STANDARD FORMULARY EXCEPTION CRITERIA						
Therapy Class	**Brand Name**	**Chemical Name and Dosage Form**	**Commercial FE Criteria**	**Approval Duration**	**2020 NPF Excluded Medication**	**Grandfathering?**
Antipsychotics (Oral)	Abilify	aripiprazole tablets and oral solution	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Antipsychotics (Oral)	Abilify Discmelt	aripiprazole orally disintigrating tablets (ODT)	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Acne Vulgaris Agents (Topical)	Acanya Gel	benzoyl peroxide 2.5% and clindamycin phosphate 1.2% gel	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Proton Pump Inhibitors (PPIs)	Aciphex	rabeprazole sodium tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Proton Pump Inhibitors (PPIs)	Aciphex Sprinkle and authorized generic	rabeprazole sodium delayed-release capsules	Approve if the patient has tried five proton pump inhibitors (PPIs). **Note**: Examples of PPIs include rabeprazole delayed-release (DR) tablets (Aciphex, generics), Dexilant DR capsules, esomeprazole DR capsules (Nexium, generics), Nexium DR packet (granules for oral suspension), pantoprazole DR tablets (Protonix, generics), Protonix suspension (granules), lansoprazole orally dissolving tablets (Prevacid/Solutabs, generics), omeprazole DR capsules (Prilosec, generics), Prilosec DR suspension, omeprazole/sodium bicarbonate capsules (Zegerid, generics), or omeprazole/sodium bicarbonate packet (Zegerid, generics). **2.** Patients < 18 years of age OR patients who have difficulty swallowing tablets/capsules: Approve if the patient has tried two proton pump inhibitors (PPIs). **Note**: The requested agent would NOT count as a trial of an alternative. **Note**: If an approval is entered, it will be entered for the authorized generic.	1 year	Yes	
Ophthalmic Anti-Inflammatory Agents - NSAIDs	Acuvail	ketorolac tromethamine 0.45% preservative-free solution	**1.** Approve if the patient has tried two products from the following list (if two are formulary, or one of the following if one is formulary): diclofenac ophthalmic solution (generics), bromfenac 0.09% ophthalmic solution (generics), Prolensa, BromSite, Nevanac, Ilevro, or ketorolac ophthalmic solution (Acular, Acular LS, generics). If none are formulary, approve. **2.** Patients with a sulfite allergy: approve if the patient has tried two of the following, if two are formulary (or one if only one is formulary): BromSite, diclofenac ophthalmic solution (generics), Nevanac, Ilevro, or ketorolac ophthalmic solution (Acular, Acular LS, generics). If none are formulary, approve. **3.** Patients with a known sensitivity to a preservative (e.g., benzalkonium chloride [BAK]): approve if the patient has tried diclofenac ophthalmic solution (generics), if formulary. If diclofenac ophthalmic solution is non-formulary, approve.	1 year	Yes	
Pulmonary Arterial Hypertension (PAH) - Phosphodiesterase 5 Inhibitors	Adcirca	tadalafil tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Central Nervous System Stimulants and Non-Stimulants	Adderall	dextroamphetamine/amphetamine tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Diabetes Agents - Glucagon-Like Peptide-1 (GLP-1) Agonists	Adlyxin	lixisenatide injection	**1.** Approve if the patient has tried two formulary alternatives from the following list (or one if only one is formulary): Trulicity, Byetta, Bydureon/Bydureon BCise, Ozempic, or Victoza **[documentation required]**. If none are formulary, approve. **NOTE:** Bydureon vial, Bydureon BCise, Bydureon Pen count as one alternative. **2.** Patients with a personal or family history of medullary thyroid carcinoma or in patients with Multiple Endocrine Neoplasia syndrome type 2 (MEN 2): approve if the patient has tried Byetta **[documentation required]**, if formulary. If Byetta is non-formulary, approve.	1 year	Yes	
Diabetes Agents - Insulin (Rapid-Acting and Other)	Admelog	insulin lispro vial, SoloStar (prefilled pen)	Approve if the patient has tried two formulary alternatives from the following list (or one if only one is formulary): Apidra, Insulin Lispro (authorized generic)/Humalog, Fiasp, or NovoLog/Insulin Aspart (authorized generic). If none are formulary, approve. **Note**: Insulin Lispro vial, Insulin Lispro Kwikpen, Humalog vial, Humalog cartridge, Humalog Kwikpen, Humalog JR would all count as one alternative. Apidra vial, Apidra SoloStar would both count as one alternative. Fiasp vial, Fiasp Flextouch, Fiasp penfill would all count as one alternative. NovoLog vial, NovoLog cartridge, NovoLog Flexpen, Insulin Aspart vial, Insulin Aspart cartridge, Insulin Aspart pen would all count as one alternative.	1 year	Yes	
Central Nervous System Stimulants and Non-Stimulants	Adzenys XR suspension and authorized generic	amphetamine extended-release oral suspension	Approve if the patient has tried three of the following central nervous system (CNS) stimulants, if three are formulary (or two if two are formulary, or one if one is formulary): Dyanavel XR oral suspension; Vyvanse capsules or chewable tablets; Adderall XR and generics; Mydayis XR; or Adzenys XR - ODT. If none are formulary, approve. **Note**: Vyvanse capsule and Vyvanse chewable tablets would count as one alternative. Adderall XR and generics for Adderall XR would count as one alternative.	1 year	Yes - Authorized generic only	

Antiplatelet Agents	Aggrenox	aspririn- dipyridamole extended-release capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Antiemetics - Serotonin Receptor Antagonists (Oral and Inejctable)	Akynzeo	netupitant/palonsetron capsules	**1.** Approve if the patient has tried one formulary 5-HT3 receptor antagonist from the following list: ondansetron (Zofran, generics), granisetron (generics), Sancuso, Anzemet tablets, palonosetron (Aloxi, generics) AND one of aprepitant capsules (Emend, generics) or Varubi tablets, if one is formulary. If none are formulary, approve. **2.** Approve if the patient has already started Akynzeo to complete all cycles in the current course of chemotherapy.	1 year	Yes	
Short-Acting Beta-Agonists (Inhaled)	albuterol HFA inhaler	albuterol sulfate inhalation aerosol (authorized generic to Ventolin HFA)	**1.** Patient is directed to use Ventolin HFA (brand). If Ventolin HFA (brand) is non-formulary, approve if the patient has tried one product from the following list, if formulary: albuterol HFA (ProAir HFA, generics), albuterol HFA (Proventil HFA, generics), ProAir Respiclick, ProAir Digihaler, Xopenex HFA, or levalbuterol HFA inhaler. If none are formulary, approve. **2.** Patients < 12 years of age or patients who have a low inspiratory flow rate and are unable to use a dry powder inhaler (DPI): Patient is directed to use Ventolin HFA (brand). If Ventolin HFA (brand) is non-formulary, approve if the patient has tried one product from the following list, if formulary: albuterol HFA (ProAir HFA, generics), albuterol HFA (Proventil HFA, generics), Xopenex HFA, or levalbuterol HFA inhaler. If none are formulary, approve.	1 year	Yes	
Topical Dermatological Drugs - Miscellaneous	Alcortin A	hydrocortisone 2%/ iodoquinol 1%/ aloe 1% gel	Approve if the patient has tried three single-entity corticosteroid topical agents (e.g., hydrocortisone cream/lotion/ointment [multiple brand and generic products], betamethasone cream/ointment/lotion [Diprolene, generics], clobetasol cream/gel/lotion [Temovate, Clobex, generics], fluocinolone ointment/cream [Synalar, generics], fluocinonide cream/ointment/gel [generics], mometasone cream/lotion/ointment [Elocon, generics], triamcinolone cream/ointment/lotion [generics]) AND one prescription topical anti-infective agent (e.g., mupirocin 2% cream [Bactroban, generics], mupirocin 2% ointment [Bactroban, generics], Centany ointment, Centany AT ointment, Altabax ointment).	1 year	Yes	
Cancer Agents - ALK Positive NSCLC (Oral)	Alcensa	alectinib capsules	Approve if the patient has anaplastic lymphoma kinase (ALK)-positive Non-Small Cell Lung Cancer (NSCLC).	1 year	Yes	
Ophthalmic Anti-Allergics	Alocril	nedocromil sodium 2% ophthalmic solution	Approve if the patient has tried three products from the following list (if three are formulary; or two if two are formulary; or one if one is formulary): Alomide, cromolyn sodium 4% solution (generics), azelastine 0.05% solution (generics), Bepreve, epinastine 0.05% solution (Elestat, generics), ketotifen 0.025 % solution (Zaditor, Alaway, generics [OTC]), Lastacaft, olopatadine 0.2% solution (Pataday, generics), olopatadine 0.1% solution (Patanol, generics), Pazeo, or Zerviate. If none are formulary, approve.	1 year	Yes	
Diabetes Agents - Dipeptidyl Peptidase-4 (DPP-4) Inhibitor Combination Products	alogliptin and metformin tablets	alogliptin and metformin tablets (authorized generic of Kazano)	Approve if the patient has tried three metformin-DPP-4 inhibitor combination products from the following list (if three are formulary, or two if two are formulary, or one if one is formulary): Janumet, Janumet XR, Jentadueto, Jentadueto XR, Kombiglyze XR. If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics) AND two of the following, if two are formulary (or one if only one is formulary): Onglyza, alogliptin (Nesina, generics), Tradjenta, or Januvia. If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics). Note: Janumet and Janumet XR would count as one alternative. Jentadueto and Jentadueto XR would count as one alternative.	1 year	Yes	
Diabetes Agents - Dipeptidyl Peptidase-4 (DPP-4) Inhibitor Combination Products	alogliptin and pioglitazone tablets	alogliptin and pioglitazone tablets (authorized generic of Oseni)	Approve if the patient has tried pioglitazone (Actos, generics) AND two of the following, if two are formulary (or one if only one is formulary): Onglyza, alogliptin (Nesina, generics), Tradjenta, or Januvia. If none are formulary, approve if the patient has tried pioglitazone (Actos, generics). **NOTE:** A trial of Oseni or the alogliptin and pioglitazone combination tablets (authorized generics) would not count toward this requirement.	1 year	Yes	
Ophthalmic Anti-Allergics	Alomide	lodoxamide tromethamine 0.1% ophthalmic solution	**1.** Approve if the patient has tried three products from the following list (if three are formulary; or two if two are formulary; or one if one is formulary): Alocril, cromolyn sodium 4% solution (generics), azelastine 0.05% solution (generics), Bepreve, epinastine 0.05% solution (Elestat, generics), ketotifen 0.025 % solution (Zaditor, Alaway, generics [OTC]), Lastacaft, olopatadine 0.2% solution (Pataday, generics), olopatadine 0.1% solution (Patanol, generics), Pazeo, or Zerviate. If none are formulary, approve. **2.** For a diagnosis of vernal keratoconjunctivitis, vernal conjunctivitis, and vernal keratitis, approve if the patient has tried cromolyn sodium 4% solution (generics). If cromolyn sodium 4% solution (generic) is non-formulary, approve.	1 year	Yes	
HMG-CoA Reductase Inhibitors and Combination Products	Altoprev	lovastatin extended-release tablets	Approve if the patient has tried three statins from the following list (or two if only two are formulary, or one if only one is formulary): atorvastatin {Lipitor, generics}, rosuvastatin {Crestor, generics}, fluvastatin, {Lescol/XL, generics}, pitavastatin {Livalo, Nikita, Zypitamag}, pravastatin {Pravachol}, or simvastatin {Zocor, generics}. If none are formulary, approve.	1 year	Yes	
Sedative-Hypnotics and Related Agents	Ambien	zolpidem tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Sedative-Hypnotics and Related Agents	Ambien CR	zolipidem extended-release tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Multiple Sclerosis Drugs (Oral)	Ampyra	dalfampridine extended-release tablets	NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. See Ampyra FE MSB criteria	1 year	MSB Exclusion *This criteria applies only to the NPF	
Direct Muscle Relaxants	Amrix and generic	cyclobenzaprine extended-release 15 mg and 30 mg capsule	Approve if the patient has tried and cannot take cyclobenzaprine 5 mg or 10 mg tablets (generics), if formulary. If cyclobenzaprine 5 mg or 10 mg tablets (generics) are non-formulary, approve.	1 year	Yes	

Testosterone Products (Topical)	Androgel	testosterone 1% gel packets and pump	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Corticosteroids (Topical)	Anusol-HC	hydrocortisone acetate cream	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Corticosteroids (Topical)	Anusol-HC	hydrocortisone acetate suppository	Approve if the patient has tried hydrocortisone acetate suppositories. If hydrocortisone acetate suppositories are non-formulary, approve.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Opioids (Oral) - Other	Apadaz and authorized generic	benzhydrocodone and acetaminophen tablets	Approve if the patient has tried two other hydrocodone/acetaminophen containing products (e.g., Vicodin, Vicodin ES, Norco, Lortab, Lorcet, multiple generics).	1 month	Yes	
Diabetes Agents - Insulin (Rapid-Acting and Other)	Apidra	insulin glulisine vial/Solostar (prefilled pen)	Approve if the patient has tried two formulary alternatives from the following list (or one if only one is formulary): Insulin Lispro (authorized generic)/Humalog, Admelog, NovoLog/Insulin Aspart (authorized generic), or Fiasp. If none are formulary, approve. **Note**: Insulin Lispro vial, Insulin Lispro Kwikpen, Humalog vial, Humalog cartridge, Humalog Kwikpen, Humalog JR would all count as one alternative. Admelog vial, Admelog Solostar would both count as one alternative. Fiasp vial, Fiasp Flextouch, Fiasp penfill would all count as one alternative. NovoLog vial, NovoLog cartridge, NovoLog Flexpen, Insulin Aspart vial, Insulin Aspart cartridge, Insulin Aspart pen would all count as one alternative.	1 year	Yes	
Erythroid Stimulants (ESAs)	Aranesp	darbepoetin alfa	Approve if the patient has tried one product from the following list: Epogen, Procrit or Retacrit **[documentation required]**, if one is formulary. If none are formulary, approve.	1 year	Yes	
Aromatase inhibitor	Arimidex	anastrozole tablets	**NOTE**: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria**: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Inflammatory Bowel Agents	Asacol HD	mesalamine 800 mg delayed release tablet	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Angiotensin Receptor Blockers (ARBs) and Combination Products	Atacand	candesartan cilexetil tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Angiotensin Receptor Blockers (ARBs) and Combination Products	Atacand HCT	candesartan/hydrochlorothiazide tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Acne Vulgaris Agents (Topical)	Atralin	tretinoin gel (0.05%)	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Human Immunodeficiency Virus (HIV-1) - Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTI)-Based Combination Products	Atripla	efavirenz 600 mg, emtricitabine 200 mg, tenofovir disoproxil fumarate 300 mg tablets	**1.** Approve if the patient has tried one of the following products: Biktarvy, Genvoya, Odefsey, Stribild, Complera, Triumeq, Symtuza, Symfi or Symfi Lo **[documentation required]**, if formulary. If none are formulary, approve. 2. Approve if the patient is currently taking single-entity or combination products containing efavirenz, emtricitabine, and tenofovir disoproxil fumarate and is requesting Atripla for a single tablet regimen. 3. Patients already started on therapy with Atripla, approve.	1 year	Yes	Yes
Multiple Sclerosis Drugs (Oral)	Aubagio	teriflunomide tablets	**1.** Approve if the patient has tried two of the following (if two are formulary or one if one is formulary): Gilenya, Zeposia, Tecfidera, Vumerity, or Mayzent **[documentation required]**. If none are formulary, approve. **Note**: Fumarate-based products (Tecfidera and Vumerity) count as one alternative. If only fumarate-based products are formulary, only one has to be tried. **2.** For patients with an underlying cardiovascular condition (e.g., heart failure, myocardial infarction, stroke, transient ischemic attack, unstable angina, atrioventricular [AV] block, cardiac arrhythmias, bradyarrhythmias), approve if the patient has tried one other oral disease-modifying therapy (e.g., Tecfidera, Vumerity) **[documentation required]**. **3.** Approve if the patient has been established on Aubagio for greater than or equal to 120 days.	1 year	Yes	Yes
Epinephrine Self-Administered Injectables	Auvi-Q	epinephrine 0.15 mg and 0.3 mg auto-injector	**1.** Approve if the patient has tried and could not appropriately administer one product from the following list, if formulary: epinephrine auto-injector (EpiPen/EpiPen Jr., generics). If none are formulary, approve. **2.** Approve if the patient or his/her caregiver is blind or significantly visually-impaired.	1 year	Yes	

Epinephrine Self-Administered Injectables	Auvi-Q	epinephrine 0.1 mg auto-injector	**1.** Approve if the patient has tried and could not appropriately administer one product from the following list, if formulary: epinephrine auto-injector (EpiPen/EpiPen Jr., generics). If none are formulary, approve. **2.** Approve if the patient or his/her caregiver is blind or significantly visually-impaired. **3.** Patient weighs less than 33 pounds (15 kg): approve.	1 year	Yes	
Angiotensin Receptor Blockers (ARBs) and Combination Products	Avalide	irbesartan/hydrochlorothiazide tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Angiotensin Receptor Blockers (ARBs) and Combination Products	Avapro	irbesartan tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Cancer Agents - Bevacizumab-containing Agents	Avastin	bevacizumab injection for intravenous use	**1.** Approve if the patient has tried Mvasi or Zirabev, if formulary. If neither are formulary, approve. **2.** If the patient has already been started on therapy with Avastin, approve.	1 year	Yes	Yes
Testosterone Products (Injectable)	Aveed	testosterone undecanoate for intramuscular use	Approve if the patient has tried one of the following injectable testosterone products, if one is formulary: testosterone enanthate injection [generics], testosterone cypionate injection [Depo-Testosterone, generics], or Xyosted. If none are formulary, approve.	1 year	Yes	
Benign Prostatic Hyperplasia (Alpha Blockers and 5-Alpha Reductase Inhibitors)	Avodart	dutasteride capsules	**NOTE**: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria**: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Angiotensin Receptor Blockers (ARBs) and Combination Products	AZOR	amlodipine besylate/olmesartan medoxomil tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Hepatitis B Agents	Baraclude tablets	entecavir tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Nasal Steroids	Beconase AQ	beclomethasone nasal spray	Approve if the patient has tried three other nasal steroids. **NOTE:** Examples include: fluticasone nasal spray (prescription or over-the-counter [OTC]), mometasone nasal spray (Nasonex, generics), triamcinolone nasal spray (prescription or OTC), flunisolide nasal spray (generics), Omnaris, Qnasl, budesonide nasal spray (prescription or OTC), or Zetonna.	1 year	Yes	
Angiotensin Receptor Blockers (ARBs) and Combination Products	Benicar	olmesartan medoxomil tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Angiotensin Receptor Blockers (ARBs) and Combination Products	Benicar HCT	olmesartan/hydrochlorothiazide tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Hereditary Angioedema Products	Berinert	C1 esterase inhibitor [human] powder for intravenous injection	See Hereditary Angioedema Medications - Berinert FE	1 year	Yes	
Selective Serotonin Reuptake Inhibitors (SSRIs)	Brisdelle	paroxetine capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	

Respiratory - Corticosteroid/Long-Acting Beta-Agonist Combination Inhalers	budesonide-formoterol (authorized generic of Symbicort)	budesonide-formoterol (inhalation aerosol)	**1.** The patient is directed to use Symbicort (brand), if formulary. If Symbicort (brand) is non-formulary, approve if the patient has tried two of the following, if two are formulary (or one if only one is formulary): Advair HFA, fluticasone proprionate/salmeterol inhalation powder, Wixela (Advair Diskus, generics), fluticasone propionate/salmeterol multidose dry powder inhaler (AirDuo RespiClick, authorized generics), Breo Ellipta, or Dulera. If none are formulary, approve. **2.** Patients < 18 years of age: approve if the patient has tried two of the following, if two are formulary (or one if only one is formulary): Advair HFA, fluticasone propionate/salmeterol multidose dry powder inhaler (AirDuo RespiClick, authorized generics), Dulera, or fluticasone proprionate/salmeterol inhalation powder, Wixela (Advair Diskus, generics). If none are formulary, approve. **3.** Patients < 12 years of age: approve if the patient has tried one of the following (if one is formulary): fluticasone proprionate/salmeterol inhalation powder, Wixela (Advair Diskus, generics) or Dulera. If none are non-formulary, approve. **4.** Patients < 12 years of age with a low inspiratory flow rate who are unable to use a dry powder inhaler (DPI): approve if the patient has tried Dulera, if formulary. If Dulera is non-formulary, approve. **5.** Patients with a low inspiratory flow rate who are unable to use a dry powder inhaler (DPI): approve if the patient has tried both Advair HFA and Dulera, if both are formulary (or one if only one is formulary). If neither are formulary, approve. **6.** Patients with COPD: Approve if the patient has tried both fluticasone proprionate/salmeterol inhalation powder, Wixela (Advair Diskus, generics) and Breo Ellipta, if both are formulary (or one if only one is formulary). If none are formulary, approve. **7.** Patients with COPD AND a low inspiratory flow rate who are unable to use a dry-powder inhaler (DPI): approve.	1 year	Yes	
Analgesics - Butalbital-Containing Products	Bupap tablet	butalbital 50 mg, acetaminophen 300 mg tablet	Approve if the patient has tried one other formulary butalbital-containing product, if one is formulary (e.g., butalbital/acetaminophen tablet, butalbital/acetaminophen/caffeine capsule or tablet, butalbital/ acetaminophen/caffeine/codeine capsule, butalbital/aspirin/caffeine capsule or tablet, butalbital/aspirin/caffeine/codeine capsule). If none are formulary, approve.	1 year	Yes	
Long-Acting Opioids (Transdermal)	Butrans	buprenorphine transdermal system	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Antipsychotics (Oral)	Caplyta	lumateperone capsules	**1.** Approve if the patient has tried three oral antipsychotic agents (e.g., risperidone tablets/orally disintegrating tablets [ODT]/solution [Risperdal, generics], olanzapine tablets/ODT [Zyprexa/Zydis, generics], quetiapine tablets [Seroquel, generics], quetiapine extended-release tablets [Seroquel XR, generics], aripiprazole tablets [Abilify, generics], ziprasidone capsules [Geodon, generics], Fanapt tablets, Latuda tablets, Rexulti tablets, Vraylar capsules, or Saphris sublingual tablets, paliperidone ER tablets [Invega, generics]). **2.** Approve if the patient is currently taking Caplyta. **3.** Approve if the patient has taken Caplyta at any time in the past.	1 year	Yes	Yes
Actinic Keratosis Agents (Topical)	Carac and authorized generic 0.5%	fluorouracil 0.5% cream	Approve if the patient has tried one of the following products, if formulary: Tolak, Fluoroplex, fluorouracil 2% solution, fluorouracil 5% solution, or fluorouracil 5% cream (Efudex, generics). If none are formulary, approve.	1 year	Yes	
NSAIDS (Cox2)	Celebrex	celecoxib capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Selective Serotonin Reuptake Inhibitors (SSRIs)	Celexa	citalopram tablets	**NOTE**: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria**: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Otic Antibiotics and Combination Products	Cetraxal	ciprofloxacin 0.2% otic solution	Approve if the patient has tried one of the following, if one is formulary: ofloxacin otic solution (generics) or ciprofloxacin 0.2% otic solution (generic). If none are formulary, approve.	1 year	Yes	
Human Chorionic Gonadotropin, HCG Agents	chorionic gonadotropin	chorionic gonadotropin 10,000 unit powder for intramuscular injection	**1.** Approve if the patient has tried one product from the following list (if one is formulary): Pregnyl, Novarel or Ovidrel. If none are formulary, approve. **2.** For a diagnosis of cryptorchidism or hypogonadism, approve if the patient has tried Pregnyl or Novarel, if formulary. If neither are formulary, approve. **3.** For a diagnosis related to infertility or induction of ovulation, approve a one-time fill if the patient may be at risk of missing the optimal administration timeframe window of the product (in order to avoid disruption of the current fertility medication cycle).	1 year	Yes	
Erectile Dysfunction Agents - Phosphodiesterase Type 5 (PDE-5) Inhibitors	Cialis	tadalafil tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Inflammatory Conditions – SC TNF Antagonists	Cimzia	certolizumab powder for injection	See Inflammatory Conditions - Cimzia FE	Up to 1 year	Yes	Yes
Immunological Agents	Cinqair	reslizumab for intravenous injection	1. Approve if the patient has tried one formulary alternative from the following list: Nucala or Fasenra. If neither is formulary, approve if the patient has tried Dupixent. If Dupixent is non-formulary, approve. 2. Approve if the patient has already been started on therapy with Cinqair.	1 year	Yes	Yes

Otic Antibiotics and Combination Products	ciprofloxacin/ fluocinolone otic solution (authorized generic to Otovel)	ciprofloxacin and fluocinolone acetonide otic solution, 0.3%/0.025%	**1.** Approve if the patient has tried Otovel, if formulary. If Otovel is non-formulary, approve if the patient has tried Ciprodex otic suspension or Cipro HC otic suspenstion (if one is formulary). If none are formulary, approve. **2.** Patients treating acute otitis media through tympanostomy tubes (AOMT), patients with a perforated ear drum (tympanic membrane), or patients < 1 year of age: approve if the patient has tried Otovel or Ciprodex otic suspension, if one is formulary. If neither are formulary, approve. **3.** Patient has a known hypersensitity to a preservative (e.g., benzalkonium chloride [BAK], benzyl alcohol), approve if the patient has tried Otovel, if formulary. If Otovel is non-formulary, approve.	1 year	Yes	
Estrogen and Estrogen Combination Products (Topical)	Climara Pro	estradiol/ levonorgestrel patch	Approve if the patient has tried CombiPatch, if formulary. If CombiPatch is non-formulary, approve if the patient has tried one oral estrogen/progestin combination product (e.g., estradiol/norethindrone [Activella, generics], Prempro, Premphase, ethinyl estradiol/norethindrone acetate [Femhrt, generics], Prefest, Angeliq).	1 year	Yes	
Acne Vulgaris Agents (Topical)	Clindagel 1% gel and authorized generic	clindamycin 1% gel	Approve if the patient has tried topical clindamycin phosphate gel AND topical erythromycin gel.	1 year	Yes	
Corticosteroids (Topical)	Cloderm cream (and authorized generic)	clocortolone pivalate 0.1% cream	Approve if the patient has tried two generic prescription-strength topical corticosteroid products (e.g., betamethasone valerate, fluocinolone acetonide, triamcinolone acetonide). **NOTE:** The two products must be chemically unique (i.e., a trial of betamethasone 0.1% and 0.05% would NOT fulfill the requirement).	1 year	Yes - Authorized generic only	
Gout Medications	colchicine capsules	colchicine capsules	Approve if the patient has tried one product from the following list: colchicine tablets (Colcrys, generics), Mitigare capsules, or Gloperba oral solution, if one is formulary. If none are formulary, approve.	1 year	Yes	
Human Immunodeficiency Virus (HIV-1) - Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTI)-Based Combination Products	Complera	emtricitabline/rilpivirine /tenofovir disoproxil fumarate (TDF) tablets	**1.** Approve if the patient has tried Odefsey, if formulary. If Odefsey is non-formulary, approve if the patient has tried one of the following products: Biktarvy, Genvoya, Stribild, Triumeq, Symtuza, Atripa, Symfi or Symfi Lo, if formulary. If none are formulary, approve. **2.** Approve if the patient is currently taking single-entity or combination products containing emtricitabine, rilpivirine, and tenofovir disoproxil fumarate and is requesting Complera for a single-table regimen. **3.** Patients already started on therapy with Complera: approve.	1 year	Yes	Yes
Alpha and beta-blocker	Coreg	carvedilol tablet	NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Corticosteroids (Rectal Formulations)	Cortifoam	hydrocortisone acetate aerosol foam	**1.** Approve if the patient has tried Uceris foam, if formulary. If Uceris foam is non-formulary, approve if the patient has tried one corticosteroid enema from the following list (if one is formulary): Colocort enema, Cortenema or hydrocortisone enema.. If none are formulary, approve. **2.** Patients who are unable to retain a corticosteroid enema: approve if the patient has tried Uceris, if formulary. If Uceris non-formulary, approve.	1 year	Yes	
Ophthalmic Drugs for Glaucoma - Carbonic Anhydrase Inhibitor/Beta-Adrenergic Blocker	Cosopt	dorzolamide 2%/timolol 0.5% ophthalmic solution	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Angiotensin Receptor Blockers (ARBs) and Combination Products	Cozaar	losartan tablet	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
HMG-CoA Reductase Inhibitors and Combination Products	Crestor	rosuvastatin tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Wilson's Disease Agents	Cuprimine	penicillamine capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Serotonin and Norepinephrine Reuptake Inhibitors (SNRIs)	Cymbalta	duloxetine HCl capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Thyroid Supplements	Cytomel	liothyronine sodium tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	

Human Immunodeficiency Virus (HIV-1) - Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTI)-Based Combination Products	Delstrigo	doravirine/lamivudine/tenofovir disoproxil fumarate tablets	**1.** Approve if the patient has tried one of the following products: Biktarvy, Genvoya, Odefsey, Stribild, Complera, Triumeq, Symtuza, Symfi or Symfi Lo, if formulary. If none are formulary, approve. **2.** Approve if the patient is currently taking single-entity or combination products containing doravirine, lamivudine, and tenofovir disoproxil fumarate and is requesting Delstrigo for a single tablet regimen. **3.** Patients already started on therapy with Delstrigo, approve.	1 year	Yes	Yes
Inflammatory Bowel Agents	Delzicol	mesalamine delayed-release capsule	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Overactive Bladder Agents (Oral and Topical)	Detrol	tolterodine tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Overactive Bladder Agents (Oral and Topical)	Detrol LA	tolterodine, extended-release capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Diabetic Supplies	Diabetic Supplies	Blood glucose meters/test strips/control solutions/continuous glucose monitoring products	**1.** Approve if the patient has tried one formulary meter/test strip/control solution (e.g. Freestyle, One Touch, Verio, Verio Flex, Precision, Accu-Check, Breeze, Contour, Truetest, Truetrack). If none are formulary, approve. Note: This is not an all-inclusive list of blood glucose meters/test strips/control solutions. Note: A TRIAL OF THE REQUESTED PRODUCT WOULD NOT COUNT TOWARD THIS REQUIREMENT. **2.** If requesting a continuous glucose monitoring (CGM) monitor/receiver or supplies (sensor, transmitter), approve if the patient has tried one formulary CGM product (e.g., Freestyle Libre, Dexcom, Eversense). If no CGMs are formulary, approve if the patient has tried one traditional formulary meter/test strip/control solution. If none are formulary, approve. Note: This is not an all-inclusive list of continuous glucose monitoring products. Note: A TRIAL OF THE REQUESTED PRODUCT WOULD NOT COUNT TOWARD THIS REQUIREMENT. **3.** Patients who are blind or significantly visually impaired who are requesting a meter with audio capabilities: approve if the patient has tried one other formulary meter with audio capabilities (e.g., Advocate [Redi-Code], Arkray [Glucocard Expression, Glucocard Shine Express], Foracare [Fora D40D, Fora D40G, For a Premium V10 BLE, Fora Test N' Go, For a Tn'G Voice, Fora V30], Oak Tree Health [EasyMax V, Fortiscare V3], Omnis Health [Embrace Talk], Prodigy [Prodigy Autocode, Prodigy Voice], Relion Premier Voice). If none are formulary, approve. Note: This is not an all-inclusive list of blood glucose meters with audio capabilities. Note: A TRIAL OF THE REQUESTED PRODUCT WOULD NOT COUNT TOWARD THIS REQUIREMENT. **4.** Patients using an insulin pump/meter system that is not compatible with one of the available formulary alternatives: approve. **5.** If the request is for Freestyle Precision Neo strips for use in a Freestyle Libre reader, approve.	3 years	Yes - certain diabetic supplies	
NSAIDs (Topical)	diclofenac epolamine 1.3% topical patch (authorized generic of Flector Patch)	diclofenac epolamine 1.3% topical patch	Direct the patient to use Flector patch (brand). If Flector patch (brand) is non-formulary, approve if the patient has tried two products from the following list (if two are formulary or one if one is formulary): Licart 1.3% topical system, Pennsaid 2.0% topical solution (pump), diclofenac sodium 1.5% topical solution (generics), or prescription diclofenac sodium topical 1% gel (Voltaren 1% gel, generics), if one is formulary. If none are formulary, approve if the patient has tried over-the-counter Voltaren 1% gel.	1 year	Yes	
Angiotensin Receptor Blockers (ARBs) and Combination Products	Diovan	valsartan tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Angiotensin Receptor Blockers (ARBs) and Combination Products	Diovan HCT	valsartan/hydrochlorothiazide tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Inflammatory Bowel Agents	Dipentum	olsalazine capsule	Approve if the patient has tried two products from the following list (if two are formulary, or one if one is formulary): mesalamine delayed-release tablets (Asacol HD, generics), sulfasalazine (generics), mesalamine delayed-release tablets (Lialda, generics), Delzicol, balsalazide (Colazal, generics), mesalamine extended-release capsules (Apriso, generics) or Pentasa. If none are formulary, approve.	1 year	Yes	
Benzodiazepines and Combination Products	Doral and authorized generic	quazepam tablets	Approve if the patient has tried estazolam or lorazepam, if formulary. If neither are formulary, approve.	1 year	Yes -brand only	
Oral Agents for Rosacea	doxycycline 40 mg capsules (authorized generic of Oracea)	doxycycline 40 mg capsules	Approve if the patient has tried one other formulary oral doxycycline product. **NOTE:** A trial of the requested product does not count toward the requirement.	1 year	Yes	

Serotonin and Norepinephrine Reuptake Inhibitors (SNRIs)	Drizalma Sprinkle	duloxetine delayed-release capsules	**1.** Approve if the patient has tried one product from the following list (if one is formulary): duloxetine capsules (Cymbalta, generics), Fetzima, desvenlafaxine succinate extended-release (ER) [Pristiq, generics], Khedezla ER, venlafaxine ER capsules (Effexor XR, generics), or venlafaxine extended-release tablets. If none are formulary, approve. **2.** Approve if the patient is unable to swallow, has difficulty swallowing, or requires administration via a nasogastric tube.	1 year	Yes	
Long-Acting Muscarinic Antagonist (LAMA)/Long-Acting Beta-Agonist (LABA) Combination Inhalers	Duaklir Pressair	aclidinium bromide and formoterol fumarate inhalation powder	Approve if the patient has tried one of Anoro Ellipta, Bevespi Aerosphere, or Stiolto Respimat, if one is formulary. If none are formulary, approve if the patient has tried one formulary single-entity long-acting beta-agonist (LABA) inhaler: Serevent Diskus or Striverdi Respimat AND one formulary single-entity long-acting muscarinic antagonist (LAMA) inhaler: Incruse Ellipta, Spiriva HandiHaler, Spiriva Respimat, or Tudorza Ressair. If there are no formulary single-entity LABAs, approve. If there are no formulary single-entity LAMAs, approve.	1 year	Yes	
Hyaluronic Acid Derivatives	Durolane	hyaluronic acid intraarticular injection	**1.** Approve if the patient has tried five formulary intra-articular hyaluronic acid products from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Euflexxa, Gel-One, Gel-Syn, GenVisc 850, Hyalgan, Monovisc, Orthovisc, Supartz FX, Synvisc, Synvisc-One, Hymovis, Visco-3, Sodium hyaluronate (formerly Synojoynt), Triluron, or Trivisc **[documentation required]**. If none are formulary, approve Durolane. **2.** Patient has a known allergy to avian or avian-derived products (e.g., eggs, feathers): approve if the patient has tried five formulary products from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Euflexxa, Orthovisc, Monovisc, Hymovis, Gel-Syn, GenVisc 850, Sodium hyaluronate (formerly Synojoynt), or Trivisc **[documentation required]**. If none are formulary, approve Durolane.	1 year	Yes	
Beta-Blocker and Beta-Blocker Combination Products	Dutoprol and authorized generic	metoprolol succinate extended-release/HCTZ tablets	1. Approve if the patient has tried a metoprolol-HCTZ (immediate-release) tablets. **2.** Approve if the patient has tried metoprolol succinate extended-release tablets (Toprol XL, generics) AND hydrochlorothiazide (HCTZ).	1 year	Yes- brand only	
Serotonin and Norepinephrine Reuptake Inhibitors (SNRIs)	Effexor XR	venlafaxine HCl extended-release capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Topical Agents for Atopic Dermatitis	Elidel	pimecrolimus cream	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Long-Acting Opioids (Oral)	Embeda	morphine sulfate and naltrexone hydrochloride extended-release capsules	Approve if the patient has tried two other oral long-acting opioid products. For example: OxyContin, oxycodone ER tablets [generics], Xtampza ER, morphine sulfate controlled-release/extended-release capsules or tablets [MS Contin, generics; Kadian, generics for some strengths], Arymo ER, Nucynta ER, oxymorphone extended-release tablets, Zohydro ER, Hysingla ER, hydromorphone extended-release tablets [Exalgo, generics], or MorphaBond.	1 year	Yes	
Antiemetics and Antivertigo Agents	Emend capsules and Emend Trifold Pack	aprepitant oral capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Antiemetics and Antivertigo Agents	Emend oral solution	aprepitant oral solution	**1.** Approve if the patient has tried one formulary alternative from the following list: aprepitant capsules (Emend, generics), Varubi tablets or Akynzeo capsules. If none are formulary, approve. **2.** Patients ≥ 12 and <18 years of age: approve if the patient has tried aprepitant capsules (Emend, generics), if formulary. If aprepitant capsules (Emend, generics) are non-formulary, approve. **3.** Patients < 12 years of age: approve. **4.** Patients who cannot swallow or have difficulty swallowing capsules, approve. **5.** Approve if the patient has already started Emend oral solution to complete all cycles in the current course of chemotherapy.	1 year	Yes	
Duchenne Muscular Dystrophy (DMD) Agents	Emflaza	deflazacort tablets and oral suspension	Duchenne Muscular Dystrophy (DMD): Approve if the patient meets the following criteria (A and B): **A.** The patient is 2 years of age or older; AND **B.** The patient meets ONE of the following conditions ([i] or [ii]) **i.** The patient has tried prednisone for ≥ 6 months **[documentation required]** AND according to the prescribing physician, the patient has had at least one of the following significant intolerable adverse effects (AEs) [a, b, c, or d]: **a.** Cushingoid appearance **[documentation required]**; OR **b.** Central (truncal) obesity **[documentation required]**; OR **c.** Undesirable weight gain, defined as a ≥ 10% of body weight gain increase over a 6-month period **[documentation required]**; OR **d.** Diabetes and/or hypertension that is difficult to manage according to the prescribing physician **[documentation required]**. **ii.** According to the prescribing physician, the patient has experienced a severe behavioral adverse event while on prednisone therapy that has or would require a prednisone dose reduction **[documentation required]**.	1 year	Yes	
Progestin Drugs	Endometrin	progesterone vaginal insert	**1.** Approve if the patient has tried Crinone 8% gel, if formulary. If Crinone 8% gel is non-formulary, approve. **2.** Patients started on a course of therapy with Endometrin for progesterone supplementation/replacement to achieve or maintain pregnancy: approve to complete the current course of therapy.	1 year	Yes	
Angiotensin Converting Enzyme (ACE) Inhibitors	Epaned	enalapril maleate powder for oral solution, enalapril maleate oral solution	**1.** Approve if the patients has tried enalapril tablets (Vasotec, generics), if formulary. If enalapril tablets (Vasotec, generics) are non-formulary, approve. **2.** Approve if the patient cannot swallow or has difficulty swallowing tablets.	1 year	Yes	

Acne Vulgaris Agents (Topical)	Epiduo	adapalene 0.1%-benzoyl peroxide 2.5% gel	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Acne Vulgaris Agents (Topical)	Epiduo Forte	adapalene 0.3%-benzoyl peroxide 2.5%	Approve if the patient has tried adapalene 0.1%-benzoyl peroxide 2.5% gel (Epiduo, generics).	1 year	Yes	
Epinephrine Self-Administered Injectables	epinephrine auto-injector (authorized generic for Adrenaclick)	epinephrine 0.15 mg, 0.3 mg auto-injector authorized generic (Impax and A-S Medication)	Approve if the patient has tried one product from the following list, if one is formulary: epinephrine auto-injector (EpiPen/EpiPen Jr., generics). If none are formulary, approve.	1 year	Yes	
Erythroid Stimulants (ESAs)	Epogen	epoetin alfa	**1.** Approve if the patient has tried one product from the following list: Procrit, Aranesp or Retacrit **[documentation required]**, if one is formulary. If none are formulary, approve. **2.** Pediatric patients with anemia due to cancer chemotherapy: approve if the patient has tried Procrit or Retacrit **[documentation required]**, if formulary. If neither are formulary, approve. **3.** Patients undergoing surgery requesting agent for the reduction of allogeneic red blood cell transfusion: approve if the patient has tried Procrit or Retacrit **[documentation required]**, if formulary. If neither are formulary, approve. **4.** Patients with anemia and human immunodeficiency virus (HIV) infection who are receiving zidovudine: approve if the patient has tried Procrit or Retacrit **[documentation required]**, if formulary. If neither are formulary, approve.	1 year	Yes	
Proton Pump Inhibitors (PPIs)	esomeprazole strontium	esomeprazole strontium 49.3 mg capsules	Approve if the patient has tried five proton pump inhibitors (PPIs). **Note**: Examples of PPIs include rabeprazole delayed-release (DR) tablets (Aciphex, generics), Aciphex Sprinkle DR capsules or authorized generic, Dexilant DR capsules, esomeprazole DR capsules (Nexium, generics), pantoprazole DR tablets (Protonix, generics), Protonix suspension (granules), lansoprazole DR capsules (Prevacid, generics), lansoprazole oral disintegrating tablets (Prevacid Solutab, generics), omeprazole DR capsules (Prilosec, generics), Prilosec DR suspension, omeprazole/sodium bicarbonate capsules (Zegerid, generics), or omeprazole/sodium bicarbonate packet (Zegerid, generics).	1 year	Yes	
Estrogen and Estrogen Combination Products (Topical)	Estrogel	estradiol gel 0.06%	Approve if the patient has tried one formulary non-patch topical estradiol product: Elestrin, Evamist, Divigel, if one is formulary. If none are formulary, approve if the patient has tried one estradiol patch (e.g., Alora, estradiol patch [Climara, generics], Minivelle, estradiol patch [Vivelle Dot, generics]).	1 year	Yes	
Bone Modifiers - Other	Evenity	romosozumab-aqqg injection for subcutaneous use	**1.** Approve if patient has tried one of the following products: an oral or intravenous bisphosphonate (e.g., alendronate [Fosamax, Fosamax Plus D, generics], ibandronate tablets [Boniva, generics], alendronate oral solution, Binosto, risedronate [Actonel, Atelvia, generics], zoledronic acid [Reclast, generics], ibandronate injection [Boniva, generics]), Forteo, Tymlos, or Prolia. **2.** Patients with severe renal impairment (e.g., creatinine clearance < 35 mL/min) or chronic kidney disease (CKD): approve. **3.** Patients who have had an osteoporotic fracture or a fragility fracture: approve. **4.** Patients who cannot swallow/have difficulty tablets, cannot remain in an upright position (post oral bisphosphonate administration), or have a history of a gastrointestinal medical condition (e.g., esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia]): approve.	1 year	Yes	
Central Nervous System/Autonomic Drugs	Evzio and authorized generic	naloxone hydrochloride injection (auto-injector)	Approve if the prescriber can confirm that the patient's caregiver is blind or significantly visually impaired. **NOTE:** If the prescriber does not know or cannot confirm that the patient's caregiver is blind or significantly visually impaired, the request should NOT be approved. **NOTE**: Denial reason is: Coverage is provided in situations where the prescriber can confirm that the patient's caregiver is blind or significantly visually impaired. The patient should be prescribed naloxone syringe for injection or Narcan Nasal Spray, whichever is formulary.	1 year	Yes	
Antifungals (Topical)	Exelderm and authorized generic (sulconazole nitrate 1%)	sulconazole nitrate 1% (cream and solution)	Approve if the patient has tried four topical antifungals (e.g., naftifine 1% or 2% cream or 1% gel (Naftin, generics), Naftin 2% gel, Lotrimin Ultra [over-the-counter {OTC}], clotrimazole 1% cream [OTC formulation], econazole 1% cream, Ecoza 1% foam, ketoconazole 2% cream or foam [Extina, generics], Oxistat 1% lotion, oxiconazole 1% cream (Oxistat, generics), Ertaczo 2% cream, ciclopirox 0.77% cream or gel [generics], Luzu 1% cream, Mentax 1% cream, Xolegel 2% gel).	1 year	Yes - Authorized generic only	
Angiotensin Receptor Blockers (ARBs) and Combination Products	Exforge	valsartan/amlodipine tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Angiotensin Receptor Blockers (ARBs) and Combination Products	Exforge HCT	valsartan/amlodipine/hydrochlorothiazide tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Chelating Agents	Exjade	deferasirox tablets for oral suspension	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Duchenne Muscular Dystrophy (DMD) Agents	Exondys 51	eteplirsen injection for intravenous use	No exceptions are recommended. The effectiveness of Exondys 51 has not been established at this time. (**NOTE:** It is not appropriate to use standard global criteria for this medication; Denial reason is: No exceptions are recommended. The effectiveness of Exondys 51 has not been established at this time.)	N/A	Yes	
Multiple Sclerosis Drugs (Injectable)	Extavia	interferon beta-1b injection	**1.** Approve if the patient has tried one formulary product from the following list: Betaseron, Rebif, Avonex, or Plegridy **[documentation required]**. If none are formulary, approve. **2.** If Betaseron is non-formulary, approve if the patient has been established on Extavia for greater than or equal to 120 days.	1 year	Yes	Yes

HMG-CoA Reductase Inhibitors and Combination Products	Ezallor Sprinkle	rosuvastatin capsules	**1.** Approve if the patient has tried three statins from the following list (or two if only two are formulary, or one if only is formulary): lovastatin, rosuvastatin (Crestor, generics), atorvastatin (Lipitor, generics), fluvastatin (Lescol/XL, generics), pitavastatin (Livalo, Nikita, Zypitamag), pravastatin (Pravachol), or simvastatin (Zocor, generics). If none are formulary, approve. **2.** Patients who cannot swallow or have difficulty swallowing tablets or capsules, approve.	1 year	Yes	
Estrogen Products (Vaginal)	Femring	estradiol vaginal ring (0.05 mg and 0.10 mg)	Approve if the patient has tried two formulary alternatives from the following list (or one if only one is formulary): Imvexxy vaginal insert, Premarin cream, estradiol 0.01% cream (Estrace Cream, generics), Estring vaginal ring, estradiol vaginal tablet (e.g., Yuvafem, Vagifem, generics), Alora patch, estradiol patch (Climara, generics), estradiol patch (Vivelle Dot, generics), Menostar patch, estradiol tablets (Estrace, generics), Menest tablets, or Premarin tablets. If none are formulary, approve.	1 year	Yes	
NSAIDs (Oral)	Fenoprofen capsules [brand]	fenoprofen capsules	Approve if the patient has tried five prescription-strength, oral NSAIDs. **Note**: For example: fenoprofen (tablets/generic), diclofenac (Voltaren XR, generics), ibuprofen (e.g., Motrin, generics), naproxen (e.g., Naprosyn, Naprelan, generics), etodolac (generics), meloxicam (Mobic, generics), nabumetone (generics), piroxicam (Feldene, generics), indomethacin (generics). **Note**: Over-the-counter (OTC) NSAIDs would count if prescription-strength doses were used. **Note**: Five unique NSAIDs should be tried.	1 year	Yes	
NSAIDs (Oral)	Fenortho	fenoprofen capsules	Approve if the patient has tried five prescription-strength, oral NSAIDs. **Note**: For example: fenoprofen (tablets/generic), diclofenac (Voltaren XR, generics), ibuprofen (e.g., Motrin, generics), naproxen (e.g., Naprosyn, Naprelan, generics), etodolac (generics), meloxicam (Mobic, generics), nabumetone (generics), piroxicam (Feldene, generics), indomethacin (generics). **Note**: Over-the-counter (OTC) NSAIDs would count if prescription-strength doses were used. **Note**: Five unique NSAIDs should be tried.	1 year	Yes	
Fentanyl Transmucosal Products	Fentora and authorized generic	fentanyl buccal tablet	See Opioids Transmucosal - Fentora FE	1 year	Yes	
Diabetes Agents - Insulin (Rapid-Acting and Other)	Fiasp	insulin aspart injection vial, pen, cartridge	Approve if the patient has tried two formulary alternatives from the following list (or one if only one is formulary): Apidra, Insulin Lispro (authorized generic)/Humalog, Admelog, or NovoLog/Insulin Aspart (authorized generic). If none are formulary, approve. **Note**: Insulin Lispro vial, Insulin Lispro Kwikpen, Humalog vial, Humalog cartridge, Humalog Kwikpen, Humalog JR would all count as one alternative. Admelog vial, Admelog Solostar would both count as one alternative. Apidra vial, Apidra SoloStar would both count as one alternative. NovoLog vial, NovoLog cartridge, NovoLog Flexpen, Insulin Aspart vial, Insulin Aspart cartridge, Insulin Aspart pen would all count as one alternative.	1 year	Yes	
Hereditary Angioedema Products	Firazyr	icatibant injection for subcutaneous use	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
HMG-CoA Reductase Inhibitors and Combination Products	FloLipid and authorized generic	simvastatin oral suspension	**1.** Approve if the patient has tried three statins from the following list (or two if only two are formulary, or one if only one is formulary): lovastatin, simvastatin {Zocor, generics}, pravastatin {Pravachol, generics}, atorvastatin {Lipitor, generics}, rosuvastatin (Crestor, generics), fluvastatin {Lescol/XL, generics}, Altoprev, or pitavastatin {Livalo, Nikita, Zypitamag}. If none are formulary, approve. **2.** Patients who cannot swallow or have difficulty swallowing tablets or capsules: approve.	1 year	Yes - Authorized generic only	
Ophthalmic Corticosteroids	FML Forte	fluorometholone 0.25% ophthalmic suspension	**1.** Approve if patient has tried two formulary ophthalmic corticosteroids from the following list: dexamethasone (generics), Maxidex, fluorometholone (FML Liquifilm, generics), FML S.O.P., Flarex, Inveltys, Durezol, loteprednol etabonate (Lotemax, generics), Lotemax SM, prednisolone (Pred Forte, Omnipred, generics), or Pred Mild, if two are formulary (or one if one is formulary). If none are formulary, approve. **2.** If the patient has elevated intraocular pressure (IOP) or glaucoma after a trial of another corticosteroid (i.e., topical, inhaled, oral, ophthalmic): approve if the patient has tried one of the following, if one is formulary: loteprednol etabonate (Lotemax, generics), Lotemax SM, Inveltys, fluorometholone (FML Liquifilm, generics), FML S.O.P., Flarex, or Durezol. If none are formulary, approve.	1 year	Yes	
Ophthalmic Corticosteroids	FML S.O.P.	fluorometholone ophthalmic ointment 0.1%	**1.** Approve if patient has tried two formulary ophthalmic corticosteroids from the following list: dexamethasone (generics), Maxidex, fluorometholone (FML Liquifilm, generics), Flarex, FML Forte, Inveltys, Durezol, loteprednol etabonate (Lotemax, generics), Lotemax SM, prednisolone (Pred Forte, Omnipred, generics), or Pred Mild, if two are formulary (or one if one is formulary). If none are formulary, approve. **2.** Approve if the patient has elevated intraocular pressure (IOP) or glaucoma after a trial of another corticosteroid (i.e., topical, inhaled, oral, ophthalmic): approve if the patient has tried one of the following, if one is formulary: loteprednol etabonate (Lotemax, generics), Lotemax SM, Inveltys, fluorometholone (FML Liquifilm, generics), Flarex, FML Forte, or Durezol. If none are formulary, approve.	1 year	Yes	
Central Nervous System Stimulants and Non-Stimulants	Focalin and Focalin XR	dexmethylphenidate tablets and extended-release capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Ovulatory Stimulants	Follistim AQ	follitropin beta	Approve if the patient has tried one product from the following list: Gonal-F/Gonal-F RFF, if formulary. If Gonal-F/Gonal-F RFF is non-formulary, approve.	1 year	Yes	
Phosphate Binders	Fosrenol chewable tablets	lanthanum carbonate chewablet tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	

Phosphate Binders	Fosrenol oral powder	lanthanum carbonate oral powder	**1.** Approve if the patient has tried one of sevelamer hydrochloride tablets (Renagel, generics), Velphoro chewable tablets, Auryxia tablets, or sevelamer carbonate tablets/powder for oral suspension (Renvela, generics), if one is formulary. If none are formulary, approve. **2.** Patients who are unable to chew and swallow tablets: approve if the patient has tried sevelamer carbonate powder for oral suspension (Renvela powder, generics), if formulary. If sevelamer carbonate powder for oral suspension (Renvela powder, generics) is non-formulary, approve.	1 year	Yes	
Gonadotropin-Releasing Hormone (GnRH) Antagonists	ganirelix injection	ganirelix acetate injection	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Hyaluronic Acid Derivatives	Gel-One	hyaluronate gel injection	Approve if the patient has tried five formulary intra-articular hyaluronic acid products from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Durolane, Euflexxa, Gel-Syn, GenVisc 850, Hyalgan, Monovisc, Orthovisc, Supartz FX, Synvisc, Synvisc-One, Hymovis, Visco-3, Sodium hyaluronate (formerly Synojoynt), Triluron, or Trivisc **[documentation required]**. If none are formulary, approve Gel-One.	1 year	Yes	
Hyaluronic Acid Derivatives	Gel-Syn	sodium hyaluronate injection	**1.** Approve if the patient has tried five formulary intra-articular hyaluronic acid products from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Durolane, Euflexxa, Gel-One, GenVisc 850, Hyalgan, Hymovisc, Monovisc, Orthovisc, Supartz FX, Synvisc, Synvisc-One, Visco-3, Sodium hyaluronate (formerly Synojoynt), Triluron, or Trivisc **[documentation required]**. If none are formulary, approve Gel-Syn. **2.** Patients who have already been started on an injection series with Gel-Syn: approve to complete the series. **3.** Patient has a known allergy to avian or avian-derived products (e.g., eggs, feathers): approve if the patient has tried five formulary products from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Orthovisc, Monovisc, Durolane, Euflexxa, Hymovis, GenVisc 850, Sodium hyaluronate (formerly Synojoynt), or Trivisc **[documentation required]**. If none are formulary, approve Gel-Syn.	1 year	Yes	
Hyaluronic Acid Derivatives	GenVisc 850	sodium hyaluronate injection	**1.** Approve if the patient has tried five formulary intra-articular hyaluronic acid products from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Durolane, Euflexxa, Gel-One, Gel-Syn, Hyalgan, Monovisc, Orthovisc, Supartz FX, Synvisc, Synvisc-One, Hymovis, Visco-3, Sodium hyaluronate (formerly Synojoynt), Triluron, or Trivisc **[documentation required]**. If none are formulary, approve GenVisc 850. **2.** Patients who have already been started on an injection series with Genvisc 850: approve to complete the series. **3.** Patient has a known allergy to avian or avian-derived products (e.g., eggs, feathers): approve if the patient has tried five formulary product from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Orthovisc, Monovisc, Durolane, Gel-Syn, Hymovis, Euflexxa, Sodium hyaluronate (formerly Synojoynt), or Trivisc **[documentation required]**. If none are formulary, approve GenVisc 850.	1 year	Yes	
Cancer Agents - Tyrosine Kinase Inhibitors	Gleevec	imatinib tablets	**NOTE**: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. See Gleevec FE MSB criteria	1 year	MSB Exclusion *This criteria applies only to the NPF	
Diabetes Agents - Other	Glucophage	metformin tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Diabetes Agents - Other	Glucophage XR	metformin extended-release tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Diabetes Agents - Other	Glumetza	metformin extended-release tablets	Approve if the patient has tried BOTH one metformin immediate-release tablet product AND two other formulary metformin extended-release products (if two are formulary or one if one is formulary): metformin extended-release tablets, Fortamet (brand or generic), or Riomet ER. **NOTE:** A trial of Glumetza would NOT count toward this requirement.	1 year	Yes	
Antiparkinson Drugs	Gocovri ER	amantadine extended-release capsules	Approve if the patient has tried one product from the following list: amantadine capsules, amantadine tablets, or amantadine oral solution AND experienced inadequate efficacy or intolerability with the product.	1 year	Yes	
Colony Stimulating Factors	Granix	tbo-filgrastim injection	**1.** Approve if the patient has tried three of the following products (if three are formulary, or two if two are formulary, or one if one is formulary): Neupogen, Nivestym, or Zarxio [documentation required]. If none are formulary, approve. **2.** Patients requiring a dose < 180 mcg: approve if the patient has tried Neupogen or Nivestym [documentation required], if formulary. If neither are formulary, approve. **3.** Patients who initiated therapy with Granix and requires further medication to complete the current cycle of chemotherapy: approve.	1 year	Yes	
Cancer Agents - Trastuzumab-containing Agents	Herceptin	trastuzumab for intravenous injection	**1.** Approve if the patient has tried three products from the following list: Kanjinti, Trazimera, Ogivri, Ontruzant, or Herzuma, if three are formulary (or two if two are formulary, or one if one is formulary). If none are formulary, approve. **2.** If the patient has already been started on therapy with Herceptin, approve.	1 year	Yes	Yes
Cancer Agents - Trastuzumab-containing Agents	Herceptin Hylecta	trastuzumab and hyaluronidase-oysk for subcutaneous use	**1.** Approve if the patient has tried one product from the following list (if one is formulary): Herceptin intravenous (IV), Kanjinti, Trazimera, Ogivri, Ontruzant, or Herzuma. If none are formulary, approve. **2.** Approve if the patient is unable to obtain and/or maintain intravenous access. **3.** If the patient has already been started on therapy with Herceptin Hylecta, approve.	1 year	Yes	Yes

Cancer Agents - Trastuzumab-containing Agents	Herzuma	trastuzumab-pkrb for intravenous injection	**1.** Approve if patient has tried three products from the following list: Herceptin intravenous (IV), Kanjinti, Ogivri, Ontruzant, or Trazimera, if three are formulary (or two if two are formulary, or one if one is formulary). If none are formulary, approve. **2.** If the patient has already been started on therapy with Herzuma, approve.	1 year	Yes	Yes
Immune Globulins - Intravenous (IVIG) and Subcutaneous (SCIG)	Hizentra	immune globulin subcutaneous [human] 20% liquid	**1.** Approve if the patient has tried Cuvitru or Xembify, if formulary. If neither are formulary, approve. **2.** If Hizentra is being used for a diagnosis of chronic inflammatory demyelinating polyneuropathy (CIDP), approve.	1 year	Yes	
Growth Hormone Products	Humatrope	somatropin injection	Approve if the patient has tried five of the following (if five are formulary, or four if four are formulary, or three if three are formulary, or two if only two are formulary, or one if only one is formulary): Genotropin, Norditropin, Nutropin AQ, Omnitrope, Saizen, or Zomacton. If none are formulary, approve.	1 year	Yes	
Hyaluronic Acid Derivatives	Hyalgan	sodium hyaluronate injection	**1.** Approve if the patient has tried five formulary intra-articular hyaluronic acid products from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Durolane, Euflexxa, Gel-One, Gel-Syn, GenVisc 850, Monovisc, Orthovisc, Supartz FX, Synvisc, Synvisc-One, Hymovis, Visco-3, Sodium hyaluronate (formerly Synojoynt), Triluron, or Trivisc **[documentation required]**. If none are formulary, approve Hyalgan. **2.** Patients who have already been started on an injection series with Hyalgan: approve to complete the series.	1 year	Yes	
Hyaluronic Acid Derivatives	Hymovis	hyaluronic acid injection	**1.** Approve if the patient has tried five formulary intra-articular hyaluronic acid products from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Durolane, Euflexxa, Gel-One, Gel-Syn, GenVisc 850, Hyalgan, Monovisc, Orthovisc, Supartz FX, Synvisc, Synvisc-One, Visco-3, Sodium hyaluronate (formerly Synojoynt), Triluron, or Trivisc **[documentation required]** If none are formulary, approve Hymovis. **2.** Patients who have already been started on an injection series with Hymovis: approve to complete the series. **3.** Patient has a known allergy to avian or avian-derived products (e.g., eggs, feathers): approve if the patient has tried five formulary products from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Orthovisc, Monovisc, Durolane, Euflexxa, Gel-Syn, GenVisc 850, Sodium hyaluronate (formerly Synojoynt), or Trivisc **[documentation required]**. If none are formulary, approve Hymovis.	1 year	Yes	
Angiotensin Receptor Blockers (ARBs) and Combination Products	Hyzaar	losartan/hydrochlorothiazide tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Inflammatory Conditions – SC Non-TNF Biologics	Ilumya	tildrakizumab SC injection	Inflammatory Conditions - Ilumya FE	UP to 1 year	Yes	Yes
Migraine Agents - Triptans	Imitrex injection	sumatriptan succinate solution for injection (injectable pen/cartridges)	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Migraine Agents - Triptans	Imitrex nasal spray	sumatriptan nasal spray	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Migraine Agents - Triptans	Imitrex tablets	sumatriptan succinate tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Beta-Blocker and Beta-Blocker Combination Products	Inderal LA	propranolol HCl capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Vesicular Monoamine Transporter Type 2 (VMAT2) Inhibitors	Ingrezza and titration pack	valbenazine capsules	Approve if the patient has tried Austedo **[documentation required]**, if formulay. If Austedo is non-formulary, approve if the patient has tried tetrabenazine tablets (Xenazine, generics), if formulary. If tetrabenazine tablets (Xenazine, generics) are non-formulary, approve.	1 year	Yes	
Myelofibrosis Agents	Inrebic	febratinib capsules	**1.** Approve if the patient has tried Jakafi, if formulary. If Jakafi is non-formulary, approve. **2.** Approve if the patient has already been started on Inrebic.	1 year	Yes	Yes
Diabetes Agents - Insulin (Rapid-Acting and Other)	Insulin Lispro JR	Insulin lispro JR	Direct the patient to Humalog JR (brand). If Humalog JR (brand) is non-formulary, approve.	1 year	Yes	
Diabetes Agents - Insulin (Rapid-Acting and Other)	Insulin Lispro Mix 75/25	75% Insulin lispro protamine/25% insulin lispro Kwikpen	Direct the patient is Humalog 75/25 (brand), if formulary. If Humalog 75/25 (brand) is non-formulary, approve if the patient has tried one of Novolog 70/30 or Insulin Aspart Protamine-Insulin Aspart Mix, if formulary. If neither are formulary, approve if the patient has tried one formulary rapid-acting insulin or rapid-acting insulin containing products from the following list: Apidra, Insulin Lispro (authorized generic)/Humalog, Admelog, Novolog/Insulin Aspart (authorized generic), Humalog 50/50, or Fiasp. If none are formulary, approve.	1 year	Yes	

Central Nervous System Stimulants and Non-Stimulants	Intuniv	guanfacine HCl tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Ophthalmic Drugs for Glaucoma - Beta-Adrenergic Blocker	Istalol	timolol maleate 0.5% ophthalmic solution	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Chelating Agents	Jadenu	deferasirox tablets	Approve if the patient has tried one product from the following list (if one is formulary): deferasirox tablets (Exjade, generics) or Jadenu Sprinkes. If neither are formulary, approve.	1 year	Yes	
Chelating Agents	Jadenu Sprinkles	deferasirox oral granules	1. Approve if the patient has tried one product from the following list (if one is formulary): deferasirox tablets (Exjade, generics) or Jadenu tablets. If neither are formulary, approve. 2. If the patient cannot swallow or had difficulty swallowing tablets: approve if the patient has tried deferasirox tablets (Exjade, generics) if formulary. If deferasirox tablets (Exjade, generics) is non-formulary, approve.	1 year	Yes	
Testosterone Products (Oral)	Jatenzo	testosterone undecanoate capsule	Approve if the patient has tried two forms of topical testosterone (e.g., gel, solution, patches).	1 year	Yes	
Beta-Blocker and Beta-Blocker Combination Products	Kapspargo Sprinkle	metoprolol succinate extended-release capsules	**1.** Approve if the patient has tried metoprolol succinate extended-release tablets, if formulary. If non-formulary, approve. **2.** If the patient requires a dosage form which can be opened and sprinkled for alternative administration (e.g., for patients unable to swallow capsules, for nasogastric tube administration), approve.	1 year	Yes	
Calcium Channel Blockers (CCBs)	Katerzia	amlodipine oral suspension	**1.** Approve if the patient has tried amlodipine tablets or Norvasc tablets. **2.** Approve if the patient is unable to swallow or has difficulty swallowing tablets.	1 year	Yes	
Diabetes Agents - Dipeptidyl Peptidase-4 (DPP-4) Inhibitor Combination Products	Kazano	alogliptin and metformin tablets	Approve if the patient has tried three metformin-DPP-4 inhibitor combination products from the following list (if three are formulary, or two if two are formulary, or one if one is formulary): Jentadueto, Jentadueto XR, Janumet, Janumet XR, Kombiglyze XR. If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics) AND two of the following, if two are formulary (or one if only one is formulary): Onglyza, alogliptin tablets (Nesina, generics), Tradjenta, or Januvia. If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics). Note: Jentadeuto and Jentadueto XR would count as one alternative. Janumet and Janumet XR would count as one alternative.	1 year	Yes	
Antiepileptics	Keppra	levetiracetam tablets and solution	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Antiepileptics	Keppra XR	levetiracetam exteended-release tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Inflammatory Conditions – SC Non-TNF Biologics	Kevzara	sarilumab subcutaneous injection	See Inflammatory Conditions - Kevzara FE	Up to 1 year	Yes	Yes
Inflammatory Conditions – SC Non-TNF Biologics	Kineret	anakinra SC injection	See Inflammatory Conditions - Kineret FE	1 year	Yes	Yes
Cancer Agents - Cyclin-Dependent Kinase 4/6 Inhibitors	Kisqali	ribociclib tablets	See Cancer Agents - Cyclin-Dependent Kinase 4-6 Inhibitors- Kisqali FE	1 year	Yes	Yes
Cancer Agents - Cyclin-Dependent Kinase 4/6 Inhibitors	Kisqali-Femara Co-Pack	ribociclib tablets and letrozole tablets	See Cancer Agents - Cyclin-Dependent Kinase 4-6 Inhibitors- Kisqali-Femara Co-Pack FE	1 year	Yes	Yes
Diabetes Agents - Dipeptidyl Peptidase-4 (DPP-4) Inhibitor Combination Products	Kombiglyze XR	saxagliptin plus metformin extended-release tablets	Approve if the patient has tried three metformin-DPP-4 inhibitor combination products from the following list (if three are formulary, or two if two are formulary, or one if one is formulary): alogliptin and metformin tablets, Jentadueto, Jentadueto XR, Kazano, Janumet, Janumet XR. If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics) AND two of the following, if two are formulary (or one if only one is formulary): alogliptin tablets (Nesina, generics), Onglyza, Tradjenta, or Januvia. If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics). Note: Jentadueto and Jentadueto XR would count as one alternative. Alogliptin/metformin tablets and Kazano would count as one alternative. Janumet and Janumet XR would count as one alternative.	1 year	Yes	
Endocrine Drugs - Miscellaneous	Korlym	mifepristone 300 mg tablets	**1.** Approve if patient has tried one product from the following list (if one is formulary): ketoconazole tablets, Metopirone capsules, Signifor/Signifor LAR injection, or Lysodren tablets. If none are formulary, approve. **2.** Approve if the patient has already been started on Korlym therapy.	1 year	Yes	
Antiepileptics	Lamictal	lamotrigine tablets and chewable tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	

Antiepileptics	Lamictal ODT	lamotrigine oral disintegrating tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Antiepileptics	Lamictal XR	lamotrigine extended-release tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Fentanyl Transmucosal Products	Lazanda	fentanyl nasal spray	See Opioids Transmucosal - Lazanda FE	1 year	Yes	
Hepatitis C - Oral Agents	ledipasvir/sofosbuvir tablets 90 mg/400 mg (Authorized generic for Harvoni)	ledipasvir/sofosbuvir tablets 90 mg/400 mg	Patient is directed to use Harvoni 90 mg/400 mg. If Harvoni 90 mg/400 mg is non-formulary, approve.	24 weeks	Yes	
Pulmonary Arterial Hypertension (PAH) - Endothelin Receptor Antagonists	Letairis	ambrisentan tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Short-Acting Beta-Agonists (Inhaled)	levalbuterol HFA inhaler	levalbuterol inhalation aerosol (authorized generic)	**1.** Approve if the patient has tried one formulary albuterol containing inhaler from the following list: albuterol HFA (Proventil HFA, generics), Ventolin HFA, albuterol HFA inhaler (authorized generic for Ventolin HFA), albuterol HFA (ProAir HFA, generics), ProAir Respiclick, ProAir Digihaler, if one is formulary. If none are formulary, approve. **2.** Patients < 12 years of age or patients who have a low inspiratory flow rate and are unable to use a dry powder inhaler (DPI): approve if the patient has tried one product from the following list (if one is formulary): albuterol HFA (ProAir HFA, generics), Ventolin HFA, albuterol HFA inhaler (authorized generic for Ventolin HFA), or albuterol HFA (Proventil HFA, generics). If none are formulary, approve.	1 year	Yes	
Selective Serotonin Reuptake Inhibitors (SSRIs)	Lexapro	escitalopram oxalate tablets and oral solution	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Benzodiazepines and Combination Products	Librax	chlordiazepoxide/clidinium bromide capsules	Approve if the patient has tried clidinium-chlordiazepoxide capsules. If clidinium-chlordiazepoxide capsules are non-formulary, approve.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Topical Dermatological Drugs - Miscellaneous	Lidoderm	lidocaine 5% patch	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
HMG-CoA Reductase Inhibitors and Combination Products	Lipitor	atorvastatin tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Diabetes Agents - Insulin (Rapid-Acting and Other)	Lispro (authorized generic to Humalog)	Insulin lispro vial/Kwikpen	Direct the patient to brand Humalog, if formulary. If brand Humalog is non-formulary, approve if the patient has tried two formulary alternatives from the following list (or one if only one is formulary): Admelog, Apidra, Fiasp, or Novolog/Insulin Aspart (authorized generic). If none are formulary, approve. **Note**: NovoLog vial, NovoLog cartridge, NovoLog Flexpen, Insulin Aspart vial, Insulin Aspart cartridge, Insulin Aspart pen would all count as one alternative. Admelog vial, Admelog SoloStar would both count as one alternative. Apidra vial, Apidra SoloStar would both count as one alternative. Fiasp vial, Fiasp Flextouch, Fiasp penfill would all count as one alternative.	1 year	Yes	
Corticosteroids (Topical)	Locoid	hydrocortisone butyrate 0.1% lotion	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Corticosteroids (Topical)	Locoid Lipocream	hydrocortisone butyrate 0.1% cream	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Contraceptives	Loestrin and Loestrin FE	ethinyl estradiol/norethindrone and ferrous fumarate tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	

ACE-Inhibitor/CCB Combination Product	Lotrel	amlodipine/benazepril capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Low Molecular Weight Heparins and Related Agents	Lovenox	enoxaparin sodium injection (syringe/vial)	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Alpha-2 Agonists	Lucemyra	lofexidine tablets	Approve if the patient has tried clonidine.	1 year	Yes	
Sedative-Hypnotics and Related Agents	Lunesta	eszopiclone tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Antifungals (Topical)	Luzu and authorized generic (luliconazole 1% cream)	luliconazole 1% cream	Approve if the patient has tried four topical antifungals (e.g., naftifine 1% or 2% cream or 1% gel (Naftin, generics), Naftin 2% gel, Lotrimin Ultra [over-the-counter {OTC}], clotrimazole 1% cream [OTC formulation], econazole 1% cream, Ecoza 1% foam, ketoconazole 2% cream or foam [Extina, generics], Oxistat 1% lotion, oxiconazole 1% cream (Oxistat, generics), Ertaczo 2% cream, Exelderm 1% cream or solution, ciclopirox 0.77% cream or gel [generics], Mentax 1% cream, Xolegel 2% gel).	1 year	Yes - Authorized generic only	
Gabapentin and Gabapentin-Like Medications	Lyrica	pregabalin capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Gabapentin and Gabapentin-Like Medications	Lyrica CR	pregabalin controlled-release capsules	**1.** Approve if the patient has tried one formulary alternative from the following list: gabapentin capsules/tablets (Neurontin, generics), Gralise tablets, Horizant tablets, or pregabalin capsules (Lyrica, generics) **[documentation required]**. If none are formulary, approve. **2.** Approve if the patient is already receiving Lyrica CR capsules.	1 year	Yes	Yes
Hepatitis C - Oral Agents	Mavyret	glecaprevir/ pibrentasvir tablets	See Hepatitis C - Mavyret FE Criteria	Up to 16 weeks	Yes	
Migraine Agents - Triptans	Maxalt	rizatriptan tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Migraine Agents - Triptans	Maxalt MLT	rizatriptan orally disintegrating tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Ophthalmic Corticosteroids	Maxidex	dexamethasone 0.1% ophthalmic suspension	**1.** Approve if the patient has tried two formulary ophthalmic corticosteroids from the following list (if two are formulary; or one if one is formulary): dexamethasone (generics), Durezol, loteprednol etabonate (Lotemax, generics), Lotemax SM, Inveltys, fluorometholone (FML Liquifilm, generics), FML Forte/S.O.P., Flarex, prednisolone (Pred Forte, Omnipred, generics), or Pred Mild. If none are fomualry, approve. **2.** If the patient has elevated intraocular pressure (IOP) or glaucoma after a trial of another corticosteroid (i.e., topical, inhaled, oral, ophthalmic): approve if the patient has tried one product from the following list (if one is formulary): fluorometholone (FML Liquifilm, generics), loteprednol etabonate (Lotemax, generics), Lotemax SM, Inveltys, Flarex, FML Forte/S.O.P., or Durezol. If none are formulary, approve.	1 year	Yes	
Angiotensin Receptor Blockers (ARBs) and Combination Products	Micardis	telmisartan tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Angiotensin Receptor Blockers (ARBs) and Combination Products	Micardis HCT	telmisartan/hydrochlorothiazide tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Contraceptives	Minastrin 24 FE	norethindrone - ethinyl estradiol - iron chewable tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Erythroid Stimulants (ESAs)	Mircera	methoxy polyethylene glycol-epoetin beta solution for injection	Approve if the patient has tried two of the following, if two are formulary (or one if only one is formulary): Epogen, Procrit, Retacrit or Aranesp **[documentation required]**. If none are formulary, approve.	1 year	Yes	
Thrombocytopenia agents	Mulpleta	lusutrombopag tablets	**1.** Approve if the patient has tried Doptelet, if formulary. If Doptelet is non-formulary, approve. **2.** Approve if the patient has already started a course of therapy with Mulpleta in order to finish the course.	1 month	Yes	Yes

NSAIDs (Oral)	Nalfon	fenoprofen capsules	Approve if the patient has tried five prescription-strength, oral NSAIDs. **Note**: Examples include: fenoprofen (tablets/generic), diclofenac (Voltaren XR, generics), ibuprofen (e.g., Motrin, generics), naproxen (e.g., Naprosyn, Naprelan, generics), etodolac (generics), meloxicam (Mobic, generics), nabumetone (generics), piroxicam (Feldene, generics), indomethacin (generics). **Note**: Over-the-counter (OTC) NSAIDs would count if prescription-strength doses were used. **Note**: Five unique NSAIDs should be tried.	1 year	Yes	
Alzheimer's Disease Agents	Namenda XR	memantine extended-release capsule	NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Nasal Steroids	Nasonex	mometasone furoate nasal spray	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Diabetes Agents - Dipeptidyl Peptidase-4 (DPP-4) Inhibitors	Nesina and authorized generic	alogliptin tablets	Approve if the patient has tried two products from the following list (if two are formulary, or one if only one is formulary): Onglyza, Tradjenta, or Januvia. If none are formulary, approve.	1 year	Yes	
Colony Stimulating Factors	Neupogen	filgrastim injection	**1.** Approve if the patient has tried three of the following products (if three are formulary, or two if two are formulary, or one if one is formulary): Zarxio, Nivestym, or Granix [documentation required]. If none are formulary, approve. **2.** For allogeneic donor PBPC mobilization: approve if the patient has tried Zarxio or Nivestym [documentation required], if formulary. If neither are formulary, approve. 3. Patients requiring a dose < 180 mcg: approve if the patient has tried Nivestym [documentation required]. If Nivestym is non-formulary, approve. 4. Patients who require administration by intravenous (IV) infusion: approve if the patient has tried Zarxio or Nivestym [documentation required], if formulary. If neither are formulary, approve. **5.** Patients who initiated therapy with Neupogen and requires further medication to complete the current cycle of chemotherapy: approve.	1 year	Yes	
Gabapentin and Gabapentin-Like Medications	Neurontin	gabapentin tablet, capsule and solution	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Ophthalmic Anti-Inflammatory Agents - NSAIDs	Nevanac	nepafenac ophthalmic suspension 0.1%	**1.** Approve if the patient has tried two products from the following list (if two are formulary, or one of the following if one is formulary): diclofenac ophthalmic solution (generics), ketorolac ophthalmic solution (Acular, Acular LS, generics), Acuvail, Ilevro, Prolensa, BromSite or bromfenac 0.09% ophthalmic solution (generics). If none are formulary, approve. **2.** Patients with a sulfite allergy: approve if the patient has tried two of the following, if two are formulary (or one if only one is formulary): BromSite, diclofenac ophthalmic solution (generics), Ilevro, ketorolac ophthalmic solution (Acular, Acular LS, generics), or Acuvail. If none are formulary, approve. **3.** Patients < 18 years of age: approve if the patient has tried ketorolac ophthalmic solution (Acular, Acular LS, generics) or Ilevro, if one is formulary. If neither are formulary, approve.	1 year	Yes	
Nocturnal Polyuria Agents	Noctiva	desmopressin acetate nasal spray for intranasal use	Approve if the patient meets ALL of the following criteria (A, B, C, D, and E): **A.** The patient is ≥ 50 years of age; AND **B.** The diagnosis of nocturnal polyuria has been confirmed with a 24-hour urine collection before treatment initiation and the patient meets one of the following (i or ii): i. The nocturnal urine volume exceeds 20% of the total 24-hour urine volume in patients < 65 years of age; OR ii. The nocturnal urine volume exceeds 33% of the total 24-hour urine volume in patients ≥ 65 years of age; AND **C.** The patient has tried non-pharmacologic techniques or lifestyle interventions to manage the nocturia (e.g., nighttime fluid restriction, avoidance of caffeine and alcohol, earlier timing of medications, leg elevation and/or use of compression stockings); AND **D.** Prior to desmopressin therapy, the patient awakens at least two times per night to void; AND **E.** The patient tried one of Nocdurna (desmopressin acetate sublingual tablets) or oral desmopressin acetate tablets (DDAVP® tablets, generics).	1 year	Yes	
Opioids (Oral) - Other	Norco	hydrocodone/acetaminophen tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Central Nervous System/Autonomic Drugs	Northera	droxydopa capsules	Approve if the patient has tried two of the following, if two are formulary (or one if one is formulary): midodrine tablets (generics); fludrocortisone tablets; desmopressin tablets/nasal spray; dihydroergotamine injection/nasal spray; indomethacin capsules/injection; or pyridostigmine tablets. If none are formulary, approve.	1 year	Yes	
Calcium Channel Blockers (CCBs)	Norvasc	amlodipine tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	

Diabetes Agents - Insulin (Human)	Novolin 70/30 Flexpen and Relion Novolin 70/30 Flexpen	insulin, 70/30 pen	**1.** Approve if the patient has tried Humulin 70/30 Kwikpens or Humulin 70/30 vials, if formulary. If both Humulin 70/30 Kwikpens and Humulin 70/30 vials are non-formulary, approve. **2.** If only Humulin 70/30 vials are formulary, approve in patients who are visually impaired, disabled (unable to draw up dose because of arthritis or otherwise physically disabled), or have coordination issues.	1 year	Yes	
Diabetes Agents - Insulin (Human)	Novolin 70/30 vials and Relion Novolin 70/30 vials	insulin, 70/30 vials	Approve if the patient has tried Humulin 70/30 vials or Humulin 70/30 Kwikpens, if formulary. If both Humulin 70/30 vials and Humulin 70/30 Kwikpens are non-formulary, approve.	1 year	Yes	
Diabetes Agents - Insulin (Human)	Novolin N Flexpen and Relion Novolin N Flexpen	insulin, NPH pen	**1.** Approve if the patient has tried Humulin N Kwikpens or Humulin N vials, if formulary. If both Humulin N Kwikpens and Humulin N vials are non-formulary, approve. **2.** If only Humulin N vials are formulary, approve in patients who are visually impaired, disabled (unable to draw up dose because of arthritis or otherwise physically disabled), or have coordination issues.	1 year	Yes	
Diabetes Agents - Insulin (Human)	Novolin N vials and Relion Novolin N vials	insulin, NPH vials	Approve if the patient has tried Humulin N vials or Humulin N Kwikpens, if formulary. If both Humulin N vials and Humulin N Kwikpens are non-formulary, approve.	1 year	Yes	
Diabetes Agents - Insulin (Human)	Novolin R Flexpen and Relion Novolin R U-100 Flexpen	insulin, regular pen	**1.** Approve if the patient has tried Humulin R U-100 vials, if formulary. If Humulin R U-100 vials are non-formulary, approve. **2.** Approve in patients who are visually impaired, disabled (unable to draw up dose because of arthritis or otherwise physically disable), or have coordination issues.	1 year	Yes	
Diabetes Agents - Insulin (Human)	Novolin R R U-100 vials and Relion Novolin R vials	insulin, regular vials	Approve if the patient has tried Humulin R U-100 vials, if formulary. If Humulin R U-100 vials are non-formulary, approve.	1 year	Yes	
Diabetes Agents - Insulin (Rapid-Acting and Other)	NovoLog 70/30 and authorized generic (insulin aspart protamine-insulin aspart)	insulin aspart protamine/insulin aspart, Flexpen (prefilled syringe)/vial	Approve if the patient has tried Humalog 75/25, if formulary. If Humalog 75/25 is non-formulary, approve if the patient has tried one formulary rapid-acting insulin or rapid-acting insulin containing product from the following list: Apidra, Insulin Lispro (authorized generic)/Humalog, Admelog, Novolog/Insulin Asaprt, Humalog 50/50, or Fiasp. If none are formulary, approve.	1 year	Yes	
Diabetes Agents - Insulin (Rapid-Acting and Other)	NovoLog and authorized generic (insulin aspart)	insulin aspart syringe, cartridge/Flexpen (prefilled syringe)/vial	Approve if the patient has tried two formulary alternatives from the following list (or one if only one is formulary): Apidra, Fiasp, Insulin Lispro (authorized generic)/Humalog, or Admelog. If none are formulary, approve. **Note**: Insulin Lispro vial, Insulin Lispro Kwikpen, Humalog vial, Humalog cartridge, Humalog Kwikpen, Humalog JR would all count as one alternative. Admelog vial, Admelog Solostar would both count as one alternative. Apidra vial, Apidra SoloStar would both count as one alternative. Fiasp vial, Fiasp Flextouch, Fiasp penfill would all count as one alternative.	1 year	Yes	
Antifungals (Oral)	Noxafil tablets	posaconazole delayed-release tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Growth Hormone Products	Nutropin AQ Nuspin	somatropin injection	Approve if the patient has tried five of the following (if five are formulary, or four if four are formulary, or three if three are formulary, or two if only two are formulary, or one if only one is formulary): Genotropin, Humatrope, Norditropin, Omnitrope, Saizen, or Zomacton. If none are formulary, approve.	1 year	Yes	
Wakefulness Agents	Nuvigil	armodafinil tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Hemophilia - Factor VIII Products (recombinant standard half-life)	Nuwiq	antihemophilic factor [recombinant] for intravenous injection	**1.** Patient has tried two formulary recombinant Factor VIII products from the following list (if two are formulary, or one if one is formulary): Advate, Recombinate, Kogenate FS, Xyntha, Novoeight, Kovaltry, Afstyla. If none are formulary, approve. **2.** Patient is currently receiving Nuwiq or has received Nuwiq in the past: approve	1 year	Yes	Yes
Cancer Agents - Trastuzumab-containing Agents	Ogivri	trastuzumab- dkst intravenous injection	**1.** Approve if the patient has tried three products from the following list: Herceptin intravenous (IV), Trazimera, Kanjinti, Ontruzant, or Herzuma, if three are formulary (or two if two are formulary, or one if one is formulary). If none are formulary, approve. **2.** If the patient has already been started on therapy with Ogivri, approve.	1 year	Yes	Yes
Inflammatory Conditions – Targeted Synthetic DMARDs (Oral)	Olumiant	baricitinib tablets	Inflammatory Conditions - Olumiant FE	Up to 1 year	Yes	Yes
Nasal Steroids	Omnaris	ciclesonide nasal spary	Approve if the patient has tried three other nasal steroids. **NOTE:** Example include: fluticasone propionate spray (prescription or over-the-counter [OTC]), Beconase AQ, mometasone nasal spray (Nasonex, generics), triamcinolone nasal spray (prescription or OTC), flunisolide nasal spray (generics), Qnasl, budesonide nasal spray (prescription or OTC), or Zetonna.	1 year	Yes	
Growth Hormone Products	Omnitrope	somatropin injection	Approve if the patient has tried five of the following (if five are formulary, or four if four are formulary, or three if three are formulary, or two if only two are formulary, or one if only one is formulary): Genotropin, Humatrope, Norditropin, Nutropin AQ, Saizen, or Zomacton. If none are formulary, approve.	1 year	Yes	
Diabetes Agents - Dipeptidyl Peptidase-4 (DPP-4) Inhibitors	Onglyza	saxagliptin tablets	Approve if the patient has tried two products from the following list (if two are formulary, or one if only one is formulary): alogliptin tablets (Nesina, generics), Tradjenta, or Januvia. If none are formulary, approve.	1 year	Yes	

Amyloidoisis-associated Polyneuropathy Agents	Onpattro	patisiran for intravenous use	Approve if the patient meets the following criteria (i and ii): i.) The patient meets the following criteria (A, B, C, and D): A. The patient has a diagnosis of Polyneuropathy of Hereditary Transthyretin-Mediated Amyloidosis (hATTR) and the transthyretin (TTR) mutation was verified by genetic testing; AND B. The patient has symptomatic peripheral neuropathy; AND C. The patient has tried or is currently receiving at least one systemic agent for symptoms of polyneuropathy from one of the following pharmacologic classes: a gabapentin-type product (e.g., gabapentin [Neurontin], Lyrica [pregabalin capsules]), duloxetine, or a tricyclic antidepressant (e.g., amitriptyline, nortriptyline); AND D. The patient is 18 years of age or older; AND ii.) The patient meets one of the following criteria (A, B, or C): A. The patient has tried Tegsedi, if formulary; OR B. Tegsedi is non-formulary; OR C. The patient has already been started on Onpattro.	1 year	Yes	
Inflammatory Conditions – SC Non-TNF Biologics	Orencia for SC use	abatacept injection for subcutaneous use	See Inflammatory Conditions - Orencia SC FE	Up to 1 year	Yes	Yes
Inflammatory Conditions – Infused Non-TNF Biologics	Orencia IV	abatacept injection for intravenous use	**1. The patient has tried at least one biologic:** Approve. Examples**:** a tocilizumab product (e.g., Actemra IV, Actemra SC), a sarilumab product (Kevzara), an etanercept product, an adalimumab product, a certolizumab pegol product (e.g., Cimzia), a golimumab product (e.g., Simponi Aria or SC), an infliximab product, a rituximab product, a secukinumab product (e.g., Cosentyx), an ixekizumab product (e.g., Taltz), or a ustekizumab product (e.g., Stelara SC). If none are formulary, approve. **2. According to the prescriber, the patient previously experienced a serious infection:** Approve. **3. The patient is currently taking Orencia IV or SC:** Approve if the patient has been established on Orencia IV or SC for ≥ 90 days. **4. The patient has been started on Orencia IV or SC for < 90 days:** Refer to the appropriate criteria above.	1 year	Yes	Yes
Contraceptives	Orhto Tri-cyclen LO	ethinyl estradiol/norgestimate tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Contraceptives	Ortho Tri-cyclen	ethinyl estradiol/norgestimate tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Antiparkinson Drugs	Osmolex ER	amantadine extended-release tablets	Approve if the patient has tried one product from the following list: amantadine capsules, amantadine tablets, or amantadine oral solution AND experienced inadequate efficacy or intolerability with the product.	1 year	Yes	
Gastrointestinal Drugs - Miscellaneous	Osmoprep	sodium phosphate, monobasic, monohydrate, sodium phosphate, diabasic anhydrous tablet	Approve if the patient has tried three other bowel evacuant products (e.g., peg-electrolyte solution, Prepopik, Suprep).	1 month	Yes	
Sickle Cell Disease Agents	Oxbryta	voxelotor tablets	**1.** Approve if the patient has tried two of the following agents (if two are formulary, or one if one is formulary): 1) a hydroxyurea product (hydroxyurea, Droxia, Siklos), 2) Endari, or 3) Adakveo. If none are formulary, approve. **2.** For patients who are < 16 years of age OR for a patient who is not a candidate for intravenous (IV) therapy, according to the prescriber: approve if the patient has tried BOTH of the following agents, if formulary: 1) a hydroxyurea product (hydroxyurea, Droxia, Siklos) AND 2) Endari. If one is formulary, try the product which is formulary (a hydroxyurea product or Endari). If none are formulary, approve. **3.** If, according to the prescriber, the patient is not a candidate for a hydroxyurea product (e.g., a patient who is planning to become pregnant; a pregnant patient; or a patient with an immunosuppressive condition [such as cancer]), approve if the patient has tried one of Adakveo or Endari, if formulary. If neither are formulary, approve. If only Adakveo is formulary, approve if the patient is < 16 years of age OR if, according to the prescriber, the patient is not a candidate for intravenous therapy (IV).	1 year	Yes	
Long-Acting Opioids (Oral)	oxycodone ER	oxycodone extended-release tablets	**1.** Approve if the patient has tried two other oral long-acting opioid products. For example: morphine sulfate controlled-release/extended-release capsules or tablets [MS Contin, generics; Kadian, generics for some strengths], hydromorphone extended-release tablets [Exalgo, generics], oxymorphone extended-release, Nucynta ER, Zohydro ER, OxyContin, Xtampza ER, Hysingla ER, Arymo ER, or MorphaBond. **2.** Patient is intolerant or allergic to morphine: approve if the patient has tried one product from the following list (if one is formulary): Nucynta ER, Zohydro ER, Hysingla ER, Xtampza ER, or OxyContin. If none are formulary, approve. **3.** Patient has renal insufficiency: approve if the patient has tried one product from the following list (if one is formulary): Nucynta ER, Zohydro ER, Hysingla ER, Xtampza ER, or OxyContin. If none are formulary, approve. **4.** Patients ≥ 11 years and < 18 years of age: approve if the patient has tried OxyContin, if formulary. If Oxycontin is non-formulary, approve.	1 year	Yes	
Direct Muscle Relaxants	Ozobax	baclofen oral solution	**1.** Approve if the patient has tried baclofen tablets or tizanidine tablets. **2.** Approve if the patient is unable to or has difficulty swallowing tablets.	1 year	Yes	

Allergen Immunotherapy	Palforzia	peanut [Arachis hypogaea] allergen powder-dnfp for oral administration	Approve Palforzia if the patient meets the following criteria (A, B, C, D, E, F, and G): A) The patient has a peanut allergy; AND B) The patient meets ONE of the following (i or ii): i. Patient is 4 to 17 years of age; OR ii. Patient is ≥ 18 years of age AND has been previously started on therapy with Palforzia prior to becoming 18 years of age; AND C) The medication is prescribed by or in consultation with an allergist or immunologist; AND D) Per the prescriber, the patient has a history of an allergic reaction to peanut that met each of the following (i, ii, and iii): i. The patient demonstrated signs and symptoms of a significant systemic allergic reaction; AND Note: Signs and symptoms of a significant systemic allergic reaction include hives, swelling, wheezing, hypotension, and gastrointestinal symptoms. ii. This reaction occurred within a short period of time following a known ingestion of peanut or peanut-containing food; AND iii. The prescriber deemed this reaction significant enough to require a prescription for an epinephrine auto-injector; AND Note: Examples of epinephrine auto-injectors include EpiPen, EpiPen Jr., Auvi-Q, and generic epinephrine auto-injectors. E) The patient has a positive skin prick test (SPT) response to peanut with a wheal diameter ≥ 3 mm larger than the negative control; AND F) The patient has a positive in vitro test (i.e., a blood test) for peanut-specific IgE (psIgE) with a level ≥ 0.35 kUA/L; AND G) Per the prescriber, Palforzia will be used in conjunction with a peanut-avoidant diet.	1 year	Yes	
Pancreatic Enzymes	Pancreaze	pancrelipase delayed-release (enteric-coated) capsules	Approve if the patient has tried three products from the following list (if three are formulary or two if two are formulary, or one if one is formulary): Creon, Pertzye, or Zenpep. If none are formulary, approve.	1 year	Yes	
Ophthalmic Anti-Allergics	Pataday	olopatadine ophthalmic solution	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
NSAIDs (Topical)	Pennsaid	diclofenac sodium topical solution 2.0% pump	Approve if the patient has tried two products from the following list (if two are formulary, or one if one is formulary): Licart 1.3% topical system, Flector Patch, diclofenac epolamine topical patch (authorized generic of Flector patch), prescription diclofenac sodium topical 1% gel (Voltaren 1% gel, generics), or diclofenac sodium 1.5% topical solution (generics). If none are formulary, approve if the patient has tried over-the-counter Voltaren 1% gel. **Note**: Flector patch (brand) and diclofenac epolamine 1.3% topical patch (authorized generic to Flector patch) are counted as one alternative.	1 year	Yes	
Opioids (Oral) - Other	Percocet	oxycodone/acetaminophen tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Pancreatic Enzymes	Pertzye	pancrelipase delayed-release capsules	Approve if the patient has tried three products from the following list (if three are formulary, or two if two are formulary, or one if one is formulary): Creon, Pancreaze, or Zenpep. If none are formulary, approve.	1 year	Yes	
Human Immunideficiency Virus (HIV-1) - Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs)	Pifeltro	doravirine tablets	**1.** Approve if the patient has tried one non-nucleoside reverse transcriptase inhibitor (NNRTI) or a NNRTI-containing product (e.g., Sustiva, Edurant, Delstrigo, Complera, Odefsey, Atripla, Symfi, Smyfi Lo). **2.** Patients already started on therapy with Pifeltro, approve.	1 year	Yes	Yes
Cancer Agents - Kinase inhibitor	Piqray	alpelisib tablets	**1.** Approve for the diagnosis of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER-2)-negative, breast cancer if the patient has a known PIK3CA mutation and the patient has tried one of the following agents: a Cyclin-Dependent Kinase 4/6 Inhibitor (e.g., Ibrance [palbociclib], Kisqali [ribociclib], Kisqali Co-Pack [ribociclib, letrozole], Verzenio [abemaciclib]), an aromatase inhibitor (e.g., letrozole, anastrozole,exemestane), tamoxifen, toremifene, or fulvestrant (e.g., Faslodex). **2.** Approve for the diagnosis of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER-2)-negative, breast cancer if the patient has a known PIK3CA mutation and the patient has already been started on Piqray.	1 year	Yes	Yes
Inflammatory Conditions	Plaquenil	hydroxychloroquine sulfate tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Antiplatelet Agents	Plavix	clopidogrel bisulfaste tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Topical Dermatological Drugs - Miscellaneous	Pliaglis and lidocaine 7% and tetracaine 7% cream (brand)	lidocaine 7% and tetracaine 7% cream	Approve if the patient has tried and cannot use two of the following, if two are formulary (or one if only one is formulary): lidocaine and prilocaine cream (EMLA cream, generics), lidocaine cream (generics, multiple strengths), Livixil Pak, Relador Pak, Relador Pak Plus, DermacinRx Prizopak, Lidopril. If none are formulary, approve.	1 year	Yes - Authorized generic only	
Anticoagulants (Oral)	Pradaxa	dabigatran etexilate mesylate capsules	**1.** Approve if the patient has tried one of Eliquis, Savaysa, or Xarelto, if one is formulary **[documentation required]**. If none are formulary, approve Pradaxa. **2.** Patients currently receiving Pradaxa for treatment of thrombosis (e.g., deep vein thrombosis [DVT] or pulmonary embolism [PE]): approve. **3.** Patients currently receiving Pradaxa for prophylaxis of DVT or PE after orthopedic surgery (e.g., hip or knee replacement surgery): approve.	1 year	Yes	

HMG-CoA Reductase Inhibitors and Combination Products	Pravachol	pravastatin tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Ophthalmic Corticosteroids	Pred Mild	prednisolone acetate 0.12% ophthalmic suspension	**1.** Approve if the patient has tried two formulary ophthalmic corticosteroids from the following list (if two are formulary; or one if one is formulary): dexamethasone (generics), Maxidex, Durezol, loteprednol etabonate (Lotemax, generics), Lotemax SM, Inveltys, fluorometholone (FML Liquifilm, generics), FML Forte/S.O.P., Flarex, or prednisolone (Pred Forte, Omnipred, generics). If none are fomualry, approve. **2.** If the patient has elevated intraocular pressure (IOP) or glaucoma after a trial of another corticosteroid (i.e., topical, inhaled, oral, ophthalmic): approve if the patient has tried one product from the following list (if one is formulary): fluorometholone (FML Liquifilm, generics), loteprednol etabonate (Lotemax, generics), Lotemax SM, Inveltys, Flarex, FML Forte/S.O.P., or Durezol. If none are formulary, approve.	1 year	Yes	
Human Chorionic Gonadotropin, HCG Agents	Pregnyl	chorionic gonadotropin 10,000 unit powder for intramuscular injection	**1.** Approve if the patient has tried one product from the following list (if one is formulary): chorionic gonadotropin, Novarel or Ovidrel. If none are formulary, approve. **2.** For a diagnosis of cryptorchidism or hypogonadism, approve if the patient has tried chorionic gonadotropin or Novarel, if formulary. If neither are formulary, approve. **3.** Patients with a latex allergy: approve if the patient has tried Novarel, if formulary. If Novarel is non-formulary, approve. **4.** For a diagnosis related to infertility or induction of ovulation, approve a one-time fill if the patient may be at risk of missing the optimal administration timeframe window of the product (in order to avoid disruption of the current fertility medication cycle).	1 year	Yes	
Proton Pump Inhibitors (PPIs)	Prevacid	lansoprazole delayed-release (DR) capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Proton Pump Inhibitors (PPIs)	Prevacid SoluTab	lansoprazole orally disintegrating tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Human Immunideficiency Virus (HIV-1) – Protease Inhibitor (PI) Based Agents	Prezcobix	darunavir and cobicistat tablets	**1.** Approve if the patient has tried one protease inhibitor (PI) or a PI-containing product (e.g., Aptivus, Reyataz, Crixivan, Viracept, Norvir, Invirase, Lexiva, Prezista, Evotaz, Kaletra). **2.** If the patient, according to the prescriber, needs to begin antiretroviral therapy urgently, approve. **3.** Approve if the patient has been started on Prezcobix.	1 year	Yes	Yes
Proton Pump Inhibitors (PPIs)	Prilosec oral suspension	omeprazole delayed-release oral suspension	**1.** Approve if the patient has tried five proton pump inhibitors (PPIs). **Note**: Examples of PPIs include rabeprazole delayed-release (DR) tablets (Aciphex, generics), Aciphex Sprinkle DR capsules or authorized generic, Dexilant DR capsules, esomeprazole DR capsules (Nexium, generics), Nexium DR packet (granules for oral suspension), pantoprazole DR tablets (Protonix, generics), Protonix suspension (granules), lansoprazole DR capsules (Prevacid, generics), lansoprazole orally disintegrating tablets (Prevacid SoluTab, generics), omeprazole DR capsules (Prilosec, generics), omeprazole/sodium bicarbonate capsules (Zegerid, generics), or omeprazole/sodium bicarbonate packet (Zegerid, generics). **2.** Patients < 18 years of age OR patients who have difficulty swallowing tablets/capsules: Approve if the patient has tried two proton pump inhibitors (PPIs). **3.** Patients < 1 year of age: approve if the patient has tried Nexium DR packet (granules for oral suspension), if formulary. If Nexium DR packet (granules for oral suspension), is non-formulary, approve. **Note**: The requested agent would NOT count as a trial of an alternative.	1 year	Yes	
Opioids (Oral) - Other	Primlev tablet	oxycodone-acetaminophen	Direct patient to use oxycodone-acetaminophen.	N/A	Yes	
Serotonin and Norepinephrine Reuptake Inhibitors (SNRIs)	Pristiq	dexvenlafaxine succinate tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Short-Acting Beta-Agonists (Inhaled)	ProAir Digihaler	albuterol sulfate inhalation powder	**1.** Approve if the patient has tried one product from the following list, if formulary: albuterol HFA (ProAir HFA, generics), ProAir Respiclick, albuterol HFA (Proventil HFA, generics), Ventolin HFA, albuterol HFA inhaler (authorized generics to Ventolin HFA), Xopenex HFA, or levalbuterol HFA inhaler. If none are formulary, approve. **2.** Patients who are unable to coordinate breath and actuation with a metered-dose inhaler (MDI): approve if the patient has tried ProAir Respiclick, if formulary. If ProAir Respiclick is non-formulary, approve.	1 year	Yes	
Nephropathic Cystinosis Medications	Procysbi	cysteamine bitartrate dealyed-release capsules and granule packets	Approve if the patient meets the following criteria (A, B, C, and D): A. Patients with nephropathic cystinosis; AND B. According to the prescriber, the diagnosis was confirmed by one of the following (i or ii): i. Genetic testing confirmed a mutation of the CTNS gene; OR ii. White blood cell cystine concentration above the upper limit of the normal reference range for the reporting laboratory; AND C. The patient will not be using Cystagon and Procysbi concurrently; AND D. The patient has tried Cystagon, if formulary. If Cystagon is non-formulary, approve.	1 year	Yes	

Bone Modifiers - Other	Prolia	denosumab injection for subcutaneous use	**1.** Approve if patient has tried one of the following products: an oral or intravenous bisphosphonate (e.g., alendronate [Fosamax, Fosamax Plus D, generics], ibandronate tablets [Boniva, generics], alendronate oral solution, Binosto, risedronate [Actonel, Atelvia, generics, zoledronic acid [Reclast, generics], ibandronate injection [Boniva, generics]), Forteo, Tymlos, or Evenity. **2.** Patients with severe renal impairment (e.g., creatinine clearance < 35 mL/min) or chronic kidney disease (CKD): approve. **3.** Patients who have had an osteoporotic fracture or a fragility fracture: approve. **4.** Patients who cannot swallow/have difficulty tablets, cannot remain in an upright position (post oral bisphosphonate administration), or have a history of a gastrointestinal medical condition (e.g., esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia]): approve. **5.** Treatment of bone loss (to increase bone mass) in patients at high risk for fracture receiving androgen deprivation therapy (e.g., Lupron Depot [leuprolide for depot suspension], Eligard [leuprolide acetate for injectable suspension] or has undergone bilateral orchiectomy) for nonmetastatic prostate cancer: approve. **6.** Treatment of bone loss (to increase bone mass) in patients at high risk for fracture receiving adjuvant aromatase inhibitor therapy (e.g., anastrozole [Arimidex, generics], letrozole [Femara, generics], and exemestane [Aromasin, generics]) for breast cancer: approve.	1 year	Yes	
Proton Pump Inhibitors (PPIs)	Protonix	pantoprazole sodium delayed-release (DR) tablets and intravenous (IV) injection	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Proton Pump Inhibitors (PPIs)	Protonix oral suspension	pantoprazole delayed-release oral suspension (granules)	**1.** Approve if the patient has tried five proton pump inhibitors (PPIs). **Note**: Examples of PPIs include rabeprazole delayed-release (DR) tablets (Aciphex, generics), Aciphex Sprinkle DR capsules or authorized generic, Dexilant DR capsules, esomeprazole DR capsules (Nexium, generics), Nexium DR packet (granules for oral suspension), pantoprazole DR tablets (Protonix, generics), lansoprazole DR capsules (Prevacid, generics), omeprazole DR capsules (Prilosec, generics), lansoprazole oral disintegrating tablets (Prevacid SoluTab, generics), Prilosec DR suspension, omeprazole/sodium bicarbonate capsules (Zegerid, generics), or omeprazole/sodium bicarbonate packet (Zegerid, generics). **2.** Patients < 18 years of age OR patients who have difficulty swallowing tablets/capsules: Approve if the patient has tried two proton pump inhibitors (PPIs). **Note**: The requested agent would NOT count as a trial of an alternative.	1 year	Yes	
Short-Acting Beta-Agonists (Inhaled)	Proventil HFA	albuterol sulfate inhalation aerosol	**1.** Approve if the patient has tried one product from the following list, if formulary: albuterol HFA (ProAir HFA, generics), ProAir Respiclick, ProAir Digihaler, Ventolin HFA, albuterol HFA inhaler (authorized generic to Ventolin HFA), albuterol HFA inhaler (generic to Proventil HFA), Xopenex HFA, or levalbuterol HFA inhaler. If none are formulary, approve. **2.** Patients < 12 years of age or patients who have a low inspiratory flow rate and are unable to use a dry powder inhaler (DPI): approve if the patient has tried one product from the following list, if formulary: albuterol HFA (ProAir HFA, generics), Ventolin HFA, albuterol HFA inhaler (authorized generic to Ventolin HFA), albuterol HFA inhaler (generic to Proventil HFA), Xopenex HFA, or levalbuterol HFA inhaler. If none are formulary, approve.	1 year	Yes	
Wakefulness Agents	Provigil	modafinil tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Selective Serotonin Reuptake Inhibitors (SSRIs)	Prozac	fluoxetine HCl pulvules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Respiratory - Corticosteroid Nebulized Solutions	Pulmicort	budesonide respules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Helicobacter Pylori Agents	Pylera	bismuth subcitrate potassium, metronidazole plus tetracycline capsules	Approve if the patient meets ONE of the following (A or B): A) The patient has tried single-entity products in a regimen for peptic ulcer disease due to Helicobacter pylori (e.g., bismuth subcitrate, metronidazole, tetracycline, clarithromycin, amoxicillin, rifabutin, PPIs [e.g., omeprazole, lansoprazole]; OR B) The patient has tried any pre-packaged product for peptic ulcer disease due to Helicobacter pylori: amoxicillin/clarithromycin/lansoprazole (Prevpac, generics), Omeclamox-Pak, or Talicia.	1 month	Yes	
Angiotensin Converting Enzyme (ACE) Inhibitors	Qbrelis	lisinopril oral solution	**1.** Approve if the patients has tried lisinopril tablets (Prinivl, Zestril, generics), if formulary. If lisinopril tablets (Prinivil, Zestril, generics) are non-formulary, approve. **2.** Approve if the patient cannot swallow or has difficulty swallowing tablets.	1 year	Yes	
Cardiovascular Medications - Other	Ranexa	ranolazine tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	

Benign Prostatic Hyperplasia (Alpha Blockers and 5-Alpha Reductase Inhibitors)	Rapaflo	silosodin capsules	**NOTE**: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria**: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Hemophilia - Factor VIII Products (recombinant standard half-life)	Recombinate	antihemophilic factor [recombinant] injection	**1.** Patient has tried two formulary recombinant Factor VIII products from the following list (if two are formulary or one if one is formulary): Advate, Kogenate FS, Xyntha, Novoeight, Nuwiq, Kovaltry, Afstyla. If none are formulary, approve. **2.** Patient is currently receiving Recombinate or has received Recombinate in the past: approve.	1 year	Yes	Yes
NSAIDs (Oral)	Relafen DS	nabumetone 1,000 mg tablets	Approve if the patient has tried five prescription-strength NSAIDs. **Note**: For example: nabumetone (generics), diclofenac (Voltaren XR, generics), ibuprofen (e.g., Motrin, generics), naproxen (e.g., Naprosyn, Naprelan, generics), etodolac (generics), meloxicam (Mobic, generics), piroxicam (Feldene, generics), or indomethacin (generics). **Note**: Over-the-counter (OTC) NSAIDs would count if prescription-strength doses were used. **Note**: Five unique NSAIDs should be tried.	1 year	Yes	
Phosphate Binders	Renagel	sevelamer hydrochloride tablet	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Rituximab-containing Agents	Rituxan	rituximab intravenous injection	**1.** Approve if the patient has tried one of Truxima or Ruxience, if formulary. If neither are formulary, approve. **2.** If the patient has already been started on therapy with Rituxan intravenous (IV), approve.	1 year	Yes	
Rituximab-containing Agents	Rituxan Hycela	rituximab and hyaluronidase human injection for subcutaneous use	**1.** Approve if the patient has received at least one dose of intravenous (IV) rituximab (e.g., Rituxan, Truxima, Ruxience) and, per the prescribing physician, the patient cannot continue to receive IV rituximab due to an inability to obtain IV access. **2.** If the patient has already been started on therapy with Rituxan Hycela, approve.	1 year	Yes	
Sedative-Hypnotics and Related Agents	Rozerem	ramelteon tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Growth Hormone Products	Saizen/SaizenPrep	somatropin injection	Approve if the patient has tried five of the following (if five are formulary, or four if four are formulary, or three if three are formulary, or two if only two are formulary, or one if only one is formulary): Genotropin, Humatrope, Norditropin, Nutropin AQ, Omnitrope, or Zomacton. If none are formulary, approve.	1 year	Yes	
Somatostatin Analogs	Sandostatin LAR Depot	octreotide injectable suspension	**1.** Approve if the patient has tried one of Somatuline Depot or Signifor LAR, if one is formulary. If neither are formulary, approve. **2.** Patients with diabetes: approve the patient has tried Somatuline Depot, if formulary. If Somatuline Depot is non-formulary, approve. **3.** Patients with neuroendocrine tumors: approve. Note: This includes (but is not limited to) carcinoid tumors, vasoactive intestinal peptide tumors (VIPomas), glucagonomas, gastrinomas, insulinomas. **4.** Patients with meningioma, thymoma/thymic carcinoma, or pheochromocytoma/paraganglioma: approve.	1 year	Yes	
Anticoagulants (Oral)	Savaysa	edoxaban tablets	**1.** Approve if the patient has tried one of the following, if one is formulary: Pradaxa, Xarelto, or Eliquis **[documentation required]**. If none are formulary, approve. **2.** Patients currently receiving Savaysa for treatment of thrombosis (e.g., deep vein thrombosis [DVT] or pulmonary embolism [PE]): approve. **3.** Patients using Savaysa for treatment of DVT or PE associated with cancer: approve. **4.** Patients currently receiving Savaysa for prophylaxis of DVT or PE after orthopedic surgery (e.g., hip replacement surgery): approve.	1 year	Yes	
Endocrine Drugs - Miscellaneous	Sensipar	cinacalcet tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Antipsychotics (Oral)	Seroquel	quetiapine fumarate tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Antipsychotics (Oral)	Seroquel XR	quetiapine fumarate extended-release tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Somatostatin Analogs	Signifor LAR	pasireotide IM injection	**1.** Patients with acromegaly: approve if the patient has tried one of Sandostatin LAR Depot or Somatuline Depot, if one is formulary. If neither are formulary, approve. **2.** Patients with Cushing's disease: approve if the patient has tried Signifor (not LAR). If Signifor (not LAR) is non-formulary, approve.	1 year	Yes	
Sickle Cell Disease Agents	Siklos	hydroxyurea tablets	**1.** Approve is the patient has tried Droxia, if formulary. If Droxia is non-formulary, approve. **2.** If the patient requires Siklos 100 mg or 1,000 mg tablets to achieve a dosage that cannot be achieved with the available strengths of Droxia, approve. **3.** If the patient cannot swallow or has difficulty swallowing Droxia capsules, approve.	1 year	Yes	

Inflammatory Conditions – SC Non-TNF Biologics	Siliq	brodalumab for subcutaneous injection	See Inflammatory Conditions - Siliq FE	Up to 1 year	Yes	Yes
Inflammatory Conditions – SC TNF Antagonists	Simponi SC	golimumab subcutaneous injection	See Inflammatory Conditions - Simponi SC FE	Up to 1 year	Yes	Yes
Leukotriene Pathway Inhibitors	Singulair tablets	montelukast sodium tablets, chewable tablets, granules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Antivirals (Oral)	Sitavig	acyclovir buccal tablets	Approve if the patient has tried two of the following: acyclovir capsules/tablets, famciclovir tablets (generics), valacyclovir tablets (Valtrex, generics), Denavir 1% cream, Xerese 5%/1% cream, acyclovir 5% cream (Zovirax 5% cream, generics), or over-the-counter (OTC) Abreva 10% cream.	1 year	Yes	
Hyaluronic Acid Derivatives	Sodium hyaluronate (formerly Synojoynt)	sodium hyaluronate injection	**1.** Approve if the patient has tried five formulary intra-articular hyaluronic acid product from the following list ((if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Durolane, Euflexxa, Gel-One, Gel-Syn, GenVisc 850, Hyalgan, Monovisc, Orthovisc, Supartz FX, Synvisc, Synvisc-One, Hymovis, Trivisc, Triluron, or Visco-3 **[documentation required]**. If none are formulary, approve. **2.** Patients who have already been started on an injection series with sodium hyaluronate (formerly Synojoynt): approve to complete the series. **3.** Patient has a known allergy to avian or avian-derived products (e.g., eggs, feathers): approve if the patient has tried five formulary products from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Durolane, Euflexxa, Orthovisc, Monovisc, Hymovis, Gel-Syn, Trivisc, or GenVisc 850 **[documentation required]**. If none are formulary, approve.	1 year	Yes	
Hepatitis C - Oral Agents	sofosbuvir/velpatasvir (Authorized generic for Epclusa)	sofosbuvir/velpatasvir tablets	Patient is directed to use Epclusa. If Epclusa is non-formulary, approve.	24 weeks	Yes	
Vitamin D Analogs (Topical)	Sorilux and authorized generic	calcipotriene foam	**1.** Approve if the patient has tried calcipotriene solution, if formulary. If calcipotriene solution is non-formulary, approve. **2.** Approve if the patient has tried calcipotriene cream or ointment. **3.** If the patient is using the requested medication for plaque psoriasis and is between the ages ≥ 4 and < 18 years of age, approve.	1 year	Yes - Authorized generic only	
Hepatitis C - Oral Agents	Sovaldi	sofosbuvir tablets and oral pellets	See Hepatitis C - Sovaldi FE Criteria	Varies	Yes	
N-methyl D-aspartate (NMDA) receptor antagonists	Spravato	esketamine nasal spray	**1.** For the diagnosis of Treatment-Resistant Depression: approve if the patient has tried at least two antidepressants, each from a different pharmacologic class (e.g., selective serotonin reuptake inhibitors [SSRIs], serotonin-norepinephrine reuptake inhibitors [SNRIs], tricyclic antidepressants [TCAs], mirtazapine, bupropion, etc.) OR has tried olanzapine-fluoxetine (Symbyax, generics) or olanzapine and fluoxetine used concomitantly. **2.** For the diagnosis of Treatment-Resistant Depression: approve if the patient has already started therapy with Spravato.	1 year	Yes	Yes
NSAIDs (Oral)	Sprix and authorized generic	ketorolac tromethamine nasal spray	**1.** Approve if the patient has tried five prescription-strength, oral NSAIDs. **Note**: Examples include: diclofenac (Voltaren XR, generics), ibuprofen (e.g., Motrin, generics), naproxen (e.g., Naprosyn, Naprelan, generics), etodolac (generics), meloxicam (Mobic, generics), nabumetone (generics), piroxicam (Feldene, generics), indomethacin (generics). **Note**: Over-the-counter (OTC) NSAIDs would count if prescription-strength doses were used. **Note**: Five unique NSAIDs should be tried. **2.** Approve for patients with difficulty swallowing or for patients who cannot swallow.	1 year	Yes - Authorized generic only	
Central Nervous System Stimulants and Non-Stimulants	Strattera	atomoxetine HCl capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Human Immunodeficiency Virus (HIV-1) - integrase strand transfer inhibitor (INSTI) Combination Products	Stribild	elvitegravir/ cobicistat/ emtricitabine/ tenofovir tablets	**1.** Approve if the patient has tried Biktarvy, if formulary. If Biktarvy is non-formulary, approve. **2.** Approve if the patient has tried one integrase strand transfer inhibitor (INSTI) or an INSTI-containing product (e.g., Genvoya, Tivicay, Triumeq, Juluca, Isentress or Intress-HD). **3.** Patients already started on therapy with Stribild: approve.	1 year	Yes	Yes
Long-Acting Beta-Agonists (Inhalers)	Striverdi Respimat	olodaterol inhalation spray	**1.** Approve if the patient has tried Serevent Diskus, if formulary. If Serevent Diskus is non-formulary, approve. **2.** Patients who have a low inspiratory flow rate and are unable to use a dry-powder inhaler (DPI): approve.	1 year	Yes	
Fentanyl Transmucosal Products	Subsys	fentanyl sublingual spray	See Opioids Transmucosal - Subsys FE	1 year	Yes	
Hyaluronic Acid Derivatives	Supartz FX	sodium hyaluronate injection	**1.** Approve if the patient has tried five formulary intra-articular hyaluronic acid products from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Durolane, Euflexxa, Gel-One, Gel-Syn, GenVisc 850, Hyalgan, Monovisc, Orthovisc, Synvisc, Synvisc-One, Hymovis Visco-3, Sodium hyaluronate (formerly Synojoynt), Triluron, or Trivisc **[documentation required]**. If none are formulary, approve Supartz FX. **2.** Patients who have already been started on an injection series with Supartz FX: approve to complete the series.	1 year	Yes	
Gonadotropin-Releasing Hormone (GnRH) Analogs	Supprelin LA	histrelin subcutaneous [SC] implant	Approve if the patient has tried one of Lupron Depot-Ped, Triptodur, or Synarel, if one is formulary. If none are formulary, approve.	1 year	Yes	

Hyaluronic Acid Derivatives	Synvisc	sodium hyaluronate injection	**1.** Approve if the patient has tried five other formulary intra-articular hyaluronic acid products from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Durolane, Euflexxa, Gel-One, Gel-Syn, GenVisc 850, Hyalgan, Monovisc, Orthovisc, Supartz FX, Synvisc-One, Hymovis Visco-3, Sodium hyaluronate (fomerly Synojoynt), Triluron, or Trivisc **[documentation required]**. If none are formulary, approve Synvisc. **2.** Patients who have already been started on an injection series with Synvisc: approve to complete the series.	1 year	Yes	
Hyaluronic Acid Derivatives	Synvisc-One	sodium hyaluronate injection	Approve if the patient has tried five formulary intra-articular hyaluronic acid products from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Durolane, Euflexxa, Gel-One, Gel-Syn, GenVisc 850, Hyalgan, Monovisc, Orthovisc, Supartz FX, Synvisc, Hymovis Visco-3, Sodium hyaluronate (formerly Synojoynt), Triluron, or Trivisc **[documentation required]**. If none are formulary, approve Synvisc-One.	1 year	Yes	
Inflammatory Conditions – SC Non-TNF Biologics	Taltz	ixekizumab for SC injection	See Inflammatory Conditions - Taltz FE	Up to 1 year	Yes	Yes
Cancer Agent (Oral)	Targretin capsule	bexarotene capsule	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Thrombocytopenia agents	Tavalisse	fostamatinib disodium hexahydrate tablets	1. Approve if the patient has tried two of the following products: Promacta, Nplate, or Doptelet (if two are formulary or one if one is formulary). If none are formulary, approve. 2. Approve if the patient has been started on Tavalisse.	1 year	Yes	Yes
Testosterone Products (Topical)	Testim	testosterone gel	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Cardiovascular Medications - Other	Tikosyn	dofetilide capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Ophthalmic Drugs for Glaucoma - Beta-Adrenergic Blocker	Timoptic in Ocudose	timolol maleate 0.25% and 0.5% ophthalmic solution	**1.** Approve if the patient has tried timolol ophthalmic solution (Timoptic, generics), if formulary. If timolol ophthalmic solution (Timolol, generics) is non-formulary, approve. **2.** Approve if the patient has a known sensitivity to a preservative or when use of a preservative-free topical medication is advisable.	1 year	Yes	
NSAIDs (Oral)	Tivorbex and authorized generic	indomethacin, submicronized capsules	Approve if the patient has tried five prescription-strength, oral NSAIDs. **Note**: Examples include: diclofenac (Voltaren XR, generics), ibuprofen (e.g., Motrin, generics), naproxen (e.g., Naprosyn, Naprelan, generics), etodolac (generics), meloxicam (Mobic, generics), nabumetone (generics), piroxicam (Feldene, generics), indomethacin (generics). **Note**: Over-the-counter (OTC) NSAIDs would count if prescription-strength doses were used. **Note**: Five unique NSAIDs should be tried.	1 year	Yes	
Antibiotics (Inhaled)	TOBI	tobramycin solution for inhalation	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Antifungals (Oral)	Tolsura	itraconazole capsules	**1.** Approve if the patient has tried one of itraconazole capsules (Sporanox, generics) or itraconazole oral solution (Sporanox liquid, generics). **NOTE:** A trial of either the conventional intraconazole capsules or intraconazole solution would count toward meeting criteria regardless of the formulary status of the product. **2.** Patient has been started on a current course of therapy with Tolsura (for a non-oncychomycosis diagnosis): approve to complete the current course. **3.** Deny: If the patient is requesting Tolsura for a diagnosis of onychomycosis. **NOTE:** If the patient is requesting Tolsura for a diagnosis of onychomycosis, the request should be denied regardless of what the patient has tried for the current condition or if the patient has already been started on the product.	1 year	Yes	
Antiepileptics	Topamax	topiramate tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Corticosteroids (Topical)	Topicort spray	desoximetasone spray	Approve if the patient has tried two generic prescription-strength topical corticosteroid products (e.g., desoximetasone, triamcinolone, desonide, betamethasone, clobetasol). **NOTE:** The two products must be chemically unique (i.e., a trial of desoximetasone 0.05% and 0.25% would NOT fulfill the requirement).	1 year	Yes	
Antiepileptics	Topiramate extended-release capsules (authorized generic to Qudexy XR)	topiramate extended-release capsules	The patient is directed to use Qudexy XR (brand), if formulary. If Qudexy XR (brand) is non-formulary, approve if the patient has tried one products from the following list: topiramate tablets (Topamax, generics) or Trokendi, if one is formulary. If neither are formulary, approve.	1 year	Yes	

Beta-Blocker and Beta-Blocker Combination Products	Toprol XL	metoprolol succinate extended-release tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Antimuscarinic Agents	Transderm-Scop	scopolamine patches	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Gonadotropin-Releasing Hormone (GnRH) Analogs	Trelstar	triptorelin pamoate for injectable suspension	**1.** Approve if the patient has tried one of the following, if formulary: Lupron Depot (7.5 mg, 22.5 mg, 30 mg, or 45 mg), Eligard, or Firmagon. If none are formulary, approve. **2.** Patients currently receiving therapy with Trelstar: approve.	1 year	Yes	Yes
Migraine Agents - Triptans	Treximet	sumatriptan/ naproxen sodium tablets	Approve if the patient has tried naproxen AND sumatriptan tablets (Imitrex, generics), if formulary. If sumatriptan tablets (Imitrex, generics) are non-formulary, approve. **NOTE:** A trial of the requested agent would NOT count toward meeting this requirement.	1 year	Yes	
Angiotensin Receptor Blockers (ARBs) and Combination Products	Tribenzor	olmesartan/amlodipine /hydrochlorothiazide tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Hypolipoproteinemics	Tricor	fenofibrate tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Antiepileptics	Trileptal	oxcarbazepine tablets and suspension	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Hyaluronic Acid Derivatives	Triluron	sodium hyaluronate 1% injection	**1.** Approve if the patient has tried five formulary alternatives from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Durolane, Euflexxa, Gel-One, Gel-Syn, GenVisc 850, Hyalgan, Monovisc, Orthovisc, Supartz FX, Synvisc, Synvisc-One, Hymovis, Sodium hyaluronate (formerly Synojoynt), Visco-3, or Trivisc **[documentation required]**. If none are formulary, approve. **2.** Patients who have already been started on an injection series with Triluron: approve to complete the series.	1 year	Yes	
Hyaluronic Acid Derivatives	Trivisc	sodium hyaluronate injection	**1.** Approve if the patient has tried five formulary intra-articular hyaluronic acid product from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Durolane, Euflexxa, Gel-One, Gel-Syn, GenVisc 850, Hyalgan, Monovisc, Orthovisc, Supartz FX, Synvisc, Synvisc-One, Hymovis, Sodium hyaluronate (formerly Synojoynt), Triluron, or Visco-3 **[documentation required]**. If none are formulary, approve Trivisc. **2.** Patients who have already been started on an injection series with Trivisc: approve to complete the series. **3.** Patient has a known allergy to avian or avian-derived products (e.g., eggs, feathers): approve if the patient has tried five formulary products from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Durolane, Euflexxa, Orthovisc, Monovisc, Hymovis, Gel-Syn, Sodium hyaluronate (formerly Synojoynt), or GenVisc 850 **[documentation required]**. If none are formulary, approve Trivisc.	1 year	Yes	
Rituximab-containing Agents	Truxima	rituximab-abbs intravenous injection	**1.** Approve if the patient has tried one of Rituxan intravenous (IV) or Ruxience, if formulary. If neither are formulary, approve. **2.** If the patient has already been started on therapy with Truxima, approve.	1 year	Yes	
Respiratory - Long-Acting Muscarinic Antagonist (LAMA) Inhalers	Tudorza Pressair	aclidinium bromide inhalation powder	Approve if the patient has tried one product from the following list (if one is formulary): Incruse Ellipta, Spiriva HandiHaler, or Spiriva Respimat. If none are formulary, approve.	1 year	Yes	
Gout Medications	Uloric	febuxostat tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Benign Prostatic Hyperplasia (Alpha Blockers and 5-Alpha Reductase Inhibitors)	Uroxatral	alfuzosin tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Estrogen Products (Vaginal)	Vagifem	estradiol vaginal tablet	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	

Benzodiazepines and Combination Products	Valium	diazepam tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Antivirals (Oral)	Valtrex	valacyclovir HCl caplets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Corticosteroids (Topical)	Vanos	fluocinonide 0.1% cream	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Potassium Binders	Veltassa	patiromer powder for suspension	Approve if the patient has tried Lokelma, if formulary. If Lokelma is non-formulary, approve.	1 year	Yes	
Acne Vulgaris Agents (Topical)	Veltin	clindamycin phosphate and tretinoin gel	Approve if the patient has tried BOTH a clindamycin- AND a tretinoin- containing product (for example, Ziana, generic clindamycin/tretinoin, Retin-A, generic tretinoin, Cleocin-T, generic clindamycin).	1 year	Yes	
Corticosteroids (Topical)	Verdeso	desonide foam	Approve if the patient has tried two generic prescription-strength topical corticosteroid products (e.g., desonide, desoximetasone, triamcinolone, betamethasone, clobetasol). **NOTE:** The two products must be chemically unique (i.e., a trial of desoximetasone 0.05% and 0.25% would NOT fulfill the requirement).	1 year	Yes	
Overactive Bladder Agents (Oral and Topical)	Vesicare	solifenacin succinate tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Erectile Dysfunction Agents - Phosphodiesterase Type 5 (PDE-5) Inhibitors	Viagra	sildenafil tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Diabetes Agents - Glucagon-Like Peptide-1 (GLP-1) Agonists	Victoza	liraglutide (rDNA origin) injection	**1.** Approve if the patient has tried two formulary alternatives from the following list (or one if only one is formulary): Adlyxin, Trulicity, Byetta, Bydureon/Bydureon BCise, or Ozempic **[documentation required]**. If none are formulary, approve. **NOTE:** Bydureon vial, Bydureon BCise, Bydureon Pen count as one alternative. **2.** Approve if the patient is less than 18 years of age. **3.** If the patient, according to the prescriber, has established cardiovascular disease OR at least two risk factors for cardiovascular disease, approve if the patient has tried Ozempic or Trulicity **[documentation required]**, if formulary. If neither are formulary, approve	2 years	Yes	
Hyaluronic Acid Derivatives	Visco-3	sodium hyaluronate injection	**1.** Approve if the patient has tried five formulary alternatives from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Durolane, Euflexxa, Gel-One, Gel-Syn, GenVisc 850, Hyalgan, Monovisc, Orthovisc, Supartz FX, Synvisc, Synvisc-One, Hymovis, Sodium hyaluronate (formerly Synojoynt), Triluron, or Trivisc **[documentation required]**. If none are formulary, approve Visco-3. **2.** Patients who have already been started on an injection series with Visco-3: approve to complete the series.	1 year	Yes	
Estrogen and Estrogen Combination Products (Topical)	Vivelle-Dot	estradiol transdermal patch	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
NSAIDs (Oral)	Vivlodex	meloxicam capsules	Approve if the patient has tried five prescription-strength, oral NSAIDs. **Note**: Examples include: diclofenac (Voltaren XR, generics), ibuprofen (e.g., Motrin, generics), naproxen (e.g., Naprosyn, Naprelan, generics), etodolac (generics), meloxicam (Mobic, generics), nabumetone (generics), piroxicam (Feldene, generics), indomethacin (generics). **Note**: Over-the-counter (OTC) NSAIDs would count if prescription-strength doses were used. **Note**: Five unique NSAIDs should be tried.	1 year	Yes	
Calcitonin Gene-Related Peptide (CGRP) Agents	Vyepti	eptinezumab-jjmr injection for intravenous use	Approve if the patient has tried all three of the following products Aimovig, Emgality, or Ajovy, if formulary (or two if two are formulary or one if one is formulary). If none are formulary, approve if the patient has tried TWO standard prophylactic pharmacologic therapies, each from a different pharmacologic class (e.g., angiotensin receptor blocker, angiotensin converting enzyme inhibitor, anticonvulsant, beta-blocker, calcium channel blocker, tricyclic antidepressant, other antidepressant).	1 year	Yes	
Duchenne Muscular Dystrophy (DMD) Agents	Vyondys 53	golodirsen injection for intravenous use	No exceptions are recommended. The effectiveness of Vyondys 53 has not been established at this time. (NOTE: It is not appropriate to use standard global criteria for this medication; Denial reason is: No exceptions are recommended. The effectiveness of Vyondys 53 has not been established at this time.)	N/A	Yes	
HMG-CoA Reductase Inhibitors and Combination Products	Vytorin	ezetimibe/simvastatin tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	

Antidepressants - Other	Wellbutrin SR	bupropion HCl tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Antiparkinson Drugs	Xadago	safinamide tablets	Approve if the patient has tried one product from the following list (if one is formulary): selegiline tablets, selegiline capsules (Eldepryl, generics), rasagiline tablets (Azilect, generics), or Zelapar. If none are formulary, approve.	1 year	Yes	
Ophthalmic Drugs for Glaucoma - Prostaglandins	Xalatan	latanoprost 0.005% ophthalmic solution	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Benzodiazepines and Combination Products	Xanax	alprazolam tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Benzodiazepines and Combination Products	Xanax XR	alprazolam entended-release tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Immunosuppressant Agents	Xatmep	methotrexate oral solution	**1.** Approve if the patient cannot swallow or has difficulty swallowing oral methotrexate tablets. **2.** Approve if the patient's dose cannot be obtained using whole methotrexate tablets.	1 year	Yes	
Ophthalmic Drugs for Glaucoma - Prostaglandins	Xelpros	latanoprost 0.005% ophthalmic emulsion	**1.** Approve if the patient has tried two formulary alternatives from the following list (or one if only one is formulary): latanoprost ophthalmic solution (Xalatan, generics), bimatoprost 0.03% ophthalmic solution (generics), Lumigan, Travatan Z, Zioptan or Vyzulta. If none are formulary approve. **2.** Patient has a benzalkonium chloride sensitivity: approve if the patient has tried Zioptan or Travatan Z, if formulary. If neither is formulary, approve.	1 year	Yes	
Vesicular Monoamine Transporter Type 2 (VMAT2) Inhibitors	Xenazine	tetrabenazine tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Antibiotics (Oral)	Xifaxan 200 mg tablets	rifaximin 200 mg tablets	**1.** Approve if the patient has tried a fluroquinolone (e.g., ciprofloxacin, levofloxacin, ofloxacin), azithromycin, or Aemcolo. **2.** Approve if the patient has already started on Xifaxan in order to complete the course of therapy.	1 month	Yes	
Antibiotics (Oral)	Ximino and authorized generic	minocycyline ER capsule	Approve if the patient has tried minocycline extended-release tablets (Solodyn, generics), if formulary. If none are formulary, approve	1 year	Yes	
Short-Acting Beta-Agonists (Inhaled)	Xopenex HFA	levalbuterol inhalation aerosol	**1.** Approve if the patient has tried one formulary albuterol containing inhaler from the following list: albuterol HFA (Proventil HFA, generics), Ventolin HFA, albuterol HFA inhaler (authorized generic for Ventolin HFA), albuterol HFA (Proair HFA, generics), ProAir Respiclick, ProAir Digihaler, if one is formulary. If none are formulary, approve. **2.** Patients < 12 years of age or patients who have a low inspiratory flow rate and are unable to use a dry powder inhaler (DPI): approve if the patient has tried one product from the following list (if one is formulary): albuterol HFA (ProAir HFA, generics), Ventolin HFA, albuterol HFA inhaler (authorized generic for Ventolin HFA), albuterol HFA (Proventil HFA, generics). If none are formulary, approve.	1 year	Yes	
Cancer Agent – Multiple Myeloma Nuclear Export Inhibitor	Xpovio	selinexor tablets	**1.** Approve if the patient has tried at least two proteasome inhibitors (e.g., Velcade, Kyprolis, Ninlaro), at least two immunomodulatory drugs (e.g., Revlimid, Pomalyst, Thalomid), and an anti-CD38 monoclonal antibody (e.g., Darzalex). **2.** If the patient has already been started on Xpovio, approve.	1 year	Yes	Yes
Long-Acting Opioids (Oral)	Xtampza ER	oxycodone extended-release capsules (with DETERx)	**1.** Approve if the patient has tried two other oral long-acting opioid products. For example: morphine sulfate controlled-release/extended-release capsules or tablets [MS Contin, generics; Kadian, generics for some strengths], hydromorphone extended-release tablets [Exalgo, generics], oxymorphone extended-release, Nucynta ER, Zohydro ER, OxyContin, oxycodone ER tablets [generics], Hysingla ER, Arymo ER, or MorphaBond. **2.** Patient is intolerant or allergic to morphine: approve if the patient has tried one product from the following list (if one is formulary): Nucynta ER, Zohydro ER, Hysingla ER, oxycodone ER tablets (generics), or OxyContin. If none are formulary, approve. **3.** Patient has renal insufficiency: approve if the patient has tried one product from the following list (if one is formulary): Nucynta ER, Zohydro ER, Hysingla ER, or oxycodone ER tablets (generics), OxyContin. If none are formulary, approve.	1 year	Yes	
Hemophilia - Factor VIII Products (recombinant standard half-life)	Xyntha/ Xyntha Solofuse	antihemophilic factor [recombinant], plasma/albumin-free injection	**1.** Patient has tried two formulary recombinant Factor VIII products from the following list (if two are formulary, or one if one is formulary): Advate, Kogenate FS, Recombinate, Novoeight, Nuwiq, Kovaltry, Afstyla. If none are formulary, approve. **2.** Patient is currently receiving Xyntha or has received Xyntha in the past: approve.	1 year	Yes	Yes
Contraceptives	Yasmin	ethinyl estradiol/ drospirenone tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Proton Pump Inhibitor Combination	Yosprala and authorized generic	aspirin and omeprazole delayed-release tablets	Approve if the patient has tried aspirin AND one proton pump inhibitor (e.g., omeprazole [Prilosec, generics], rabeprazole tablets [Aciphex, generics], lansoprazole [Prevacid, generics], esomeprazole [Nexium, generics], pantoprazole [Protonix, generics]).	1 year	Yes	

Gaucher Disease Medications	Zavesca	miglustat capsules	**NOTE**: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. See Zavesca FE MSB criteria	1 year	MSB Exclusion *This criteria applies only to the NPF	
Proton Pump Inhibitors (PPIs)	Zegerid capsules	omeprazole/ sodium bicarbonate capsules	Approve if the patient has tried five proton pump inhibitors (PPIs). **Note**: Examples of PPIs include rabeprazole delayed-release (DR) tablets (Aciphex, generics), Aciphex Sprinkle DR capsules or authorized generic, Dexilant DR capsules, esomeprazole DR capsules (Nexium, generics), Nexium DR packet (granules for oral suspension), pantoprazole DR tablets (Protonix, generics), Protonix suspension (granules), lansoprazole DR capsules (Prevacid, generics), lansoprazole oral disintegrating tablets (Prevacid Solutab, generics), omeprazole DR capsules (Prilosec, generics), or Prilosec DR suspension. **Note**: The requested agent would NOT count as a trial of an alternative.	1 year	Yes	
Proton Pump Inhibitors (PPIs)	Zegerid packets	omeprazole/ sodium bicarbonate powder for oral suspension (packets)	Approve if the patient has tried five proton pump inhibitors (PPIs). **Note**: Examples of PPIs include rabeprazole delayed-release (DR) tablets (Aciphex, generics), Aciphex Sprinkle DR capsules or authorized generics, Dexilant DR capsules, esomeprazole DR capsules (Nexium, generics), Nexium DR packet (granules for oral suspension), pantoprazole DR tablets (Protonix, generics), Protonix suspension (granules), lansoprazole DR capsules (Prevacid, generics), lansoprazole oral disintegrating tablets (Prevacid Solutab, generics), omeprazole DR capsules (Prilosec, generics), or Prilosec DR suspension. **Note**: The requested agent would NOT count as a trial of an alternative.	1 year	Yes	
Antiparkinson Drugs	Zelapar	selegiline orally disintegrating tablets	**1.** Approve if the patient has tried one product from the following list (if one is formulary): selegiline tablets, selegiline capsules (Eldepryl, generics), rasagiline tablets (Azilect, generics), or Xadago. If none are formulary, approve. **2.** Approve if the patient cannot swallow or has difficulty swallowing selegiline tablets.	1 year	Yes	
Hypolipoproteinemics	Zetia	ezetimibe tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Nasal Steroids	Zetonna	ciclesonide nasal aerosol	Approve if the patient has tried three other nasal steroids. **NOTE:** Examples include: fluticasone propionate spray (prescription or over-the-counter [OTC]), Beconase AQ, mometasone nasal spray (Nasonex, generics), triamcinolone nasal spray (prescription or OTC), flunisolide nasal spray (generics), Omnaris, budesonide nasal spray (prescription or OTC), or Qnasl.	1 year	Yes	
NSAIDs (Oral)	Zipsor	diclofenac potassium capsule	Approve if the patient has tried five prescription-strength, oral NSAIDS. **Note**: Examples include: meloxicam (Mobic, generics), diclofenac (Voltaren XR, generics), ibuprofen (Motrin, generics), naproxen (Naprosyn, Naprelan, generics), etodolac (generics), nabumetone (generics), piroxicam (Feldene, generics), indomethacin (generics). **Note**: Over-the-counter (OTC) NSAIDs would count if prescription-strength doses were used. **Note**: Five unique NSAIDs should be tried.	1 year	Yes	
HMG-CoA Reductase Inhibitors and Combination Products	Zocor	simvastatin tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Selective Serotonin Reuptake Inhibitors (SSRIs)	Zoloft	sertraline HCl tablets and oral solution	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Growth Hormone Products	Zomacton (formerly Tev-Tropin)	somatropin injection	Approve if the patient has tried five of the following (if five are formulary, or four if four are formulary, or three if three are formulary, or two if only two are formulary, or one if only one is formulary): Genotropin, Humatrope, Norditropin, Nutropin AQ, Omnitrope, or Saizen. If none are formulary, approve.	1 year	Yes	
Migraine Agents - Triptans	Zomig	zolmitriptan tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Migraine Agents - Triptans	Zomig ZMT	zolmitriptan oral disintegrating tablet	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Antiepileptics	Zonegran	zonisamide capsule	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
NSAIDs (Oral)	Zorvolex	diclofenac capsules	Approve if the patient has tried five prescription-strength, oral NSAIDS. **Note**: Examples include: diclofenac (Voltaren XR, generics), ibuprofen (e.g., Motrin, generics), naproxen (e.g., Naprosyn, Naprelan, generics), etodolac (generics), meloxicam (Mobic, generics), nabumetone (generics), piroxicam (Feldene, generics), indomethacin (generics). **Note**: Over-the-counter (OTC) NSAIDs would count if prescription-strength doses were used. **Note**: Five unique NSAIDs should be tried.	1 year	Yes	

Antivirals (Topical)	Zovirax ointment	acyclovir 5% ointment	**NOTE**: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria**: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Actinic Keratosis Agents (Topical)	Zyclara 2.5% and 3.75% and authorized generic 3.75%	imiquimod 2.5% and 3.75% cream	Approve if the patient has tried imiquimod 5% cream (Aldara, generics), if formulary. If imiquimod 5% cream (Aldara, generics) is non-formulary, approve.	1 year	Yes	
Cancer Agents - Prostate Cancer (Oral)	Zytiga 250 mg ONLY	abiraterone acetate 250 mg	**Note**: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. See Zytiga 250 mg FE MSB criteria	1 year	MSB Exclusion *This criteria applies only to the NPF	