine)	

- Note: Clinical criteria must be met

+ Sublocade™ may be billed by the pharmacy if it is not dispensed directly to the patient. If not administered at the pharmacy, the drug must be released only to the administering provider or administering provider's staff, following all applicable regulations.

Central Nervous System (CNS) Agents: Multiple Sclerosis

CNS AGENTS: MULTIPLE SCLEROSIS DISEASE MODIFYING AGENTS, INJECTABLE

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
AVONEX® (interferon beta-1a) BETASERON® (interferon beta-1b) COPAXONE® (glatiramer) REBIF® (interferon beta-1a)	EXTAVIA® (interferon beta-1b) GLATOPATM (glatiramer) PLEGRIDY® (peginterferon beta-1a)

CNS AGENTS: MULTIPLE SCLEROSIS DISEASE MODIFYING AGENTS, ORAL

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
GILENYA® (fingolimod)	AUBAGIO® (teriflunomide) MAVENCLAD® (cladribine) MAYZENT® (siponimod)† TECFIDERA® (dimethyl fumarate)

† Dose limited to 2mg/day.

CNS AGENTS: MULTIPLE SCLEROSIS POTASSIUM CHANNEL BLOCKERS*

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
DALFAMPRIDINE (generic of AMPYRA®)	

Central Nervous System (CNS) Agents: Neuropathic Pain

CNS AGENTS: NEUROPATHIC PAIN

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
AMITRIPTYLINE (generic of Elavil®) CARBAMAZEPINE (generic of Tegretol®) DESIPRAMINE (generic of Norpramin®) DOXEPIN (generic of Sinequan®) DULOXETINE (generic of Cymbalta®) GABAPENTIN (generic of Neurontin®) IMIPRAMINE (generic of Tofranil®) LIDOCAINE patch (generic of Lidoderm®) NORTRIPTYLINE (generic of Pamelor®) OXCARBAZEPINE (generic of Trileptal®) PREGABALIN (generic for Lyrica®)	CLOMIPRAMINE (generic of Anafranil®) GRALISE® (gabapentin) HORIZANT® (gabapentin enacarbil) LYRICA® CR (pregabalin) ZTLIDO™ topical delivery system (lidocaine)

Central Nervous System (CNS) Agents: Parkinson's Agents

PARKINSON'S AGENTS – COMT INHIBITOR

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
ENTACAPONE (generic of Comtan®)	TASMAR® (tolcapone) TOLCAPONE (generic of Tasmar®)

PARKINSON'S AGENTS – DOPAMINERGIC AGENTS, ORAL

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
AMANTADINE	GOCOVRITM (amantadine er) OSMOLEX ERTM (amantadine er)

PARKINSON'S AGENTS – DOPAMINE RECEPTOR AGONISTS FOR INTERMITTENT TREATMENT OF OFF EPISODES

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
	APOKYN® (apomorphine) INBRIJATM (levodopa)

PARKINSON'S AGENTS – DOPAMINE RECEPTOR AGONISTS, NON-ERGOT, ORAL

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
PRAMIPEXOLE (generic of Mirapex®) ROPINIROLE (generic of Requip®)	PRAMIPEXOLE ER (generic of Mirapex ER®) ROPINIROLE ER (generic of Requip XL®)

PARKINSON'S AGENTS – DOPAMINERGIC AGENTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
CARBIDOPA† CARBIDOPA/LEVODOPA (generic of Sinemet®) CARBIDOPA/LEVODOPA CR (generic of Sinemet® CR) SELEGILINE (generic of Eldepryl®)	AZILECT® (rasagiline) CARBIDOPA/LEVODOPA dispersible tablets (generic of Parcopa®) CARBIDOPA/LEVODOPA/ENTACAPONE (generic of Stalevo®) NEUPRO® patch (rotigotine) RYTARY® (carbidopa/levodopa ER) XADAGO® (safinamide) ZELAPAR® ODT (selegiline)

†Use not recommended as monotherapy; edit may ensure used concomitantly

Central Nervous System (CNS) Agents: Restless Legs Syndrome

CNS AGENTS: RESTLESS LEGS SYNDROME AGENTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
PRAMIPEXOLE (generic of Mirapex®) ROPINIROLE (generic of Requip®)	HORIZANT® (gabapentin enacarbil) NEUPRO® patch (rotigotine)

Central Nervous System (CNS) Agents: Sedative-Hypnotics, Non-Barbiturate

CNS AGENTS: SEDATIVE-HYPNOTICS, NON-BARBITURATE

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
ESTAZOLAM (generic of Prosom®) TEMAZEPAM 15mg, 30mg (generic of Restoril®) ZALEPLON (generic of Sonata®) ZOLPIDEM (generic of Ambien®)	BELSOMRA® (suvorexant) ESZOPICLONE (generic of Lunesta®) INTERMEZZO® SL (zolpidem) ROZEREM® (ramelteon) SILENOR® (doxepin) TEMAZEPAM 7.5mg, 22.5mg (generic of Restoril®) ZOLPIDEM ER (generic of Ambien® CR) ZOLPIDEM SL (generic of Edluar®) ZOLPIMIST® (zolpidem)

Central Nervous System (CNS) Agents: Skeletal Muscle Relaxants, Non-Benzodiazepine

CNS AGENTS: SKELETAL MUSCLE RELAXANTS - ORAL

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
BACLOFEN (generic of Lioresal®) CHLORZOXAZONE (generic of Parafon Forte®) CYCLOBENZAPRINE (generic of Flexeril®) DANTROLENE (generic of Dantrium®) METHOCARBAMOL (generic of Robaxin®) TIZANIDINE tablets (generic of Zanaflex®)	CARISOPRODOL (generic of Soma®) CARISOPRODOL COMPOUND (generic of Soma Compound®) CARISOPRODOL COMPOUND W/CODEINE (generic of Soma Compound w/Codeine®) CYCLOBENZAPRINE ER (generic of Amrix®) FEXMID® (cyclobenzaprine) LORZONE® (chlorzoxazone) METAXALONE (generic of Skelaxin®) ORPHENADRINE (generic of Norflex®) ORPHENADRINE COMPOUND (generic of Norgesic®) ORPHENADRINE COMPOUND FORTE (generic of Norgesic Forte®) TIZANIDINE capsules (generic of Zanaflex®)

Central Nervous System (CNS) Agents: Smoking Deterrents

CNS AGENTS: SMOKING DETERRENTS – NICOTINE REPLACEMENT

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
COMMIT□ lozenge (nicotine) NICODERM®CQ patch (nicotine) NICORETTE® gum (nicotine) NICOTINE gum (generic of Nicorette®) NICOTINE lozenge (generic of Commit□) NICOTINE patch (generics) NICOTROL® inhaler (nicotine) NICOTROL® nasal spray(nicotine)	

CNS AGENTS: SMOKING DETERRENTS – NON-NICOTINE PRODUCTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
BUPROPION (generic of Zyban®) CHANTIX®(varenicline)	

Endocrine Agents: Androgens

ORAL AGENTS: ANDROGENS

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
	ANDROXY® (fluoxymesterone) METHYLTESTOSTERONE (generic of Android®, Methitest®, Testred®) STRIANT (testosterone)

INJECTABLE AGENTS: ANDROGENS

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
	DEPO-TESTOSTERONE (testosterone cypionate) TESTOSTERONE CYPIONATE (generic of Depo-Testosterone) TESTOSTERONE ENANTHATE (generic of Delatestryl) XYOSTEDTM (testosterone enanthate)

TOPICAL AGENTS: ANDROGENS

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
ANDRODERM® patch (testosterone) TESTOSTERONE gel (generic of Androgel® 1% packet)	ANDROGEL 1.62%® (testosterone) AXIRON® gel (testosterone) NATESTO® nasal gel (testosterone) TESTOSTERONE gel (generic of Fortesta®, Testim®) VOGELXO™ gel (testosterone)

Endocrine Agents: Diabetes – Insulin

ENDOCRINE AGENTS: DIABETES - INSULINS - Rapid and Short Acting

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
HUMULIN R® (insulin regular human) HUMULIN R 500-U® vial and pen(insulin regular human) INSULIN ASPART vial and pen (authorized generic of Novolog®) INSULIN LISPRO vial and pen (authorized generic of Humalog®) NOVOLIN R® (insulin regular human)	ADMELOG® (insulin lispro)† AFREZZA® inhalation powder (insulin human) APIDRA® vial and pen (insulin glulisine) FIASP® (insulin aspart)

†Due to the nature of the drug, allergy or therapeutic failure to Humalog is insufficient to justify use

ENDOCRINE AGENTS: DIABETES - INSULINS - Intermediate Acting

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
HUMALOG MIX 50/50, 75/25® vial and pen (insulin lispro protamine/insulin lispro) HUMULIN 70/30® vial and pen (insulin NPH/regular) INSULIN ASPART PROTAMINE/INSULIN ASPART vial and pen (authorized generic of Novolog Mix 70/30®) NOVOLIN 70/30® (insulin NPH/regular)	HUMULIN N® vial and pen (insulin NPH) † NOVOLIN N® (insulin NPH) †

†Patients who have a claim for insulin NPH in the previous 120 days will be automatically approved to continue the drug

ENDOCRINE AGENTS: DIABETES - INSULINS - Long Acting

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
LANTUS® vial and pen (insulin glargine) LEVEMIR® vial and pen (insulin detemir)	TRESIBA (insulin degludec)	BASAGLAR® (insulin glargine)† TOUJEO® (insulin glargine)

†Due to the nature of the drug, allergy or therapeutic failure to Lantus is insufficient to justify use

Endocrine Agents: Diabetes – Non-Insulin

DIABETES – ORAL HYPOGLYCEMICS, BIGUANIDES

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
METFORMIN (generic of Glucophage®) METFORMIN ER (generic of Glucophage XR®)		GLUCOPHAGE®, GLUCOPHAGE® XR (metformin) METFORMIN ER (generic of Fortamet®) METFORMIN SOLUTION (generic of Riomet®)

DIABETES – ORAL HYPOGLYCEMICS, BIGUANIDE/SULFONYLUREA COMBO

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
GLIPIZIDE/METFORMIN (generic of Metaglip®) GLYBURIDE/METFORMIN (generic of Glucovance®)		METAGLIP® (glipizide/metformin) GLUCOVANCE® (glyburide/metformin)

DIABETES – ORAL HYPOGLYCEMICS, TZD / BIGUANIDE COMBO

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
PIOGLITAZONE/ METFORMIN (generic of ActoPlus Met®)	ACTOPLUS MET XR® (pioglitazone/metformin)	

DIABETES – DIPEPTIDYL PEPTIDASE-4 INHIBITOR

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
	JANUVIA□ (sitagliptin) TRADJENTA™ (linagliptin)	ALOGLIPTIN (generic of Nesina®) ONGLYZA® (saxagliptin)

DIABETES – DIPEPTIDYL PEPTIDASE-4 INHIBITOR COMBINATIONS

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
	JANUMET□ (sitagliptin/ metformin) JANUMET XR™ (sitagliptin/ metformin) JENTADUETO™ (linagliptin/ metformin)	JENTADUETO® XR (linagliptin/ metformin) ALOGLIPTIN/METFORMIN (generic of Kazano®) KOMBIGLYZE XR® (saxagliptin/metformin)

DIABETES – ORAL HYPOGLYCEMICS, TZD / DPP-4 COMBINATION

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
		PIOGLITAZONE/ALOGLIPTIN (generic of Oseni®)

DIABETES – ORAL HYPOGLYCEMICS, SODIUM-GLUCOSE COTRANSPORTER 2 (SGLT2) INHIBITOR

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
	JARDIANCE® (empagliflozin)	FARXIGA® (dapagliflozin) INVOKANA® (canagliflozin) STEGLATROTM (ertugliflozin)

DIABETES – ORAL HYPOGLYCEMICS, SODIUM-GLUCOSE COTRANSPORTER 2 (SGLT2) INHIBITOR COMBINATIONS

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
	SYNJARDY® (empagliflozin and metformin)	GLYXAMBI® (empagliflozin/ linagliptin) INVOKAMET® (canagliflozin/ metformin) INVOKAMET® XR (canagliflozin/ metformin) SEGLUROMETTM (ertugliflozin/metformin) SYNJARDY® XR (empagliflozin and metformin) XIGDUO XR® (dapagliflozin/ metformin)

DIABETES – ORAL HYPOGLYCEMICS, SODIUM-GLUCOSE COTRANSPORTER 2 (SGLT2) INHIBITOR AND DPP-4 COMBINATIONS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
No less than 90 days of at least one preferred DPP-4 and SGLT2 product	QTERN® (dapaglifozin-saxagliptin) STEGLUJAN™ (ertugliflozin/sitagliptin)

DIABETES – ORAL HYPOGLYCEMICS, ALPHA-GLUCOSIDASE INHIBITORS

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
ACARBOSE (generic of Precose®)	GLYSET® (miglitol)	MIGLITOL (generic of Glyset®)

DIABETES – ORAL HYPOGLYCEMICS, MEGLITINIDES

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
NATEGLINIDE (generic of Starlix®) REPAGLINIDE (generic of Prandin®)		

DIABETES – ORAL HYPOGLYCEMICS, MEGLITINIDE/BIGUANIDE COMBO

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
REPAGLINIDE/ METFORMIN (generic of Prandimet®)		

DIABETES – ORAL HYPOGLYCEMICS, SULFONYLUREAS SECOND GENERATION

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
GLIMEPIRIDE (generic of Amaryl®) GLIPIZIDE (generic of Glucotrol®) GLIPIZIDE ER (generic of Glucotrol XL®) GLYBURIDE (generic of Diabeta®, Micronase®) GLYBURIDE MICRONIZED (generic of Glynase PresTabs®)		

DIABETES – ORAL HYPOGLYCEMICS, THIAZOLIDINEDIONES

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
PIOGLITAZONE (generic of Actos®)		AVANDIA® (rosiglitazone)

DIABETES – ORAL HYPOGLYCEMICS, TZD/SULFONYLUREAS COMBO

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
		GLIMEPIRIDE/PIOGLITAZONE (generic of Duetact®)

ENDOCRINE AGENTS: DIABETES – AMYLIN ANALOGS

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
No less than 90 days of at least one preferred insulin product	SYMLIN® (pramlintide)	

ENDOCRINE AGENTS: DIABETES –GLUCAGON-LIKE PEPTIDE-1 RECEPTOR AGONISTS

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
	VICTOZA® (liraglutide) TRULICITY® (dulaglutide)	ADLYXIN™ (lixisenatide) BYDUREON® (exenatide) BYDUREON® BCISE (exenatide) BYETTA (exenatide) OZEMPIC® (semaglutide)

ENDOCRINE AGENTS: DIABETES – GLUCAGON-LIKE PEPTIDE-1 RECEPTOR AGONISTS & INSULIN COMBINATIONS

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
		SOLIQUA™ 100/33 (insulin glargine/lixisenatide) XULTOPHY® 100/3.6 (insulin degludec and liraglutide)

Endocrine Agents: Estrogenic Agents

ESTROGENS – ORAL ESTROGENS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
ESTRADIOL (generic of Estrace®) Estradiol vaginal cream (generic of Estrace®) ESTROPIPATE MENEST® (esterified estrogens) PREMARIN® (conjugated estrogens)	FEMTRACE® (estradiol)

ESTROGENS – ORAL ESTROGEN/PROGESTERONE COMB

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
ETHINYL ESTRADIOL/NORETHINDRONE ACETATE (generic of FemHRT®) FEMHRT® (norethindrone/ethinylestradiol) PREMPHASE® (medroxyprogesterone/estrogens conj) PREMPRO® (medroxyprogesterone/estrogens conj)	ANGELIQ® (drospirenone/estradiol) ESTRADIOL/NORETHINDRONE ACETATE tablets (generic of Activella®) PREFEST®(estradiol/norgestimate)

ESTROGENS & ESTROGEN AGONIST/ANTAGONIST COMB

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
	DUAVEE (conjugated estrogens/bazedoxifene)

ENDOCRINE AGENTS: ESTROGENS – TRANSDERMAL ESTROGENS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
ALORA® patch (estradiol) ESTRADIOL patch (generic of Climara®, Vivelle-Dot®)	DIVIGEL® transdermal gel (estradiol) ELESTRIN® transdermal gel (estradiol) ESTRASORB® transdermal emulsion (estradiol) EVAMIST® transdermal solution (estradiol) MENOSTAR® patch (estradiol) MINIVELLE® patch (estradiol)

ESTROGENS – TRANSDERMAL ESTROGEN/ PROGESTERONE COMB

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
CLIMARA PRO® (estradiol/levonorgestrel oral) COMBIPATCH® (estradiol/norethindrone)	

ESTROGENS – VAGINAL ESTROGENS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
ESTRING® vaginal ring (estradiol) PREMARIN® vaginal cream (estrogens conjugated)	ESTRACE® vaginal cream (estradiol) FEMRING® vaginal ring (estradiol) VAGIFEM® vaginal tablet (estradiol)

Endocrine Agents: Progestin Agents

PROGESTIN – ORAL PROGESTINS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
MEDROXYPROGESTERONE ACETATE TABLET NORETHINDRONE ACETATE MEGESTROL ACETATE SUSP (generic of Megace®) PROGESTERONE	

PROGESTIN – INJECTABLE PROGESTINS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
HYDROXYPROGESTERONE CAPROATE (generic of Delalutin ®) HYDROXYPROGESTERONE CAPROATE (generic of Makena®) MAKENA® (hydroxyprogesterone caproate) PROGESTERONE IN OIL	

Endocrine Agents: Growth Hormone

GROWTH HORMONES

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
GENOTROPIN® cartridge, miniquick (somatropin) NORDITROPIN® cartridge, FlexPro, NordiFlex, vial (somatropin)	HUMATROPE® cartridge, vial (somatropin) NUTROPIN AQ® cartridge, Nuspin, vial (somatropin) NUTROPIN® vial (somatropin) OMNITROPE® cartridge, vial (somatropin) SAIZEN® cartridge, vial (somatropin) SEROSTIM® vial (somatropin) ZOMACTON® vial (somatropin)

Endocrine Agents: Osteoporosis – Bone Ossification Enhancers

ENDOCRINE AGENTS: OSTEOPOROSIS - BONE OSSIFICATION ENHANCERS - ORAL BISPHOSPHONATES

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
ALENDRONATE tablets (generic of Fosamax®) IBANDRONATE (generic of Boniva®)	ALENDRONATE ORAL SOLN 70mg/75ml (generic of Fosamax®) ATELVIA® (risedronate) BINOSTO® (alendronate sodium effervescent tablet) ETIDRONATE (generic of Didronel®) FOSAMAX PLUS D (alendronate/cholecalciferol) FOSAMAX® ORAL SOLN 70mg/75ml (alendronate) RISEDRONATE (generic of Actonel®)

ENDOCRINE AGENTS: OSTEOPOROSIS - BONE OSSIFICATION ENHANCERS - CALCITONIN-SALMON

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
CALCITONIN-SALMON (generic of Miacalcin®)	FORTICAL® (calcitonin salmon)

ENDOCRINE AGENTS: OSTEOPOROSIS – PARATHYROID HORMONE RELATED PEPTIDE ANALOG

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
	TYMLOS™ (abaloparatide)

Gastrointestinal Agents: Anti-Emetics

GASTROINTESTINAL AGENTS: ANTI-EMETIC AGENTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
EMEND® tablets, trifold, suspension (aprepitant) ONDANSETRON tablets, solution, ODT (generic of Zofran®)	ANZEMET® (dolasetron) GRANISETRON tablet, solution (generic of Kytril®) SANCUSO® patch (granisetron) VARUBI™ (rolapitant) ZUPLENZ® film (ondansetron)

GASTROINTESTINAL AGENTS: ANTI-EMETIC AGENTS: non-5-HT3 receptor antagonists

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
DIMENHYDRINATE tablets DIPHENHYDRAMINE tablets, capsules, solution MECLIZINE tablets (generic of Antivert®) METOCLOPRAMIDE tablets (generic of Reglan®) PHOSPHORATED CARBOHYDRATE SOLUTION (generic of Emetrol®) PROCHLORPERAZINE tablets, suppositories (generic of Compazine®) PROMETHAZINE tablets, suppositories (generic of Phenergan®) TRANSDERM-SCOP® patch (scopolamine) TRIMETHOBENZAMIDE capsules (generic of Tigan®)	BONJESTA® (doxylamine and pyridoxine) DICLEGIS® (doxylamine and pyridoxine) METOCLOPRAMIDE ODT (generic of Metozolv® ODT)

Gastrointestinal Agents: Irritable Bowel Syndrome (IBS) / Selected GI

IBS WITH CONSTIPATION & CHRONIC IDIOPATHIC CONSTIPATION AGENTS

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
BISACODYL(generic of Dulcolax®) CASANTHRANOL/DOCUSATE SODIUM (generic of Peri-Colace®) LACTULOSE (generic of Chronulac®) POLYETHYLENE GLYCOL (generic of Miralax®) PSYLLIUM FIBER (e.g. Konsyl®) SENNA (generic of Senokot®)	AMITIZA® capsule (lubiprostone) LINZESS™ 145mcg & 290mcg capsule (linaclotide)	LINZESS™ 72mcg capsule (linaclotide) MOTEGRITY™ (prucalopride) TRULANCE™ (plecanatide) ZELNORM™ (tegaserod)†

†Use limited to FDA approved indications.

IBS WITH DIARRHEA AGENTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
DICYCLOMINE (generic of Bentyl®) DIPHENOXYLATE/ATROPINE (generic of Lomotil®) LOPERAMIDE (Maximum of 16mg per day)	ALOSETRON (generic of Lotronex®) VIBERZI™ (eluxadoline tablet) XIFAXAN® (rifaximin)

SHORT BOWEL SYNDROME AGENTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
	NUTRESTORE ™(l-glutamine) ZORBTIVE ◦(somatropin) GATTEX ◦(teduglutide)

NON-INFECTIOUS DIARRHEA AGENTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
DIPHENOXYLATE/ATROPINE (generic of Lomotil®) LOPERAMIDE (Maximum of 16mg per day)	MYTESI ™ (crofelemer)

Gastrointestinal Agents: Opioid-Induced Constipation

GASTROINTESTINAL AGENTS: OPIOID-INDUCED CONSTIPATION AGENTS

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
BISACODYL (generic of Dulcolax®) CASANTHRANOL/DOCUSATE SODIUM (generic of Peri-Colace®) LACTULOSE (generic of Chronulac®) POLYETHYLENE GLYCOL (generic of Miralax®) PSYLLIUM FIBER (e.g. Konsyl®) SENNA (generic of Senokot®)	AMITIZA® capsule (lubiprostone) MOVANTIK® tablets (naloxegol)	RELISTOR® tablets and subcutaneous injection (methylnaltrexone bromide) SYMPROIC® (naldemedine)

Gastrointestinal Agents: Pancreatic Enzymes

GASTROINTESTINAL AGENTS: PANCREATIC ENZYMES

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
CREON® (pancrelipase) ZENPEP® (pancrelipase)	PANCREAZE® (pancrelipase) PERTZYE® (pancrelipase) ULTRESA® (pancrelipase) VIOKACE® (pancrelipase)

Gastrointestinal Agents: Proton Pump Inhibitors

GASTROINTESTINAL AGENTS: PPIs

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
LANSOPRAZOLE capsules (generic of Prevacid®) OMEPRAZOLE capsules (generic of Prilosec®) NEXIUM® packets (esomeprazole) PANTOPRAZOLE (generic of Protonix®) PROTONIX® suspension (No PA required for age 6 or under)	ACIPHEX® sprinkle capsule (rabeprazole) DEXILANT® (dexlansoprazole) ESOMEPRAZOLE STRONTIUM ESOMEPRAZOLE capsules (generic of Nexium®) OMEPRAZOLE tablets (generic of Prilosec OTC®) OMEPRAZOLE/SODIUM BICARBONATE PREVACID SOLUTAB® (lansoprazole ODT) PRILOSEC® suspension (omeprazole) PROTONIX® suspension (PA required for age over 6) RABEPRAZOLE (generic of Aciphex®)

Gastrointestinal Agents: Ulcerative Colitis Agents

GASTROINTESTINAL AGENTS: ULCERATIVE COLITIS AGENTS - ORAL

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
APRISO® (mesalamine) BALSALAZIDE DISODIUM (generic of Colazal®) MESALAMINE DR (generic for Delzicol®) PENTASA® (mesalamine) SULFASALAZINE (generic of Azulfidine®) SULFASALAZINE EC (generic of Azulfidine Entab®)	DIPENTUM® (olsalazine) GIAZO® (balsalazide disodium) MESALAMINE DR (generic for Lialda®, Asacol HD®)

GASTROINTESTINAL AGENTS: ULCERATIVE COLITIS AGENTS - RECTAL

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
MESALAMINE enema (generic of Rowasa® and SFRowasa®)	MESALAMINE (generic for Canasa® suppositories) MESALAMINE enema kit (generic for Rowasa® kit) UCERIS® foam (budesonide)

Genitourinary Agents: Benign Prostatic Hyperplasia

BENIGN PROSTATIC HYPERPLASIA AGENTS – ALPHA-1 ADRENERGIC BLOCKERS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
DOXAZOSIN (generic of Cardura®) PRAZOSIN (generic of Minipress®) TAMSULOSIN (generic of Flomax®) TERAZOSIN (generic of Hytrin®)	ALFUZOSIN (generic of Uroxatral®) CARDURA® XL (doxazosin) RAPAFLO® (silodosin)

BENIGN PROSTATIC HYPERPLASIA AGENTS – 5-ALPHA REDUCTASE INHIBITORS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
FINASTERIDE (generic of Proscar®)	DUTASTERIDE (generic of Avodart®)

BENIGN PROSTATIC HYPERPLASIA AGENTS – COMBINATION 5-ALPHA REDUCTASE INHIBITOR/ALPHA-1 ADRENERGIC BLOCKER

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
	DUTASTERIDE/TAMSULOSIN (generic of Jalyn®)

BENIGN PROSTATIC HYPERPLASIA AGENTS – PHOSPHODIESTERASE TYPE 5 INHIBITORS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
	TADALAFIL (generic for Cialis®) 2.5mg, 5mg only

Genitourinary Agents: Electrolyte Depleter Agents

ELECTROLYTE DEPLETERS FOR HYPERPHOSPHATEMIA

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
CALCIUM ACETATE (generic of PhosLo® gelcap) CALCIUM CARBONATE PHOSLYRA® solution (calcium acetate)	SEVELAMER (generic for Renagel□, Renvela®)	AURYXIA® (ferric citrate) tablets ELIPHOS® (calcium acetate) LANTHANUM CARBONATE (generic of Fosrenol®) VELPHORO® (sucroferric oxyhydroxide)

Genitourinary Agents: Urinary Antispasmodics

GENITOURINARY AGENTS: URINARY ANTISPASMODICS

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
OXYBUTYNIN ER (generic of Ditropan® XL) OXYBUTYNIN syrup (generic of Ditropan®) OXYBUTYNIN tablets (generic of Ditropan®) OXYTROL® FOR WOMEN OTC patch (oxybutynin)	SOLIFENACIN (generic of Vesicare®)	ENABLEX® (darifenacin) GELNIQUE® (oxybutynin) MYRBETRIQ® (mirabegron) TOLTERODINE (generic of Detrol®) TOLTERODINE SR (generic of Detrol® LA) TOVIAZ® (fesoterodine) TROSPIUM (generic of Sanctura®) TROSPIUM ER (generic of Sanctura® XR)

Immunomodulator Agents for Systemic Inflammatory Disease

ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
ENBREL® kit, SureClik, syringe (etanercept) HUMIRA® pen, starter packs, syringe (adalimumab)	CIMZIA® syringe (certolizumab pegol) ORENCIA® syringe (abatacept) SIMPONI™ pen, syringe (golimumab)

ANTI-INFLAMMATORY INTERLEUKIN RECEPTOR ANTAGONIST

CLINICAL PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
	COSENTYX™ (secukinumab)	ACTEMRA® syringe (tocilizumab) ILUMYA™ (tildrakizumab-asmn) KEVZARA® (sarilumab) KINERET® syringe (anakinra) SILIQTM (brodalumab) SKYRIZI™ (risankizumab-rzza) TALTZ™ (ixekizumab injection) TREMFYA™ (guselkumab)

JANUS KINASE INHIBITOR

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
	OLUMIANT® (baricitinib) XELJANZ® tablet (tofacitinib citrate) XELJANZ® XR (tofacitinib tablet, extended release)

PHOSPHODIESTERASE-4 INHIBITOR

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
	OTEZLA® tablet (apremilast)

Infectious Disease Agents: Antibiotics – Cephalosporins

CEPHALOSPORINS, FIRST GENERATION

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
CEFADROXIL capsules, suspension (generic of Duricef®) CEPHALEXIN 250mg, 500 mg capsules, suspension (generic of Keflex®)	CEPHALEXIN 750mg (generic of Keflex®) DAXBIA™ (cephalexin)

CEPHALOSPORINS, SECOND GENERATION

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
CEFACLOR (generic of Ceclor®) CEFACLOR ER (generic of Ceclor CD®) CEFACLOR suspension (no PA required for age 12 or under) (generic of Ceclor®) CEFPROZIL (generic of Cefzil®) CEFPROZIL suspension (generic of Cefzil®) (no PA required for age 12 or under) CEFTIN® suspension (no PA required for age 12 or under) (cefuroxime) CEFUROXIME (generic of Ceftin®)	CEFACLOR suspension (PA required for age over 12) (generic of Ceclor®) CEFTIN® suspension (PA required for age over 12) (cefuroxime) CEFPROZIL suspension (generic of Cefzil®) (PA required for age over 12)

CEPHALOSPORINS, THIRD GENERATION

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
CEFDINIR capsules, suspension (generic of Omnicef®)	CEFTIBUTEN capsules, suspension (generic of Cedax®) CEFPODOXIME tablets, suspension (generic of Vantin®) CEFIXIME SUSP (generic for SUPRAX®) SUPRAX® (cefixime)

Infectious Disease Agents: Antibiotics – Macrolides

INFECTIOUS DISEASE AGENTS: MACROLIDES - ORAL

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
AZITHROMYCIN tablets and suspension (generic of Zithromax®) CLARITHROMYCIN ER (generic of Biaxin XL®) CLARITHROMYCIN tablets and suspension (generic of Biaxin®) ERYTHROCIN STEARATE® (erythromycin stearate) ERYTHROMYCIN BASE ERYTHROMYCIN ETHYLSUCCINATE ERY-TAB® (erythromycin base DR)	ERYPED® (erythromycin ethylsuccinate) ZMAX™ (azithromycin ER) for oral suspension

Infectious Disease Agents: Antibiotics – Quinolones

INFECTIOUS DISEASE AGENTS: QUINOLONES, SECOND GENERATION - ORAL

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
CIPROFLOXACIN (generic of Cipro®) CIPRO® suspension (no PA required for age 12 or under) (ciprofloxacin)	CIPROFLOXACIN suspension (PA required for age over 12) (generic of Cipro®) CIPROFLOXACIN ER (generic of Cipro®XR)

INFECTIOUS DISEASE AGENTS: QUINOLONES, THIRD GENERATION - ORAL

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
LEVOFLOXACIN (generic of Levaquin®)	MOXIFLOXACIN (generic of Avelox®)

INFECTIOUS DISEASE AGENTS: QUINOLONES, OTHER - ORAL

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
	BAXDELA™ (delafloxacin)

Infectious Disease Agents: Antibiotics – Inhaled

INFECTIOUS DISEASE AGENTS: ANTIBIOTICS - INHALED

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
KITABIS® PAK (tobramycin inhalation solution with nebulizer) TOBRAMYCIN inhalation solution- (generic of TOBI™)	BETHKIS® inhalation solution (tobramycin) CAYSTON® inhalation solution (aztreonam) TOBI™ Podhaler™ (tobramycin inhalation powder)

INFECTIOUS DISEASE AGENTS: ANTIBIOTICS – INHALED AMIKACIN

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
ARIKAYCE® (amikacin)	

Infectious Disease Agents: Antibiotics – Tetracyclines

TETRACYCLINES

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
Doxycycline tablets, capsules 50mg & 100mg Doxycycline syrup Minocycline capsules Tetracycline capsules	DORYX® (doxycycline) Doxycycline tablets, capsules 20mg, 40mg, 75mg, & 150mg Doxycycline DR Minocycline ER MINOLIRATM ER (minocycline) SEYSARATM (sarecycline) SOLODYN® ER (minocycline) XIMINO® (minocycline)

TETRACYCLINES

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
	NUZYRA® (omadacycline)

Infectious Disease Agents: Antifungals for Onychomycosis & Systemic Infections

INFECTIOUS DISEASE AGENTS: AGENTS FOR ONYCHOMYCOSIS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
GRIFULVIN®V tablets (griseofulvin, microsize)	ITRACONAZOLE (generic of Sporanox®)
GRISEOFULVIN suspension (generic of Grifulvin®V)	LAMISIL Granules (terbinafine)
GRIS-PEG® (griseofulvin, ultramicrosize)	ONMEL® (itraconazole)
TERBINAFINE (generic of Lamisil®)	SPORANOX® 100mg/10ml oral solution (itraconazole)

INFECTIOUS DISEASE AGENTS: AGENTS FOR SYSTEMIC INFECTIONS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
FLUCONAZOLE (generic of Diflucan®)	CRESEMBA (isavuconazonium)
FLUCONAZOLE suspension (generic of Diflucan®)	ITRACONAZOLE capsules (generic of Sporanox®)
FLUCYTOSINE (generic of Ancobon®)	NOXAFIL (posaconazole)
KETOCONAZOLE (generic of Nizoral®)	ORAVIG® (miconazole)
	SPORANOX® 100mg/10ml oral solution (itraconazole)
	VORICONAZOLE (generic of Vfend®)
	TOLSURA (itraconazole)

Infectious Disease Agents: Antivirals – Hepatitis C Agents

INFECTIOUS DISEASE AGENTS: HEPATITIS C – DIRECT-ACTING ANTIVIRAL

CLINICAL PA REQUIRED "PREFERRED"†	PA REQUIRED "NON-PREFERRED"
SOFOSBUVIR/VELPATASVIR (generic of EPCLUSA®) [Labeler 72626] MAVYRET® (glecaprevir and pibrentasvir)	DAKLINZA™ (daclatasvir) LEDIPASVIR/SOFOSBUVIR (generic of HARVONI®) SOVALDI® (sofosbuvir) VOSEVI™ (sofosbuvir, velpatasvir, voxilaprevir) ZEPATIER™ (elbasvir and grazoprevir tablet)

†Selection of regimen will be based upon guidelines; refer to PA form for guidance.

INFECTIOUS DISEASE AGENTS: HEPATITIS C - PEGYLATED INTERFERONS

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
PEGASYS® (peginterferon alfa-2a) PEG-INTRON® (peginterferon alfa-2b)	

INFECTIOUS DISEASE AGENTS: HEPATITIS C - RIBAVIRINS

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
RIBAVIRIN (generic of Rebetol®)	COPEGUS® (ribavirin) MODERIBA PAK® (ribavirin) RIBAPAK® (ribavirin) RIBASPHERE® (ribavirin) 400mg, 600mg

Infectious Disease Agents: Antivirals – Herpes

INFECTIOUS DISEASE AGENTS: ANTIVIRALS - HERPES

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
ACYCLOVIR (generic of Zovirax®)	FAMCICLOVIR (generic of Famvir®)
VALACYCLOVIR (generic of Valtrex®)	SITAVIG® buccal tablets (acyclovir)

Infectious Disease Agents: Antivirals – HIV

HIV PROTEASE INHIBITORS AND COMBINATIONS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
EVOTAZ® (atazanavir/cobicistat) KALETRA® (lopinavir/ritonavir) REYATAZ® capsules, oral powder (atazanavir sulfate)	CRIXIVAN® (indinavir sulfate) INVIRASE® (saquinavir mesylate) LEXIVA® (fosamprenavir calcium) VIRACEPT® (nelfinavir mesylate)

HIV NON-PEPTIDIC PROTEASE INHIBITORS AND COMBINATIONS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
PREZCOBIX® (darunavir/cobicistat) PREZISTA® (darunavir ethanolate)	APTIVUS® (tipranavir; tipranavir/vitamin E) SYMTUZATM (darunavir, cobicistat, emtricitabine, tenofovir alafenamide)

HIV REVERSE TRANSCRIPTASE INHIBITORS, NUCLEOSIDE ANALOGS AND COMBINATIONS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
ABACAVIR SULFATE tablet (generic of Ziagen®) ABACAVIR/LAMIVUDINE (generic of Epzicom®) EMTRIVA® (emtricitabine) ABACAVIR/LAMIVUDINE/ZIDOVUDINE (generic TRIZIVIR®) ZIDOVUDINE (generic of Retrovir®)	DIDANOSINE capsule (generic of Videx®) LAMIVUDINE solution, tablet (generic of Epivir®) LAMIVUDINE/ZIDOVUDINE (generic of Combivir®) STAVUDINE (generic of Zerit®) VIDEX® solution (didanosine) ZIAGEN® solution (abacavir sulfate)

HIV REVERSE TRANSCRIPTASE INHIBITORS, NUCLEOTIDE ANALOGS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
VIREAD® 150 mg (tenofovir disoproxil fumarate) TENOFOVIR DISOPROXIL 300mg (generic for VIREAD®)	VIREAD® 250mg & Oral Powder (tenofovir disoproxil fumarate)

HIV REVERSE TRANSCRIPTASE INHIBITORS, NON-NUCLEOSIDE ANALOGS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
EFAVIRENZ (generic for SUSTIVA®) PIFELTRO™ (doravirine)	EDURANT® (rilpivirine) INTELENCE® (etravirine) NEVIRAPINE ER (generic of Viramune® XR) NEVIRAPINE IR (generic of Viramune®) RESCRIPTOR® (delavirdine mesylate)

HIV INTEGRASE STRAND TRANSFER INHIBITORS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
ISENTRESS® tablets, chewable tablet, powder packets (raltegravir potassium) TIVICAY® (dolutegravir sodium)	

HIV CCR5 CO-RECEPTOR ANTAGONISTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
	SELZENTRY® (maraviroc)

HIV FUSION INHIBITORS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
	FUZEON® (enfuvirtide)

HIV RTI, NUCLEOSIDE-NUCLEOTIDE ANALOGS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
DESCOVY® (emtricitabine/ tenofovir alafenamide) CIMDUO™ (lamivudine/tenofovir) TRUVADA® (emtricitabine/tenofovir)	

HIV RTI, NUCLEOSIDE-NUCLEOTIDE ANALOGS AND COMBINATIONS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
DELSTRIGO™ (doravirine, lamivudine, and tenofovir disoproxil) SYMFI & SYMFI LO™ (efavirenz/lamivudine/tenofovir)	

HIV RTI, NUCLEOSIDE, NUCLEOTIDE, & NON-NUCLEOSIDE ANALOGS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
ATRIPLA® (emtricitabine/efavirenz/tenofovir) COMPLERA® (emtricitabine/rilpivirine/tenofovir) ODEFSEY® (emtricitabine/rilpivirine/tenofovir alafenamide)	

HIV INTEGRASE INHIBITOR & RTI COMBINATION

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
DOVATO (dolutegravir/lamivudine) GENVOYA® (elvitegravir, cobicistat, emtricitabine, and tenofovir alafenamide) TRIUMEQ® (dolutegravir/abacavir/lamivudine)	STRIBILD® (elvitegravir/cobicistat/emtricitabine/ tenofovir)

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HIV INTEGRASE INHIBITOR & NUCLEOSIDE ANALOG COMBINATIONS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
BIKTARVY® (bictegravir/emtricitabine/tenofovir)	

HIV INTEGRASE INHIBITOR & NON-NUCLEOSIDE COMBINATION

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
JULUCA (dolutegravir/rilpivirine)	

HIV PHARMACOKINETIC ENHANCERS (CYP3A INHIBITORS)

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
RITONAVIR (generic for Norvir®) NORVIR® oral Solution (ritonavir)	TYBOST® (cobicistat)

Ophthalmic Agents: Antibiotic and Antibiotic-Steroid Combination Drops and Ointments

OPHTHALMIC AGENTS: ANTIBACTERIAL - QUINOLONES

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
CILOXAN® ointment (ciprofloxacin)	BESIVANCE® drops (besifloxacin)
CIPROFLOXACIN drops (generic of Ciloxan®)	GATIFLOXACIN drops (generic of Zymaxid®)
MOXIFLOXACIN (generic for Vigamox®)	LEVOFLOXACIN drops (generic of Quixin®)
OFLOXACIN drops (generic of Ocuflox®)	MOXEZA® drops (moxifloxacin)

OPHTHALMIC AGENTS: ANTIBACTERIAL – NON-QUINOLONE

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
BACITRACIN-POLYMYXIN ointment ERYTHROMYCIN ointment (generic of Ilotycin®) GENTAMICIN drops NEOMYCIN/POLYMYXIN/ BACITRACIN ointment (generic of Neosporin®) NEOMYCIN/POLYMYXIN/ GRAMICIDIN drops (generic of Neosporin®) POLYMYXIN/TRIMETHOPRIM drops (generic of Polytrim®) SULFACETAMIDE drops TOBRAMYCIN drops (generic of Tobrex®) TOBREX® ointment (tobramycin)	AZASITE® drops (azithromycin) BACITRACIN ointment GENTAMICIN ointment SULFACETAMIDE ointment

OPHTHALMIC AGENTS: ANTIBACTERIAL – STEROID COMBINATIONS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
NEOMYCIN/POLYMYXIN/ DEXAMETHASONE drops (generic of Maxitrol®) NEOMYCIN/POLYMYXIN/ DEXAMETHASONE ointment (generic of Maxitrol®) SULFACETAMIDE/ PREDNISOLONE drops (generic of Vasocidin®) TOBRADEX® drops, ointment (dexamethasone/tobramycin)	BLEPHAMIDE® drops, ointment (prednisolone/sulfacetamide) NEOMYCIN/POLYMYXIN/ HYDROCORTISONE drops (generic of Cortisporin®) NEOMYCIN/POLYMYXIN/ BACITRACIN/ HYDROCORTISONE ointment PRED-G® drops, ointment (prednisolone/ gentamicin) TOBRADEX ST® (dexamethasone/ tobramycin) TOBRAMYCIN/ DEXAMETHASONE drops (generic of TobraDex®) ZYLET® drops (tobramycin/ loteprednol)

Ophthalmic Agents: Antihistamines & Mast Cell Stabilizers

OPHTHALMIC AGENTS: MAST CELL STABILIZERS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
CROMOLYN (generic of Crolom®)	ALOCRIL® (nedocromil) ALOMIDE® (lodoxamide)

OPHTHALMIC AGENTS: ANTIHISTAMINE/MAST CELL STABILIZERS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
AZELASTINE (generic of Optivar®) KETOTIFEN (generic of Alaway®, Zaditor®) OLOPATADINE (generic of Patanol®)	BEPREVE® (bepotastine) EPINASTINE (generic of Elestat®) EMADINE® (emedastine) LASTACAFT® (alcaftadine)

Ophthalmic Agents: Dry Eye Treatments

OPHTHALMIC AGENTS: Dry Eye Treatments

STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
RESTASIS® trays (cyclosporine)	CEQUA™ (cyclosporine) RESTASIS® multi-dose (cyclosporine) XIIDRA™ (lifitegrast)

Ophthalmic Agents: Glaucoma Agents

GLAUCOMA AGENTS – BETA BLOCKERS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
BETAXOLOL CARTEOLOL LEVOBUNOLOL (generic of Betagan®) METIPRANOLOL (generic of Optipranolol®) TIMOLOL gel solution (generic of Timoptic-XE®) TIMOLOL solution (generic of Timoptic®)	BETOPTIC®S (betaxolol) ISTALOL (timolol)

GLAUCOMA AGENTS – PROSTAGLANDIN INHIBITORS

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
LATANAPROST (generic of Xalatan®)	TRAVATAN®Z (travoprost)	BIMATOPROST 0.03% LUMIGAN 0.01% (bimatoprost) TRAVAPROST VYZULTATM (latanoprostene bunod) XELPROSTM (LATANOPROST) ZIOPTAN® (tafluprost)

GLAUCOMA AGENTS – ALPHA ADRENERGIC AGONISTS/SYMPATHOMIMETICS

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
BRIMONIDINE 0.2% ALPHAGAN®P (brimonidine 0.15%)	ALPHAGAN® P (brimonidine 0.1%)	APRACLONIDINE 0.5% (generic of Iopidine®) BRIMONIDINE 0.15% (generic of Alphagan® P) IOPIDINE® 1% (apraclonidine)

GLAUCOMA AGENTS – CARBONIC ANHYDRASE INHIBITORS

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
DORZOLAMIDE (generic of Trusopt®)	AZOPT® (brinzolamide)	

GLAUCOMA AGENTS – COMBO BETA BLOCKER & ALPHA ADRENERGIC AGONIST

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
	COMBIGAN® (brimonidine/ timolol)	

GLAUCOMA AGENTS – COMBO BETA BLOCKER & CARBONIC ANHYDRASE INHIBITORS

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
DORZOLAMIDE/TIMOLOL (generic of Cosopt®)		COSOPT® PF (dorzolamide/timolol)

COMBO ALPHA-ADRENERGIC AGONIST AND CARBONIC ANHYDRASE INHIBITORS

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
SIMBRINZA™ (brinzolamide/ brimonidine)		

GLAUCOMA AGENTS – RHO KINASE INHIBITORS

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
		RHOPRESSA® (netarsudil)

GLAUCOMA AGENTS – RHO KINASE AND PROSTAGLANDIN INHIBITORS COMBINATIONS

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
		ROCKLATAN™ (netarsudil and latanoprost)

Ophthalmic Agents: NSAIDs

OPHTHALMIC NSAIDs

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
DICLOFENAC (generic of Voltaren®) FLURBIPROFEN (generic of Ocufen®) KETOROLAC (generic of Acular®, Acular LS®)	ACUVAIL® (ketorolac) BROMFENAC (generic of Bromday®, Xibrom®) BROMSITE™ (bromfenac) ILEVRO® (nepafenac) NEVANAC® (nepafenac) PROLENSA® (bromfenac)

Otic Agents: Antibacterial and Antibacterial/Steroid Combinations

OTIC AGENTS: ANTIBACTERIAL – STERIOD COMBINATION

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
CIPRO HC® suspension (ciprofloxacin with hydrocortisone) CIPRODEX® suspension (ciprofloxacin with dexamethasone) NEOMYCIN-POLYMYXIN B WITH HYDROCORTISONE solution (generic of Cortisporin® solution) NEOMYCIN-POLYMYXIN B WITH HYDROCORTISONE suspension (generic of Cortisporin® suspension)	COLY-MYCIN-S® suspension (neomycin and colistin with hydrocortisone) CORTISPORIN-TC® suspension (neomycin and colistin with hydrocortisone) OTOVEL® (ciprofloxacin with fluocinolone)

OTIC AGENTS: ANTIBACTERIAL

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
OFLOXACIN drops (generic of Floxin Otic®)	CIPROFLOXACIN (generic of Cetraxal®)

Respiratory Agents: Antihistamines – Second Generation

RESPIRATORY AGENTS: ANTIHISTAMINES: SECOND GENERATION

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
CETIRIZINE chewable (generic of Zyrtec®) (no PA required for age 6 or under) CETIRIZINE syrup (generic of Zyrtec®) (no PA required for age 6 or under) CETIRIZINE tablets (generic of Zyrtec®) LORATADINE rapid dissolve (generic of Claritin® Redi-tabs) LORATADINE syrup (generic of Claritin® Syrup) LORATADINE tablets (generic of Claritin®)	CETIRIZINE syrup (generic of Zyrtec®) (PA required for over age 6) CLARINEX® syrup (desloratadine) CLARITIN REDITABS® 5mg (loratadine) DESLORATADINE ODT (generic of Clarinex®) DESLORATADINE tablets, ODT (generic of Clarinex®) FEXOFENADINE tablets, suspension LEVOCETIRIZINE (generic of Xyzal®)

RESPIRATORY AGENTS: ANTIHISTAMINE/DECONGESTANT COMBO: SECOND GENERATION

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
CETIRIZINE/PSEUDOEPHEDRINE (generic of Zyrtec-D®) LORATADINE-D (generic of Claritin-D®)	CLARINEX-D 12, 24 HOUR® (desloratadine/ pseudoephedrine)

Respiratory Agents: Beta-Adrenergic Agonists – Inhaled, Short Acting

RESPIRATORY AGENTS: BETA-ADRENERGIC, SHORT-ACTING

Metered Dose Inhalers or Other Devices

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
ALBUTEROL HFA (authorized generics Proair®, Proventil®, Ventolin®) PROAIR RESPICLICK® (albuterol)	XOPENEX HFA® (levalbuterol)

RESPIRATORY AGENTS: BETA-ADRENERGIC, SHORT-ACTING NEBULIZERS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
ALBUTEROL (generic of Proventil®, Ventolin®) 0.083% Premixed nebulizers, 0.5% Concentrated Solution) ALBUTEROL 0.42mg/ml, 0.63mg/ml (generic of Accuneb®) (no PA required for ages 12 and under)	ALBUTEROL 0.42mg/ml, 0.63mg/ml (generic of Accuneb®) (PA required for over age 12) LEVALBUTEROL (generic of Xopenex®)

Respiratory Agents: Beta-Adrenergic Agonists – Inhaled, Long Acting

RESPIRATORY AGENTS: BETA-ADRENERGIC, LONG-ACTING (LABA), INHALERS

NO PA REQUIRED " PREFERRED"	PA REQUIRED "NON-PREFERRED"
SEREVENT DISKUS®(salmeterol)†	ARCAPTA NEOHALER® (indacaterol)† STRIVERDI RESPIMAT® (olodaterol)

†Denotes breath actuated inhaler

RESPIRATORY AGENTS: BETA-ADRENERGIC, LONG-ACTING (LABA), NEBULIZER SOLUTION

NO PA REQUIRED "	PA REQUIRED "NON-
	BROVANA□ (arformoterol) PERFOROMIST® (formoterol)

RESPIRATORY AGENTS: BETA-ADRENERGIC-STEROID COMBINATIONS (LABA/ICS)

NO PA REQUIRED " PREFERRED"	PA REQUIRED "NON-PREFERRED"
SALMETEROL/FLUTICASONE (generic of Advair Diskus®) † [Labeler 66993] DULERA® (formoterol/mometasone) SYMBICORT® (formoterol/budesonide)	ADVAIR® HFA (salmeterol/fluticasone) AIRDUOTM RESPICLICK® (fluticasone/salmeterol) † BREO® ELLIPTA® (fluticasone/vilanterol)† SALMETEROL/FLUTICASONE (generic of Advair Diskus®) † [All other labelers] WIXELA™ Inhub™ (salmeterol/fluticasone) †

†Denotes breath actuated inhaler

RESPIRATORY AGENTS: BETA-ADRENERGIC-MUSCARINIC COMBINATIONS (LABA/LAMA)

NO PA REQUIRED " PREFERRED"	PA REQUIRED "NON-PREFERRED"
BEVESPI AEROSPHERE□ (glycopyrrolate/ formoterol) † UTIBRON□ NEOHALER® (indacaterol and glycopyrrolate)†	ANORO□ ELLIPTA (umeclidinium/vilanterol)† STIOLTO□ (tiotropium/olodaterol)

†Denotes breath actuated inhaler

ANTI-INFLAMMATORY INTERLEUKIN RECEPTOR ANTAGONIST

STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
	DUPIXENT® (dupilumab)

Respiratory Agents: Chronic Obstructive Pulmonary Disease

RESPIRATORY AGENTS: COPD ANTICHOLINERGICS

NO PA REQUIRED " PREFERRED"	PA REQUIRED "NON-PREFERRED"
ATROVENT HFA® (ipratropium) COMBIVENT Respimat□ (ipratropium/albuterol) IPRATROPIUM nebulizer solution IPRATROPIUM/ALBUTEROL nebulizer solution (generic of Duoneb®) SPIRIVA® Handihaler® (tiotropium)† SPIRIVA® Respimat® (tiotropium)	INCRUSE ELLIPTA® (umeclidinium)† LONHALATM MAGNAIR™(glycopyrrolate) SEEBRI™ NEOHALER® (glycopyrrolate)† TUDORZA® (aclidinium bromide)† YUPELRI™ (revefenacin)

†Denotes breath actuated inhaler

RESPIRATORY AGENTS: COPD GLUCOCORTICOID-MUSCARINIC-BETA-ADRENERGIC COMBINATION

NO PA REQUIRED" PREFERRED"	PA REQUIRED "NON-PREFERRED"
	TRELEGY ELLIPTA (fluticasone, umeclidinium and vilanterol) †

†Denotes breath actuated inhaler

RESPIRATORY AGENTS: PHOSPHODISTERASE-4 INHIBITORS

NO PA REQUIRED" PREFERRED"	PA REQUIRED "NON-PEFERRED"
	DALIRESP® (roflumilast)

Respiratory Agents: Epinephrine Auto-Injectors

RESPIRATORY AGENTS: EPINEPHRINE AUTO-INJECTORS

NO PA REQUIRED " PREFERRED"	PA REQUIRED "NON-PREFERRED"
EPINEPHRINE manufactured by labeler 49502 (authorized generic of EpiPen®) SYMJEPITTM (epinephrine)	EPINEPHRINE not manufactured by labeler 49502 (generic of Adrenaclick®, EpiPen®) EPIPEN® (epinephrine) EPIPEN JR® (epinephrine)

Respiratory Agents: Glucocorticoid Agents – Inhaled

RESPIRATORY AGENTS: GLUCOCORTICOIDS – INHALED

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
ASMANEX® Twisthaler (mometasone) FLOVENT DISKUS®† and HFA (fluticasone) PULMICORT FLEXHALER® (budesonide)†	AEROSPAN® HFA (flunisolide) ALVESCO® (ciclesonide) ARMONAIRTM RESPICLICK® (fluticasone) † ARNUITY ELLIPTA® (fluticasone furoate)† ASMANEX® HFA (mometasone) QVAR® (beclomethasone)

†Denotes breath actuated inhaler

RESPIRATORY AGENTS: GLUCOCORTICOIDS – NEBULIZERS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
BUDESONIDE nebulizer solution (generic of Pulmicort®) (no PA required for age 6 or under)	BUDESONIDE nebulizer solution (generic of Pulmicort®) (PA required for over age 6)

Respiratory Agents: Hereditary Angioedema

RESPIRATORY AGENTS: HEREDITARY ANGIOEDEMA

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
HAEGARDA® (C1 esterase inhibitor, plasma derived) RUCONEST® (C1 esterase inhibitor, recombinant) TAKHZYRO™ (lanadelumab-flyo)	BERINERT® (C1 esterase inhibitor, plasma derived) CINRYZE® (C1 esterase inhibitor, plasma derived) ICATIBANT ACETATE (Generic for Firazyr®) KALBITOR® (ecallantide)

Respiratory Agents: Leukotriene Receptor Modifiers and Inhibitors

RESPIRATORY AGENTS: LEUKOTRIENE RECEPTOR ANTAGONISTS

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
MONTELUKAST tablets, chewable tablets, granules (generic of Singulair®)	ZAFIRLUKAST (generic of Accolate®)	ZILEUTON extended-release (generic of Zyflo CR®) ZYFLO® (zileuton)

Respiratory Agents: Nasal Preparations

RESPIRATORY AGENTS: NASAL PREPARATIONS - GLUCOCORTICOIDS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
FLUNISOLIDE FLONASE OTC® (fluticasone) FLUTICASONE (generic of Flonase®)	BECONASE®AQ (beclomethasone) BUDESONIDE (generic of Rhinocort Aqua®) DYMISTA® (fluticasone/azelastine) MOMETASONE (generic of Nasonex®) OMNARIS® (ciclesonide) QNASL® (beclomethasone) VERAMYST® (fluticasone furoate) XHANCETM (fluticasone) ZETONNA® (ciclesonide)

RESPIRATORY AGENTS: NASAL PREPARATIONS - ANTIHISTAMINES

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
AZELASTINE (generic of Astelin®, Astepro®) OLOPATADINE (generic of Patanase®)	

RESPIRATORY AGENTS: NASAL PREPARATIONS - ANTICHOLINERGICS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
IPRATROPIUM (generic of Atrovent®)	

Topical Agents: Acne Preparations

ANTIBIOTIC PRODUCTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
CLINDAMYCIN gel (generic of Cleocin T®, Clindamax®) CLINDAMYCIN lotion (generic of Cleocin T®, Clindamax®) CLINDAMYCIN solution (generic of Cleocin T®) ERYTHROMYCIN gel ERYTHROMYCIN solution (generic of A/T/S®, Akne-Mycin®)	CLINDACIN® Pak (clindamycin/skin cleanser kit) CLINDAMYCIN foam (generic of Evoclin®) CLINDAMYCIN pledgets (generic of Cleocin T®) ERYTHROMYCIN pads (generic of Ery Pads®)

ACNE PREPARATIONS – OTHER PRODUCTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
AZELEX® cream (azelaic acid)	ACZONE® gel (dapsone) FINACEA® gel (azelaic acid)

BENZOYL PEROXIDE AND COMBINATION PRODUCTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
CLINDAMYCIN-BENZOYL PEROXIDE gel (generic of Benzaclin®, Duac®) BENZOYL PEROXIDE cleanser 5%, 6% & 10% BENZOYL PEROXIDE gel 2.5%, 5%, 10% BPO (benzoyl peroxide) Gel 4% & 8% BENZOYL PEROXIDE wash (generic of Benzac AC ®, Benzac W®, Brevoxyl®, Desquam-X®, Pacnex®) ERYTHROMYCIN-BENZOYL PEROXIDE gel (generic of Benzamycin®) NEUAC® gel (clindamycin-benzoyl peroxide) PANOXYL® 10% foam, wash (benzoyl peroxide)	ACANYA® (clindamycin-benzoyl peroxide) BENZOYL PEROXIDE foam (generic of Benzefoam®) ONEXTON™ gel (clindamycin-benzoyl peroxide)

RETINOID AND COMBINATION PRODUCTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
DIFFERIN® cream, gel, lotion (adapalene) TAZORAC® cream, gel (tazarotene) TRETINOIN cream, gel (generic of Retin-A®) TRETINOIN micro gel (generic of Retin-A® micro)	ADAPALENE cream, gel (generic of Differin®) ALTRENOTM lotion (tretinoin) ATRALIN® gel (tretinoin) ADAPALENE/BENZOYL PEROXIDE gel (generic of EPIDUO®) FABIOR® foam (adapalene) PLIXDATM pad (adapalene) CLINDAMYCIN/TRETINOIN (generic of VELTIN®) ZIANA® gel (clindamycin/tretinoin)

ODIUM SULFACETAMIDE AND COMBINATION PRODUCTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
SODIUM SULFACETAMIDE lotion (generic of Klaron®) SODIUM SULFACETAMIDE-SULFUR wash (generic of Avar® cleanser, Clenia® foaming wash, Plexion® cleanser, Rosac® wash)	SODIUM SULFAETAMIDE pads (generic of AVAR, AVAR LS) OVACE PLUS® (sodium sulfacetamide) SODIUM SULFACETAMIDE-SULFUR cream, gel SULFACETAMIDE SODIUM-SULFUR topical suspension

Topical Agents: Anti-Fungals

TOPICAL AGENTS: ANTI-FUNGALS

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
CICLOPIROX cream, gel, topical suspension, shampoo (generic of Loprox®)	CICLOPIROX kit (generic of CNL® Nail lacquer kit)
CICLOPIROX solution (generic of Penlac®)	ERTACZO® (sertaconazole)
CLOTRIMAZOLE (generic of Lotrimin®)	EXELDERM® (sulconazole)
CLOTRIMAZOLE/BETAMETHASONE (generic of Lotrisone®)	JUBLIA® solution (efinaconazole)
ECONAZOLE (generic of Spectazole®)	KERYDIN® solution (tavaborole)
KETOCONAZOLE cream & shampoo (generic of Kuric®, Nizoral®)	KETOCONAZOLE foam(generic of Extina®)
MICONAZOLE	LUZU® (luliconazole)
NYSTATIN	MENTAX® (butenafine)
NYSTATIN/TRIAMCINOLONE	NAFTIFINE CREAM
TERBINAFINE (generic of Lamisil®)	NAFTIN® GEL (naftifine)
TOLNAFTATE (generic of Tinactin®)	OXICONAZOLE (generic of OXISTAT®)
	PEDIADERM AF® cream (nystatin)
	VUSION® ointment (miconazole/zinc)

Topical Agents: Anti-Parasitics

ANTI-PARASITICS, TREATMENT OF SCABIES

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
PERMETHRIN cream (generic of Elimite®)	EURAX® cream, lotion (crotamiton)

ANTI-PARASITICS, TREATMENT OF LICE

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
LICE kit [piperonyl butoxide-pyrethrins shampoo, comb, permethrin home spray] (generic of Rid® complete kit) NATROBA® (spinosad) PERMETHRIN lotion (generic of Nix® cream rinse) PIPERONYL BUTOXIDE-PYRETHRINS lotion PIPERONYL BUTOXIDE-PYRETHRINS shampoo (generic of Rid® shampoo)	MALATHION lotion (generic of Ovide®) SPINOSAD (generic of Natroba®) SKLICE® lotion (ivermectin)

Topical Agents: Corticosteroids

TOPICAL AGENTS: CORTICOSTEROIDS – LOW POTENCY

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
DESONIDE cream, ointment (generic of Desowen®) FLUOCINOLONE ACETONIDE 0.01% cream, solution (generic of Synalar®) FLUOCINOLONE body oil, scalp oil (generic of Derma-Smoothe/ FS®) HYDROCORTISONE cream, lotion, ointment	ALCLOMETASONE cream, ointment (generic of Aclovate®) CAPEX® shampoo (fluocinolone acetonide) DESONATE®gel (desonide) DESONIDE lotion (generic of Desowen®) HYDROCORTISONE ACETATE WITH ALOE gel HYDROCORTISONE WITH UREA cream (generic of Carmol HC®) PANDEL® cream (hydrocortisone probutate) PEDIADERM HC® kit

TOPICAL AGENTS: CORTICOSTEROIDS – MEDIUM POTENCY

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
BETAMETHASONE DIPROPIONATE-CALCIPOTRIENE Ointment BETAMETHASONE VALERATE cream, lotion (generic of Valisone®) FLUTICASONE PROPIONATE cream, ointment (generic of Cutivate®) MOMETASONE FUROATE cream, ointment, solution (generic of Elocon®) PREDNICARBATE cream (generic of Dermatop®) TRIAMCINOLONE ACETONIDE cream, ointment, lotion (generic of Aristocort®, Kenalog®)	BETAMETHASONE DIPROPIONATE lotion (generic of Diprolene®) CLOCORTOLONE PIVALATE (generic of Cloderm®) CORDRAN® tape (flurandrenolide) DESOXIMETASONE cream, gel, ointment (generic of Topicort®) FLUOCINOLONE ACETONIDE 0.025% cream, ointment (generic of Synalar®) FLUTICASONE PROPIONATE lotion (generic of Cutivate®) HYDROCORTISONE BUTYRATE cream, ointment, solution (generic of Locoid®) HYDROCORTISONE VALERATE cream, ointment (generic of Westcort®) LUXIQ® (betamethasone valerate foam) PREDNICARBATE ointment (generic of Dermatop®)

TOPICAL AGENTS: CORTICOSTEROIDS – HIGH POTENCY

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
AMCINONIDE ointment, cream, lotion BETAMETHASONE VALERATE ointment (generic of Valisone®) DIFLORASONE DIACETATE cream, ointment (generic of Florone®) FLUOCINONIDE cream, gel, ointment, solution (generic of Lidex®, Lidex-E®)	APEXICON-E® (diflorasone diacetate emollient base) cream BETAMETHASONE DIPROPIONATE cream, ointment (generic of Diprolene®) FLUOCINONIDE (generic of Vanos® cream) HALOG® cream, ointment (halcinonide) KENALOG® aerosol spray (triamcinolone acetonide) SERNIVOTM (betamethasone dipropionate spray)

TOPICAL AGENTS: CORTICOSTEROIDS – VERY HIGH POTENCY

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
CLOBETASOL PROPIONATE cream, foam, gel, lotion, ointment, spray, shampoo, solution (generic of Clobex®, Olux®, Temovate®)	BETAMETHASONE DIPROPIONATE AUGMENTED cream, ointment, lotion, gel (generic of Diprolene AF®) BRYHALITM (halobetasol propionate lotion) CLOBEX® lotion, shampoo,(clobetasol propionate) CLODAN® shampoo, kit (clobetasol propionate) HALOBETASOL PROPIONATE cream, ointment (generic of Ultravate®) LEXETTETM (halobetasol propionate foam) OLUX-E® foam (clobetasol propionate)

Topical Agents: Immunomodulators

TOPICAL IMMUNOMODULATORS

STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
PIMECROLIMUS (generic of Elidel®) * [Labeler 68682] PROTOPIC (tacrolimus)* *Pimecrolimus and tacrolimus have age restriction of 2 years or older	EUCRISA™ (crisaborole)* PIMECROLIMUS (generic of Elidel®) * [All other Labelers] TACROLIMUS (generic of Protopic®) *

ANTI-INFLAMMATORY INTERLEUKIN RECEPTOR ANTAGONIST

STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
	DUPIXENT® (dupilumab)