PDL & Resources

Utah Department of Health & Human Services
Integrated Healthcare

Preferred Drug List & Pharmacy Coverage Resources

Effective January 1, 2024

Preferred Drug List (PDL)

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Ultra High Cost Drugs

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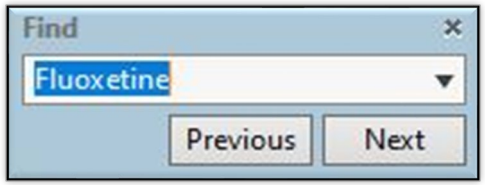
Search Tip: Use the keyboard shortcut Ctrl+F to open the Find menu. Type a word/medication to find in the document.

How to Navigate Resources

Headers and Classifications: Products are listed by Group, followed by Class/Sub-Class.

Medication/Product Group
Medication/Product Class
Medication/Product Sub-Class

Search Document:



- Open Find Menu, use the keyboard shortcut Ctrl+F (Command+F for Mac).
- Type a word/medication to find in document.
  Note: Display format will vary depending upon browser/software used to view document.
- Select "Next" or Arrow Buttons to view multiple results.

Utah Medicaid Preferred Drug List - Effective January 1, 2024

• **Drugs Not Listed on PDL:** Covered per Pharmacy Provider Manual. Manuals can be found at https://medicaid.utah.gov/utah-medicaid-official-publications

• **Listed Drug Name:** When only the generic name is listed, this includes all generic strengths, dosage forms, and formulations for that drug and in that class. The same principle applies to brand name drugs. When the strength and/or dosage form is included in a name listing, this narrows the listing to those particular strengths and/or dosage forms. A comma may be used to delineate multiple strengths, dosage forms, or formulations.

• **Non-Preferred Products:** Non-preferred products require an appropriate trial and failure of a preferred product with similar dosage form and use/indication. If a non-preferred strength/dosage form is requested, the preferred strength/dosage form must be tried before the non-preferred strength/ dosage form will be approved. Or the prescriber must demonstrate medical necessity for non-preferred. Additonal criteria found on Drug Class and Disease Specific PA Forms will also apply. Authorization Criteria can be found at https://medicaid.utah.gov/pharmacy/prior-authorization.

• **Non-Preferred Combination Products:** If separate single ingredient products are preferred, those must be tried before a non-preferred product will be approved.

• **Non-Preferred Psychotropic Products - DAW (Dispense as Written):** Non-preferred psychotropic medications may bypass the non-preferred drug prior authorization if a prescriber writes “dispense as written” on a prescription and the pharmacy submits a Dispense As Written (DAW) Code of “1” on the claim.

Note: In accordance with UCA 58-17b-606 (4) and (5), the DAW Code will not allow claims for the brand-name version of multisource drugs to bypass the prior authorization requirement, even if the brand-name version of the drug is listed as non-preferred and the prescriber writes “dispense as written” on the prescription. An exception to this is when a brand-name drug is listed on the Brand Over Generic reference; in that case, the DAW Code will only override the brand-name drug.

Note: In order for a prescription to be eligible for the pharmacy to submit the DAW Code of “1” to bypass the edit for a nonpreferred medication the prescriber must write “dispense as written” on the physical prescription. Check boxes or pre-printed forms that include “dispense as written” are not acceptable substitutes for the prescriber writing “dispense as written” on the prescription. Electronic prescriptions must state “dispense as written” as either a note or as part of the prescription drug order to satisfy this requirement. Verbal orders that include “dispense as written” must be reduced to writing on the prescription by the pharmacist accepting the verbal order and documented in the member’s medical record.

• **Over-the-Counter (OTC) Products:** PDL listing is for legend drugs and does not include all covered over-the-counter (OTC) products. A complete listing of covered OTC products is located in this document following the PDL. Please note, OTC products are not covered through the outpatient pharmacy benefit program for members residing in nursing homes. The nursing-home reimbursement rate includes payment for OTC products.

• **Updates:** PDL changes will be posted monthly, changes effective in the posted month are highlighted in yellow. This may include changes to the status (preferred/non-preferred) or a change to the way the drug is listed. A date older than the release of a new form of a drug does not mean the newer form is excluded from that listing.

• **Vaccines for children:** Claims for pediatric Medicaid members (age 18 and younger) for vaccines eligible through the Vaccines for Children Program must be submitted through the Vaccines for Children Program. For additional information, please refer to the Pharmacy Services Provider Manual or visit https://immunize.utah.gov/vaccines-for-children-program/

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Analgesics

Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)

Preferred Drugs	Status	Type	Last Update	Limits	Mandatory 3-Month	Brand Required	Additional Note
celecoxib	Preferred	Generic	09/01/20				
diclofenac gel	Preferred	Generic	11/01/19				
diclofenac Na DR 50, 75mg	Preferred	Generic	01/01/12				
diclofenac potassium 50mg	Preferred	Generic	07/01/12				
Flector patch	Preferred	Brand	01/01/18			Flector	
flurbiprofen	Preferred	Generic	01/01/12				
ibuprofen	Preferred	Generic	09/28/09				
indomethacin	Preferred	Generic	01/01/21				
ketorolac tablet	Preferred	Generic	09/28/09	4 units /day for 5 days 20 units /180 days			Limits apply to oral, nasal, and injectable formulations.
ketorolac injection	Preferred	Generic	09/28/09	4 units /day for 5 days 20 units /180 days			Covered under medical benefit using appropriate HCPCS
meloxicam tablet	Preferred	Generic	09/28/09				
nabumetone	Preferred	Generic	09/28/09				
naproxen tablet, EC	Preferred	Generic	09/28/09				
Pennsaid	Preferred	Brand	01/01/18				
sulindac	Preferred	Generic	01/01/12				

Non Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
Anjeso	Non Preferred	Brand	07/01/20		Medication Coverage Exception		
Caldolor	Non Preferred	Brand	12/01/22		Medication Coverage Exception		
Celebrex	Non Preferred	Brand	09/01/20		Medication Coverage Exception		
Daypro	Non Preferred	Brand	02/01/16		Medication Coverage Exception		
diclofenac Na DR 25mg, 100mg	Non Preferred	Generic	01/01/13		Medication Coverage Exception		
diclofenac ER	Non Preferred	Generic	01/01/22		Medication Coverage Exception		
diclofenac patch	Non Preferred	Generic	04/01/19		Medication Coverage Exception	Flector	
diclofenac potassium 25mg	Non Preferred	Generic	01/01/23		Medication Coverage Exception		
diclofenac solution	Non Preferred	Generic	05/30/14		Medication Coverage Exception		
etodolac	Non Preferred	Generic	01/01/24		Medication Coverage Exception		
etodolac ER	Non Preferred	Generic	05/30/14		Medication Coverage Exception		
Feldene	Non Preferred	Brand	01/01/13		Medication Coverage Exception		
fenoprofen	Non Preferred	Generic	01/01/13		Medication Coverage Exception		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
ibuprofen lysine injection	Non Preferred	Generic	11/01/20		Medication Coverage Exception	Neoprofen	
Indocin suppository	Non Preferred	Brand	09/01/18		Medication Coverage Exception		
Indocin suspension	Non Preferred	Brand	01/01/20		Medication Coverage Exception		
ketoprofen, ER	Non Preferred	Generic	01/01/19		Medication Coverage Exception		
ketorolac nasal	Non Preferred	Generic	06/01/20	4 units /day for 5 days 20 units /180 days	Medication Coverage Exception		Limits apply to oral, nasal, and injectable formulations.
Licart	Non Preferred	Brand	06/01/20		Medication Coverage Exception		
meclofenamate	Non Preferred	Generic	01/01/13		Medication Coverage Exception		
mefenamic acid	Non Preferred	Generic	01/01/13		Medication Coverage Exception		
meloxicam capsule	Non Preferred	Generic	09/01/22		Medication Coverage Exception	Vivlodex	
Mobic	Non Preferred	Brand	01/01/13		Medication Coverage Exception		
Nalfon	Non Preferred	Brand	01/01/13		Medication Coverage Exception		
Naprelan CR	Non Preferred	Brand	08/01/17		Medication Coverage Exception	Naprelan CR	
naproxen Na	Non Preferred	Generic	01/01/19		Medication Coverage Exception		
naproxen Na CR	Non Preferred	Generic	08/01/17		Medication Coverage Exception	Naprelan CR	
naproxen susp	Non Preferred	Generic	01/01/20		Medication Coverage Exception		
Neoprofen	Non Preferred	Brand	11/01/20		Medication Coverage Exception	Neoprofen	
Oxaprozin	Non Preferred	Generic	02/01/16		Medication Coverage Exception		
piroxicam	Non Preferred	Generic	01/01/13		Medication Coverage Exception		
Relafen	Non Preferred	Brand	10/01/19		Medication Coverage Exception		
Sprix	Non Preferred	Brand	06/01/20	4 units /day for 5 days 20 units /180 days	Medication Coverage Exception		Limits apply to oral, nasal, and injectable formulations.
Tolmetin	Non Preferred	Brand	01/01/13		Medication Coverage Exception		
Zorvolex	Non Preferred	Brand	11/01/13		Medication Coverage Exception		

Short Acting Opioids

- **Cancer Pain:** MME and quantity limits may be overridden if the prescriber writes Diagnosis Code (G89.3 Neoplasm related pain) for cancer related pain on the face of the prescription.
- **Children**: 18 years of age and younger, short-acting opioid prescriptions that exceed a 7 day supply require prior authorization.
- **Initial Fill**: Initial prescriptions that exceed a 7 day supply or 3 day for dental providers require prior authorization. A prescription is considered "initial" if the drug has not been filled for the member in the past 60 days.
- **MME**: In addition to the drug-specific limits below, 90 MME limit applies for any combination of opioids.
- **Pregnancy:** Pregnant women, short-acting opioid prescriptions that exceed a 7 day supply require prior authorization.

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Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
Actiq	Preferred	Brand	01/01/15	Cancer-related pain only	Opioid	Actiq	
codeine tablet	Preferred	Generic	01/01/15	90 MME & 6 tablets /day	Opioid		
hydromorphone liquid	Preferred	Generic	01/01/15	90 MME & 16 ml /day	Opioid		
hydromorphone tablet	Preferred	Generic	01/01/15	90 MME & 6 tablets /day	Opioid		
morphine conc. (10mg/ml)	Preferred	Generic	01/01/15	90 MME & 8 ml /day	Opioid		
morphine conc. (20mg/ml)	Preferred	Generic	01/01/15	90 MME & 4 ml /day	Opioid		
morphine tablet	Preferred	Generic	01/01/15	90 MME & 3 tablets /day	Opioid		
Nucynta	Preferred	Generic	01/01/21	90 MME & 3 tablets /day	Opioid		
oxycodone 20mg, 30mg	Preferred	Generic	01/01/15	90 MME & 3 tablets /day	Opioid		
oxycodone 5mg, 10mg, 15mg	Preferred	Generic	01/01/15	90 MME & 6 tablets /day	Opioid		
oxycodone solution (1mg/ml)	Preferred	Generic	01/01/15	90 MME & 20 ml /day	Opioid		
tramadol tablet	Preferred	Generic	01/01/15	90 MME & 400mg /day	Opioid		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Dilaudid	Non Preferred	Brand	10/01/19	90 MME & 6 tablets /day	Opioid		
fentanyl lozenge	Non Preferred	Generic	01/01/15	Cancer-related pain only	Opioid	Actiq	
fentanyl tablet	Non Preferred	Generic	07/01/19	Cancer-related pain only	Opioid	Fentora	
Fentora	Non Preferred	Brand	01/01/20	Cancer-related pain only	Opioid	Fentora	
hydromorphone suppository	Non Preferred	Generic	09/01/21	90 MME & 3 suppositories /day	Opioid		
meperidine solution	Non Preferred	Generic	01/01/15	90 MME & 8 ml /day	Opioid		
meperidine tablet	Non Preferred	Generic	01/01/15	90 MME & 1.8 tablets /day	Opioid		
morphine suppository	Non Preferred	Generic	01/01/15	90 MME & 3 suppository/day	Opioid		
Olinvyk	Non Preferred	Brand	12/01/20	90 MME	Opioid		
Oxaydo	Non Preferred	Brand	10/01/15	90 MME & 3 tablets /day	Opioid		
oxycodone capsule 5mg	Non Preferred	Generic	10/01/19	90 MME & 4 capsules /day	Opioid		
oxycodone conce. (20mg/ml)	Non Preferred	Generic	10/01/19	90 MME & 4 ml /day	Opioid		
oxymorphone	Non Preferred	Generic	08/01/17	90 MME & 3 tablets /day	Opioid		
Roxicodone 5mg, 15mg	Non Preferred	Brand	09/01/18	90 MME & 6 tablets /day	Opioid		
Roxicodone 30mg	Non Preferred	Brand	09/01/18	90 MME & 3 tablets /day	Opioid		
tramadol solution	Non Preferred	Generic	02/01/23	90 MME & 400mg /day	Opioid		

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Long Acting Opioids							
• **Cancer Pain:** MME and quantity limits may be overridden if the prescriber writes Diagnosis Code (G89.3 Neoplasm related pain) for cancer related pain on the face of the prescription.							
• **Benzodiazepine and Opioid Combination:** Concurrent long-acting opioids and benzodiazepines (within 45 days of each other) require prior authorization.							
• **MME**: In addition to the drug-specific limits below, 90 MME limit applies for any combination of opioids.							
• **Mutually Exclusive:** Methadone and Fentanyl are mutually exclusive with each other and all long acting opioids. All other opioids are not.							
• **Short before Long:** Short acting opioid fill (within 30 days) is required before initiation of long acting opioid therapy.							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Butrans	Preferred	Brand	01/01/20	90 MME & 4 patches /28 days	Opioid	Butrans	
Conzip ER	Preferred	Brand	06/01/23	90 MME & 1 capsule /day	Opioid	Conzip ER	
fentanyl patch 12.5, 25mcg	Preferred	Generic	01/01/19	90 MME & 1 patch /3 days	Opioid		
fentanyl patch 50, 75, 100mcg	Preferred	Generic	01/01/19	Cancer-related pain only	Opioid		
morphine ER tablet 15mg	Preferred	Generic	01/01/14	90 MME & 3 tablets /day	Opioid		
morphine ER tablet >15mg	Preferred	Generic	01/01/14	90 MME & 2 tablets /day	Opioid		
Nucynta ER	Preferred	Brand	10/01/17	90 MME & 2 tablets /day	Opioid		
OxyContin	Preferred	Brand	01/01/20	90 MME & 2 tablets /day	Opioid	OxyContin	
Xtampza ER	Preferred	Brand	01/01/22	90 MME & 2 tablets /day	Opioid		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Belbuca	Non Preferred	Brand	01/01/16	90 MME & 2 films /day	Opioid		
buprenorphine films	Non Preferred	Generic	10/01/21	90 MME & 2 films /day	Opioid	Belbuca	
buprenorphine patch	Non Preferred	Generic	10/30/14	90 MME & 4 patches /28 days	Opioid	Butrans	
fentanyl patch 37.5, 62.5, 87.5mcg	Non Preferred	Generic	09/28/09	90 MME & 1 patch /3 days	Opioid		
hydrocodone ER capsule	Non Preferred	Generic	01/01/20	90 MME & 1 capsule /day	Opioid	Zohydro ER	
hydrocodone ER tablet	Non Preferred	Generic	01/01/20	90 MME & 1 capsule /day	Opioid	Hysingla ER	
hydromorphone ER	Non Preferred	Generic	01/01/15	90 MME & 1 tablet /day	Opioid		
Hysingla ER	Non Preferred	Brand	12/15/14	90 MME & 2 tablets /day	Opioid	Hysingla ER	
Kadian	Non Preferred	Brand	01/01/17	90 MME & 1 capsule /day	Opioid	Kadian	
levorphanol	Non Preferred	Generic	01/01/15	90 MME	Opioid		
methadone	Non Preferred	Generic	01/01/16	90 MME & 15mg /day	Methadone		
Methadose	Non Preferred	Brand	01/01/16	90 MME & 15mg /day	Methadone		
morphine ER capsule	Non Preferred	Generic	09/28/09	90 MME & 1 tablet/ day	Opioid	Kadian	

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
MS Contin 15mg	Non Preferred	Brand	09/01/16	90 MME & 3 tablets /day			
MS Contin >15mg	Non Preferred	Brand	09/01/16	90 MME & 2 tablets /day	Opioid		
oxycodone ER	Non Preferred	Generic	01/01/20	90 MME & 2 tablets /day	Opioid	OxyContin	
oxymorphone ER	Non Preferred	Generic	07/01/17	90 MME & 2 tablets /day	Opioid		
tramadol ER capsule	Non Preferred	Generic	01/01/16	90 MME & 1 tablet /day	Opioid	Conzip ER	
tramadol ER tablet	Non Preferred	Generic	01/01/16	90 MME & 1 tablet /day	Opioid		
Zohydro ER	Non Preferred	Brand	01/01/14	90 MME & 2 tablets /day	Opioid	Zohydro ER	

Opioid Combinations

• **Cancer Pain:** MME and quantity limits may be overridden if the prescriber writes Diagnosis Code (G89.3 Neoplasm related pain) for cancer related pain on the face of the prescription.

• **Children**: 18 years of age and younger, short-acting opioid prescriptions that exceed a 7 day supply require prior authorization.

• **Initial Fill**: Initial prescriptions that exceed a 7 day supply or 3 day for dental providers require prior authorization. A prescription is considered "initial" if the drug has not been filled for the member in the past 60 days.

• **MME**: In addition to the drug-specific limits below, 90 MME limit applies for any combination of opioids.

• **Pregnancy:** Pregnant women, short-acting opioid prescriptions that exceed a 7 day supply require prior authorization.

Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
apap/codeine liquid	Preferred	Generic	05/01/17	90 MME & 15 ml /day	Opioid		
apap/codeine tablet	Preferred	Generic	05/01/17	90 MME & 6 tablets /day	Opioid		
hydrocodone/apap liquid	Preferred	Generic	05/01/17	90 MME & 60 ml /day	Opioid		
hydrocodone/apap tablet	Preferred	Generic	05/01/17	90 MME & 6 tablets /day	Opioid		
oxycodone/apap liquid	Preferred	Generic	05/01/17	90 MME & 20 ml /day	Opioid		
oxycodone/apap tablet	Preferred	Generic	05/01/17	90 MME & 6 tablets /day	Opioid		
tramadol/apap	Preferred	Generic	05/01/17	90 MME & 8 tablets /day	Opioid		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Apadaz	Non Preferred	Brand	03/01/19	90 MME & 4 tablets /day	Opioid		
benzhydrocodone/apap	Non Preferred	Generic	01/01/21	90 MME & 4 tablets /day	Opioid		
dihydrocodeine/apap/caf	Non Preferred	Generic	01/01/19	90 MME & 4 tablets /day	Opioid		
hydrocodone/ibu	Non Preferred	Generic	05/01/17	90 MME & 4 tablets /day	Opioid		
Lortab solution	Non Preferred	Brand	05/01/17	90 MME & 60 ml /day	Opioid		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
pentazocine/naloxone	Non Preferred	Generic	01/01/22	90 MME & 4 tablets /day	Opioid		
Percocet	Non Preferred	Brand	05/01/17	90 MME & 6 tablets /day	Opioid		
Primlev	Non Preferred	Brand	05/01/17	90 MME & 4 tablets /day	Opioid		
Seglentis	Non Preferred	Brand	03/01/22	90 MME & 4 tablets /day	Opioid		
Ultracet	Non Preferred	Brand	05/01/17	90 MME & 8 tablets /day	Opioid		
Opioid Use Disorder Treatments							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Brixadi monthly	Preferred	Brand	08/01/23	Minimum Age: 16 Years Old 1 prefilled syringe/ 26 days	Not Required if within Limits Buprenorphine/Naloxone		Must be dispensed directly to the provider, not the patient.
Brixadi weekly	Preferred	Brand	08/01/23	Minimum Age: 16 Years Old 4 prefilled syringes/ 26 days	Not Required if within Limits Buprenorphine/Naloxone		Must be dispensed directly to the provider, not the patient.
buprenorphine	Preferred	Generic	02/01/21	Minimum Age: 16 Years Old 24 mg & 3 units/day	Not Required if within Limits Buprenorphine/Naloxone		
buprenorphine/naloxone tablet	Preferred	Generic	01/01/22	24 mg & 3 units/day	Not Required if within Limits Buprenorphine/Naloxone		
naltrexone tablet	Preferred	Generic	12/01/17				
Sublocade	Preferred	Brand	01/01/19	Minimum Age: 16 Years Old 1.5 units/ 26 days	Not Required if within Limits Buprenorphine/Naloxone		Must be dispensed directly to the provider, not the patient.
Suboxone film	Preferred	Brand	01/01/12	24 mg & 3 units/day	Not Required if within Limits Buprenorphine/Naloxone	Suboxone film	
Vivitrol	Preferred	Brand	01/01/18	Minimum Age: 18 Years Old 1 unit /28 days	Not Required if within Limits Buprenorphine/Naloxone		Must be dispensed directly to the provider, not the patient.
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
buprenorphine/naloxone film	Non Preferred	Generic	01/01/15	24 mg & 3 units/day	Buprenorphine/Naloxone	Suboxone film	
Zubsolv	Non Preferred	Brand	01/01/17	24 mg & 3 units/day	Buprenorphine/Naloxone		
Androgens							
Topical Androgens							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Androderm	Preferred	Brand	01/01/19	Male only	Androgens		
Androgel	Preferred	Brand	01/01/24	Male only	Androgens		
Testim	Preferred	Brand	01/01/24	Male only	Androgens		
testosterone gel	Preferred	Generic	07/01/23	Male only	Androgens		

Non Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
Fortesta	Non Preferred	Brand	06/01/12	Male only	Androgens		
Natesto	Non Preferred	Brand	07/01/20	Male only	Androgens		
testosterone solution	Non Preferred	Generic	06/24/14	Male only	Androgens		
Vogelxo	Non Preferred	Brand	06/09/14	Male only	Androgens		
Misc Androgens							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
danazol	Preferred	Generic	02/15/16		Androgen		
testosterone cypionate	Preferred	Generic	06/01/16	Male only	Androgen		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Aveed	Non Preferred	Brand	03/17/14	Male only	Androgen		
Depo-Testosterone	Non Preferred	Brand	06/01/16	Male only	Androgen		
Jatenzo	Non Preferred	Brand	01/01/20	Male only	Androgen		
Methitest	Non Preferred	Brand	01/01/13	Male only	Androgen		
methyltestosterone	Non Preferred	Generic	02/15/16	Male only	Androgen		
oxandrolone	Non Preferred	Generic	01/01/13	Male only	Androgen		
Testopel	Non Preferred	Brand	01/01/15	Male only	Androgen		Covered under medical benefit using appropriate HCPCS
testosterone enanthate	Non Preferred	Generic	12/01/18	Male only	Androgen		
Tlando	Non Preferred	Brand	05/01/22	Male only	Androgen		
Xyosted	Non Preferred	Brand	12/01/18	Male only	Androgen		
Antibiotics							
3rd Generation Cephalosporins							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
cefdinir	Preferred	Generic	02/01/10				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
cefixime	Non Preferred	Generic	01/01/20		Medication Coverage Exception		
cefpodoxime	Non Preferred	Generic	01/01/20		Medication Coverage Exception		
Suprax	Non Preferred	Brand	01/01/19		Medication Coverage Exception		

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Quinolones							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Cipro suspension	Preferred	Brand	02/01/10			Cipro susp	
ciprofloxacin 250, 500, 750mg	Preferred	Generic	02/01/10				
levofloxacin	Preferred	Generic	02/01/16				
moxifloxacin	Preferred	Generic	01/01/21				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Baxdela	Non Preferred	Brand	10/01/17		Medication Coverage Exception		
Cipro tablet	Non Preferred	Brand	02/01/10		Medication Coverage Exception		
ciprofloxacin 100mg tablet	Non Preferred	Generic	01/01/22		Medication Coverage Exception		
ciprofloxacin suspension	Non Preferred	Generic	01/01/20		Medication Coverage Exception	Cipro susp	
ofloxacin tablet	Non Preferred	Generic	02/01/10		Medication Coverage Exception		
Tetracyclines							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
doxycycline monohydrate 50, 100mg capsule	Preferred	Generic	01/01/20				
doxycycline hyclate 50, 100mg	Preferred	Generic	01/01/20				
minocycline 50, 75, 100mg capsule	Preferred	Generic	01/01/20				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
demeclocycline	Non Preferred	Generic	01/01/20		Medication Coverage Exception		
Doryx	Non Preferred	Brand	01/01/20		Medication Coverage Exception		
doxycycline (unless listed preferred)	Non Preferred	Generic	01/01/20		Medication Coverage Exception		
minocycline ER capsule	Non Preferred	Generic	12/01/22		Medication Coverage Exception		
minocycline tablet	Non Preferred	Generic	01/01/20		Medication Coverage Exception		
Minolira	Non Preferred	Brand	01/01/20		Medication Coverage Exception		
Nuzyra	Non Preferred	Brand	01/01/20		Medication Coverage Exception		
Solodyn	Non Preferred	Brand	01/01/20		Medication Coverage Exception		
tetracycline	Non Preferred	Generic	01/01/20		Medication Coverage Exception		
Vibramycin	Non Preferred	Brand	01/01/20		Medication Coverage Exception		
Ximino	Non Preferred	Brand	01/01/20		Medication Coverage Exception		

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Anticoagulants

Oral

Preferred Drugs	Status	Type	Last Update	Limits	Mandatory 3-Month	Brand Required	Additional Note
Eliquis	Preferred	Brand	01/01/14				
Pradaxa	Preferred	Brand	01/01/14			Pradaxa	
Xarelto	Preferred	Brand	01/01/13				
warfarin	Preferred	Generic	06/01/20				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
dabigatran	Non Preferred	Generic	08/01/22		Medication Coverage Exception	Pradaxa	
Savaysa	Non Preferred	Brand	01/20/15		Medication Coverage Exception		

Injectable

Preferred Drugs	Status	Type	Last Update	Limits	Mandatory 3-Month	Brand Required	Additional Note
enoxaparin	Preferred	Generic	01/01/19				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Arixtra	Non Preferred	Brand	01/01/13		Medication Coverage Exception		
fondaparinux	Non Preferred	Generic	01/01/13		Medication Coverage Exception		
Fragmin	Non Preferred	Brand	01/01/18		Medication Coverage Exception		
Lovenox	Non Preferred	Brand	01/01/19		Medication Coverage Exception		

Antidiabetics

Short Acting Insulin

• **Insulin Pen Day Supply:** Insulin pens may be billed for up to a140-day supply, with a limit of one box for claims over 30-days, in accordance with the FDA's recommendation "dispense in original sealed carton". Day supply on submitted claims should reflect the actual days the medication will last and/or expire.

Preferred Drugs	Status	Type	Last Update	Limits	Mandatory 3-Month	Brand Required	Additional Note
Apidra	Preferred	Brand	01/01/17	60ml per 30 days			
Humalog U-100	Preferred	Brand	01/01/20	60ml per 30 days		Humalog	
insulin aspart	Preferred	Generic	01/01/24	60ml per 30 days			
Novolog	Preferred	Brand	02/01/10	60ml per 30 days			

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Non Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
Admelog	Non Preferred	Brand	02/01/18	60ml per 30 days	Medication Coverage Exception		
Afrezza	Non Preferred	Brand	07/01/17	60ml per 30 days	Medication Coverage Exception		
Fiasp	Non Preferred	Brand	02/01/18	60ml per 30 days	Medication Coverage Exception		
Humalog U-200	Non Preferred	Brand	01/01/20	60ml per 30 days	Medication Coverage Exception		
Humulin-R	Non Preferred	Brand	01/01/17	60ml per 30 days	Medication Coverage Exception		
insulin lispro	Non Preferred	Generic	05/01/19	60ml per 30 days	Medication Coverage Exception	Humalog	
Lyumjev	Non Preferred	Brand	07/01/20	60ml per 30 days	Medication Coverage Exception		
Myxredlin	Non Preferred	Brand	09/01/19	60ml per 30 days	Medication Coverage Exception		
Novolin-R	Non Preferred	Brand	01/01/17	60ml per 30 days	Medication Coverage Exception		
Intermediate Acting Insulin							
• **Insulin Pen Day Supply:** Insulin pens may be billed for up to a 140-day supply, with a limit of one box for claims over 30-days, in accordance with the FDA's recommendation "dispense in original sealed carton". Day supply on submitted claims should reflect the actual days the medication will last and/or expire.							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Novolin-N	Preferred	Brand	01/01/21	60ml per 30 days			
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Humulin-N	Non Preferred	Brand	01/01/21	60ml per 30 days	Medication Coverage Exception		
Long Acting Insulin							
• **Insulin Pen Day Supply:** Insulin pens may be billed for up to a 140-day supply, with a limit of one box for claims over 30-days, in accordance with the FDA's recommendation "dispense in original sealed carton". Day supply on submitted claims should reflect the actual days the medication will last and/or expire.							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Lantus	Preferred	Brand	01/01/17	60ml per 30 days			
Levemir	Preferred	Brand	09/28/09	60ml per 30 days			
Toujeo	Preferred	Brand	07/01/19	60ml per 30 days			

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Non Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
Basaglar	Non Preferred	Brand	12/01/16	60ml per 30 days	Medication Coverage Exception		
insulin degludec	Non Preferred	Generic	05/01/23	60ml per 30 days	Medication Coverage Exception		
insulin glargine	Non Preferred	Generic	11/01/21	60ml per 30 days	Medication Coverage Exception		
Rezvoglar	Non Preferred	Brand	04/01/23	60ml per 30 days	Medication Coverage Exception		
Semglee	Non Preferred	Brand	01/01/21	60ml per 30 days	Medication Coverage Exception		
Soliqua	Non Preferred	Brand	02/01/20	60ml per 30 days	Medication Coverage Exception		Trial & Failure of preferred Long Acting Insulin AND GLP-1 Agonist required.
Tresiba	Non Preferred	Brand	03/15/16	60ml per 30 days	Medication Coverage Exception		
Xultophy	Non Preferred	Brand	02/01/20	60ml per 30 days	Medication Coverage Exception		Trial & Failure of preferred Long Acting Insulin AND GLP-1 Agonist required.

Insulin Mixtures

• **Insulin Pen Day Supply:** Insulin pens may be billed for up to a 140-day supply, with a limit of one box for claims over 30-days, in accordance with the FDA's recommendation "dispense in original sealed carton". Day supply on submitted claims should reflect the actual days the medication will last and/or expire.

Preferred Drugs	Status	Type	Last Update	Limits	Mandatory 3-Month	Brand Required	Additional Note
Humalog 50/50	Preferred	Brand	09/28/09	60ml per 30 days		Humalog	
Humalog 75/25	Preferred	Brand	09/28/09	60ml per 30 days		Humalog	
Humulin 70/30	Preferred	Brand	01/01/20	60ml per 30 days		Humulin	
insulin aspart protamine/aspart	Preferred	Generic	01/01/24	60ml per 30 days			
Novolog 70/30	Preferred	Brand	02/01/10	60ml per 30 days			

Non Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
Novolin 70/30	Non Preferred	Brand	01/01/19	60ml per 30 days	Medication Coverage Exception		
insulin lispro protamine/lispro	Non Preferred	Generic	05/01/20	60ml per 30 days	Medication Coverage Exception	Humalog 75/25	

Sulfonylurea Combinations

Preferred Drugs	Status	Type	Last Update	Limits	Mandatory 3-Month	Brand Required	Additional Note
glyburide/metformin	Preferred	Generic	07/01/14		90 Day Supply Required		

Non Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
Duetact	Non Preferred	Brand	10/01/17		Medication Coverage Exception		
glipizide/metformin	Non Preferred	Generic	07/01/14		Medication Coverage Exception		
pioglitazone/glimepiride	Non Preferred	Generic	10/01/17		Medication Coverage Exception		

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GLP-1 Agonists							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Trulicity	Preferred	Brand	01/01/21				
Victoza	Preferred	Brand	01/01/14				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Adlyxin	Non Preferred	Brand	09/01/17		Medication Coverage Exception		
Bydureon BCise	Non Preferred	Brand	01/01/21		Medication Coverage Exception		
Byetta	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
Mounjaro	Non Preferred	Brand	06/01/22		Medication Coverage Exception		
Ozempic	Non Preferred	Brand	01/01/21		Medication Coverage Exception		
Rybelsus	Non Preferred	Brand	10/01/19		Medication Coverage Exception		
Soliqua	Non Preferred	Brand	02/01/20		Medication Coverage Exception		Trial & Failure of preferred Long Acting Insulin AND GLP-1 Agonist required.
Xultophy	Non Preferred	Brand	02/01/20		Medication Coverage Exception		Trial & Failure of preferred Long Acting Insulin AND GLP-1 Agonist required.
DPP- 4 Inhibitors							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Januvia	Preferred	Brand	09/28/09		90 Day Supply Required		
Onglyza	Preferred	Brand	01/01/24			Onglyza	
Tradjenta	Preferred	Brand	11/01/16		90 Day Supply Required		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
alogliptin	Non Preferred	Generic	04/01/16		Medication Coverage Exception	Nesina	
Nesina	Non Preferred	Brand	04/01/16		Medication Coverage Exception	Nesina	
saxagliptin	Non Preferred	Generic	09/01/23		Medication Coverage Exception	Onglyza	
Zituvio	Non Preferred	Brand	01/01/24		Medication Coverage Exception		

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DPP- 4 Inhibitor Combinations							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Janumet, XR	Preferred	Brand	11/01/16		90 Day Supply Required		
Jentadueto, XR	Preferred	Brand	01/01/20		90 Day Supply Required		
Kombiglyze XR	Preferred	Brand	08/01/21		90 Day Supply Required	Kombiglyze XR	
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
alogliptin/pioglitazone	Non Preferred	Generic	01/01/19		Medication Coverage Exception	Oseni	
alogliptin/metformin	Non Preferred	Generic	01/01/20		Medication Coverage Exception		
Glyxambi	Non Preferred	Brand	02/11/15		Medication Coverage Exception		Trial and Failure of a preferred DPP- 4 Inhib. AND SGLT-2 Inhib. required.
Kazano	Non Preferred	Brand	02/01/18		Medication Coverage Exception		
Oseni	Non Preferred	Brand	01/01/19		Medication Coverage Exception	Oseni	
Qtern	Non Preferred	Brand	12/01/17		Medication Coverage Exception		Trial and Failure of a preferred DPP- 4 Inhib. AND SGLT-2 Inhib. required.
saxagliptin/metformin	Non Preferred	Generic	09/01/23		Medication Coverage Exception	Kombiglyze XR	
Steglujan	Non Preferred	Brand	02/01/18		Medication Coverage Exception		Trial and Failure of a preferred DPP- 4 Inhib. AND SGLT-2 Inhib. required.
Trijardy XR	Non Preferred	Brand	04/01/20		Medication Coverage Exception		Trial and Failure of a preferred DPP- 4 Inhib. AND SGLT-2 Inhib. required.
SGLT-2 Inhibitors							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Farxiga	Preferred	Brand	01/01/18		90 Day Supply Required		
Invokana	Preferred	Brand	01/01/21		90 Day Supply Required		
Jardiance	Preferred	Brand	01/01/19		90 Day Supply Required		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Brenzavvy	Non Preferred	Brand	08/01/23		Medication Coverage Exception		
Inpefa	Non Preferred	Brand	07/01/23		Medication Coverage Exception		
Steglatro	Non Preferred	Brand	02/01/18		Medication Coverage Exception		

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SGLT-2 Inhibitor Combinations							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Invokamet	Preferred	Brand	01/01/21		90 Day Supply Required		
Synjardy, XR	Preferred	Brand	01/01/18		90 Day Supply Required		
Xigduo XR	Preferred	Brand	01/01/18		90 Day Supply Required		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Glyxambi	Non Preferred	Brand	02/11/15		Medication Coverage Exception		Trial and Failure of a preferred DPP- 4 Inhib. AND SGLT-2 Inhib. required.
Invokamet XR	Non Preferred	Brand	01/01/18		Medication Coverage Exception		
Qtern	Non Preferred	Brand	12/01/17		Medication Coverage Exception		Trial and Failure of a preferred DPP- 4 Inhib. AND SGLT-2 Inhib. required.
Segluromet	Non Preferred	Brand	03/01/18		Medication Coverage Exception		
Steglujan	Non Preferred	Brand	02/01/18		Medication Coverage Exception		Trial and Failure of a preferred DPP- 4 Inhib. AND SGLT-2 Inhib. required.
Trijardy XR	Non Preferred	Brand	04/01/20		Medication Coverage Exception		Trial and Failure of a preferred DPP- 4 Inhib. AND SGLT-2 Inhib. required.
Glucagon Products							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Baqsimi	Preferred	Brand	01/01/23				
Glucagen	Preferred	Brand	07/01/21				
Zegalogue	Preferred	Brand	01/01/22				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
glucagon	Non Preferred	Generic	07/01/21		Medication Coverage Exception		
Gvoke	Non Preferred	Brand	01/01/24		Medication Coverage Exception		

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Antifungals

Oral

Preferred Drugs	Status	Type	Last Update	Limits	Mandatory 3-Month	Brand Required	Additional Note
clotrimazole lozenge	Preferred	Generic	10/01/11				
fluconazole	Preferred	Generic	10/01/11				
griseofulvin suspension	Preferred	Generic	01/01/13				
itraconazole 100mg capsule	Preferred	Generic	01/01/24				
ketoconazole tablet	Preferred	Generic	01/15/12				
nystatin	Preferred	Generic	10/01/11				
terbinafine	Preferred	Generic	10/01/11				
voriconazole	Preferred	Generic	10/01/15				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Ancobon	Non Preferred	Brand	01/01/23		Medication Coverage Exception	Ancobon	
Brexafemme	Non Preferred	Brand	08/01/21		Medication Coverage Exception		
Cresemba	Non Preferred	Brand	04/01/15		Medication Coverage Exception		
Diflucan	Non Preferred	Brand	01/01/13		Medication Coverage Exception		
flucytosine	Non Preferred	Generic	08/01/16		Medication Coverage Exception	Ancobon	
griseofulvin tablet	Non Preferred	Generic	10/01/11		Medication Coverage Exception		
itraconazole solution	Non Preferred	Generic	04/01/13		Medication Coverage Exception	Sporanox	
Noxafil	Non Preferred	Brand	08/01/19		Medication Coverage Exception	Noxafil	
posaconazole	Non Preferred	Generic	08/01/19		Medication Coverage Exception	Noxafil	
Sporanox	Non Preferred	Brand	04/01/13		Medication Coverage Exception		
Tolsura	Non Preferred	Brand	01/01/19		Medication Coverage Exception		
Vfend	Non Preferred	Brand	01/01/13		Medication Coverage Exception		

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Antihemophilia

Factor VIII

Preferred Drugs	Status	Type	Last Update	Limits	Mandatory 3-Month	Brand Required	Additional Note
Adynovate	Preferred	Brand	10/01/18				
Hemofil M	Preferred	Brand	01/01/23				
Jivi	Preferred	Brand	01/01/23				
Kovaltry	Preferred	Brand	01/01/23				
Novoeight	Preferred	Brand	10/01/18				
Xyntha	Preferred	Brand	10/01/18				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Advate	Non Preferred	Brand	01/01/24		Medication Coverage Exception		
Afstyla	Non Preferred	Brand	01/01/20		Medication Coverage Exception		
Altuviiio	Non Preferred	Brand	04/01/23		Medication Coverage Exception		
Eloctate	Non Preferred	Brand	10/01/18		Medication Coverage Exception		
Esperoct	Non Preferred	Brand	02/01/20		Medication Coverage Exception		
Koate, DVI	Non Preferred	Brand	01/01/23		Medication Coverage Exception		
Kogenate FS	Non Preferred	Brand	10/01/18		Medication Coverage Exception		
Nuwiq	Non Preferred	Brand	10/01/18		Medication Coverage Exception		
Obizur	Non Preferred	Brand	07/01/20		Medication Coverage Exception		
Recombinate	Non Preferred	Brand	01/01/20		Medication Coverage Exception		

Factor VIII/von Willebrand Factor

Preferred Drugs	Status	Type	Last Update	Limits	Mandatory 3-Month	Brand Required	Additional Note
Alphanate	Preferred	Brand	01/01/19				
Humate P	Preferred	Brand	01/01/19				
Wilate	Preferred	Brand	01/01/19				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Vonvendi	Non Preferred	Brand	01/01/19		Medication Coverage Exception		

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Factor IX							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Alphanine	Preferred	Brand	01/01/19				
Alprolix	Preferred	Brand	01/01/21				
Benefix	Preferred	Brand	01/01/19				
Feiba	Preferred	Brand	01/01/19				
Profilnine	Preferred	Brand	01/01/24				
Rixubis	Preferred	Brand	01/01/19				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Idelvion	Non Preferred	Brand	01/01/19		Medication Coverage Exception		
Ixinity	Non Preferred	Brand	01/01/21		Medication Coverage Exception		
Rebinyn	Non Preferred	Brand	01/01/19		Medication Coverage Exception		

Antihistamines

1st Generation

Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
cyproheptadine	Preferred	Generic	07/01/14				See OTC list for additional options
diphenhydramine	Preferred	Generic	07/01/14				See OTC list for additional options
hydroxyzine hydrochloride	Preferred	Generic	07/01/14				See OTC list for additional options
hydroxyzine pamoate	Preferred	Generic	07/01/14				See OTC list for additional options
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
carbinoxamine	Non Preferred	Generic	07/01/14		Medication Coverage Exception		
clemastine	Non Preferred	Generic	07/01/14		Medication Coverage Exception		
Karbinal suspension	Non Preferred	Brand	12/01/20		Medication Coverage Exception		
Ryclora	Non Preferred	Brand	10/01/19		Medication Coverage Exception		
Ryvent	Non Preferred	Brand	12/01/20		Medication Coverage Exception		
Vistaril	Non Preferred	Brand	07/01/14		Medication Coverage Exception		

2nd Generation

Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
cetirizine solution	Preferred	Generic	01/01/18				See OTC list for additional options
levocetirizine tablet	Preferred	Generic	01/01/19				See OTC list for additional options

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Non Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
Clarinex	Non Preferred	Brand	07/01/14		Medication Coverage Exception		
desloratadine	Non Preferred	Generic	07/01/14		Medication Coverage Exception		
levocetirizine solution	Non Preferred	Generic	01/01/19		Medication Coverage Exception		

Anti-infectives (NOS)

Amebicide & Antiprotozoal Agents

Preferred Drugs	Status	Type	Last Update	Limits	Mandatory 3-Month	Brand Required	Additional Note
atovaquone	Preferred	Generic	10/01/21				
metronidazole	Preferred	Generic	01/01/22				
tinidazole	Preferred	Generic	05/15/16				

Non Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
Flagyl	Non Preferred	Brand	01/01/22		Medication Coverage Exception		
Lampit	Non Preferred	Brand	12/01/20		Medication Coverage Exception		
Mepron	Non Preferred	Brand	10/01/21		Medication Coverage Exception		
Nebupent	Non Preferred	Brand	01/01/15		Medication Coverage Exception		
nitazoxanide	Non Preferred	Generic	01/01/21		Medication Coverage Exception		
paromomycin	Non Preferred	Generic	01/01/15		Medication Coverage Exception		
Pentam	Non Preferred	Brand	01/01/21		Medication Coverage Exception		
pentamidine	Non Preferred	Generic	01/01/21		Medication Coverage Exception		
Solosec	Non Preferred	Brand	02/01/18		Medication Coverage Exception		

Antimalarials

Preferred Drugs	Status	Type	Last Update	Limits	Mandatory 3-Month	Brand Required	Additional Note
hydroxychloroquine	Preferred	Generic	01/01/18				
primaquine	Preferred	Generic	01/01/16				

Non Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
atovaquone/proguanil	Non Preferred	Generic	01/01/19		Medication Coverage Exception		
chloroquine	Non Preferred	Generic	01/01/19		Medication Coverage Exception		
Coartem	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
Daraprim	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
Krintafel	Non Preferred	Brand	02/01/19		Medication Coverage Exception		
Malarone	Non Preferred	Brand	01/01/19		Medication Coverage Exception		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
mefloquine	Non Preferred	Generic	01/01/16		Medication Coverage Exception		
pyrimethamine	Non Preferred	Generic	10/01/21		Medication Coverage Exception		
Qualaquin	Non Preferred	Brand	01/01/19		Medication Coverage Exception		
quinine	Non Preferred	Generic	01/01/19		Medication Coverage Exception		
Vaginal							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
clindamycin vaginal cream	Preferred	Generic	03/01/16				See OTC list for additional options
metronidazole vaginal	Preferred	Generic	04/18/13				See OTC list for additional options
Vandazole	Preferred	Generic	01/01/13				See OTC list for additional options
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Cleocin	Non Preferred	Brand	03/01/16		Medication Coverage Exception		
Clindesse	Non Preferred	Brand	11/01/16		Medication Coverage Exception		
Gynazole-1	Non Preferred	Brand	10/01/11		Medication Coverage Exception		
Nuvessa	Non Preferred	Brand	03/06/15		Medication Coverage Exception		
terconazole	Non Preferred	Generic	10/01/11		Medication Coverage Exception		
Xaciato	Non Preferred	Generic	02/01/23		Medication Coverage Exception		
Antivirals							
Anti-Influenza - Oral							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
oseltamivir	Preferred	Generic	01/01/20				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Relenza	Non Preferred	Brand	01/01/23		Medication Coverage Exception		
ribavirin (inhaled)	Non Preferred	Generic	01/01/14		Medication Coverage Exception		
rimantadine	Non Preferred	Generic	06/01/13		Medication Coverage Exception		
Tamiflu	Non Preferred	Brand	01/01/20		Medication Coverage Exception		
Virazole	Non Preferred	Brand	01/01/14		Medication Coverage Exception		
Xofluza	Non Preferred	Brand	11/01/18		Medication Coverage Exception		
Antiretrovirals - Entry, Fusion Inhibitors							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Selzentry	Preferred	Brand	07/01/17			Selzentry	

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Non Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
Fuzeon	Non Preferred	Brand	07/01/17		Medication Coverage Exception		
maraviroc	Non Preferred	Generic	03/01/22		Medication Coverage Exception	Selzentry	
Rukobia	Non Preferred	Brand	08/01/20		Rukobia		
Trogarzo	Non Preferred	Brand	10/01/19		Medication Coverage Exception		
Antiretrovirals - Integrase Inhibitors							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Isentress	Preferred	Brand	07/01/17				
Tivicay	Preferred	Brand	07/01/17				
Antiretrovirals - Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs)							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
efavirenz	Preferred	Generic	05/01/23				
Intelence	Preferred	Brand	07/01/17			Intelence	
nevirapine	Preferred	Generic	07/01/17		90 Day Supply Required		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Edurant	Non Preferred	Brand	01/01/24		Medication Coverage Exception		
etravirine	Non Preferred	Generic	07/01/21		Medication Coverage Exception	Intelence	
Pifeltro	Non Preferred	Brand	01/01/22		Medication Coverage Exception		
Viramune	Non Preferred	Brand	07/01/17		Medication Coverage Exception		
Nucleoside/Nucleotide Reverse Transcriptase Inhibitors (NRTIs)							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
abacavir solution	Preferred	Brand	12/01/20				See NIH Guidelines
abacavir tablet	Preferred	Generic	07/01/17		90 Day Supply Required		See NIH Guidelines
Emtriva	Preferred	Brand	07/01/17			Emtriva	See NIH Guidelines
lamivudine	Preferred	Generic	07/01/17				See NIH Guidelines
tenofovir disoproxil 300mg	Preferred	Generic	07/01/18				See NIH Guidelines
Viread 150mg, 200mg, 250mg, powder	Preferred	Brand	07/01/18				See NIH Guidelines
zidovudine	Preferred	Generic	07/01/17		90 Day Supply Required		See NIH Guidelines

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Non Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
didanosine	Non Preferred	Generic	07/01/17		Medication Coverage Exception		See NIH Guidelines
emtricitabine	Non Preferred	Generic	10/01/20		Medication Coverage Exception	Emtriva	See NIH Guidelines
Epivir	Non Preferred	Brand	07/01/17		Medication Coverage Exception		See NIH Guidelines
Retrovir	Non Preferred	Brand	07/01/17		Medication Coverage Exception		See NIH Guidelines
stavudine	Non Preferred	Generic	07/01/17		Medication Coverage Exception		See NIH Guidelines
Viread 300mg	Non Preferred	Generic	07/01/18		Medication Coverage Exception		See NIH Guidelines
Ziagen	Non Preferred	Brand	12/01/20		Medication Coverage Exception		See NIH Guidelines
Protease Inhibitors							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
atazanavir capsule	Preferred	Generic	06/01/21				
darunavir	Preferred	Generic	07/01/23				
Norvir powder, solution	Preferred	Brand	01/01/16				
Prezista	Preferred	Brand	01/01/16				
Reyataz powder	Preferred	Brand	01/01/20				
ritonavir tablet	Preferred	Generic	01/01/21				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Aptivus	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
fosamprenavir	Non Preferred	Generic	01/01/16		Medication Coverage Exception	Lexiva	
Invirase	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
Lexiva	Non Preferred	Brand	01/01/16		Medication Coverage Exception	Lexiva	
Norvir tablet	Non Preferred	Brand	01/01/21		Medication Coverage Exception		
Reyataz capsule	Non Preferred	Brand	06/01/21		Medication Coverage Exception		
Viracept	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
Antiretrovirals- Combination Products							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
abacavir/lamivudine	Preferred	Generic	07/01/17				
Biktarvy	Preferred	Brand	03/01/18				
Cimduo	Preferred	Brand	05/01/18				
Delstrigo	Preferred	Brand	01/01/21				
Descovy	Preferred	Brand	07/01/17				
Dovato	Preferred	Brand	05/01/19				

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
efavirenz/emtricitabine/tenofovir	Preferred	Generic	01/01/22				
emtricitabine/tenofovir	Preferred	Generic	01/01/22				
Evotaz	Preferred	Brand	01/01/17				
Genvoya	Preferred	Brand	07/01/17				
lamivudine/zidovudine	Preferred	Generic	07/01/17				
lopinavir/ritonavir	Preferred	Generic	07/01/21				
Odefsey	Preferred	Brand	07/01/17				
Prezcobix	Preferred	Brand	07/01/17				
Symfi	Preferred	Brand	05/01/18			Symfi	
Symfi Lo	Preferred	Brand	05/01/18			Symfi Lo	
Triumeq	Preferred	Brand	07/01/17				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
abacavir/lamivudine/zidovudine	Non Preferred	Generic	07/01/17		Medication Coverage Exception	Trizivir	
Apretude	Non Preferred	Brand	02/01/22		Medication Coverage Exception		
Atripla	Non Preferred	Brand	01/01/22		Medication Coverage Exception		
Cabenuva	Non Preferred	Brand	03/01/21		Cabenuva		
Combivir	Non Preferred	Brand	07/01/17		Medication Coverage Exception		
Complera	Non Preferred	Brand	07/01/17		Medication Coverage Exception		
efavirenz/lamivudine/tenofovir	Non Preferred	Generic	09/01/20		Medication Coverage Exception	Symfi,Lo	
Epzicom	Non Preferred	Brand	07/01/17		Medication Coverage Exception		
Juluca	Non Preferred	Brand	12/01/17		Medication Coverage Exception		
Kaletra	Non Preferred	Generic	07/01/21		Medication Coverage Exception		
Stribild	Non Preferred	Brand	07/01/17		Medication Coverage Exception		
Symtuza	Non Preferred	Brand	08/01/18		Medication Coverage Exception		
Trizivir	Non Preferred	Brand	07/01/17		Medication Coverage Exception	Trizivir	
Truvada	Non Preferred	Brand	01/01/22		Medication Coverage Exception		

Hepatitis C

Direct Acting Antivirals (DAAs)

Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Mavyret	Preferred	Brand	09/01/17		Hepatitis C		
sofosbuvir/velpatasvir	Preferred	Generic	04/01/21		Hepatitis C		

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Non Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
Epclusa	Non Preferred	Brand	04/01/21		Hepatitis C		
Harvoni	Non Preferred	Brand	01/01/20		Hepatitis C	Harvoni	
sofosbuvir/ledipasvir	Non Preferred	Generic	01/01/20		Hepatitis C	Harvoni	
Sovaldi	Non Preferred	Brand	01/01/18		Hepatitis C		
Viekira Pak	Non Preferred	Brand	01/01/18		Hepatitis C		
Vosevi	Non Preferred	Brand	08/01/17		Hepatitis C		
Zepatier	Non Preferred	Brand	01/01/20		Hepatitis C		

Herpes Simplex, Varicella Zoster, & Cytomegalovirus

Preferred Drugs	Status	Type	Last Update	Limits	Mandatory 3-Month	Brand Required	Additional Note
acyclovir	Preferred	Generic	01/01/14				
valacyclovir	Preferred	Generic	01/01/14				
valganciclovir tablet	Preferred	Generic	01/01/22				

Non Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
cidofovir	Non Preferred	Generic	01/01/22		Medication Coverage Exception		
famciclovir	Non Preferred	Generic	06/01/13		Medication Coverage Exception		
foscarnet	Non Preferred	Generic	01/01/22		Medication Coverage Exception		
ganciclovir	Non Preferred	Generic	07/01/21		Medication Coverage Exception		
Livtencity	Non Preferred	Brand	01/01/22		Medication Coverage Exception		
Prevymis	Non Preferred	Brand	01/01/18		Medication Coverage Exception		
Sitavig	Non Preferred	Brand	03/01/16		Medication Coverage Exception		
Valcyte	Non Preferred	Brand	06/01/13		Medication Coverage Exception		
valganciclovir sol	Non Preferred	Generic	06/01/13		Medication Coverage Exception		
Valtrex	Non Preferred	Brand	01/01/14		Medication Coverage Exception		
Zovirax	Non Preferred	Brand	06/01/13		Medication Coverage Exception		

Appetite Stimulants

Preferred Drugs	Status	Type	Last Update	Limits	Mandatory 3-Month	Brand Required	Additional Note
megestrol	Preferred	Generic	01/01/15				All strengths except 625 mg/5ml

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Non Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
dronabinol	Non Preferred	Generic	01/01/15		Medication Coverage Exception		
Marinol	Non Preferred	Brand	01/01/15		Medication Coverage Exception		
megestrol 625 mg/5ml	Non Preferred	Generic	01/01/22		Medication Coverage Exception		

Bile Acid Sequestrants

Preferred Drugs	Status	Type	Last Update	Limits	Mandatory 3-Month	Brand Required	Additional Note
cholestyramine	Preferred	Generic	01/01/15				
colesevelam	Preferred	Generic	01/01/24				
Colestid tablet	Preferred	Brand	01/01/23				
colestipol granule	Preferred	Generic	02/01/23				
colestipol tablet	Preferred	Generic	02/01/23				

Non Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
Colestid granule	Non Preferred	Brand	11/01/23		Medication Coverage Exception		
Colestid powder	Non Preferred	Brand	11/01/23		Medication Coverage Exception		
Questran	Non Preferred	Brand	01/01/15		Medication Coverage Exception		
Welchol	Non Preferred	Brand	01/01/24		Medication Coverage Exception		

Bone Density Regulators

Preferred Drugs	Status	Type	Last Update	Limits	Mandatory 3-Month	Brand Required	Additional Note
alendronate tablet	Preferred	Generic	10/01/09		84 Day Supply Required		

Non Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
Actonel	Non Preferred	Brand	01/01/18		Medication Coverage Exception		
alendronate solution	Non Preferred	Generic	01/01/22		Medication Coverage Exception		
Atelvia	Non Preferred	Brand	01/01/18		Medication Coverage Exception	Atelvia	
Boniva	Non Preferred	Brand	04/15/13		Medication Coverage Exception		
calcitonin	Non Preferred	Generic	01/01/16		Medication Coverage Exception		
Evenity	Non Preferred	Brand	05/01/19		Parathyroid Hormone Analogs		
Forteo	Non Preferred	Brand	10/01/20		Parathyroid Hormone Analogs		
Fosamax	Non Preferred	Brand	10/01/09		Medication Coverage Exception		
Fosamax-D	Non Preferred	Brand	10/01/09		Medication Coverage Exception		
ibandronate	Non Preferred	Generic	04/15/13		Medication Coverage Exception		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Miacalcin	Non Preferred	Generic	01/01/16		Medication Coverage Exception		
pamidronate	Non Preferred	Generic	10/01/09		Medication Coverage Exception		
Prolia	Non Preferred	Brand	01/01/14		Medication Coverage Exception		
risedronate	Non Preferred	Generic	01/01/18		Medication Coverage Exception		
Reclast	Non Preferred	Brand	01/01/22		Medication Coverage Exception		
teriparatide	Non Preferred	Generic	12/01/20		Parathyroid Hormone Analogs		
Tymlos	Non Preferred	Brand	06/01/17		Parathyroid Hormone Analogs		
Xgeva	Non Preferred	Brand	10/15/15		Medication Coverage Exception		
zoledronic acid	Non Preferred	Generic	01/01/22		Medication Coverage Exception		

Cardiovascular

Antianginal Agents

Preferred Drugs	Status	Type	Last Update	Limits	Mandatory 3-Month	Brand Required	Additional Note
isosorbide dinitrate	Preferred	Generic	01/01/16				
isosorbide mononitrate	Preferred	Generic	01/01/16				
isosorbide mononitrate ER	Preferred	Generic	01/01/16		90 Day Supply Required		
nitroglycerin patch	Preferred	Generic	01/01/18				
nitroglycerin sublingual	Preferred	Generic	01/01/20				
ranolazine	Preferred	Generic	01/01/24				

Non Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
Gonitro powder	Non Preferred	Brand	11/01/17		Medication Coverage Exception		
Isordil	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
Nitro-Bid ointment	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
Nitro-Dur patch	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
nitroglycerin lingual spray	Non Preferred	Generic	01/01/16		Medication Coverage Exception		
Nitrolingual	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
Nitrostat	Non Preferred	Brand	01/01/20		Medication Coverage Exception		
Ranexa	Non Preferred	Brand	10/01/19		Medication Coverage Exception		

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Antihyperlipidemics							
HMG Co-A Reductase Inhibitors ("Statins")							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
atorvastatin	Preferred	Generic	02/01/22		90 Day Supply Required		
Lipitor	Preferred	Brand	01/01/22		90 Day Supply Required		
lovastatin	Preferred	Generic	09/28/09		90 Day Supply Required		
pravastatin	Preferred	Generic	09/28/09		90 Day Supply Required		
rosuvastatin	Preferred	Generic	08/01/20		90 Day Supply Required		
simvastatin	Preferred	Generic	09/28/09		90 Day Supply Required		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Altoprev	Non Preferred	Brand	01/01/13		Medication Coverage Exception		
Crestor	Non Preferred	Brand	08/01/20		Medication Coverage Exception		
Ezallor	Non Preferred	Brand	07/01/19		Medication Coverage Exception		
fluvastatin	Non Preferred	Generic	10/01/18		Medication Coverage Exception		
fluvastatin ER	Non Preferred	Generic	10/01/18		Medication Coverage Exception	Lescol XL	
Lescol XL	Non Preferred	Brand	10/01/18		Medication Coverage Exception	Lescol XL	
Livalo	Non Preferred	Brand	01/01/13		Medication Coverage Exception		
Zocor	Non Preferred	Brand	01/01/13		Medication Coverage Exception		
Zypitamag	Non Preferred	Brand	04/01/18		Medication Coverage Exception		
Cholesterol-Lowering Combinations							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Caduet	Preferred	Brand	01/01/21			Caduet	
ezetimibe/simvastatin	Preferred	Generic	01/01/22				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
amlodipine/atorvastatin	Non Preferred	Generic	01/01/21		Medication Coverage Exception	Caduet	
Nexlizet	Non Preferred	Brand	06/01/20		Medication Coverage Exception		
Vytorin	Non Preferred	Brand	01/01/22		Medication Coverage Exception		
PCSK-9 Inhibitors							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Praluent	Preferred	Brand	01/01/22		PCSK9 Inhibitor		

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Non Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
Leqvio	Non Preferred	Brand	02/01/22		PCSK9 Inhibitor		
Repatha	Non Preferred	Brand	01/01/22		PCSK9 Inhibitor		
Fibrates							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Antara	Preferred	Brand	01/01/22				
fenofibrate 48, 50, 54, 134mg	Preferred	Generic	01/01/23				
fenofibrate 145, 150, 160, 200mg	Preferred	Generic	01/01/23				
gemfibrozil	Preferred	Generic	09/28/09		90 Day Supply Required		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
choline fenofibrate	Non Preferred	Generic	01/01/17		Medication Coverage Exception		
fenofibrate 40, 43, 67, 120, 130mg	Non Preferred	Generic	01/01/17		Medication Coverage Exception		
fenofibrate micronized	Non Preferred	Generic	09/28/09		Medication Coverage Exception		
fenofibric acid	Non Preferred	Generic	01/01/13		Medication Coverage Exception		
Fenoglide	Non Preferred	Brand	07/01/15		Medication Coverage Exception		
Lipofen	Non Preferred	Brand	05/14/14		Medication Coverage Exception		
Lopid	Non Preferred	Brand	01/01/13		Medication Coverage Exception		
Tricor	Non Preferred	Brand	01/01/17		Medication Coverage Exception		
Trilipix	Non Preferred	Brand	01/01/17		Medication Coverage Exception		
Miscellaneous Antihyperlipidemics							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
ezetimibe	Preferred	Generic	01/01/20				
omega-3 acid ethyl esters	Preferred	Generic	01/01/20				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
icosapent ethyl	Non Preferred	Generic	12/01/20		Medication Coverage Exception	Vascepa	
Juxtapid	Non Preferred	Brand	01/01/20		Medication Coverage Exception		
Lovaza	Non Preferred	Brand	01/01/20		Medication Coverage Exception		
Nexletol	Non Preferred	Brand	04/01/20		Medication Coverage Exception		
Vascepa	Non Preferred	Brand	11/01/15		Medication Coverage Exception	Vascepa	
Zetia	Non Preferred	Brand	01/01/20		Medication Coverage Exception		

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Antihypertensives							
Alpha/Beta-Adrenergic Blocking Agents							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
carvedilol	Preferred	Generic	09/28/09		90 Day Supply Required		
labetalol	Preferred	Generic	09/28/09		90 Day Supply Required		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
carvedilol ER	Non Preferred	Generic	12/01/17		Medication Coverage Exception		
Coreg	Non Preferred	Brand	09/28/09		Medication Coverage Exception		
Coreg CR	Non Preferred	Brand	01/01/23		Medication Coverage Exception		
Angiotensin Converting Enzyme (ACE) Inhibitors							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
benazepril	Preferred	Generic	09/28/09		90 Day Supply Required		
enalapril	Preferred	Generic	09/28/09		90 Day Supply Required		
fosinopril	Preferred	Generic	09/28/09		90 Day Supply Required		
lisinopril	Preferred	Generic	09/28/09		90 Day Supply Required		
quinapril	Preferred	Generic	09/28/09		90 Day Supply Required		
ramipril	Preferred	Generic	09/28/09		90 Day Supply Required		
trandolapril	Preferred	Generic	01/01/14		90 Day Supply Required		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Accupril	Non Preferred	Brand	09/28/09		Medication Coverage Exception		
Altace	Non Preferred	Brand	09/28/09		Medication Coverage Exception		
captopril	Non Preferred	Generic	01/01/23		Medication Coverage Exception		
Epaned	Non Preferred	Brand	04/18/14		Medication Coverage Exception		
Lotensin	Non Preferred	Brand	09/28/09		Medication Coverage Exception		
moexipril	Non Preferred	Generic	01/01/13		Medication Coverage Exception		
perindopril	Non Preferred	Generic	01/01/14		Medication Coverage Exception		
Qbrelis	Non Preferred	Brand	09/01/16		Medication Coverage Exception		
Vasotec	Non Preferred	Brand	09/28/09		Medication Coverage Exception		
Zestril	Non Preferred	Brand	09/28/09		Medication Coverage Exception		

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Angiotensin Converting Enzyme (ACE) Inhibitor Combinations							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
amlodipine/benazepril	Preferred	Generic	11/01/19				
benazepril/hctz	Preferred	Generic	07/01/20				
enalapril/hctz	Preferred	Generic	09/28/09		90 Day Supply Required		
lisinopril/hctz	Preferred	Generic	09/28/09		90 Day Supply Required		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Accuretic	Non Preferred	Brand	09/28/09		Medication Coverage Exception		
captopril/hydrochlorothiazide	Non Preferred	Generic	01/01/21		Medication Coverage Exception		
fosinopril/hydrochlorothiazide	Non Preferred	Generic	01/01/19		Medication Coverage Exception		
Lotrel	Non Preferred	Brand	11/01/19		Medication Coverage Exception		
quinapril/hydrochlorothiazide	Non Preferred	Generic	01/01/22		Medication Coverage Exception		
trandolapril/verapamil	Non Preferred	Generic	01/01/20		Medication Coverage Exception		
Vaseretic	Non Preferred	Brand	09/28/09		Medication Coverage Exception		
Zestoretic	Non Preferred	Brand	09/28/09		Medication Coverage Exception		
Angiotensin Receptor Blockers (ARBs)							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Edarbi	Preferred	Brand	01/01/19				
irbesartan	Preferred	Generic	10/15/15				
losartan	Preferred	Generic	04/01/12		90 Day Supply Required		
olmesartan	Preferred	Generic	01/01/21		90 Day Supply Required		
telmisartan	Preferred	Generic	01/01/23				
valsartan	Preferred	Generic	08/01/21		90 Day Supply Required		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Atacand	Non Preferred	Brand	10/15/15		Medication Coverage Exception		
Avapro	Non Preferred	Brand	10/15/15		Medication Coverage Exception		
Benicar	Non Preferred	Brand	01/01/21		Medication Coverage Exception		
candesartan	Non Preferred	Generic	10/15/15		Medication Coverage Exception		
Cozaar	Non Preferred	Brand	09/28/09		Medication Coverage Exception		
Diovan	Non Preferred	Brand	08/01/21		Medication Coverage Exception		
Micardis	Non Preferred	Brand	01/01/23		Medication Coverage Exception		

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Angiotensin Receptor Blocker (ARB) + Thiazide Combinations							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Edarbyclor	Preferred	Brand	01/01/19				
irbesartan/hydrochlorothiazide	Preferred	Generic	01/01/14		90 Day Supply Required		
losartan/hydrochlorothiazide	Preferred	Generic	09/28/09		90 Day Supply Required		
olmesartan/hydrochlorothiazide	Preferred	Generic	08/01/17		90 Day Supply Required		
valsartan/hydrochlorothiazide	Preferred	Generic	10/15/15		90 Day Supply Required		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Atacand HCT	Non Preferred	Brand	01/01/14		Medication Coverage Exception		
Avalide	Non Preferred	Brand	01/01/14		Medication Coverage Exception		
Benicar HCT	Non Preferred	Brand	08/01/17		Medication Coverage Exception		
candesartan/hydrochlorothiazide	Non Preferred	Generic	01/01/14		Medication Coverage Exception		
Diovan HCT	Non Preferred	Brand	10/15/15		Medication Coverage Exception		
Hyzaar	Non Preferred	Brand	09/28/09		Medication Coverage Exception		
Micardis HCT	Non Preferred	Brand	01/01/23		Medication Coverage Exception		
telmisartan/hydrochlorothiazide	Non Preferred	Generic	03/01/23		Medication Coverage Exception		
Angiotensin Receptor Blocker (ARB) Combinations - Other							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
amlodipine/olmesartan	Preferred	Generic	08/01/17				
amlodipine/olmesartan/HCTZ	Preferred	Generic	08/01/17				
amlodipine/valsartan	Preferred	Generic	01/01/19				
amlodipine/valsartan/HCTZ	Preferred	Generic	03/01/21				
Entresto	Preferred	Brand	06/01/20				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Azor	Non Preferred	Generic	08/01/17		Medication Coverage Exception		
Exforge	Non Preferred	Brand	01/01/19		Medication Coverage Exception		
Exforge HCT	Non Preferred	Brand	03/01/21		Medication Coverage Exception		
telmisartan/amlodipine	Non Preferred	Generic	01/01/12		Medication Coverage Exception		
Tribenzor	Non Preferred	Brand	08/01/17		Medication Coverage Exception		

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Beta-Adrenergic Blocking Agents - Cardio Selective							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
atenolol	Preferred	Generic	09/28/09		90 Day Supply Required		
Bystolic	Preferred	Brand	01/01/19		90 Day Supply Required	Bystolic	
metoprolol succinate	Preferred	Generic	10/15/15		90 Day Supply Required		
metoprolol tartrate	Preferred	Generic	01/01/20		90 Day Supply Required		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
acebutolol	Non Preferred	Generic	08/01/17		Medication Coverage Exception		
betaxolol	Non Preferred	Generic	01/01/14		Medication Coverage Exception		
bisoprolol	Non Preferred	Generic	01/01/14		Medication Coverage Exception		
First-Atenol	Non Preferred	Brand	11/01/19		Medication Coverage Exception		
First-Meto	Non Preferred	Brand	02/01/19		Medication Coverage Exception		
Kapspargo	Non Preferred	Brand	08/01/18		Medication Coverage Exception		
Lopressor	Non Preferred	Brand	09/28/09		Medication Coverage Exception		
nebivolol	Non Preferred	Generic	10/01/21		Medication Coverage Exception	Bystolic	
Tenormin	Non Preferred	Brand	09/28/09		Medication Coverage Exception		
Toprol XL	Non Preferred	Brand	10/15/15		Medication Coverage Exception		
Beta-Adrenergic Blocking Agents - Cardio Nonselective							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
nadolol	Preferred	Generic	10/15/15		90 Day Supply Required		
propranolol	Preferred	Generic	04/01/13		90 Day Supply Required		
propranolol SR	Preferred	Generic	03/01/16				
sotalol	Preferred	Generic	01/01/14		90 Day Supply Required		
sotalol AF	Preferred	Generic	01/01/19				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Betapace	Non Preferred	Brand	09/28/09		Medication Coverage Exception		
Betapace AF	Non Preferred	Brand	01/01/19		Medication Coverage Exception		
Corgard	Non Preferred	Brand	10/15/15		Medication Coverage Exception		
Hemangeol	Non Preferred	Brand	05/07/14		Medication Coverage Exception		
Inderal XL	Non Preferred	Brand	03/01/16		Medication Coverage Exception		
Inderal LA	Non Preferred	Brand	03/01/16		Medication Coverage Exception		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Innopran XL	Non Preferred	Brand	09/28/09		Medication Coverage Exception		
pindolol	Non Preferred	Brand	01/01/23		Medication Coverage Exception		
Sotylize	Non Preferred	Brand	02/19/15		Medication Coverage Exception		
timolol	Non Preferred	Generic	01/01/21		Medication Coverage Exception		
Beta-Adrenergic Blocking Agent Combinations							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
atenolol/chlorthalidone	Preferred	Generic	09/28/09		90 Day Supply Required		
bisoprolol/HCTZ	Preferred	Generic	09/28/09		90 Day Supply Required		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
metoprolol/hydrochlorothiazide	Non Preferred	Generic	01/01/13		Medication Coverage Exception		
Tenoretic	Non Preferred	Brand	09/28/09		Medication Coverage Exception		
Ziac	Non Preferred	Brand	09/28/09		Medication Coverage Exception		
Calcium Channel Blocking Agents							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
amlodipine	Preferred	Generic	09/28/09		90 Day Supply Required		
diltiazem capsule	Preferred	Generic	09/28/09				
diltiazem solution	Preferred	Generic	09/28/09				
diltiazem tablet	Preferred	Generic	09/28/09				
felodipine ER	Preferred	Generic	09/28/09		90 Day Supply Required		
nifedipine	Preferred	Generic	01/01/14				
nifedipine ER	Preferred	Generic	01/01/14				
verapamil tablet	Preferred	Generic	09/28/09				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Calan SR	Non Preferred	Brand	09/28/09		Medication Coverage Exception		
Cardizem	Non Preferred	Brand	09/28/09		Medication Coverage Exception		
Cardizem CD	Non Preferred	Brand	09/28/09		Medication Coverage Exception		
Cardizem LA	Non Preferred	Brand	03/01/16		Medication Coverage Exception		
diltiazem ER tablet	Non Preferred	Generic	03/01/16		Medication Coverage Exception		
isradipine	Non Preferred	Generic	01/01/19		Medication Coverage Exception		
Katerzia	Non Preferred	Brand	08/01/19		Medication Coverage Exception		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
levamlodipine	Non Preferred	Generic	06/01/22		Medication Coverage Exception		
nicardipine	Non Preferred	Brand	01/01/19		Medication Coverage Exception		
nimodipine	Non Preferred	Generic	09/28/09		Medication Coverage Exception		
nisoldipine	Non Preferred	Generic	04/01/13		Medication Coverage Exception		
Norliqva	Non Preferred	Brand	10/01/22		Medication Coverage Exception		
Norvasc	Non Preferred	Brand	09/28/09		Medication Coverage Exception		
Nymalize	Non Preferred	Brand	07/08/13		Medication Coverage Exception		
Procardia XL	Non Preferred	Brand	01/01/14		Medication Coverage Exception		
Sular	Non Preferred	Brand	04/01/13		Medication Coverage Exception		
Tiazac	Non Preferred	Brand	03/01/16		Medication Coverage Exception		
verapamil capsule	Non Preferred	Generic	01/01/14		Medication Coverage Exception		
Verelan	Non Preferred	Brand	01/01/20		Medication Coverage Exception		
Verelan PM	Non Preferred	Brand	01/01/20		Medication Coverage Exception		
Diuretics - Loop							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
bumetanide	Preferred	Generic	01/01/20				
furosemide	Preferred	Generic	01/01/16				
torsemide	Preferred	Generic	01/01/16		90 Day Supply Required		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Bumex	Non Preferred	Brand	01/01/20		Medication Coverage Exception		
Edecrin	Non Preferred	Brand	11/01/17		Medication Coverage Exception		
ethacrynic acid	Non Preferred	Generic	11/01/17		Medication Coverage Exception		
Lasix	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
Diuretics - Potassium Sparing & Combination							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
amiloride	Preferred	Generic	01/01/19				
amiloride/HCTZ	Preferred	Generic	01/01/16		90 Day Supply Required		
eplerenone	Preferred	Generic	01/01/23				
spironolactone	Preferred	Generic	01/01/16				
spironolactone/HCTZ	Preferred	Generic	01/01/16				
triamterene/HCTZ	Preferred	Generic	01/01/16		90 Day Supply Required		

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Non Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
Aldactazide	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
Aldactone	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
CaroSpir	Non Preferred	Brand	11/01/17		Medication Coverage Exception	CaroSpir	
Inspra	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
Maxzide	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
spironolactone 25mg/5ml	Non Preferred	Generic	11/01/23		Medication Coverage Exception	CaroSpir	
triamterene	Non Preferred	Generic	09/01/19		Medication Coverage Exception		
Platelet Aggregation Inhibitors							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
clopidogrel 75mg	Preferred	Generic	06/01/12		90 Day Supply Required		
prasugrel	Preferred	Generic	07/01/18				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Brilinta	Non Preferred	Brand	01/01/13		Medication Coverage Exception		
clopidogrel 300mg	Non Preferred	Generic	01/01/14		Medication Coverage Exception		
dipyridamole	Non Preferred	Generic	06/01/12		Medication Coverage Exception		
Effient	Non Preferred	Brand	07/01/18		Medication Coverage Exception		
Plavix	Non Preferred	Brand	01/01/13		Medication Coverage Exception		
Zontivity	Non Preferred	Brand	10/01/15		Medication Coverage Exception		
Platelet Aggregation Inhibitors-Miscellaneous, Combinations							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
asa/dipyridamole	Preferred	Generic	06/01/20				
cilostazol	Preferred	Generic	11/01/12				
pentoxifylline	Preferred	Generic	07/01/12				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Agrylin	Non Preferred	Brand	01/01/20		Medication Coverage Exception		
anagrelide	Non Preferred	Generic	01/01/20		Medication Coverage Exception		

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Central Nervous System

Antidementia Agents - Oral

Preferred Drugs	Status	Type	Last Update	Limits	Mandatory 3-Month	Brand Required	Additional Note
donepezil 5, 10mg	Preferred	Generic	10/01/13		90 Day Supply Required		
donepezil ODT	Preferred	Generic	01/01/19				
memantine tablet	Preferred	Generic	02/01/16		90 Day Supply Required		
rivastigmine capsule	Preferred	Generic	05/15/16				

Non Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
Aricept	Non Preferred	Brand	01/15/13		Medication Coverage Exception		
donepezil 23mg	Non Preferred	Generic	10/01/13		Medication Coverage Exception		
galantamine ER	Non Preferred	Generic	09/28/09		Medication Coverage Exception		
memantine ER	Non Preferred	Generic	03/01/18		Medication Coverage Exception	Namenda XR	
memantine solution	Non Preferred	Generic	03/15/16		Medication Coverage Exception		
Namenda tablet	Non Preferred	Brand	02/01/16		Medication Coverage Exception		
Namenda XR	Non Preferred	Brand	03/01/18		Medication Coverage Exception	Namenda XR	
Namzaric	Non Preferred	Brand	04/15/15		Medication Coverage Exception		

Antidementia Agents - Topical

Preferred Drugs	Status	Type	Last Update	Limits	Mandatory 3-Month	Brand Required	Additional Note
Exelon	Preferred	Brand	09/28/09			Exelon	

Non Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
Adlarity	Non Preferred	Brand	07/01/22		Medication Coverage Exception		
rivastigmine patch	Non Preferred	Generic	09/15/15		Medication Coverage Exception	Exelon	

Hypnotics - Benzodiazepines

- **Cumulative limit:** 30 units in 30 days. Cumulative limits apply across all hypnotic classes.
- **Benzodiazepine and Opioid Combination:** Concurrent long-acting opioids and benzodiazepines (within 45 days of each other) require prior authorization.

Preferred Drugs	Status	Type	Last Update	Limits	Brand Required	Additional Note
temazepam 15, 30mg	Preferred	Generic	06/01/13	cumulative across hypnotic classes: 30 units /30 days		Benzo/Opioid Combo Requires PA

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Non Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
estazolam	Non Preferred	Generic	06/01/13	cumulative: 30 units /30 days	Medication Coverage Exception		Benzo/Opioid Combo Requires PA
Halcion	Non Preferred	Brand	06/01/13	cumulative: 30 units /30 days	Medication Coverage Exception		Benzo/Opioid Combo Requires PA
midazolam	Non Preferred	Generic	11/01/16	cumulative: 30 units /30 days	Medication Coverage Exception		Benzo/Opioid Combo Requires PA
Restoril	Non Preferred	Brand	06/01/13	cumulative: 30 units /30 days	Medication Coverage Exception		Benzo/Opioid Combo Requires PA
temazepam 7.5, 22.5mg	Non Preferred	Generic	06/01/13	cumulative: 30 units /30 days	Medication Coverage Exception		Benzo/Opioid Combo Requires PA
triazolam	Non Preferred	Generic	06/01/13	cumulative: 30 units /30 days	Medication Coverage Exception		Benzo/Opioid Combo Requires PA
Hypnotics - Non Benzodiazepines, Non Barbiturates							
• **Cumulative limit:** 30 units in 30 days. Cumulative limits apply across all hypnotic classes.							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**		**Brand Required**	**Additional Note**
eszopiclone	Preferred	Generic	01/01/20	cumulative across hypnotic classes: 30 units /30 days			
ramelteon	Preferred	Generic	01/01/23	cumulative across hypnotic classes: 30 units /30 days			
zaleplon	Preferred	Generic	10/15/15	cumulative across hypnotic classes: 30 units /30 days			
zolpidem tablet	Preferred	Generic	01/01/20	cumulative across hypnotic classes: 30 units /30 days			
zolpidem CR tablet	Preferred	Generic	01/01/20	cumulative across hypnotic classes: 30 units /30 days			
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Ambien	Non Preferred	Brand	06/01/13	cumulative: 30 units /30 days	Medication Coverage Exception		
Ambien CR	Non Preferred	Brand	06/01/13	cumulative: 30 units /30 days	Medication Coverage Exception		
Belsomra	Non Preferred	Brand	12/10/14	cumulative: 30 units /30 days	Medication Coverage Exception		
Dayvigo	Non Preferred	Brand	05/01/20	cumulative: 30 units /30 days	Medication Coverage Exception		
doxepin tablet	Non Preferred	Generic	01/01/20	cumulative: 30 units /30 days	Medication Coverage Exception	Silenor	
Edluar	Non Preferred	Brand	06/01/13	cumulative: 30 units /30 days	Medication Coverage Exception		
Hetlioz	Non Preferred	Brand	10/01/20	cumulative: 30 units /30 days	Hetlioz		
Lunesta	Non Preferred	Brand	04/28/14	cumulative: 30 units /30 days	Medication Coverage Exception		
Quviviq	Non Preferred	Brand	06/01/22	cumulative: 30 units /30 days	Medication Coverage Exception		
Rozerem	Non Preferred	Brand	01/01/23	cumulative: 30 units /30 days	Medication Coverage Exception		
Silenor	Non Preferred	Brand	01/01/21	cumulative: 30 units /30 days	Medication Coverage Exception	Silenor	
zolpidem 7.5mg capsule	Non Preferred	Generic	06/01/23	cumulative: 30 units /30 days	Medication Coverage Exception		
zolpidem SL	Non Preferred	Generic	11/01/18	cumulative: 30 units /30 days	Medication Coverage Exception		
Zolpimist	Non Preferred	Brand	06/01/13	cumulative: 30 units /30 days	Medication Coverage Exception		

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Mental Health

Short Acting ADHD Stimulants

- **Concurrent Use:** Concurrent use of both amphetamine and methylphenidate drug classes, requires prior authorization for members under 18 years.
- **DAW (Dispense as written) :** Non-preferred psychotropic medications listed on PDL may bypass non-preferred drug prior authorization if a prescriber writes “dispense as written” on prescription and pharmacy submits a Dispense As Written (DAW) Code of “1” on the claim. See Pg.3 Explanation for details.
- **Max Allowed:** A maximum of two (2) ADHD stimulants is allowed. Use of three (3) or more ADHD stimulants, requires prior authorization.

Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
amphetamine/dextroamphetamine t	Preferred	Generic	07/01/20	Minimum Age: 4 Years Old			
dexmethylphenidate	Preferred	Generic	01/01/22	Minimum Age: 4 Years Old			
Methylin solution	Preferred	Brand	07/01/20	Minimum Age: 4 Years Old			
methylphenidate solution	Preferred	Generic	07/01/20	Minimum Age: 4 Years Old			
methylphenidate tablet	Preferred	Generic	07/01/20	Minimum Age: 4 Years Old			
procentra solution	Preferred	Generic	01/01/22	Minimum Age: 4 Years Old			
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Adderall	Non Preferred	Brand	07/01/20	Minimum Age: 4 Years Old	Medication Coverage Exception		
amphetamine sulfate tablet	Non Preferred	Generic	07/01/20	Minimum Age: 4 Years Old	Medication Coverage Exception	Evekeo	
Desoxyn	Non Preferred	Brand	07/01/20	Minimum Age: 6 Years Old	Medication Coverage Exception	Desoxyn	
Dexedrine	Non Preferred	Brand	07/01/20	Minimum Age: 4 Years Old	Medication Coverage Exception		
dextroamphetamine	Non Preferred	Generic	07/01/20	Minimum Age: 4 Years Old	Medication Coverage Exception		
dextroamphetamine solution	Non Preferred	Generic	07/01/20	Minimum Age: 4 Years Old	Medication Coverage Exception		
Evekeo	Non Preferred	Brand	07/01/20	Minimum Age: 4 Years Old	Medication Coverage Exception	Evekeo	
Evekeo ODT	Non Preferred	Brand	07/01/20	Minimum Age: 4 Years Old	Medication Coverage Exception		
Focalin	Non Preferred	Brand	01/01/22	Minimum Age: 4 Years Old	Medication Coverage Exception		
methamphetamine	Non Preferred	Brand	07/01/20	Minimum Age: 6 Years Old	Medication Coverage Exception	Desoxyn	
methylphenidate chewable	Non Preferred	Generic	07/01/20	Minimum Age: 4 Years Old	Medication Coverage Exception		
Ritalin	Non Preferred	Brand	07/01/20	Minimum Age: 4 Years Old	Medication Coverage Exception		
Zenzedi	Non Preferred	Brand	07/01/20	Minimum Age: 4 Years Old	Medication Coverage Exception		

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Long Acting ADHD Stimulants							
• **Concurrent Use:** Concurrent use of both amphetamine and methylphenidate drug classes, requires prior authorization for members under 18 years.							
• **DAW (Dispense as written) :** Non-preferred psychotropic medications listed on PDL may bypass non-preferred drug prior authorization if a prescriber writes "dispense as written" on prescription and pharmacy submits a Dispense As Written (DAW) Code of "1" on the claim. See Pg.3 Explanation for details.							
• **Max Allowed:** A maximum of two (2) ADHD stimulants is allowed. Use of three (3) or more ADHD stimulants, requires prior authorization.							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Adderall XR	Preferred	Brand	01/01/22	Minimum Age: 4 Years Old		Adderall XR	
Concerta	Preferred	Brand	07/01/20	Minimum Age: 4 Years Old		Concerta	
dexmethylphenidate ER	Preferred	Generic	01/01/24	Minimum Age: 4 Years Old			
Dyanavel XR suspension	Preferred	Brand	07/01/20	Minimum Age: 6 Years Old			
Quillichew ER	Preferred	Brand	07/01/20	Minimum Age: 4 Years Old			
Quillivant suspension	Preferred	Brand	07/01/20	Minimum Age: 4 Years Old			Must be dispensed in original container with full bottle qty.
Vyvanse cap	Preferred	Brand	07/01/20	Minimum Age: 4 Years Old			
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Adhansia XR	Non Preferred	Brand	07/01/20	Minimum Age: 6 Years Old	Medication Coverage Exception		
Adzenys XR ODT	Non Preferred	Brand	07/01/20	Minimum Age: 6 Years Old	Medication Coverage Exception		
amphet/dextroamphet ER cap	Non Preferred	Generic	01/01/22	Minimum Age: 4 Years Old	Medication Coverage Exception	Adderall XR	
amphet/dextroamphet 3-bead cap ER 24HR	Non Preferred	Generic	11/01/23	Minimum Age: 4 Years Old	Medication Coverage Exception	Mydayis	
Aptensio XR	Non Preferred	Brand	07/01/20	Minimum Age: 4 Years Old	Medication Coverage Exception		
Azstarys	Non Preferred	Brand	08/01/21	Minimum Age: 6 Years Old	Medication Coverage Exception		
Cotempla XR ODT	Non Preferred	Brand	07/01/20	Minimum Age: 6 Years Old	Medication Coverage Exception		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Daytrana	Non Preferred	Brand	07/01/20	Minimum Age: 4 Years Old	Medication Coverage Exception	Daytrana	
Dexedrine Spansule	Non Preferred	Brand	07/01/20	Minimum Age: 4 Years Old	Medication Coverage Exception		
dextroamphetamine ER	Non Preferred	Generic	07/01/20	Minimum Age: 4 Years Old	Medication Coverage Exception		
Dyanavel XR chewable	Non Preferred	Brand	08/01/22	Minimum Age: 6 Years Old	Medication Coverage Exception		
Focalin XR	Non Preferred	Brand	01/01/24	Minimum Age: 4 Years Old	Medication Coverage Exception		
Jornay PM	Non Preferred	Brand	06/01/19	Minimum Age: 6 Years Old	Medication Coverage Exception		
lisdexamfetamine	Non Preferred	Generic	09/01/23	Minimum Age: 6 Years Old	Medication Coverage Exception	Vyvanse	
methylphenidate ER (biphasic)	Non Preferred	Generic	07/01/20	Minimum Age: 4 Years Old	Medication Coverage Exception		
methylphenidate ER (osmotic release	Non Preferred	Generic	07/01/20	Minimum Age: 4 Years Old	Medication Coverage Exception	Concerta	
methylphenidate ER capsule	Non Preferred	Generic	07/01/20	Minimum Age: 4 Years Old	Medication Coverage Exception		
methylphenidate patch	Non Preferred	Generic	08/01/22	Minimum Age: 4 Years Old	Medication Coverage Exception	Daytrana	
Mydayis	Non Preferred	Brand	07/01/20	Minimum Age: 4 Years Old	Medication Coverage Exception	Mydayis	
Relexxii	Non Preferred	Brand	07/01/20	Minimum Age: 4 Years Old	Medication Coverage Exception		
Ritalin LA	Non Preferred	Generic	07/01/20	Minimum Age: 4 Years Old	Medication Coverage Exception		
Vyvanse chewable	Non Preferred	Brand	01/01/22	Minimum Age: 4 Years Old	Medication Coverage Exception		
Xelstrym	Non Preferred	Brand	11/01/22	Minimum Age: 6 Years Old	Medication Coverage Exception		

Non-Stimulants for ADHD

• **DAW (Dispense as written) :** Non-preferred psychotropic medications listed on PDL may bypass non-preferred drug prior authorization if a prescriber writes “dispense as written” on prescription and pharmacy submits a Dispense As Written (DAW) Code of “1” on the claim. See Pg.3 Explanation for details.

Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
atomoxetine	Preferred	Generic	10/01/17				
clonidine ER	Preferred	Generic	04/01/23				
guanfacine ER	Preferred	Generic	04/01/23				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Intuniv	Non Preferred	Brand	04/01/23		Medication Coverage Exception		
Qelbree	Non Preferred	Brand	05/01/21		Medication Coverage Exception		
Strattera	Non Preferred	Brand	10/01/17		Medication Coverage Exception		

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Anticonvulsants							
• **DAW (Dispense as written) :** Non-preferred psychotropic medications listed on PDL may bypass non-preferred drug prior authorization if a prescriber writes “dispense as written” on prescription and pharmacy submits a Dispense As Written (DAW) Code of “1” on the claim. See Pg.3 Explanation for details.							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Aptiom	Preferred	Brand	01/01/17				
Briviact	Preferred	Brand	01/01/23				
carbamazepine chewable	Preferred	Generic	01/01/17		90 Day Supply Required		
carbamazepine ER	Preferred	Generic	08/01/17				
Celontin	Preferred	Brand	01/01/17			Celontin	
clobazam	Preferred	Generic	01/01/20	Cumulative across class: 120 units /30 days			
clonazepam	Preferred	Generic	01/01/17	Cumulative across class: 120 units /30 days			
Diastat	Preferred	Brand	01/01/23	Cumulative across class: 120 units /30 days		Diastat	
Dilantin 30mg	Preferred	Brand	01/01/17				
divalproex	Preferred	Generic	01/01/17		90 Day Supply Required		Included in more than one class
ethosuximide	Preferred	Generic	06/01/19				
gabapentin	Preferred	Generic	10/01/16	3600mg /day			Pregabalin/ Gabapentin combo is restricted
Gabitril	Preferred	Brand	01/01/18				
lacosamide	Preferred	Generic	01/01/23				
lamotrigine chewable	Preferred	Generic	11/01/16		90 Day Supply Required		
lamotrigine tablet	Preferred	Generic	11/01/16		90 Day Supply Required		
levetiracetam	Preferred	Generic	10/01/16				
Lyrica capsule	Preferred	Brand	01/01/19	600mg /day		Lyrica	Pregabalin/ Gabapentin combo is restricted
Nayzilam	Preferred	Brand	01/01/21	Cumulative:120 units /30 days			
oxcarbazepine tablet	Preferred	Generic	10/01/16		90 Day Supply Required		
Peganone	Preferred	Brand	10/01/16				
phenytoin	Preferred	Generic	01/01/17				
primidone	Preferred	Generic	01/01/17				

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Tegretol solution	Preferred	Brand	01/01/17			Tegretol	
Tegretol tablet	Preferred	Brand	01/01/17		90 Day Supply Required	Tegretol	
tiagabine	Preferred	Generic	02/01/21				
topiramate capsule	Preferred	Generic	01/01/19				Included in more than one class
topiramate tablet	Preferred	Generic	01/01/19		90 Day Supply Required		Included in more than one class
valproic acid	Preferred	Generic	01/01/17				
Valtoco	Preferred	Brand	05/01/20	Cumulative:120 units /30 days			
Xcopri	Preferred	Brand	01/01/21				
zonisamide	Preferred	Generic	10/01/16		90 Day Supply Required		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Banzel	Non Preferred	Brand	10/01/16		Medication Coverage Exception	Banzel	
carbamazepine suspension	Non Preferred	Generic	01/01/17		Medication Coverage Exception	Tegretol	
carbamazepine tablet	Non Preferred	Generic	01/01/17		Medication Coverage Exception	Tegretol	
Carbatrol	Non Preferred	Brand	01/01/17		Medication Coverage Exception		
clonazepam ODT	Non Preferred	Generic	01/01/17	Cumulative:120 units /30 days	Medication Coverage Exception		
Depakote	Non Preferred	Brand	01/01/17		Medication Coverage Exception		Included in more than one class
Diacomit	Non Preferred	Brand	07/01/19		Medication Coverage Exception		
diazepam rectal	Non Preferred	Generic	01/01/23	Cumulative:120 units /30 days	Medication Coverage Exception	Diastat	
Dilantin 100mg	Non Preferred	Brand	01/01/17		Medication Coverage Exception		
Dilantin chewable	Non Preferred	Brand	01/01/17		Medication Coverage Exception		
Elepsia XR	Non Preferred	Brand	05/01/21		Medication Coverage Exception		
Epidiolex	Non Preferred	Brand	01/01/19		Epidiolex Prior Auth Form		
Eprontia	Non Preferred	Brand	12/01/21		Medication Coverage Exception		
felbamate	Non Preferred	Generic	10/01/16		Medication Coverage Exception	Felbatol	
Felbatol	Non Preferred	Brand	10/01/16		Medication Coverage Exception	Felbatol	
Fintepla	Non Preferred	Brand	08/01/20		Medication Coverage Exception		
Fycompa	Non Preferred	Brand	01/01/19		Medication Coverage Exception		
Gralise	Non Preferred	Brand	09/01/18	3600mg /day	Medication Coverage Exception		Pregabalin/ Gabapentin combo is restricted
Horizant	Non Preferred	Brand	09/01/18	3600mg /day	Medication Coverage Exception		Pregabalin/ Gabapentin combo is restricted
Keppra	Non Preferred	Brand	10/01/16		Medication Coverage Exception		

Utah Medicaid Preferred Drug List - Effective January 1, 2024

Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Klonopin	Non Preferred	Brand	01/01/17	Cumulative:120 units /30 days	Medication Coverage Exception		
Lamictal	Non Preferred	Brand	10/01/16		Medication Coverage Exception		
Lamictal ODT	Non Preferred	Brand	10/01/16		Medication Coverage Exception	Lamictal ODT	
Lamictal XR	Non Preferred	Brand	10/01/16		Medication Coverage Exception		
lamotrigine ER	Non Preferred	Generic	10/01/16		Medication Coverage Exception		
lamotrigine ODT	Non Preferred	Generic	10/01/16		Medication Coverage Exception	Lamictal ODT	
Lyrica CR	Non Preferred	Brand	01/01/19	600mg /day	Medication Coverage Exception		Pregabalin/ Gabapentin combo is restricted
Lyrica solution	Non Preferred	Brand	01/01/19	600mg /day	Medication Coverage Exception		Pregabalin/ Gabapentin combo is restricted
methsuximide	Non Preferred	Generic	12/01/23		Medication Coverage Exception	Celontin	
Motpoly XR	Non Preferred	Brand	11/01/23		Medication Coverage Exception		
Mysoline	Non Preferred	Brand	01/01/17		Medication Coverage Exception		
Neurontin	Non Preferred	Brand	10/01/16		Medication Coverage Exception		
Onfi	Non Preferred	Brand	11/01/18		Medication Coverage Exception		
oxcarbazepine suspension	Non Preferred	Generic	10/01/16		Medication Coverage Exception		
Oxtellar XR	Non Preferred	Brand	10/01/16		Medication Coverage Exception		
Phenytek	Non Preferred	Brand	01/01/17		Medication Coverage Exception		
pregabalin	Non Preferred	Generic	08/01/19	600mg /day	Medication Coverage Exception	Lyrica	Pregabalin/ Gabapentin combo is restricted
Qudexy XR	Non Preferred	Brand	01/01/19		Medication Coverage Exception		Included in more than one class
rufinamide	Non Preferred	Generic	12/01/20		Medication Coverage Exception	Banzel	
Sabril	Non Preferred	Brand	09/01/17		Medication Coverage Exception		
Spritam	Non Preferred	Brand	10/01/16		Medication Coverage Exception		
Sympazan	Non Preferred	Brand	12/01/18		Medication Coverage Exception		
Tegretol XR	Non Preferred	Brand	08/01/17		Medication Coverage Exception		
Topamax	Non Preferred	Brand	10/01/16		Medication Coverage Exception		
topiramate ER	Non Preferred	Generic	01/01/19		Medication Coverage Exception	Trokendi XR	Included in more than one class
Trileptal	Non Preferred	Brand	10/01/16		Medication Coverage Exception		
Trileptal suspension	Non Preferred	Brand	10/01/16		Medication Coverage Exception		
Trokendi XR	Non Preferred	Brand	10/01/16		Medication Coverage Exception	Trokendi XR	Included in more than one class
vigabatrin	Non Preferred	Generic	09/01/17		Medication Coverage Exception		
Vimpat	Non Preferred	Brand	01/01/23		Medication Coverage Exception		
Zarontin	Non Preferred	Brand	06/01/19		Medication Coverage Exception		
Ztalmy	Non Preferred	Brand	02/01/23		Medication Coverage Exception		

Utah Medicaid Preferred Drug List - Effective January 1, 2024

Atypical Antipsychotics							
• **Children under 18:** Utah Medicaid restricts the use of multiple antipsychotics in children under 18 years old.							
• **Children under 6:** Prior Authorization is required for all antipsychotics prescribed to children under 6 years old.							
• **DAW (Dispense as written) :** Non-preferred psychotropic medications listed on PDL may bypass non-preferred drug prior authorization if a prescriber writes "dispense as written" on prescription and pharmacy submits a Dispense As Written (DAW) Code of "1" on the claim. See Pg.3 Explanation for details.							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Abilify Asimtufii	Preferred	Brand	01/01/24	Minimum Age: 18 Years Old	Antipsychotics in Children or Medication Coverage		Must be dispensed directly to the provider, not the patient.
Abilify Maintena	Preferred	Brand	10/01/16	Minimum Age: 18 Years Old	Antipsychotics in Children		Must be dispensed directly to the provider, not the patient.
aripiprazole tablet	Preferred	Generic	01/01/18	age 6-11 years: 15mg /day age 12-17 years: 30mg /day	Antipsychotics in Children		
Aristada	Preferred	Brand	05/01/18	Minimum Age: 18 Years Old	Antipsychotics in Children		Must be dispensed directly to the provider, not the patient.
clozapine tablet	Preferred	Generic	10/01/16	age 8-11 years: 300mg /day age 12-17 years: 600mg /day	Antipsychotics in Children		
Invega Hafyera	Preferred	Brand	10/01/21	Minimum Age: 18 Years Old	Antipsychotics in Children		Must be dispensed directly to the provider, not the patient.
Invega Sustenna	Preferred	Brand	05/01/18	Minimum Age: 18 Years Old	Antipsychotics in Children		Must be dispensed directly to the provider, not the patient.
Invega Trinza	Preferred	Brand	05/01/18	Minimum Age: 18 Years Old	Antipsychotics in Children		Must be dispensed directly to the provider, not the patient.
lurasidone	Preferred	Generic	02/01/23	age 10-17 years: 80mg /day	Antipsychotics in Children		
olanzapine	Preferred	Generic	10/01/16	age 6-17 years: 20mg /day	Antipsychotics in Children		
olanzapine ODT	Preferred	Generic	01/01/20	age 6-17 years: 20mg /day	Antipsychotics in Children		
Perseris	Preferred	Brand	01/01/19	Minimum Age: 18 Years Old	Antipsychotics in Children		Must be dispensed directly to the provider, not the patient.
quetiapine	Preferred	Generic	01/01/19	age 6-9 years: 400mg /day age 10-17 years: 800mg /day	Antipsychotics in Children		
quetiapine ER	Preferred	Generic	01/01/19	age 6-9 years: 400mg /day age 10-17 years: 800mg /day	Antipsychotics in Children		
risperidone solution	Preferred	Generic	01/01/18	age 6-11 years: 3mg /day age 12-17 years: 6mg /day	Antipsychotics in Children		
risperidone tablet	Preferred	Generic	01/01/18	age 6-11 years: 3mg /day age 12-17 years: 6mg /day	Antipsychotics in Children		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Saphris	Preferred	Brand	01/01/18	age 10-17 years: 20mg /day	Antipsychotics in Children	Saphris	
Zyprexa Relprevv	Preferred	Brand	01/01/21	Minimum Age: 18 Years Old	Antipsychotics in Children		Must be dispensed directly to the provider, not the patient.
ziprasidone	Preferred	Generic	01/01/18	age 7-9 years: 60mg /day age 10-17 years: 160mg /day	Antipsychotics in Children		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Abilify	Non Preferred	Brand	01/01/18	age 6-11 years: 15mg /day age 12-17 years: 30mg /day	Antipsychotics in Children or Medication Coverage Exception		
Abilify Mycite	Non Preferred	Brand	07/01/20	Minimum Age: 18 Years Old	Abilify Mycite Prior Auth		
aripiprazole ODT	Non Preferred	Generic	01/01/18	age 6-11 years: 15mg /day age 12-17 years: 30mg /day	Antipsychotics in Children or Medication Coverage Exception		
aripiprazole solution	Non Preferred	Generic	01/01/18	age 6-11 years: 15mg /day age 12-17 years: 30mg /day	Antipsychotics in Children or Medication Coverage Exception		
asenapine SL tablet	Non Preferred	Generic	01/01/21	age 10-17 years: 20mg /day	Antipsychotics in Children or Medication Coverage Exception	Saphris	
Caplyta	Non Preferred	Generic	02/01/20	Minimum Age: 18 Years Old	Antipsychotics in Children or Medication Coverage Exception		
clozapine ODT	Non Preferred	Generic	10/01/16	age 8-11 years: 300mg /day age 12-17 years: 600mg /day	Antipsychotics in Children or Medication Coverage Exception		
Clozaril	Non Preferred	Brand	10/01/16	age 8-11 years: 300mg /day age 12-17 years: 600mg /day	Antipsychotics in Children or Medication Coverage Exception		
Fanapt	Non Preferred	Brand	10/01/16	Minimum Age: 18 Years Old	Antipsychotics in Children or Medication Coverage Exception		
Geodon capsule	Non Preferred	Brand	01/01/18	age 10-17 years: 160mg /day	Antipsychotics in Children or Medication Coverage Exception		
Geodon injection	Non Preferred	Brand	04/01/20	age 10-17 years: 160mg /day	Antipsychotics in Children or Medication Coverage Exception		
Invega	Non Preferred	Brand	10/01/16	age 12-17 years: 12mg	Antipsychotics in Children or Medication Coverage Exception		
Latuda	Non Preferred	Brand	05/01/23	age 10-17 years: 80mg /day	Antipsychotics in Children or Medication Coverage Exception		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Lybalvi	Non Preferred	Brand	10/01/21	Minimum Age: 18 Years Old	Antipsychotics in Children or Medication Coverage Exception		
olanzapine injection	Non Preferred	Generic	10/01/16	Minimum Age: 18 Years Old	Antipsychotics in Children or Medication Coverage Exception		Must be dispensed directly to the provider, not the patient.
paliperidone	Non Preferred	Generic	10/01/16	age 12-17 years: 12mg	Antipsychotics in Children or Medication Coverage Exception		
Rexulti	Non Preferred	Brand	10/01/16	age 12-17 years: 4mg /day	Antipsychotics in Children or Medication Coverage Exception		
Risperdal	Non Preferred	Brand	10/01/16	age 6-11 years: 3mg /day age 12-17 years: 6mg /day	Antipsychotics in Children or Medication Coverage Exception		
Risperdal Consta, Rykindo	Non Preferred	Brand	10/01/23	Minimum Age: 18 Years Old	Antipsychotics in Children or Medication Coverage Exception		Must be dispensed directly to the provider, not the patient.
risperidone injection	Non Preferred	Generic	10/01/16	Minimum Age: 18 Years Old	Antipsychotics in Children or Medication Coverage Exception	Risperdal Consta	Must be dispensed directly to the provider, not the patient.
risperidone ODT	Non Preferred	Generic	10/01/16	age 6-11 years: 3mg /day age 12-17 years: 6mg /day	Antipsychotics in Children or Medication Coverage Exception		
Secuado	Non Preferred	Brand	01/01/20	Minimum Age: 18 Years Old	Antipsychotics in Children or Medication Coverage Exception		
Seroquel	Non Preferred	Brand	10/01/16	age 6-9 years: 400mg /day age 10-17 years: 800mg /day	Antipsychotics in Children or Medication Coverage Exception		
Seroquel XR	Non Preferred	Brand	10/01/16	age 6-9 years: 400mg /day age 10-17 years: 800mg /day	Antipsychotics in Children or Medication Coverage Exception		
Uzedy	Non Preferred	Brand	06/01/23	Minimum Age: 18 Years Old	Antipsychotics in Children or Medication Coverage Exception		
Versacloz	Non Preferred	Brand	10/01/16	age 8-11 years: 300mg /day age 12-17 years: 600mg /day	Antipsychotics in Children or Medication Coverage Exception		
Vraylar	Non Preferred	Brand	01/01/19	Minimum Age: 18 Years Old	Antipsychotics in Children or Medication Coverage Exception		
Ziprasidone injection	Non Preferred	Generic	04/01/20	age 10-17 years: 160mg /day	Antipsychotics in Children or Medication Coverage Exception		
Zyprexa	Non Preferred	Brand	10/01/16	age 6-17 years: 20mg /day	Antipsychotics in Children or Medication Coverage Exception		
Zyprexa Zydis	Non Preferred	Brand	10/01/16	age 6-17 years: 20mg /day	Antipsychotics in Children or Medication Coverage Exception		

Utah Medicaid Preferred Drug List - Effective January 1, 2024

Antidepressants - SSRI/SNRI							
• **DAW (Dispense as written) :** Non-preferred psychotropic medications listed on PDL may bypass non-preferred drug prior authorization if a prescriber writes "dispense as written" on prescription and pharmacy submits a Dispense As Written (DAW) Code of "1" on the claim. See Pg.3 Explanation for details.							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
citalopram tablet	Preferred	Generic	02/01/17		90 Day Supply Required		
desvenlafaxine succinate	Preferred	Generic	10/01/23				
duloxetine 20, 30, 60mg	Preferred	Generic	10/01/16		90 Day Supply Required		
escitalopram tablet	Preferred	Generic	10/01/16		90 Day Supply Required		
fluoxetine capsule	Preferred	Generic	10/01/16		90 Day Supply Required		
fluoxetine solution	Preferred	Generic	10/01/16				
fluoxetine tablet	Preferred	Generic	01/01/24				
paroxetine [non-ER] tablet	Preferred	Generic	10/01/16		90 Day Supply Required		All strengths except 7.5mg
Pristiq	Preferred	Brand	10/01/22				
Savella	Preferred	Brand	01/01/18				
sertraline tablet	Preferred	Generic	10/01/16		90 Day Supply Required		
venlafaxine ER capsule	Preferred	Generic	10/01/16		90 Day Supply Required		
venlafaxine tablet [non-ER]	Preferred	Generic	01/01/19				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Brisdelle	Non Preferred	Brand	10/01/17		Medication Coverage Exception	Brisdelle	
Celexa	Non Preferred	Brand	10/01/16		Medication Coverage Exception		
citalopram capsule	Non Preferred	Generic	03/01/22		Medication Coverage Exception		
citalopram solution	Non Preferred	Generic	10/01/16		Medication Coverage Exception		
Cymbalta	Non Preferred	Brand	10/01/16		Medication Coverage Exception		
desvenlafaxine (base)	Non Preferred	Generic	10/01/16		Medication Coverage Exception		
Drizalma	Non Preferred	Brand	10/01/19		Medication Coverage Exception		
duloxetine 40mg	Non Preferred	Generic	10/01/16		Medication Coverage Exception		
Effexor XR	Non Preferred	Brand	10/01/16		Medication Coverage Exception		
escitalopram solution	Non Preferred	Generic	10/01/16		Medication Coverage Exception		
Fetzima	Non Preferred	Brand	10/01/16		Medication Coverage Exception		
fluoxetine weekly (90mg)	Non Preferred	Generic	01/01/18		Medication Coverage Exception		
fluvoxamine	Non Preferred	Generic	10/01/16		Medication Coverage Exception		
fluvoxamine ER	Non Preferred	Generic	10/01/16		Medication Coverage Exception		
Lexapro	Non Preferred	Brand	10/01/16		Medication Coverage Exception		
olanzapine/fluoxetine	Non Preferred	Generic	10/01/16		Medication Coverage Exception		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
paroxetine 7.5mg	Non Preferred	Generic	10/01/17		Medication Coverage Exception	Brisdelle	
paroxetine ER tablet	Non Preferred	Generic	10/01/16		Medication Coverage Exception		
paroxetine suspension	Non Preferred	Generic	06/01/22		Medication Coverage Exception		
Paxil CR	Non Preferred	Brand	10/01/16		Medication Coverage Exception		
Paxil tablet, suspension	Non Preferred	Brand	10/01/16		Medication Coverage Exception		
Pexeva	Non Preferred	Brand	10/01/16		Medication Coverage Exception		
Prozac	Non Preferred	Brand	10/01/16		Medication Coverage Exception		
sertraline capsule	Non Preferred	Generic	11/01/21		Medication Coverage Exception		
sertraline concentrate	Non Preferred	Generic	10/01/16		Medication Coverage Exception		
Symbyax	Non Preferred	Brand	10/01/16		Medication Coverage Exception		
venlafaxine ER tablet	Non Preferred	Generic	10/01/16		Medication Coverage Exception		
Zoloft	Non Preferred	Brand	10/01/16		Medication Coverage Exception		

Antidepressants -TCAs

• **DAW (Dispense as written) :** Non-preferred psychotropic medications listed on PDL may bypass non-preferred drug prior authorization if a prescriber writes “dispense as written” on prescription and pharmacy submits a Dispense As Written (DAW) Code of “1” on the claim. See Pg.3 Explanation for details.

Preferred Drugs	Status	Type	Last Update	Limits	Mandatory 3-Month	Brand Required	Additional Note
amitriptyline	Preferred	Generic	01/01/18				Included in more than one class
doxepin capsule, concentrate	Preferred	Generic	01/01/18				
imipramine HCl tablet	Preferred	Generic	01/01/18				
nortriptyline capsule	Preferred	Generic	01/01/18				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
amitriptyline/chlordiazepoxide	Non Preferred	Generic	01/01/18		Medication Coverage Exception		
amitriptyline/perphenazine	Non Preferred	Generic	01/01/18		Medication Coverage Exception		
amoxapine	Non Preferred	Generic	01/01/18		Medication Coverage Exception		
Anafranil	Non Preferred	Brand	01/01/18		Medication Coverage Exception		
clomipramine	Non Preferred	Generic	01/01/18		Medication Coverage Exception		
desipramine	Non Preferred	Generic	01/01/18		Medication Coverage Exception		
imipramine pamoate capsule	Non Preferred	Generic	01/01/18		Medication Coverage Exception		
Norpramin	Non Preferred	Brand	01/01/18		Medication Coverage Exception		
nortriptyline solution	Non Preferred	Generic	01/01/18		Medication Coverage Exception		
Pamelor	Non Preferred	Brand	01/01/18		Medication Coverage Exception		
protriptyline	Non Preferred	Generic	01/01/18		Medication Coverage Exception		
trimipramine	Non Preferred	Generic	01/01/19		Medication Coverage Exception		

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Antidepressants - Miscellaneous							
• **DAW (Dispense as written) :** Non-preferred psychotropic medications listed on PDL may bypass non-preferred drug prior authorization if a prescriber writes “dispense as written” on prescription and pharmacy submits a Dispense As Written (DAW) Code of “1” on the claim. See Pg.3 Explanation for details.							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Aplenzin	Preferred	Brand	01/01/24				
bupropion	Preferred	Generic	10/19/16				
bupropion SR	Preferred	Generic	10/19/16		90 Day Supply Required		
bupropion XL 150, 300mg	Preferred	Generic	10/19/16		90 Day Supply Required		
Marplan	Preferred	Brand	01/01/18				
mirtazapine 7.5mg	Preferred	Generic	06/01/23				
mirtazapine 15, 30, 45mg	Preferred	Generic	10/01/16		90 Day Supply Required		
mirtazapine ODT	Preferred	Generic	10/01/16				
phenelzine	Preferred	Generic	01/01/18				
trazodone 50, 100, 150mg	Preferred	Generic	10/01/16		90 Day Supply Required		
trazodone 300mg	Preferred	Generic	06/01/23				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Auvelity	Non Preferred	Brand	02/01/23		Medication Coverage Exception		
bupropion 450mg ER	Non Preferred	Generic	10/01/18		Medication Coverage Exception	Forfivo XL	
Emsam	Non Preferred	Brand	01/01/18		Medication Coverage Exception		
Forfivo XL	Non Preferred	Brand	10/01/18		Medication Coverage Exception	Forfivo XL	
Nardil	Non Preferred	Brand	01/01/18		Medication Coverage Exception		
nefazodone	Non Preferred	Generic	10/01/16		Medication Coverage Exception		
Remeron	Non Preferred	Brand	10/01/16		Medication Coverage Exception		
Remeron ODT	Non Preferred	Brand	10/01/16		Medication Coverage Exception		
tranylcypromine	Non Preferred	Generic	03/01/19		Medication Coverage Exception		
Trintellix	Non Preferred	Brand	10/01/16		Medication Coverage Exception		
Viibryd	Non Preferred	Brand	10/01/16		Medication Coverage Exception	Viibryd	
vilazodone	Non Preferred	Generic	07/01/22		Medication Coverage Exception	Viibryd	
Wellbutrin	Non Preferred	Brand	10/19/16		Medication Coverage Exception		

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Anxiolytic Benzodiazepines

• **DAW (Dispense as written) :** Non-preferred psychotropic medications listed on PDL may bypass non-preferred drug prior authorization if a prescriber writes "dispense as written" on prescription and pharmacy submits a Dispense As Written (DAW) Code of "1" on the claim. See Pg.3 Explanation for details.

• **Cumulative limit:** 120 units in 30 days. Cumulative limits apply across class.

Preferred Drugs	Status	Type	Last Update	Limits	Brand Required	Additional Note
alprazolam tablet	Preferred	Generic	01/01/17	Cumulative across class: 120 units /30 days		
chlordiazepoxide	Preferred	Generic	01/01/17	Cumulative across class: 120 units /30 days		
diazepam tablet	Preferred	Generic	01/01/17	Cumulative across class: 120 units /30 days		
lorazepam tablet	Preferred	Generic	01/01/17	Cumulative across class: 120 units /30 days		

Non Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
alprazolam concentrate	Non Preferred	Generic	01/01/17	Cumulative: 120 units /30 days	Medication Coverage Exception		
alprazolam ODT	Non Preferred	Generic	01/01/17	Cumulative: 120 units /30 days	Medication Coverage Exception		
Ativan	Non Preferred	Brand	01/01/17	Cumulative: 120 units /30 days	Medication Coverage Exception		
clorazepate	Non Preferred	Generic	01/01/17	Cumulative: 120 units /30 days	Medication Coverage Exception		
diazepam concentrate	Non Preferred	Generic	01/01/17	Cumulative: 120 units /30 days	Medication Coverage Exception		
diazepam solution	Non Preferred	Generic	01/01/17	Cumulative: 120 units /30 days	Medication Coverage Exception		
lorazepam concentrate	Non Preferred	Generic	01/01/17	Cumulative: 120 units /30 days	Medication Coverage Exception		
Loreev XR	Non Preferred	Brand	10/01/21	Cumulative: 120 units /30 days	Medication Coverage Exception		
oxazepam	Non Preferred	Generic	01/01/17	Cumulative: 120 units /30 days	Medication Coverage Exception		
Xanax	Non Preferred	Brand	01/01/17	Cumulative: 120 units /30 days	Medication Coverage Exception		

Wakefulness Promoting Agents

Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
armodafinil	Preferred	Generic	01/01/22		Wakefulness Promoting Agents		
modafinil	Preferred	Generic	01/01/22		Wakefulness Promoting Agents		
Nuvigil	Preferred	Brand	01/01/24		Wakefulness Promoting Agents		
Provigil	Preferred	Brand	01/01/24		Wakefulness Promoting Agents		

Non Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
Sunosi	Non Preferred	Brand	01/01/23		Wakefulness Promoting Agents		
Wakix	Non Preferred	Brand	01/01/22		Wakefulness Promoting Agents		

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Contraceptives							
Low Dose and Mono-phasic - Oral							
Preferred Drugs	Status	Type	Last Update	Limits	Mandatory 3-Month	Brand Required	Additional Note
afirmelle	Preferred	Generic	11/01/19	Female only	84 Day Supply Required		
altavera	Preferred	Generic	01/01/12	Female only	84 Day Supply Required		
alyacen 1/35	Preferred	Generic	01/01/13	Female only	84 Day Supply Required		
apri	Preferred	Generic	01/01/14	Female only	84 Day Supply Required		
aubra	Preferred	Generic	05/05/15	Female only	84 Day Supply Required		
aurovela 1/20	Preferred	Generic	01/01/21	Female only	84 Day Supply Required		
aurovela 24 FE 1/20	Preferred	Generic	01/01/24	Female only	84 Day Supply Required		
aurovela FE 1.5/30, 1/20	Preferred	Generic	01/01/21	Female only	84 Day Supply Required		
aviane	Preferred	Generic	03/15/16	Female only	84 Day Supply Required		
ayuna	Preferred	Generic	07/01/19	Female only	84 Day Supply Required		
balziva	Preferred	Generic	01/01/20	Female only	84 Day Supply Required		
Beyaz	Preferred	Brand	01/01/21	Female only	84 Day Supply Required		
blisovi FE 1/20, 1.5/30	Preferred	Generic	11/01/16	Female only	84 Day Supply Required		
charlotte 24 FE chew	Preferred	Generic	01/01/24	Female only	84 Day Supply Required		
chateal	Preferred	Generic	01/01/14	Female only	84 Day Supply Required		
cyred	Preferred	Generic	01/01/16	Female only	84 Day Supply Required		
dasetta 1/35	Preferred	Generic	01/01/13	Female only	84 Day Supply Required		
desogestrel/ee	Preferred	Generic	12/01/20	Female only	84 Day Supply Required		
drospirenone/ee	Preferred	Generic	01/01/21	Female only	84 Day Supply Required		
enskyce	Preferred	Generic	01/01/14	Female only	84 Day Supply Required		
estarylla	Preferred	Generic	01/01/14	Female only	84 Day Supply Required		
falmina	Preferred	Generic	01/01/13	Female only	84 Day Supply Required		
femynor	Preferred	Generic	03/01/18	Female only	84 Day Supply Required		
finzala FE chew 1/20	Preferred	Generic	01/24/23	Female only	84 Day Supply Required		
gianvi	Preferred	Generic	01/01/21	Female only	84 Day Supply Required		
hailey FE 1/20, FE 1.5/30, 24 FE	Preferred	Generic	01/01/23	Female only	84 Day Supply Required		
isibloom	Preferred	Generic	07/01/18	Female only	84 Day Supply Required		
jasmiel	Preferred	Generic	01/01/21	Female only	84 Day Supply Required		
juleber	Preferred	Generic	05/15/16	Female only	84 Day Supply Required		
junel FE 1/20, 1.5/30	Preferred	Generic	01/01/16	Female only	84 Day Supply Required		
junel FE 24 1/20	Preferred	Generic	01/24/23	Female only	84 Day Supply Required		
kalliga	Preferred	Generic	11/01/19	Female only	84 Day Supply Required		
kurvelo	Preferred	Generic	01/01/14	Female only	84 Day Supply Required		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
larin 1/20	Preferred	Generic	01/01/21	Female only	84 Day Supply Required		
larin FE 1/20, 1.5/30	Preferred	Generic	01/01/22	Female only	84 Day Supply Required		
larin FE 24 1/20	Preferred	Generic	01/01/24	Female only	84 Day Supply Required		
larissia	Preferred	Generic	09/01/17	Female only	84 Day Supply Required		
lessina	Preferred	Generic	10/01/11	Female only	84 Day Supply Required		
levonorgestrel/ee	Preferred	Generic	01/01/16	Female only	84 Day Supply Required		
levora	Preferred	Generic	03/15/16	Female only	84 Day Supply Required		
lillow	Preferred	Generic	09/01/17	Female only	84 Day Supply Required		
loestrin 1/20-21	Preferred	Generic	01/01/22	Female only	84 Day Supply Required		
loestrin 21 1.5/30	Preferred	Generic	01/01/22	Female only	84 Day Supply Required		
loestrin FE 1.5/30, 1/20	Preferred	Generic	12/01/22	Female only	84 Day Supply Required		
loryna	Preferred	Generic	01/01/19	Female only	84 Day Supply Required		
lo-zumandimine	Preferred	Generic	01/01/21	Female only	84 Day Supply Required		
lutera	Preferred	Generic	10/01/11	Female only	84 Day Supply Required		
marlissa	Preferred	Generic	01/01/13	Female only	84 Day Supply Required		
melodetta 24 chewable	Preferred	Generic	01/01/24	Female only	84 Day Supply Required		
mibelas 24 chew	Preferred	Generic	01/01/24	Female only	84 Day Supply Required		
microgestin 24 FE 1/20	Preferred	Generic	01/01/24	Female only	84 Day Supply Required		
microgestin FE 1/20, FE 1.5/30	Preferred	Generic	01/01/21	Female only	84 Day Supply Required		
mili	Preferred	Generic	06/01/18	Female only	84 Day Supply Required		
mono-linyah	Preferred	Generic	04/01/13	Female only	84 Day Supply Required		
necon 0.5/35	Preferred	Generic	01/01/24	Female only	84 Day Supply Required		
nikki	Preferred	Generic	01/01/21	Female only	84 Day Supply Required		
norethindrone/ee 1/20	Preferred	Generic	01/01/23	Female only	84 Day Supply Required		
norethindrone/ee FE 1/20, 1.5/30	Preferred	Generic	01/01/21	Female only	84 Day Supply Required		
norethindrone/ee FE capsule	Preferred	Generic	01/01/24	Female only	84 Day Supply Required		
norethindrone/ee FE chewable	Preferred	Generic	01/01/24	Female only	84 Day Supply Required		
norgestimate/ee	Preferred	Generic	01/01/13	Female only	84 Day Supply Required		
nortrel 1/35	Preferred	Generic	01/01/24	Female only	84 Day Supply Required		
nylia	Preferred	Generic	01/01/22	Female only	84 Day Supply Required		
nymyo	Preferred	Generic	01/01/21	Female only	84 Day Supply Required		
ocella	Preferred	Generic	01/01/19	Female only	84 Day Supply Required		
philith	Preferred	Generic	01/01/20	Female only	84 Day Supply Required		
pirmella 1/35	Preferred	Generic	01/01/20	Female only	84 Day Supply Required		
portia	Preferred	Generic	01/01/12	Female only	84 Day Supply Required		
previfem	Preferred	Generic	01/01/13	Female only	84 Day Supply Required		
reclipsen	Preferred	Generic	01/01/14	Female only	84 Day Supply Required		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
sprintec	Preferred	Generic	10/01/11	Female only	84 Day Supply Required		
sronyx	Preferred	Generic	10/01/11	Female only	84 Day Supply Required		
syeda	Preferred	Generic	01/01/19	Female only	84 Day Supply Required		
tarina FE, 24	Preferred	Generic	01/01/24	Female only	84 Day Supply Required		
Tyblume	Preferred	Brand	01/01/24	Female only	84 Day Supply Required		
vestura	Preferred	Generic	01/01/22	Female only	84 Day Supply Required		
vienva	Preferred	Generic	12/01/16	Female only	84 Day Supply Required		
vyfemla	Preferred	Generic	01/01/20	Female only	84 Day Supply Required		
vylibra	Preferred	Generic	03/01/18	Female only	84 Day Supply Required		
Yasmin	Preferred	Brand	01/01/21	Female only	84 Day Supply Required		
Yaz	Preferred	Brand	01/01/21	Female only	84 Day Supply Required		
zumandimine	Preferred	Generic	01/01/21	Female only	84 Day Supply Required		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
aurovela 1.5/30	Non Preferred	Generic	01/01/21	Female only	Medication Coverage Exception		
Balcoltra	Non Preferred	Brand	05/01/18	Female only	Medication Coverage Exception		
blisovi 24 FE 1/20	Non Preferred	Generic	03/15/16	Female only	Medication Coverage Exception		
briellyn	Non Preferred	Generic	01/01/21	Female only	Medication Coverage Exception		
cryselle	Non Preferred	Generic	01/01/22	Female only	Medication Coverage Exception		
drospirenone/ee/levomefolate	Non Preferred	Generic	11/01/19	Female only	Medication Coverage Exception		
elinest	Non Preferred	Generic	01/01/22	Female only	Medication Coverage Exception		
ethynodiol/ee	Non Preferred	Generic	01/01/18	Female only	Medication Coverage Exception		
FaLessa kit	Non Preferred	Brand	01/01/16	Female only	Medication Coverage Exception		
gemmily	Non Preferred	Generic	12/01/20	Female only	Medication Coverage Exception		
hailey 1.5/30	Non Preferred	Generic	09/01/19	Female only	Medication Coverage Exception		
joyeaux	Non Preferred	Generic	09/01/23	Female only	Medication Coverage Exception		
junel 1.5/30	Non Preferred	Generic	01/01/18	Female only	Medication Coverage Exception		
kaitlib	Non Preferred	Generic	10/01/18	Female only	Medication Coverage Exception		
kelnor 1/35, 1/50	Non Preferred	Generic	01/01/22	Female only	Medication Coverage Exception		
larin 1.5/30	Non Preferred	Generic	01/01/21	Female only	Medication Coverage Exception		
layolis	Non Preferred	Generic	01/01/16	Female only	Medication Coverage Exception		
low-ogestrel	Non Preferred	Generic	12/01/21	Female only	Medication Coverage Exception		
merzee	Non Preferred	Generic	02/01/21	Female only	Medication Coverage Exception		
microgestin 1.5/30	Non Preferred	Generic	01/01/22	Female only	Medication Coverage Exception		
Minastrin 24 FE chewable	Non Preferred	Generic	11/01/19	Female only	Medication Coverage Exception		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
norethindrone/ee 1.5/30	Non Preferred	Generic	12/01/23	Female only	Medication Coverage Exception		
nortrel 0.5/35	Non Preferred	Generic	02/01/19	Female only	Medication Coverage Exception		
Safyral	Non Preferred	Brand	01/01/19	Female only	Medication Coverage Exception		
taysofy	Non Preferred	Generic	12/01/22	Female only	Medication Coverage Exception		
Taytulla	Non Preferred	Brand	10/01/16	Female only	Medication Coverage Exception		
tydemy	Non Preferred	Generic	04/01/18	Female only	Medication Coverage Exception		
wera	Non Preferred	Generic	01/01/18	Female only	Medication Coverage Exception		
wymzya	Non Preferred	Generic	01/01/13	Female only	Medication Coverage Exception		
zovia	Non Preferred	Generic	01/01/19	Female only	Medication Coverage Exception		
Bi-phasic - Oral							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
azurette	Preferred	Generic	01/01/18	Female only	84 Day Supply Required		
bekyree	Preferred	Generic	01/01/18	Female only	84 Day Supply Required		
desogestrel/ee	Preferred	Generic	01/01/18	Female only	84 Day Supply Required		
kariva	Preferred	Generic	01/01/22	Female only	84 Day Supply Required		
pimtrea	Preferred	Generic	01/01/18	Female only	84 Day Supply Required		
simliya	Preferred	Generic	01/01/23	Female only	84 Day Supply Required		
viorele	Preferred	Generic	01/01/23	Female only	84 Day Supply Required		
volnea	Preferred	Generic	02/01/20	Female only	84 Day Supply Required		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Lo Loestrin	Non Preferred	Brand	01/01/12	Female only	Medication Coverage Exception		
Mircette	Non Preferred	Brand	01/01/16	Female only	Medication Coverage Exception		

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Tri-phasic and Multi-phasic - Oral							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Natazia	Preferred	Brand	01/01/16	Female only	84 Day Supply Required		
norgestimate/ee	Preferred	Generic	01/01/16	Female only	84 Day Supply Required		
tri femynor	Preferred	Generic	06/01/17	Female only	84 Day Supply Required		
tri-estaryll, tri-lo-estaryll	Preferred	Generic	11/01/19	Female only	84 Day Supply Required		
tri-linyah	Preferred	Generic	04/01/13	Female only	84 Day Supply Required		
tri-lo-marzia	Preferred	Generic	02/01/20	Female only	84 Day Supply Required		
tri-mili, tri-lo-mili	Preferred	Generic	07/01/19	Female only	84 Day Supply Required		
tri-nymo	Preferred	Generic	12/01/23	Female only	84 Day Supply Required		
tri-previfem	Preferred	Generic	01/01/13	Female only	84 Day Supply Required		
tri-sprintec, tri-lo-sprintec	Preferred	Generic	03/15/16	Female only	84 Day Supply Required		
tri-vylibra	Preferred	Generic	03/01/18	Female only	84 Day Supply Required		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
alyacen 7/7/7	Non Preferred	Generic	01/01/24	Female only	Medication Coverage Exception		
aranelle	Non Preferred	Generic	01/01/23	Female only	Medication Coverage Exception		
dasetta 7/7/7	Non Preferred	Generic	01/01/24	Female only	Medication Coverage Exception		
enpresse	Non Preferred	Generic	01/01/24	Female only	Medication Coverage Exception		
leena	Non Preferred	Generic	01/01/24	Female only	Medication Coverage Exception		
levonest	Non Preferred	Generic	01/01/22	Female only	Medication Coverage Exception		
levonorgestrel/ee	Non Preferred	Generic	01/01/22	Female only	Medication Coverage Exception		
nortrel 7/7/7	Non Preferred	Generic	01/01/24	Female only	Medication Coverage Exception		
nylia 7/7/7	Non Preferred	Generic	01/01/24	Female only	Medication Coverage Exception		
pirmella 7/7/7	Non Preferred	Generic	01/01/24	Female only	Medication Coverage Exception		
tilia FE	Non Preferred	Generic	01/01/11	Female only	Medication Coverage Exception		
tri-legest FE	Non Preferred	Generic	01/01/11	Female only	Medication Coverage Exception		
trivora	Non Preferred	Generic	01/01/22	Female only	Medication Coverage Exception		
velivet	Non Preferred	Generic	09/01/17	Female only	Medication Coverage Exception		
Extended and Continuous Cycle - Oral							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
amethia	Preferred	Generic	01/01/24	Female only	91 Day Supply Required		
ashlyna	Preferred	Generic	01/01/24	Female only	91 Day Supply Required		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
camrese	Preferred	Generic	01/01/22	Female only	91 Day Supply Required		
camrese Lo	Preferred	Generic	01/01/22	Female only	91 Day Supply Required		
daysee	Preferred	Generic	01/01/24	Female only	91 Day Supply Required		
iclevia	Preferred	Generic	01/01/22	Female only	91 Day Supply Required		
jaimiess	Preferred	Generic	01/01/24	Female only	91 Day Supply Required		
jolessa	Preferred	Generic	01/01/16	Female only	91 Day Supply Required		
levonorgestrel/ee [91 day]	Preferred	Generic	01/01/19	Female only	91 Day Supply Required		
Loseasonique	Preferred	Brand	01/01/13	Female only	91 Day Supply Required		
Seasonique	Preferred	Brand	01/01/24	Female only	91 Day Supply Required		
setlakin	Preferred	Generic	01/01/17	Female only	91 Day Supply Required		
simpesse	Preferred	Generic	01/01/24	Female only	91 Day Supply Required		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
amethyst	Non Preferred	Generic	01/01/13	Female only	Medication Coverage Exception		
dolishale	Non Preferred	Generic	05/01/21	Female only	Medication Coverage Exception		
fayosim	Non Preferred	Generic	05/01/17	Female only	Medication Coverage Exception		
introvale	Non Preferred	Generic	01/01/24	Female only	Medication Coverage Exception		
jaimiess Lo	Non Preferred	Generic	02/01/20	Female only	Medication Coverage Exception		
levonorgestrel/ee [84 day]	Non Preferred	Generic	01/01/20	Female only	Medication Coverage Exception		
norethindrone/ee FE	Non Preferred	Generic	12/01/23	Female only	Medication Coverage Exception		
Quartette	Non Preferred	Brand	01/01/14	Female only	Medication Coverage Exception		
rivelsa	Non Preferred	Generic	05/01/17	Female only	Medication Coverage Exception		

Cytokine Modulators

Immunomodulators

Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Avsola	Preferred	Brand	01/01/23				
Enbrel	Preferred	Brand	02/01/10				
Humira	Preferred	Brand	02/01/10				
Otezla	Preferred	Brand	01/01/22				
Taltz	Preferred	Brand	01/01/23				
Xeljanz	Preferred	Brand	01/01/22				
Xeljanz XR	Preferred	Brand	01/01/22				

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Non Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
Actemra	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
adalimumab (all biosimilars)	Non Preferred	generic	08/01/23		Medication Coverage Exception		
Arcalyst	Non Preferred	Brand	11/01/19		Medication Coverage Exception		
Bimzelx	Non Preferred	Brand	11/01/23		Medication Coverage Exception		
Cibinqo	Non Preferred	Brand	03/01/22		Medication Coverage Exception		Included in more than one class
Cimzia	Non Preferred	Brand	01/01/13		Medication Coverage Exception		
Cosentyx	Non Preferred	Brand	01/01/21		Medication Coverage Exception		
Entyvio	Non Preferred	Brand	09/01/20		Medication Coverage Exception		Covered under medical benefit using appropriate HCPCS
Ilaris	Non Preferred	Brand	11/01/19		Medication Coverage Exception		
Ilumya	Non Preferred	Brand	09/01/18		Medication Coverage Exception		
Inflectra	Non Preferred	Brand	11/01/19		Medication Coverage Exception		
infliximab	Non Preferred	generic	12/01/21		Medication Coverage Exception		
Kevzara	Non Preferred	Brand	11/01/17		Medication Coverage Exception		
Kineret	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
Litfulo	Non Preferred	Brand	08/01/23		Medication Coverage Exception		
Olumiant	Non Preferred	Brand	07/01/18		Medication Coverage Exception		
Omvoh	Non Preferred	Brand	12/01/23		Medication Coverage Exception		
Orencia	Non Preferred	Brand	01/01/14		Medication Coverage Exception		
Remicade	Non Preferred	Brand	11/01/19		Medication Coverage Exception		
Renflexis	Non Preferred	Brand	11/01/19		Medication Coverage Exception		
Rinvoq	Non Preferred	Brand	09/01/19		Medication Coverage Exception		Included in more than one class
Siliq	Non Preferred	Brand	05/01/19		Medication Coverage Exception		
Simponi	Non Preferred	Brand	02/01/10		Medication Coverage Exception		
Skyrizi	Non Preferred	Brand	05/01/19		Medication Coverage Exception		
Sotyktu	Non Preferred	Brand	10/01/22		Medication Coverage Exception		
Spevigo	Non Preferred	Brand	09/01/23		Rare Disease Medications		
Stelara	Non Preferred	Brand	10/01/11		Medication Coverage Exception		
Tremfya	Non Preferred	Brand	05/01/19		Medication Coverage Exception		
Velsipity	Non Preferred	Brand	11/01/23		Medication Coverage Exception		

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Dermatological

Topical Acne Products - Antibiotics & Combinations

Preferred Drugs	Status	Type	Last Update	Limits	Mandatory 3-Month	Brand Required	Additional Note
adapalene/benzoyl peroxide gel	Preferred	Generic	01/01/24				
benzoyl peroxide/erythromycin	Preferred	Generic	01/01/13				
clindamycin gel	Preferred	Generic	01/01/20				
clindamycin lotion	Preferred	Generic	01/01/20				
clindamycin pad	Preferred	Generic	01/01/20				
clindamycin solution	Preferred	Generic	01/01/20				
clindamycin/benzoyl peroxid	Preferred	Generic	01/01/19				
erythromycin 2% gel	Preferred	Generic	01/01/13				
erythromycin 2% solution	Preferred	Generic	01/01/13				
Onexton	Preferred	Brand	01/01/16				
Ziana	Preferred	Brand	01/01/13			Ziana	

Non Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
Acanya	Non Preferred	Brand	01/01/19		Medication Coverage Exception		
adapalene/benzoyl peroxide pad	Non Preferred	Generic	02/01/21		Medication Coverage Exception		
Benzamycin	Non Preferred	Brand	08/01/11		Medication Coverage Exception		
Cabtreo	Non Preferred	Brand	12/01/23		Medication Coverage Exception		
Cleocin T lotion	Non Preferred	Brand	08/01/11		Medication Coverage Exception		
Clindacin kit	Non Preferred	Brand	01/01/20		Medication Coverage Exception		
Clindagel	Non Preferred	Brand	08/01/11		Medication Coverage Exception		
clindamycin foam	Non Preferred	Brand	01/01/19		Medication Coverage Exception	Evoclin	
clindamycin/tretinoin	Non Preferred	Generic	08/01/17		Medication Coverage Exception	Ziana	
dapsone	Non Preferred	Generic	11/01/17		Medication Coverage Exception		
EryGel	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
erythromycin pad	Non Preferred	Generic	01/01/16		Medication Coverage Exception		
Klaron	Non Preferred	Brand	05/15/16		Medication Coverage Exception		
sulfacetamide sodium lotion	Non Preferred	Generic	01/01/18		Medication Coverage Exception		

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Topical Acne Products - Retinoids							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Retin-A	Preferred	Brand	01/01/14			Retin-A	
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
adapalene	Non Preferred	Generic	01/01/19		Medication Coverage Exception		
Altreno	Non Preferred	Brand	05/01/19		Medication Coverage Exception		
Arazlo	Non Preferred	Brand	12/01/20		Medication Coverage Exception		
Atralin	Non Preferred	Brand	11/01/17		Medication Coverage Exception		
Fabior	Non Preferred	Brand	01/01/14		Medication Coverage Exception		
Retin-A Micro	Non Preferred	Brand	08/01/11		Medication Coverage Exception		
tazarotene	Non Preferred	Brand	01/01/21		Medication Coverage Exception		
tretinoin	Non Preferred	Generic	01/01/14		Medication Coverage Exception	Retin-A	
Topical Acne Products - Miscellaneous							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Azelex	Preferred	Brand	01/01/14				
sulfacetamide/sulfur emulsion	Preferred	Generic	12/01/16				
sulfacetamide/sulfur liquid	Preferred	Generic	12/01/16				
sulfacetamide/sulfur suspension	Preferred	Generic	12/01/16				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
azelaic acid gel	Non Preferred	Generic	12/01/18		Medication Coverage Exception		
brimonidine gel	Non Preferred	Generic	02/01/23		Medication Coverage Exception		
selenium sulfide	Non Preferred	Generic	04/01/12		Medication Coverage Exception		
sulfacetamide gel	Non Preferred	Generic	01/01/18		Medication Coverage Exception		
sulfacetamide/sulfur cleanser	Non Preferred	Generic	01/01/24		Medication Coverage Exception		
sulfacetamide/sulfur cream	Non Preferred	Generic	12/01/16		Medication Coverage Exception		
sulfacetamide/sulfur foam	Non Preferred	Generic	12/01/16		Medication Coverage Exception		
Sumadan XLT kit	Non Preferred	Brand	10/01/17		Medication Coverage Exception		
Winlevi	Non Preferred	Brand	07/01/23		Medication Coverage Exception		
ZMA	Non Preferred	Brand	12/01/23		Medication Coverage Exception		

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Oral Acne Products							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
isotretinoin 10, 20, 30, 40mg	Preferred	Generic	01/01/23				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Absorica	Non Preferred	Brand	01/01/14		Medication Coverage Exception		
amnesteem	Non Preferred	Generic	08/01/11		Medication Coverage Exception		
claravis	Non Preferred	Generic	01/01/20		Medication Coverage Exception		
isotretinoin 25, 35mg	Non Preferred	Generic	01/01/14		Medication Coverage Exception		
zenatane	Non Preferred	Generic	01/01/23		Medication Coverage Exception		
Topical Antifungals							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
ciclopirox cream	Preferred	Generic	08/01/17				
ciclopirox gel	Preferred	Generic	08/01/17				
ciclopirox shampoo	Preferred	Generic	08/01/17				
ciclopirox suspension	Preferred	Generic	08/01/17				
clotrimazole cream	Preferred	Generic	01/01/20				
clotrimazole solution	Preferred	Generic	01/01/20				
Ertaczo	Preferred	Brand	01/01/14				
ketoconazole cream	Preferred	Generic	10/01/11				
ketoconazole shampoo	Preferred	Generic	10/01/11				
nystatin	Preferred	Generic	11/01/18				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
ciclopirox solution	Non Preferred	Generic	10/01/11		Medication Coverage Exception		
econazole	Non Preferred	Generic	04/01/13		Medication Coverage Exception		
Exelderm	Non Preferred	Brand	12/01/22		Medication Coverage Exception		
Jublia	Non Preferred	Brand	09/15/14		Medication Coverage Exception		
Kerydin	Non Preferred	Brand	09/15/14		Medication Coverage Exception	Kerydin	
ketoconazole foam	Non Preferred	Generic	10/01/11		Medication Coverage Exception		
Loprox	Non Preferred	Brand	08/01/17		Medication Coverage Exception		
luliconazole	Non Preferred	Generic	03/01/19		Medication Coverage Exception		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Luzu	Non Preferred	Brand	03/01/19		Medication Coverage Exception		
Mentax	Non Preferred	Brand	10/01/11		Medication Coverage Exception		
naftifine	Non Preferred	Generic	08/01/17		Medication Coverage Exception		
Naftin	Non Preferred	Brand	01/01/19		Medication Coverage Exception		
oxiconazole	Non Preferred	Generic	10/01/11		Medication Coverage Exception		
Oxistat	Non Preferred	Brand	10/01/11		Medication Coverage Exception		
tavaborole	Non Preferred	Generic	11/01/20		Medication Coverage Exception	Kerydin	
Topical Antivirals							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
acyclovir ointment	Preferred	Generic	01/01/23				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
acyclovir cream	Non Preferred	Generic	03/01/19		Medication Coverage Exception		
Denavir	Non Preferred	Brand	01/01/14		Medication Coverage Exception	Denavir	
penciclovir	Non Preferred	Generic	12/01/22		Medication Coverage Exception	Denavir	
Xerese	Non Preferred	Brand	06/01/13		Medication Coverage Exception		
Zovirax	Non Preferred	Brand	01/01/23		Medication Coverage Exception		
Atopic Dermatitis (Non-Steroidal)							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Adbry	Preferred	Brand	01/01/23				Step Therapy required; must fail a preferred topical calcineurin inhibitor
Dupixent	Preferred	Brand	01/01/22		Monoclonal Antibodies for Asthma and Other Indications		Included in more than one class
Elidel	Preferred	Brand	01/01/23			Elidel	
Protopic	Preferred	Brand	01/01/19				
tacrolimus	Preferred	Generic	08/01/22				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Cibinqo	Non Preferred	Brand	03/01/22		Medication Coverage Exception		Included in more than one class
Eucrisa	Non Preferred	Brand	09/01/18		Medication Coverage Exception		
Opzelura	Non Preferred	Brand	04/01/22		Medication Coverage Exception		
pimecrolimus	Non Preferred	Generic	01/01/23		Medication Coverage Exception	Elidel	
Rinvoq	Non Preferred	Brand	09/01/19		Medication Coverage Exception		Included in more than one class

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Very Potent - Corticosteroids							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
betamethasone augmented cream	Preferred	Generic	10/01/13				
betamethasone dipropionate cream	Preferred	Generic	01/01/18				
betamethasone dipropionate lotion	Preferred	Generic	10/01/13				
clobetasol cream	Preferred	Generic	01/01/18				
clobetasol ointment	Preferred	Generic	01/01/18				
clobetasol shampoo	Preferred	Brand	08/01/20				
clobetasol solution	Preferred	Generic	01/01/18				
halobetasol cream	Preferred	Generic	11/01/19				
halobetasol ointment	Preferred	Generic	11/01/19				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Apexicon E	Non Preferred	Brand	10/01/13		Medication Coverage Exception		
betamethasone augmented gel	Non Preferred	Generic	10/01/13		Medication Coverage Exception		
betamethasone augmented lotion	Non Preferred	Generic	10/01/13		Medication Coverage Exception		
betamethasone augmented ointment	Non Preferred	Generic	10/01/13		Medication Coverage Exception		
betamethasone ointment	Non Preferred	Generic	10/01/13		Medication Coverage Exception		
Bryhali	Non Preferred	Brand	12/01/18		Medication Coverage Exception		
clobetasol foam	Non Preferred	Generic	01/01/18		Medication Coverage Exception		
clobetasol gel	Non Preferred	Generic	01/01/18		Medication Coverage Exception		
clobetasol lotion	Non Preferred	Generic	01/01/18		Medication Coverage Exception		
clobetasol spray	Non Preferred	Generic	01/01/18		Medication Coverage Exception		
diflorasone	Non Preferred	Generic	11/01/17		Medication Coverage Exception		
Diprolene	Non Preferred	Brand	10/01/13		Medication Coverage Exception		
fluocinonide 0.1%	Non Preferred	Generic	01/01/14		Medication Coverage Exception		
flurandrenolide	Non Preferred	Generic	03/01/17		Medication Coverage Exception		
halobetasol foam	Non Preferred	Generic	11/01/19		Medication Coverage Exception		
Impeklo	Non Preferred	Brand	09/01/21		Medication Coverage Exception		
Lexette	Non Preferred	Brand	12/01/18		Medication Coverage Exception		
Olux-E	Non Preferred	Brand	12/01/22		Medication Coverage Exception		
Psorcon	Non Preferred	Brand	11/01/17		Medication Coverage Exception		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Tovet	Non Preferred	Brand	07/01/20		Medication Coverage Exception		
Ultravate	Non Preferred	Brand	11/01/19		Medication Coverage Exception		
Vanos	Non Preferred	Brand	01/01/14		Medication Coverage Exception		
Potent - Corticosteroids							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
desoximetasone 0.25%	Preferred	Generic	01/01/24				
fluocinonide 0.05% cream	Preferred	Generic	01/01/19				
fluocinonide 0.05% gel	Preferred	Generic	01/01/24				
fluocinonide 0.05% ointment	Preferred	Generic	01/01/19				
fluocinonide 0.05% solution	Preferred	Generic	01/01/19				
Halog	Preferred	Brand	01/01/20			Halog	
mometasone 0.1% ointment	Preferred	Generic	10/01/13				
triamcinolone 0.5%	Preferred	Generic	11/01/19				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
amcinonide	Non Preferred	Generic	10/01/13		Medication Coverage Exception		
halcinonide	Non Preferred	Generic	01/01/20		Medication Coverage Exception	Halog	
Topicort	Non Preferred	Brand	10/01/13		Medication Coverage Exception		
Midstrength - Corticosteroids							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
betamethasone val	Preferred	Generic	01/01/20				
fluticasone cream	Preferred	Generic	01/01/20				
fluticasone ointment	Preferred	Generic	01/01/20				
mometasone 0.1% cream	Preferred	Generic	10/01/13				
mometasone 0.1% solution	Preferred	Generic	10/01/13				
triamcinolone 0.1% ointment	Preferred	Generic	10/01/13				
triamcinolone 0.1% cream	Preferred	Generic	10/01/13				
triamcinolone 0.1% lotion	Preferred	Generic	10/01/13				

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Non Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
Beser	Non Preferred	Brand	07/01/20		Medication Coverage Exception		
clocortolone	Non Preferred	Generic	01/01/14		Medication Coverage Exception		
Cloderm	Non Preferred	Brand	01/01/14		Medication Coverage Exception		
desoximetasone 0.05%	Non Preferred	Generic	10/01/13		Medication Coverage Exception		
fluocinolone 0.025% cream	Non Preferred	Generic	01/01/22		Medication Coverage Exception		
fluocinolone 0.025% ointment	Non Preferred	Generic	01/01/22		Medication Coverage Exception		
fluticasone lotion	Non Preferred	Generic	01/01/21		Medication Coverage Exception	Cutivate	
hydrocortisone val 0.2% cream	Non Preferred	Generic	01/01/16		Medication Coverage Exception		
hydrocortisone val 0.2% ointment	Non Preferred	Generic	01/01/16		Medication Coverage Exception		
Kenalog spray	Non Preferred	Brand	04/01/20		Medication Coverage Exception		
Luxiq	Non Preferred	Brand	10/01/17		Medication Coverage Exception		
Pandel	Non Preferred	Brand	01/01/19		Medication Coverage Exception		
prednicarbate	Non Preferred	Generic	01/01/15		Medication Coverage Exception		
Synalar cream	Non Preferred	Brand	01/01/24		Medication Coverage Exception		
Synalar ointment	Non Preferred	Brand	01/01/24		Medication Coverage Exception		
Topicort	Non Preferred	Brand	10/01/13		Medication Coverage Exception		
triamcinolone topical spray	Non Preferred	Generic	01/01/23		Medication Coverage Exception		
Mild - Corticosteroids							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Capex	Preferred	Brand	10/01/13				
Derma-Smoothe/FS	Preferred	Brand	01/01/24				
desonide	Preferred	Generic	11/01/16				
fluocinolone 0.01% cream	Preferred	Generic	01/01/16				
fluocinolone 0.01% oil	Preferred	Generic	01/01/22				
hydrocortisone 1% cream	Preferred	Generic	10/01/13				
hydrocortisone 1% ointment	Preferred	Generic	10/01/13				
hydrocortisone 2.5% cream	Preferred	Generic	10/01/13				
hydrocortisone 2.5% lotion	Preferred	Generic	10/01/13				
hydrocortisone 2.5% ointment	Preferred	Generic	10/01/13				
hydrocortisone 2.5% rectal cream	Preferred	Generic	01/01/22				
hydrocortisone enema	Preferred	Generic	01/01/22				
triamcinolone 0.025% cream	Preferred	Generic	10/01/13				
triamcinolone 0.025% lotion	Preferred	Generic	10/01/13				
triamcinolone 0.025% ointment	Preferred	Generic	10/01/13				

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Non Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
alclometasone	Non Preferred	Generic	01/01/20		Medication Coverage Exception		
Anusol-HC	Non Preferred	Brand	01/01/22		Medication Coverage Exception		
budesonide rectal foam	Non Preferred	Generic	05/01/23		Medication Coverage Exception	Uceris	
Cortenema	Non Preferred	Brand	01/01/22		Medication Coverage Exception		
fluocinolone 0.01% solution	Non Preferred	Generic	11/01/19		Medication Coverage Exception		
hydrocortisone butyrate	Non Preferred	Generic	11/01/19		Medication Coverage Exception		
Locoid	Non Preferred	Brand	11/01/19		Medication Coverage Exception		
Synalar solution	Non Preferred	Brand	11/01/19		Medication Coverage Exception		
Texacort	Non Preferred	Brand	10/01/13		Medication Coverage Exception		
triamcinolone 0.05% ointment	Non Preferred	Generic	01/01/22		Medication Coverage Exception		
Uceris	Non Preferred	Brand	01/01/22		Medication Coverage Exception	Uceris	
Steroid/Antifungal Combinations							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
clotrimazole/betamethasone	Preferred	Generic	12/01/19				
nystatin/triamcinolone	Preferred	Generic	01/01/22				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
clotrimazole/betamethasone lotion	Non Preferred	Generic	12/01/19		Medication Coverage Exception		
Local Anesthetic Agents							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
lidocaine cream (except 4.12%)	Preferred	Generic	01/01/15	60 grams /30 days			
lidocaine gel	Preferred	Generic	01/01/15	60 grams /30 days			
lidocaine ointment	Preferred	Generic	01/01/15	60 grams /30 days			
lidocaine patch	Preferred	Generic	03/01/23	90 patches /30 days			
lidocaine solution	Preferred	Generic	01/01/15	60 ml /30 days			
lidocaine/hydrocortisone rectal cream	Preferred	Generic	01/01/15	60 grams /30 days			
lidocaine/prilocaine	Preferred	Generic	11/01/16	60 grams /30 days			
Lidoderm	Preferred	Brand	11/01/21	90 patches /30 days			

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Non Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
Epifoam	Non Preferred	Brand	01/01/15		Medication Coverage Exception		
lidocaine 4.12% cream	Non Preferred	Generic	01/01/24	60 grams /30 days	Medication Coverage Exception		
lidocaine/hydrocortisone rectal gel	Non Preferred	Generic	01/01/15	60 grams /30 days	Medication Coverage Exception		
Lidogel	Non Preferred	Brand	09/01/21	60 grams /30 days	Medication Coverage Exception		
Lidorex	Non Preferred	Brand	12/01/23	60 grams /30 days	Medication Coverage Exception		
Lidotral	Non Preferred	Brand	12/02/23	60 grams /30 days	Medication Coverage Exception		
Lidotran	Non Preferred	Brand	12/03/23	60 grams /30 days	Medication Coverage Exception		
Lydexa	Non Preferred	Brand	12/01/20	60 grams /30 days	Medication Coverage Exception		
Pliaglis	Non Preferred	Brand	11/01/18	60 grams /30 days	Medication Coverage Exception		
Proctofoam	Non Preferred	Brand	01/01/15		Medication Coverage Exception		
Qutenza	Non Preferred	Brand	12/01/22	4/fill, one fill/90 days	Medication Coverage Exception		
Synera	Non Preferred	Brand	01/01/15	5 patches /30 days	Medication Coverage Exception		
Ztlido	Non Preferred	Brand	02/01/19	3 patches /day	Medication Coverage Exception		
Scabicides/Pediculicides							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Natroba	Preferred	Generic	01/01/22			Natroba	
permethrin	Preferred	Generic	01/01/15				
Vanalice	Preferred	Brand	01/01/20				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Crotan	Non Preferred	Brand	11/01/18		Medication Coverage Exception		
Eurax	Non Preferred	Brand	11/01/18		Medication Coverage Exception		
ivermectin lotion	Non Preferred	Generic	01/01/22		Medication Coverage Exception		
lindane	Non Preferred	Generic	01/01/16		Medication Coverage Exception		
malathion	Non Preferred	Generic	01/01/15		Medication Coverage Exception		
Ovide	Non Preferred	Brand	01/01/15		Medication Coverage Exception		
spinosad	Non Preferred	Generic	01/01/15		Medication Coverage Exception	Natroba	

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Diagnostic Products

Diabetic Continuous Glucose Monitors

Preferred Product	Status	Type	Last Update	Limits	Required Prior Authorization Form	Covered NDCs
Dexcom G6 Receiver	Preferred	Brand	04/01/21	1 receiver /365 days	Continuous Glucose Monitor	08627-0091-11
Dexcom G6 Sensor	Preferred	Brand	04/01/21	3 sensors /30 days	Continuous Glucose Monitor	08627-0053-03
Dexcom G6 Transmitter	Preferred	Brand	04/01/21	1 transmitter /90 days	Continuous Glucose Monitor	08627-0016-01
Dexcom G7 Receiver	Preferred	Brand	01/01/23	1 receiver /365 days	Continuous Glucose Monitor	08627-0078-01
Dexcom G7 Sensor	Preferred	Brand	01/01/23	3 sensors /30 days	Continuous Glucose Monitor	08627-0077-01
Non Preferred Product	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Covered NDCs**
FreeStyle Libre Reader	Non Preferred	Brand	04/01/21	1 reader /365 days	Continuous Glucose Monitor	57599-0000-21, 57599-0002-00, 57599-0803-00
FreeStyle Libre Sensor	Non Preferred	Brand	04/01/21	1 pack /30 days	Continuous Glucose Monitor	57599-0000-19, 57599-0001-01, 57599-0800-00
Guardian Connect Transmitter	Non Preferred	Brand	04/01/21	1 transmitter /365 days	Continuous Glucose Monitor	63000-0285-85
Guardian Sensor 3	Non Preferred	Brand	04/01/21	1 pack /30 days	Continuous Glucose Monitor	63000-0358-44

Diabetic Glucose Meters

- **Nursing Home Members -** OTC Diabetic test supplies are not covered through the outpatient pharmacy benefit program for members in nursing homes.
- **DME -** Non-preferred products must be approved and billed through Durable Medical Equipment (DME).

Preferred Product	Status	Type	Last Update	Limits	Covered NDCs
FreeStyle	Preferred	Brand	01/01/18		99073-0711-43, 99073-0709-14, 99073-0708-05, 57599-5175-01
Precision	Preferred	Brand	01/01/18		57599-8814-01
Non Preferred Product	**Status**	**Type**	**Last Update**	**Limits**	**Additional Note**
All other Glucose Meters	Non Preferred	All	01/01/18		Must be approved and billed through DME.

Diabetic Testing Strips

- **Nursing Home Members -** OTC Diabetic test supplies are not covered through the outpatient pharmacy benefit program for members in nursing homes.
- **DME -** Non-preferred products must be approved and billed through Durable Medical Equipment (DME).

Preferred Product	Status	Type	Last Update	Limits	Covered NDCs
Freestyle Test Strips	Preferred	Brand	01/01/18	200 strips /30 days	99073-0120-50, 99073-0121-01, 99073-0708-22, 99073-0708-27, 99073-0712-27, 99073-0712-31
Precision Test Strips	Preferred	Brand	01/01/18	200 strips /30 days	57599-9728-04, 57599-9877-05, 57599-1577-01, 57599-1579-04
Non Preferred Product	**Status**	**Type**	**Last Update**	**Limits**	**Additional Note**
All other diabetic test strips	Non Preferred	All	01/01/18		Must be approved and billed through DME.

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Diabetic Testing Lancets

• **Nursing Home Members -** OTC Diabetic test supplies are not covered through the outpatient pharmacy benefit program for members in nursing homes.

• **DME -** Non-preferred products must be approved and billed through Durable Medical Equipment (DME).

Preferred Product	Status	Type	Last Update	Limits	Covered NDCs
Autolet lancing device	Preferred	Brand	01/01/22		08470-0270-01
Sure Comfort lancets	Preferred	Brand	01/01/24	200 units /30 days	86227-0018-10, 86227-0021-10, 86227-0023-10, 86227-0030-11 86227-0281-05, 86227-0301-05
Unilet lancets	Preferred	Brand	01/01/22	200 units /30 days	08470-0565-01, 08470-0575-01, 08470-0585-01
Unistik lancets	Preferred	Brand	01/01/22	200 units /30 days	08470-1002-01, 08470-1004-01, 08470-1012-01, 08470-1014-01, 08470-1022-01, 08470-1024-01, 08470-1042-01, 08470-1044-01, 08470-1402-01, 08470-1404-01, 08470-1412-01, 08470-1414-01, 08470-1422-01, 08470-1424-01, 08470-1442-01, 08470-1444-01, 08470-1614-01, 08470-1634-01, 08470-1644-01

Non Preferred Product	Status	Type	Last Update	Limits	Additional Note
All other lancets	Non Preferred	All	01/01/18		Must be approved and billed through DME.

Epinephrine

Injection Devices

Preferred Drugs	Status	Type	Last Update	Limits	Covered NDCs
Mylan epinephrine	Preferred	Generic	01/01/18		49502-0102-01, 4950-0102-02, 49502-0101-01, 49502-0101-02

Non Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
Auvi-Q	Non Preferred	Brand	06/01/23		Medication Coverage Exception		
epinephrine	Non Preferred	Generic	01/01/18		Medication Coverage Exception		
EpiPen	Non Preferred	Brand	01/01/18		Medication Coverage Exception		
Symjepi	Non Preferred	Brand	08/01/19		Medication Coverage Exception		

Estrogens

• **Gender Dysphoria:** When used for the treatment of Gender Dysphoria, the Hormone Therapy for Gender Dysphoria prior authorization form is required

Oral Single Ingredient

Preferred Drugs	Status	Type	Last Update	Limits	Mandatory 3-Month	Brand Required	Additional Note
estradiol	Preferred	Generic	10/01/11	Female only	84 Day Supply Required		
Premarin	Preferred	Brand	01/01/17	Female only	84 Day Supply Required		

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Non Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
Estrace tablet	Non Preferred	Brand	10/01/11	Female only	Medication Coverage Exception		
Menest	Non Preferred	Brand	01/01/20	Female only	Medication Coverage Exception		
Oral Combination							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Angeliq	Preferred	Brand	01/01/19	Female only	84 Day Supply Required		
Premphase	Preferred	Brand	01/01/17	Female only	84 Day Supply Required		
Prempro	Preferred	Brand	10/01/11	Female only	84 Day Supply Required		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Activella	Non Preferred	Brand	01/01/19	Female only	Medication Coverage Exception		
amabelz	Non Preferred	Generic	01/01/18	Female only	Medication Coverage Exception		
Bijuva	Non Preferred	Brand	03/01/19	Female only	Medication Coverage Exception		
Duavee	Non Preferred	Brand	11/01/16	Female only	Medication Coverage Exception		
estradiol/norethindrone	Non Preferred	Generic	01/01/18	Female only	Medication Coverage Exception		
estrogens/methyltestosterone	Non Preferred	Generic	06/01/23	Female only	Medication Coverage Exception		
fyavolv	Non Preferred	Generic	11/01/16	Female only	Medication Coverage Exception		
jinteli	Non Preferred	Generic	10/01/11	Female only	Medication Coverage Exception		
mimvey	Non Preferred	Generic	10/01/11	Female only	Medication Coverage Exception		
Prefest	Non Preferred	Brand	10/01/11	Female only	Medication Coverage Exception		
Topical & Miscellaneous							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month/ Required PA Form**	**Brand Required**	**Additional Note**
Climara Pro	Preferred	Brand	01/01/16	Female only	84 Day Supply Required		
Combipatch patch	Preferred	Brand	01/01/14	Female only	84 Day Supply Required		
Elestrin gel	Preferred	Brand	01/01/18	Female only			
Evamist spray	Preferred	Brand	01/01/19	Female only			
Vivelle-DOT patch	Preferred	Brand	01/01/21	Female only		Vivelle-DOT	
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Climara patch	Non Preferred	Brand	01/01/16	Female only	Medication Coverage Exception		
Divigel	Non Preferred	Brand	01/01/23	Female only	Medication Coverage Exception		
estradiol patch (once weekly)	Non Preferred	Generic	10/01/11	Female only	Medication Coverage Exception		
estradiol patch (twice weekly)	Non Preferred	Generic	10/01/11	Female only	Medication Coverage Exception	Vivelle-DOT	
Menostar	Non Preferred	Brand	01/01/22	Female only	Medication Coverage Exception		
Minivelle patch	Non Preferred	Brand	01/01/20	Female only	Medication Coverage Exception		

Vaginal							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Estring	Preferred	Brand	01/01/20	Female only	90 Day Supply Required		
Femring	Preferred	Brand	01/02/20	Female only	90 Day Supply Required		
Premarin cream	Preferred	Brand	10/01/11	Female only			
Vagifem	Preferred	Brand	01/01/17	Female only		Vagifem	
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Estrace cream	Non Preferred	Brand	02/01/18	Female only	Medication Coverage Exception		
estradiol cream	Non Preferred	Generic	02/01/18	Female only	Medication Coverage Exception		
estradiol vaginal tablet	Non Preferred	Generic	01/01/17	Female only	Medication Coverage Exception	Vagifem	

Gastrointestinal (GI)

Antiemetics - Anticholinergics							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Diclegis	Preferred	Brand	01/01/21			Diclegis	
meclizine	Preferred	Generic	11/01/16				
prochlorperazine tablet	Preferred	Generic	01/01/15				
promethazine 12.5mg suppository	Preferred	Generic	12/01/23				
promethazine 25mg suppository	Preferred	Generic	01/01/15				
promethazine injection	Preferred	Generic	12/01/23				
promethazine syrup	Preferred	Generic	12/01/23				
promethazine tablet	Preferred	Generic	01/01/15				
Tigan capsule	Preferred	Brand	01/01/15			Tigan	
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Antivert	Non Preferred	Brand	12/01/22		Medication Coverage Exception		
Bonjesta	Non Preferred	Brand	01/01/22		Medication Coverage Exception		
Compro suppository	Non Preferred	Brand	01/01/15		Medication Coverage Exception		
dimenhydrinate injection	Non Preferred	Generic	01/01/15		Medication Coverage Exception		
doxylamine/pyridoxine	Non Preferred	Generic	07/01/19		Medication Coverage Exception	Diclegis	
Phenergan	Non Preferred	Brand	01/01/15		Medication Coverage Exception		
prochlorperazine suppository	Non Preferred	Generic	01/01/15		Medication Coverage Exception		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
prochlorperazine injection	Non Preferred	Generic	12/01/21		Medication Coverage Exception		Covered under medical benefit using appropriate HCPCS
promethazine 50mg suppositor	Non Preferred	Generic	12/01/22		Medication Coverage Exception		
scopolamine	Non Preferred	Generic	06/01/16		Medication Coverage Exception		
Tigan injection	Non Preferred	Brand	01/01/15		Medication Coverage Exception		
Transderm-SC	Non Preferred	Brand	06/01/16		Medication Coverage Exception		
trimethobenzamide capsule	Non Preferred	Generic	01/01/15		Medication Coverage Exception	Tigan	
Bowel Evacuant Combinations							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Colyte	Preferred	Brand	01/01/18				
gavilyte-c	Preferred	Generic	01/01/18				
gavilyte-g	Preferred	Generic	01/01/18				
gavilyte-n	Preferred	Generic	01/01/18				
Moviprep	Preferred	Brand	06/01/21			Moviprep	
Golytely	Preferred	Brand	01/01/16				
Nulytely	Preferred	Brand	01/01/16				
PEG-3350/electrolytes	Preferred	Generic	01/01/18	Cumulative: 1054g /30 days			
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Clenpiq	Non Preferred	Brand	01/01/18		Medication Coverage Exception		
NaSO4 / KSO4 / MgSO4	Non Preferred	Generic	08/01/22		Medication Coverage Exception		
PEG 3350/electrolytes/ascorbic acid	Non Preferred	Generic	10/01/20		Medication Coverage Exception		
PEG/NASUL, NaCl/K	Non Preferred	Generic	06/01/21		Medication Coverage Exception	Moviprep	
Plenvu	Non Preferred	Brand	09/01/18		Medication Coverage Exception		
Suflave	Non Preferred	Brand	08/01/23		Medication Coverage Exception		
Suprep	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
Sutab	Non Preferred	Brand	12/01/20		Medication Coverage Exception		
PAMORAs							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Movantik	Preferred	Brand	01/01/20		PAMORA		
Relistor inject	Preferred	Brand	01/01/19		PAMORA		

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Non Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
Relistor tablet	Non Preferred	Brand	01/01/19		PAMORA		
Symproic	Non Preferred	Brand	11/01/17		PAMORA		
Oral - Inflammatory Bowel Agents							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Apriso	Preferred	Brand	01/01/20			Apriso	
balsalazide	Preferred	Generic	07/01/14				
Delzicol	Non Preferred	Brand	09/01/21			Delzicol	
Dipentum	Preferred	Brand	01/01/19				
Lialda	Preferred	Brand	01/01/18			Lialda	
Pentasa	Preferred	Brand	01/01/17			Pentasa	
sulfasalazine	Preferred	Generic	07/01/14				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Azulfidine	Non Preferred	Brand	07/01/14		Medication Coverage Exception		
Colazal	Non Preferred	Brand	07/01/14		Medication Coverage Exception		
mesalamine DR capsule	Non Preferred	Generic	06/01/19		Medication Coverage Exception	Delzicol	
mesalamine DR tablet 1.2g	Non Preferred	Generic	01/01/18		Medication Coverage Exception	Lialda	
mesalamine DR tablet 800mg	Non Preferred	Generic	01/01/20		Medication Coverage Exception		
mesalamine ER capsule 0.375g	Non Preferred	Generic	01/01/20		Medication Coverage Exception	Apriso	
mesalamine ER capsule 500mg	Non Preferred	Generic	01/01/20		Medication Coverage Exception	Pentasa	
Zeposia	Non Preferred	Brand	12/01/20		Medication Coverage Exception		Included in more than one class
Rectal - Inflammatory Bowel Agents							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
mesalamine enema	Preferred	Generic	11/01/20				
mesalamine suppository	Preferred	Generic	01/01/24				
SfRowasa enema	Preferred	Brand	01/01/20				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Canasa suppository	Non Preferred	Brand	01/01/24		Medication Coverage Exception		
mesalamine kit	Non Preferred	Generic	07/01/14		Medication Coverage Exception		
Rowasa	Non Preferred	Brand	07/01/14		Medication Coverage Exception		

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Irritable Bowel Syndrome Agents							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
alosetron	Preferred	Generic	01/01/24				
Linzess	Preferred	Brand	01/01/16				
lubiprostone	Preferred	Generic	01/01/24				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Amitiza	Non Preferred	Brand	01/01/24		Medication Coverage Exception		
Ibsrela	Non Preferred	Brand	05/01/22		Medication Coverage Exception		
Lotronex	Non Preferred	Brand	01/01/24		Medication Coverage Exception		
Trulance	Non Preferred	Brand	03/01/17		Medication Coverage Exception		
Viberzi	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
Pancreatic Enzymes							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Creon	Preferred	Brand	08/01/11				
Zenpep	Preferred	Brand	08/01/11				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Pertzye	Non Preferred	Brand	01/01/14		Medication Coverage Exception		
Viokace	Non Preferred	Brand	12/01/17		Medication Coverage Exception		
Phosphate Binders							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
calcium acetate	Preferred	Generic	10/15/15				
Fosrenol chewable	Preferred	Brand	01/01/19			Fosrenol	
Phoslyra solution	Preferred	Brand	07/01/14				
Renagel	Preferred	Brand	07/01/14			Renagel	
Renvela powder	Preferred	Brand	01/01/21			Renvela	
Renvela tablet	Preferred	Brand	07/01/22			Renvela	
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Auryxia	Non Preferred	Brand	10/15/15		Medication Coverage Exception		
Fosrenol powder	Non Preferred	Brand	05/01/23		Medication Coverage Exception		
lanthanum	Non Preferred	Generic	01/01/19		Medication Coverage Exception	Fosrenol	

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
sevelamer carbonate	Non Preferred	Generic	01/01/21		Medication Coverage Exception	Renvela	
sevelamer hydrochloride	Non Preferred	Generic	03/01/19		Medication Coverage Exception	Renagel	
Velphoro	Non Preferred	Brand	07/01/14		Medication Coverage Exception		
Proton Pump Inhibitors							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Dexilant	Preferred	Brand	01/01/18			Dexilant	
esomeprazole capsule	Preferred	Generic	04/01/18				
lansoprazole ODT	Preferred	Generic	01/01/23	Members under 12 years old or with feeding tube.			
omeprazole	Preferred	Generic	01/01/19		90 Day Supply Required		
pantoprazole tablet, injection	Preferred	Generic	01/01/13		90 Day Supply Required		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Aciphex	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
dexlansoprazole	Non Preferred	Generic	01/01/22		Medication Coverage Exception	Dexilant	
esomeprazole granules	Non Preferred	Generic	05/01/21	Members under 12 years old or with feeding tube.	Medication Coverage Exception	Nexium granules	
esomeprazole injection	Non Preferred	Generic	12/01/22		Medication Coverage Exception		
Konvomep	Non Preferred	Brand	06/01/23		Medication Coverage Exception		
lansoprazole capsule	Non Preferred	Generic	02/01/10		Medication Coverage Exception		
Nexium capsule	Non Preferred	Brand	04/01/18		Medication Coverage Exception		
Nexium granules	Non Preferred	Brand	01/01/23	Members under 12 years old or with feeding tube.	Medication Coverage Exception	Nexium granules	
Nexium IV	Non Preferred	Brand	12/01/22		Medication Coverage Exception		
omeprazole/sodium bicarb ODT	Non Preferred	Generic	01/01/14		Medication Coverage Exception		
pantoprazole pak	Non Preferred	Brand	06/01/18		Medication Coverage Exception	Protonix pak	
Prevacid capsule	Non Preferred	Brand	02/01/10		Medication Coverage Exception		
Prevacid Solutabs	Non Preferred	Brand	02/01/10	Members under 12 years old or with feeding tube.	Medication Coverage Exception		
Prilosec	Non Preferred	Brand	01/01/18		Medication Coverage Exception		
Protonix pak	Non Preferred	Brand	06/01/18		Medication Coverage Exception	Protonix pak	
Protonix tablet, injection	Non Preferred	Brand	06/01/18		Medication Coverage Exception		
rabeprazole	Non Preferred	Generic	01/01/16		Medication Coverage Exception		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Yosprala	Non Preferred	Brand	08/01/19		Medication Coverage Exception		
Zegerid	Non Preferred	Brand	01/01/14		Medication Coverage Exception		
Gout							
Acute Gout							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
colchicine tablet	Preferred	Brand	01/01/24				
probenecid/colchicine	Preferred	Generic	01/01/19				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
colchicine capsule	Non Preferred	Generic	01/01/19		Medication Coverage Exception	Mitigare	
Colcrys	Non Preferred	Brand	01/01/24		Medication Coverage Exception		
Mitigare	Non Preferred	Brand	01/01/21		Medication Coverage Exception	Mitigare	
Chronic Gout							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
allopurinol tablet	Preferred	Generic	07/01/17		90 Day Supply Required		
febuxostat	Preferred	Generic	01/01/24				
probenecid	Preferred	Generic	07/01/17				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
allopurinol injection	Non Preferred	Generic	01/01/20		Medication Coverage Exception	Aloprim	
Aloprim	Non Preferred	Brand	12/01/20		Medication Coverage Exception	Aloprim	
Uloric	Non Preferred	Brand	08/01/19		Medication Coverage Exception		
Growth Hormone							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Genotropin	Preferred	Brand	10/01/10		Growth Hormone		
Norditropin	Preferred	Brand	01/01/14		Growth Hormone		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Humatrope	Non Preferred	Brand	01/01/15		Growth Hormone		
Ngenla	Non Preferred	Brand	09/01/23		Growth Hormone		
Nutropin	Non Preferred	Brand	01/01/13		Growth Hormone		
Omnitrope	Non Preferred	Brand	01/01/13		Growth Hormone		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
Saizen	Non Preferred	Brand	11/01/19		Growth Hormone		
Serostim	Non Preferred	Brand	10/01/10		Growth Hormone		
Skytrofa	Non Preferred	Brand	12/01/21		Growth Hormone		
Sogroya	Non Preferred	Brand	06/01/23		Growth Hormone		
Zomacton	Non Preferred	Brand	11/01/16		Growth Hormone		
Zorbtive	Non Preferred	Brand	01/01/13		Growth Hormone		
Hematopoietics							
Erythropoiesis Stimulating Agents (ESAs)							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Epogen	Preferred	Brand	01/01/18				
Mircera	Preferred	Brand	01/01/22				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Aranesp	Non Preferred	Brand	01/01/21		Medication Coverage Exception		
Procrit	Non Preferred	Brand	01/01/18		Medication Coverage Exception		
Retacrit	Non Preferred	Brand	01/01/22		Medication Coverage Exception		
Granulocyte Colony Stimulating Factors (G-CSFs)							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Neupogen	Preferred	Brand	01/01/23				
Nyvepria	Preferred	Brand	01/01/23				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Fulphila	Non Preferred	Brand	01/01/23		Medication Coverage Exception		
Granix	Non Preferred	Brand	01/01/23		Medication Coverage Exception		
Leukine	Non Preferred	Brand	01/01/23		Medication Coverage Exception		
Neulasta	Non Preferred	Brand	01/01/23		Medication Coverage Exception		
Nivestym	Non Preferred	Brand	01/01/24		Medication Coverage Exception		
Releuko	Non Preferred	Brand	01/01/23		Medication Coverage Exception		
Rolvedon	Non Preferred	Brand	11/01/23		Medication Coverage Exception		
Stimufend	Non Preferred	Brand	01/01/23		Medication Coverage Exception		
Udenyca	Non Preferred	Brand	01/01/23		Medication Coverage Exception		
Zarxio	Non Preferred	Brand	01/01/23		Medication Coverage Exception		
Ziextenzo	Non Preferred	Brand	01/01/23		Medication Coverage Exception		

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Immune Globulin

Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
Gamastan	Preferred	Brand	07/01/20		Immunoglobulin Therapy		
Gammagard	Preferred	Brand	07/01/20		Immunoglobulin Therapy		
Gammagard S/D	Preferred	Brand	07/01/20		Immunoglobulin Therapy		
Gamunex-C	Preferred	Brand	07/01/20		Immunoglobulin Therapy		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Asceniv	Non Preferred	Brand	07/01/20		Immunoglobulin Therapy		
Bivigam	Non Preferred	Brand	07/01/20		Immunoglobulin Therapy		
Cutaquig	Non Preferred	Brand	07/01/20		Immunoglobulin Therapy		
Cuvitru	Non Preferred	Brand	07/01/20		Immunoglobulin Therapy		
Flebogamma	Non Preferred	Brand	07/01/20		Immunoglobulin Therapy		
Gammaked	Non Preferred	Brand	07/01/20		Immunoglobulin Therapy		
Gammaplex	Non Preferred	Brand	07/01/20		Immunoglobulin Therapy		
Hizentra	Non Preferred	Brand	07/01/20		Immunoglobulin Therapy		
Hyqvia	Non Preferred	Brand	07/01/20		Immunoglobulin Therapy		
Octagam	Non Preferred	Brand	07/01/20		Immunoglobulin Therapy		
Panzyga	Non Preferred	Brand	07/01/20		Immunoglobulin Therapy		
Privigen	Non Preferred	Brand	07/01/20		Immunoglobulin Therapy		
Xembify	Non Preferred	Brand	07/01/20		Immunoglobulin Therapy		

Prenatal Vitamins

Preferred Drugs	Status	Type	Last Update	Limits	Mandatory 3-Month	Brand Required	Additional Note
Select-OB+DHA	Preferred	Brand	01/01/18	Member must be pregnant			
Vitafol Fe+	Preferred	Brand	01/01/17	Member must be pregnant			
Vitafol Gummies	Preferred	Brand	01/01/19	Member must be pregnant			
Vitafol One	Preferred	Brand	01/01/18	Member must be pregnant			
Vitafol Ultra	Preferred	Brand	01/01/17	Member must be pregnant			
Vitafol-OB+DHA	Preferred	Brand	04/01/17	Member must be pregnant			
ALL OTHER Prenatal w/ DHA/Folate	Preferred	Generic	01/01/16	Member must be pregnant			

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Non Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
ALL NON-DHA/Folate products	Non Preferred	Generic	01/01/16	Member must be pregnant	Medication Coverage Exception		
Citranatal 90 DHA	Non Preferred	Brand	01/01/24	Member must be pregnant	Medication Coverage Exception		
Citranatal Assure	Non Preferred	Brand	01/01/24	Member must be pregnant	Medication Coverage Exception		
Citranatal Bloom	Non Preferred	Brand	01/01/24	Member must be pregnant	Medication Coverage Exception		
Citranatal DHA	Non Preferred	Brand	04/01/23	Member must be pregnant	Medication Coverage Exception		
Citranatal Harmony	Non Preferred	Brand	01/01/24	Member must be pregnant	Medication Coverage Exception		
C-Nate DHA	Non Preferred	Brand	01/01/19	Member must be pregnant	Medication Coverage Exception		
Enbrace HR	Non Preferred	Brand	11/01/19	Member must be pregnant	Medication Coverage Exception		
Nestabs One	Non Preferred	Brand	01/01/19	Member must be pregnant	Medication Coverage Exception		
OB Complete, Gold, Petite, DHA	Non Preferred	Brand	01/01/19	Member must be pregnant	Medication Coverage Exception		
PNV DHA	Non Preferred	Brand	01/01/21	Member must be pregnant	Medication Coverage Exception		
PNV Omega	Non Preferred	Brand	01/01/19	Member must be pregnant	Medication Coverage Exception		
Prenaissance	Non Preferred	Brand	01/01/19	Member must be pregnant	Medication Coverage Exception		
Prenate DHA	Non Preferred	Brand	01/01/15	Member must be pregnant	Medication Coverage Exception		
Prenate Enhance	Non Preferred	Brand	01/01/18	Member must be pregnant	Medication Coverage Exception		
Prenate Essential	Non Preferred	Brand	01/01/15	Member must be pregnant	Medication Coverage Exception		
Prenate Mini	Non Preferred	Brand	01/01/16	Member must be pregnant	Medication Coverage Exception		
Prenate Pixie	Non Preferred	Brand	01/01/15	Member must be pregnant	Medication Coverage Exception		
Prenate Restore	Non Preferred	Brand	01/01/17	Member must be pregnant	Medication Coverage Exception		
Relnate DHA	Non Preferred	Brand	01/01/19	Member must be pregnant	Medication Coverage Exception		
Taron-C DHA	Non Preferred	Brand	01/01/24	Member must be pregnant	Medication Coverage Exception		
Taron-Prex	Non Preferred	Brand	01/01/20	Member must be pregnant	Medication Coverage Exception		
Tristart DHA, One	Non Preferred	Brand	01/01/19	Member must be pregnant	Medication Coverage Exception		
Tri-tabs DHA	Non Preferred	Brand	01/01/21	Member must be pregnant	Medication Coverage Exception		
Vinate DHA	Non Preferred	Brand	01/01/15	Member must be pregnant	Medication Coverage Exception		
Virt-C DHA	Non Preferred	Brand	01/01/24	Member must be pregnant	Medication Coverage Exception		
Virt-Nate	Non Preferred	Brand	01/01/19	Member must be pregnant	Medication Coverage Exception		
Wescap-C DHA	Non Preferred	Brand	01/01/24	Member must be pregnant	Medication Coverage Exception		
Wesnate	Non Preferred	Brand	01/01/23	Member must be pregnant	Medication Coverage Exception		
Zatean -PN	Non Preferred	Brand	01/01/19	Member must be pregnant	Medication Coverage Exception		

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Muscle Relaxants

Antispasmodic Agents

Preferred Drugs	Status	Type	Last Update	Limits	Mandatory 3-Month	Brand Required	Additional Note
cyclobenzaprine 5, 10mg	Preferred	Generic	09/28/09	Cumulative: 90 units /30 days			
methocarbamol	Preferred	Generic	01/01/19	Cumulative:180 units /30 days			Inj covered under medical benefit using appropriate HCPCS
orphenadrine	Preferred	Generic	01/01/21	Cumulative: 60 units /30 days			
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Amrix	Non Preferred	Brand	09/28/09	Cumulative: 90 units /30 days	Medication Coverage Exception		
carisoprodol	Non Preferred	Generic	01/01/14	Cumulative:120 units /30 days	Medication Coverage Exception		
chlorzoxazone	Non Preferred	Generic	01/01/21	Cumulative:120 units /30 days	Medication Coverage Exception		
cyclobenzaprine 7.5mg	Non Preferred	Generic	01/01/14	Cumulative: 90 units /30 days	Medication Coverage Exception		
cyclobenzaprine ER	Non Preferred	Generic	01/01/22	Cumulative: 90 units /30 days	Medication Coverage Exception		
Fexmid	Non Preferred	Brand	01/01/14	Cumulative: 90 units /30 days	Medication Coverage Exception		
Lorzone	Non Preferred	Brand	01/01/14	Cumulative:120 units /30 days	Medication Coverage Exception		
metaxalone	Non Preferred	Generic	01/01/16	Cumulative:120 units /30 days	Medication Coverage Exception		
Robaxin injection	Non Preferred	Brand	12/01/22		Medication Coverage Exception		Covered under medical benefit using appropriate HCPCS
Soma	Non Preferred	Brand	01/01/14	Cumulative:120 units /30 days	Medication Coverage Exception		

Antispasticity Agents

Preferred Drugs	Status	Type	Last Update	Limits	Mandatory 3-Month	Brand Required	Additional Note
baclofen injection	Preferred	Brand/ Generic	09/28/09				Covered under medical benefit using appropriate HCPCS
baclofen suspension	Preferred	Generic	08/01/22				
baclofen tablet	Preferred	Generic	09/28/09				
tizanidine	Preferred	Generic	04/01/22	Cumulative:180 units /30 days			

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Non Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
Dantrium	Non Preferred	Brand	01/01/13	Cumulative:120 units /30 days	Medication Coverage Exception		
dantrolene	Non Preferred	Generic	01/01/13	Cumulative:120 units /30 days	Medication Coverage Exception		
Fleqsuvy	Non Preferred	Brand	12/01/22		Medication Coverage Exception		
Lioresal injection	Non Preferred	Brand	04/01/23		Medication Coverage Exception		Covered under medical benefit using appropriate HCPCS
Lyvispah	Non Preferred	Brand	06/01/22		Medication Coverage Exception		
Zanaflex	Non Preferred	Brand	09/28/09	Cumulative: 90 units /30 days	Medication Coverage Exception		

Nasal

Nasal - Antihistamines

Preferred Drugs	Status	Type	Last Update	Limits	Mandatory 3-Month	Brand Required	Additional Note
azelastine 0.1%	Preferred	Generic	01/01/19				
olopatadine	Preferred	Generic	01/01/24				

Non Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
azelastine 0.15%	Non Preferred	Generic	01/01/19		Medication Coverage Exception		
Patanase	Non Preferred	Brand	11/01/18		Medication Coverage Exception		

Nasal - Corticosteroids

Preferred Drugs	Status	Type	Last Update	Limits	Mandatory 3-Month	Brand Required	Additional Note
Beconase AQ	Preferred	Brand	01/01/13				
fluticasone	Preferred	Generic	10/01/09				
mometasone	Preferred	Generic	11/01/18				
Omnaris	Preferred	Brand	01/01/22				

Non Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
flunisolide	Non Preferred	Generic	01/01/19		Medication Coverage Exception		
Qnasl	Non Preferred	Brand	01/01/13		Medication Coverage Exception		
Sinuva	Non Preferred	Brand	06/01/20		Medication Coverage Exception		
Xhance	Non Preferred	Brand	12/01/18		Medication Coverage Exception		
Zetonna	Non Preferred	Brand	01/01/22		Medication Coverage Exception		

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Neurological

Parkinson - COMT Inhibitors & Combinations

Preferred Drugs	Status	Type	Last Update	Limits	Mandatory 3-Month	Brand Required	Additional Note
amantadine	Preferred	Generic	01/01/14				
bromocriptine	Preferred	Generic	11/01/21				
carbidopa/levodopa	Preferred	Generic	01/01/14		90 Day Supply Required		
carbidopa/levodopa ER	Preferred	Generic	01/01/14				
Duopa	Preferred	Brand	01/01/20				
entacapone	Preferred	Generic	01/01/19				

Non Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
carbidopa	Non Preferred	Generic	11/01/16		Medication Coverage Exception		
carbidopa/levodopa ODT	Non Preferred	Generic	10/01/09		Medication Coverage Exception		
carbidopa/levodopa/entacapone	Non Preferred	Generic	01/01/14		Medication Coverage Exception		
Comtan	Non Preferred	Brand	01/01/19		Medication Coverage Exception		
Dhivy	Non Preferred	Brand	12/01/22		Medication Coverage Exception		
droxidopa	Non Preferred	Generic	03/01/21		Medication Coverage Exception		
Gocovri	Non Preferred	Brand	10/01/17		Medication Coverage Exception		
Inbrija	Non Preferred	Brand	03/01/19		Medication Coverage Exception		
Lodosyn	Non Preferred	Brand	11/01/16		Medication Coverage Exception		
Northera	Non Preferred	Brand	08/15/14		Medication Coverage Exception		
Ongentys	Non Preferred	Brand	10/01/20		Medication Coverage Exception		
Osmolex ER	Non Preferred	Brand	06/01/18		Medication Coverage Exception		
Parlodel	Non Preferred	Brand	11/01/21		Medication Coverage Exception		
Rytary	Non Preferred	Brand	10/01/15		Medication Coverage Exception		
Sinemet	Non Preferred	Brand	01/01/14		Medication Coverage Exception		
Stalevo	Non Preferred	Brand	01/01/14		Medication Coverage Exception		
Tasmar	Non Preferred	Brand	10/01/09		Medication Coverage Exception		
tolcapone	Non Preferred	Generic	10/01/09		Medication Coverage Exception		

Parkinson - MAO Inhibitors

Preferred Drugs	Status	Type	Last Update	Limits	Mandatory 3-Month	Brand Required	Additional Note
Azilect	Preferred	Brand	01/01/19			Azilect	
selegiline	Preferred	Generic	02/01/10				

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Non Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
rasagiline	Non Preferred	Generic	01/01/19		Medication Coverage Exception	Azilect	
Xadago	Non Preferred	Brand	06/01/17		Medication Coverage Exception		
Zelapar	Non Preferred	Brand	01/01/24		Medication Coverage Exception		
Parkinson - Non-ergot Derived Dopamine Receptor Agonists and Others							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
pramipexole	Preferred	Generic	12/02/11		90 Day Supply Required		
ropinirole	Preferred	Generic	10/01/09		90 Day Supply Required		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Apokyn	Non Preferred	Brand	04/01/22		Medication Coverage Exception		
apomorphine	Non Preferred	Generic	04/01/22		Medication Coverage Exception		
Kynmobi	Non Preferred	Brand	07/01/20		Medication Coverage Exception		
Mirapex ER	Non Preferred	Generic	01/01/20		Medication Coverage Exception	Mirapex ER	
Neupro patch	Non Preferred	Brand	10/01/09		Medication Coverage Exception		
Nourianz	Non Preferred	Brand	10/01/19		Medication Coverage Exception		
Nuplazid	Non Preferred	Brand	06/01/17		Medication Coverage Exception		
pramipexole ER	Non Preferred	Generic	01/01/20		Medication Coverage Exception	Mirapex ER	
ropinirole ER	Non Preferred	Generic	10/01/09		Medication Coverage Exception		
Migraine - Abortive Therapy							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Nurtec ODT	Preferred	Brand	06/01/20	Cumulative: 8 units /30 days	CGRP Prior Auth		Included in more than one class
Relpax	Preferred	Brand	01/01/13	Cumulative: 9 units /30 days		Relpax	
rizatriptan	Preferred	Generic	01/01/17	Cumulative: 9 units /30 days			
sumatriptan tablet	Preferred	Generic	01/01/13	Cumulative: 9 units /30 days			
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
almotriptan	Non Preferred	Generic	01/01/13	Cumulative: 9 units /30 days	Medication Coverage Exception		
butalbital/apap/caf/codeine	Non Preferred	Generic	05/01/17	20 tablets or capsules /30 days	Medication Coverage Exception		
butalbital/asa/caf/codeine	Non Preferred	Brand	05/01/17	20 tablets or capsules /30 days	Medication Coverage Exception		
butorphanol nasal spray	Non Preferred	Generic	08/01/19	2.5ml /30 days	Medication Coverage Exception		
diclofenac powder	Non Preferred	Generic	01/01/23	Cumulative: 9 units /30 days	Medication Coverage Exception		
dihydroergotamine	Non Preferred	Generic	12/01/17		Medication Coverage Exception		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
eletriptan	Non Preferred	Generic	09/01/17	Cumulative: 9 units /30 days	Medication Coverage Exception	Relpax	
Elyxyb	Non Preferred	Brand	12/01/21		Medication Coverage Exception		
Ergomar	Non Preferred	Brand	05/01/18		Medication Coverage Exception		
Fioricet/codeine	Non Preferred	Brand	05/01/17	20 tablets/caps /30 days	Medication Coverage Exception		
Frova	Non Preferred	Brand	04/01/16	Cumulative: 9 units /30 days	Medication Coverage Exception		
frovatriptan	Non Preferred	Generic	04/01/16	Cumulative: 9 units /30 days	Medication Coverage Exception		
Imitrex injection	Non Preferred	Brand	01/01/17	Cumulative: 9 units /30 days	Medication Coverage Exception		
Imitrex spray	Non Preferred	Brand	01/01/17	Cumulative: 9 units /30 days	Medication Coverage Exception		
Imitrex tablet	Non Preferred	Brand	01/01/12	Cumulative: 9 units /30 days	Medication Coverage Exception		
Maxalt	Non Preferred	Brand	01/01/14	Cumulative: 9 units /30 days	Medication Coverage Exception		
Migergot	Non Preferred	Brand	06/01/20		Medication Coverage Exception		
Migranal spray	Non Preferred	Brand	12/01/17		Medication Coverage Exception		
naratriptan	Non Preferred	Generic	01/01/13	Cumulative: 9 units /30 days	Medication Coverage Exception		
Onzetra	Non Preferred	Brand	05/01/16	Cumulative: 9 units /30 days	Medication Coverage Exception		
Reyvow	Non Preferred	Brand	02/01/20	Cumulative: 8 units /30 days	Reyvow Prior Auth		
sumatriptan injection	Non Preferred	Generic	01/01/17	Cumulative: 9 units /30 days	Medication Coverage Exception		
sumatriptan spray	Non Preferred	Generic	01/01/17	Cumulative: 9 units /30 days	Medication Coverage Exception		
sumatriptan/naproxen	Non Preferred	Generic	09/28/09	Cumulative: 9 units /30 days	Medication Coverage Exception	Treximet	
Tosymra	Non Preferred	Brand	10/01/19	Cumulative: 9 units /30 days	Medication Coverage Exception		
Treximet	Non Preferred	Brand	09/28/09	Cumulative: 9 units /30 days	Medication Coverage Exception	Treximet	
Trudhesa	Non Preferred	Brand	10/01/21	Cumulative: 8 units /30 days	Medication Coverage Exception		
Ubrelvy	Non Preferred	Brand	02/01/20	Cumulative: 16 units /30 days	CGRP Prior Auth		
Zembrace	Non Preferred	Brand	04/01/16	Cumulative: 9 units /30 days	Medication Coverage Exception		
zolmitriptan	Non Preferred	Generic	06/01/13	Cumulative: 9 units /30 days	Medication Coverage Exception		
Zavzpret	Non Preferred	Brand	06/01/23	Cumulative: 8 units /30 days	CGRP Prior Auth		
Zomig	Non Preferred	Brand	06/01/13	Cumulative: 9 units /30 days	Medication Coverage Exception		
Migraine - Prophylactic Therapy							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required PA Form/ Mandatory 3-Month**	**Brand Required**	**Additional Note**
Aimovig	Preferred	Brand	01/01/24		CGRP Prior Auth		
Ajovy	Preferred	Brand	01/01/21		CGRP Prior Auth		
amitriptyline	Preferred	Generic	01/01/18				Included in more than one class
divalproex	Preferred	Generic	01/01/17		90 Day Supply Required		Included in more than one class
propranolol	Preferred	Generic	04/01/13		90 Day Supply Required		Included in more than one class
propranolol SR	Preferred	Generic	03/01/16				Included in more than one class
topiramate capsule	Preferred	Generic	01/01/19				Included in more than one class
topiramate tablet	Preferred	Generic	01/01/19		90 Day Supply Required		Included in more than one class

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Non Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
Botox	Non Preferred	Brand	01/01/19		Botox Prior Auth		Covered under medical benefit using appropriate HCPCS
Depakote	Non Preferred	Brand	01/01/17		Medication Coverage Exception		Included in more than one class
Emgality	Non Preferred	Brand	01/01/19		CGRP Prior Auth		
Inderal LA	Non Preferred	Brand	03/01/16		Medication Coverage Exception		Included in more than one class
Inderal XL	Non Preferred	Brand	03/01/16		Medication Coverage Exception		Included in more than one class
Innopran XL	Non Preferred	Brand	09/28/09		Medication Coverage Exception		Included in more than one class
Nurtec ODT	Non Preferred	Brand	09/01/22	Cumulative: 16 units /30 days	CGRP Prior Auth		Included in more than one class
Qudexy XR	Non Preferred	Brand	01/01/19		Medication Coverage Exception		Included in more than one class
Qulipta	Non Preferred	Brand	11/01/21		CGRP Prior Auth		
timolol	Non Preferred	Generic	01/01/21		Medication Coverage Exception		Included in more than one class
Topamax	Non Preferred	Generic	10/01/16		Medication Coverage Exception		Included in more than one class
topiramate ER capsule	Non Preferred	Generic	01/01/19		Medication Coverage Exception	Trokendi XR	Included in more than one class
topiramate ER sprinkle capsule	Non Preferred	Generic	01/01/19		Medication Coverage Exception		Included in more than one class
Trokendi XR	Non Preferred	Brand	10/01/16		Medication Coverage Exception	Trokendi XR	Included in more than one class
Vyepti	Non Preferred	Brand	04/01/20		CGRP Prior Auth		
Movement Disorder Treatments - VMAT-2 Inhibitors							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Austedo, XR	Preferred	Brand	06/01/23				
tetrabenazine	Preferred	Generic	01/01/20				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Ingrezza	Non Preferred	Brand	07/01/18		Medication Coverage Exception		
Xenazine	Non Preferred	Brand	01/01/20		Medication Coverage Exception		
Multiple Sclerosis Agents							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Avonex	Preferred	Brand	02/01/10				
Copaxone 20mg	Preferred	Brand	09/28/09			Copaxone	
dalfampridine	Preferred	Generic	01/01/21				
dimethyl fumarate	Preferred	Generic	01/01/22				
teriflunomide	Preferred	Generic	04/01/23				

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Non Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
Ampyra	Non Preferred	Brand	01/01/13		Medication Coverage Exception		
Aubagio	Non Preferred	Brand	01/01/13		Medication Coverage Exception		
Bafiertam	Non Preferred	Brand	11/01/21		Medication Coverage Exception		
Betaseron	Non Preferred	Brand	01/01/23		Medication Coverage Exception		
Briumvi	Non Preferred	Brand	09/01/23		Medication Coverage Exception		
Copaxone 40mg	Non Preferred	Brand	05/30/14		Medication Coverage Exception	Copaxone	
Extavia	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
fingolimod	Non Preferred	Generic	11/01/23		Medication Coverage Exception		
Gilenya	Non Preferred	Brand	01/01/24		Medication Coverage Exception		
glatiramer	Non Preferred	Generic	07/01/15		Medication Coverage Exception	Copaxone	
Kesimpta	Non Preferred	Brand	12/01/20		Medication Coverage Exception		
Lemtrada	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
Mavenclad	Non Preferred	Brand	05/01/19		Mavenclad PA		
Mayzent	Non Preferred	Brand	04/01/19		Medication Coverage Exception		
Ocrevus	Non Preferred	Brand	10/01/20		Medication Coverage Exception		
Plegridy	Non Preferred	Brand	05/01/19		Medication Coverage Exception		
Ponvory	Non Preferred	Brand	04/01/21		Medication Coverage Exception		
Rebif	Non Preferred	Brand	01/01/15		Medication Coverage Exception		
Tascenso ODT	Non Preferred	Brand	09/01/22		Medication Coverage Exception		
Tecfidera	Non Preferred	Brand	01/01/19		Medication Coverage Exception		
Tysabri	Non Preferred	Brand	11/01/21		Medication Coverage Exception		
Vumerity	Non Preferred	Brand	01/01/22		Medication Coverage Exception		
Zeposia	Non Preferred	Brand	12/01/20		Medication Coverage Exception		Included in more than one class
Therapies for Spinal Muscular Atrophy							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Evrysdi	Preferred	Brand	12/01/20		Evrysdi, Spinraza PA		
Spinraza	Preferred	Brand	10/01/19		Evrysdi, Spinraza PA		
Zolgensma	Preferred	Brand	10/01/19		Zolgensma		

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Ophthalmics

Anti-Glaucoma - Alpha Adrenergics

Preferred Drugs	Status	Type	Last Update	Limits	Mandatory 3-Month	Brand Required	Additional Note
Alphagan P 0.1%	Preferred	Brand	01/01/14				
Alphagan P 0.15%	Preferred	Brand	01/01/13			Alphagan	
brimonidine 0.2%	Preferred	Generic	10/01/10				
Simbrinza	Preferred	Brand	01/01/24				

Non Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
apraclonidine	Non Preferred	Generic	01/01/14		Medication Coverage Exception		
brimonidine 0.1%	Non Preferred	Generic	10/01/23		Medication Coverage Exception	Alphagan	
brimonidine 0.15%	Non Preferred	Generic	10/01/10		Medication Coverage Exception	Alphagan	
lopidine	Non Preferred	Brand	01/01/14		Medication Coverage Exception		

Anti-Glaucoma - Beta Blockers

Preferred Drugs	Status	Type	Last Update	Limits	Mandatory 3-Month	Brand Required	Additional Note
Betoptic-S	Preferred	Brand	01/01/19				
Combigan	Preferred	Brand	01/01/19			Combigan	
dorzolamide/timolol	Preferred	Generic	01/01/20				
timolol solution	Preferred	Generic	04/01/16				

Non Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
betaxolol	Non Preferred	Generic	04/01/16		Medication Coverage Exception		
Betimol	Non Preferred	Brand	01/01/22		Medication Coverage Exception		
brimonidine/timolol	Non Preferred	Generic	12/01/22		Medication Coverage Exception	Combigan	
carteolol	Non Preferred	Generic	04/01/16		Medication Coverage Exception		
Cosopt PF	Non Preferred	Brand	02/01/19		Medication Coverage Exception		
dorzolamide/timolol PF	Non Preferred	Generic	02/01/19		Medication Coverage Exception		
Istalol	Non Preferred	Brand	01/01/20		Medication Coverage Exception	Istalol	
levobunolol	Non Preferred	Generic	01/01/23		Medication Coverage Exception		
timolol gel	Non Preferred	Generic	04/01/16		Medication Coverage Exception		
timolol once daily	Non Preferred	Generic	01/01/20		Medication Coverage Exception	Istalol	
timolol preservative free	Non Preferred	Generic	04/01/16		Medication Coverage Exception		
Timoptic	Non Preferred	Brand	04/01/16		Medication Coverage Exception		
Timoptic Occudose	Non Preferred	Brand	04/01/16		Medication Coverage Exception		
Timoptic-XE	Non Preferred	Brand	04/01/16		Medication Coverage Exception		

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Anti-Glaucoma - Prostaglandins							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
latanoprost	Preferred	Generic	12/02/11				
Lumigan	Preferred	Brand	01/01/19				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
bimatoprost	Non Preferred	Generic	05/06/15		Medication Coverage Exception		
Durysta	Non Preferred	Brand	10/01/20		Medication Coverage Exception		
Iyuzeh	Non Preferred	Brand	09/01/23		Medication Coverage Exception		
tafluprost	Non Preferred	Generic	12/01/22		Medication Coverage Exception	Zioptan	
Travatan Z	Non Preferred	Brand	01/01/24		Medication Coverage Exception		
travoprost	Non Preferred	Generic	01/01/20		Medication Coverage Exception		
Vyzulta	Non Preferred	Brand	12/01/17		Medication Coverage Exception		
Xalatan	Non Preferred	Brand	12/02/11		Medication Coverage Exception		
Xelpros	Non Preferred	Brand	11/01/19		Medication Coverage Exception		
Zioptan	Non Preferred	Brand	01/01/20		Medication Coverage Exception		
Ophthalmic - Antibiotics - Quinolones							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Besivance	Preferred	Brand	01/01/18				
Ciloxan oint	Preferred	Brand	01/01/21				
ciprofloxacin drops	Preferred	Generic	06/01/12				
moxifloxacin (TID formulation)	Preferred	Generic	01/01/22				
ofloxacin	Preferred	Generic	01/01/23				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Ciloxan drops	Non Preferred	Brand	11/01/16		Medication Coverage Exception		
gatifloxacin	Non Preferred	Generic	11/01/19		Medication Coverage Exception		
moxifloxacin (BID formulation)	Non Preferred	Generic	08/01/17		Medication Coverage Exception		
Ocuflox	Non Preferred	Brand	06/01/12		Medication Coverage Exception		
Vigamox	Non Preferred	Brand	01/01/18		Medication Coverage Exception		
Zymaxid	Non Preferred	Brand	11/01/19		Medication Coverage Exception		

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Ophthalmic - Antibiotics - Non Quinolones							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
bacitracin/polymyxin B	Preferred	Generic	01/01/23				
erythromycin ointment	Preferred	Generic	12/01/17				
gentamicin drops	Preferred	Generic	06/01/12				
polymyxin B/trimethoprim	Preferred	Generic	06/01/12				
sodium sulfacetamide drops	Preferred	Generic	12/01/17				
tobramycin drops	Preferred	Generic	01/01/19				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Azasite	Non Preferred	Brand	06/01/12		Medication Coverage Exception		
Baciguent	Non Preferred	Brand	09/01/20		Medication Coverage Exception		
bacitracin	Non Preferred	Generic	06/01/12		Medication Coverage Exception		
neomycin/bacitracin/polymyxin	Non Preferred	Generic	01/01/13		Medication Coverage Exception		
neomycin/polymyxin/gramicidin	Non Preferred	Generic	01/01/19		Medication Coverage Exception		
Polytrim	Non Preferred	Brand	01/01/13		Medication Coverage Exception		
sodium sulfacetamide ointment	Non Preferred	Generic	12/01/17		Medication Coverage Exception		
Tobrex ointment	Non Preferred	Brand	01/01/13		Medication Coverage Exception		
Ophthalmic - Antihistamines							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Bepreve	Preferred	Brand	01/01/18			Bepreve	
cromolyn	Preferred	Generic	01/01/14				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Alocril	Non Preferred	Brand	01/01/14		Medication Coverage Exception		
Alomide	Non Preferred	Brand	01/01/22		Medication Coverage Exception		
azelastine	Non Preferred	Generic	10/01/10		Medication Coverage Exception		
bepotastine	Non Preferred	Generic	07/01/21		Medication Coverage Exception	Bepreve	
epinastine	Non Preferred	Generic	01/01/14		Medication Coverage Exception		
olopatadine	Non Preferred	Generic	01/01/16		Medication Coverage Exception		
Zerviate	Non Preferred	Brand	05/01/20		Medication Coverage Exception		
Ophthalmic - Anti-Inflammatory - Corticosteroids							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Alrex	Preferred	Brand	06/01/12				
Flarex	Preferred	Brand	06/01/12				

Utah Medicaid Preferred Drug List - Effective January 1, 2024

Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
FML Liquifilm	Preferred	Brand	01/01/22			FML Liquifilm	
FML ointment	Preferred	Brand	01/01/18				
Lotemax drops	Preferred	Brand	06/01/19			Lotemax	
Maxidex	Preferred	Brand	06/01/12				
Pred Forte	Preferred	Brand	01/01/22			Pred Forte	
Pred Mild	Preferred	Brand	06/01/12				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
dexamethasone sodium phos P	Non Preferred	Generic	01/01/13		Medication Coverage Exception		
difluprednate	Non Preferred	Generic	10/01/21		Medication Coverage Exception	Durezol	
Durezol	Non Preferred	Brand	06/01/12		Medication Coverage Exception	Durezol	
Eysuvis	Non Preferred	Brand	12/01/20		Medication Coverage Exception		
fluorometholone	Non Preferred	Generic	01/01/22		Medication Coverage Exception	FML Liquifilm	
FML Forte	Non Preferred	Brand	01/01/24		Medication Coverage Exception		
Inveltys	Non Preferred	Brand	11/01/19		Medication Coverage Exception		
Lotemax gel	Non Preferred	Brand	06/01/12		Medication Coverage Exception		
Lotemax ointment	Non Preferred	Brand	06/01/12		Medication Coverage Exception		
loteprednol 0.5% gel	Non Preferred	Generic	03/01/21		Medication Coverage Exception	Lotemax	
loteprednol 0.5% suspension	Non Preferred	Generic	06/01/19		Medication Coverage Exception	Lotemax	
prednisolone 1% suspension	Non Preferred	Generic	01/01/22		Medication Coverage Exception	Pred Forte	
prednisolone sodium phosphat	Non Preferred	Generic	06/01/12		Medication Coverage Exception		
Ophthalmic - Anti-Inflammatory - NSAIDs							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
diclofenac	Preferred	Generic	06/01/12				
ketorolac 0.5%	Preferred	Generic	01/01/19				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Acular	Non Preferred	Brand	06/01/12		Medication Coverage Exception		
Acular LS	Non Preferred	Brand	01/01/19		Medication Coverage Exception		
Acuvail	Non Preferred	Brand	01/01/24		Medication Coverage Exception		
bromfenac	Non Preferred	Generic	01/01/13		Medication Coverage Exception		
Bromsite	Non Preferred	Brand	11/01/16		Medication Coverage Exception		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
flurbiprofen	Non Preferred	Generic	01/01/20		Medication Coverage Exception		
Ilevro	Non Preferred	Brand	01/01/14		Medication Coverage Exception		
ketorolac 0.4%	Non Preferred	Generic	01/01/19		Medication Coverage Exception		
Nevanac	Non Preferred	Brand	06/01/12		Medication Coverage Exception		
Prolensa	Non Preferred	Brand	04/16/13		Medication Coverage Exception		
Ophthalmic - Anti-Inflammatory - Combinations							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
neomycin/poly/dexameth	Preferred	Generic	06/01/12				
Tobradex ointment	Preferred	Brand	01/01/16				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Maxitrol	Non Preferred	Brand	12/01/18		Medication Coverage Exception		
neomycin/poly/bac/hc	Non Preferred	Generic	06/01/12		Medication Coverage Exception		
neomycin/poly/hc	Non Preferred	Generic	06/01/12		Medication Coverage Exception		
sodium sulfacetamide /prednise drops	Non Preferred	Generic	06/01/12		Medication Coverage Exception		
Tobradex ST	Non Preferred	Brand	01/01/18		Medication Coverage Exception		
tobramycin/dexamethasone	Non Preferred	Generic	06/01/12		Medication Coverage Exception		
Zylet	Non Preferred	Brand	01/01/24		Medication Coverage Exception		
Otics							
Otic - Antibiotics							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
ciprofloxacin otic sol 0.2%	Preferred	Generic	01/01/16				
ofloxacin otic drops	Preferred	Generic	01/01/19				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Floxin otic	Non Preferred	Brand	01/01/19		Medication Coverage Exception		
Otic - Antibiotic Combinations							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Cortisporin TC	Preferred	Brand	11/01/19				
neomycin/polymyxin/hc susp	Preferred	Generic	11/01/15				

Utah Medicaid Preferred Drug List - Effective January 1, 2024

Non Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
Cipro HC	Non Preferred	Brand	01/01/23		Medication Coverage Exception		
ciprofloxacin/dexamethasone	Non Preferred	Generic	01/01/21		Medication Coverage Exception		
ciprofloxacin/fluocinolone	Non Preferred	Generic	01/01/20		Medication Coverage Exception		
neomycin/polymyxin/hc sol	Non Preferred	Generic	11/01/15		Medication Coverage Exception		

Prostatic Hypertrophy Agents

Preferred Drugs	Status	Type	Last Update	Limits	Mandatory 3-Month	Brand Required	Additional Note
alfuzosin	Preferred	Generic	01/01/14	Male only			
doxazosin	Preferred	Generic	10/01/11	Male only	90 Day Supply Required		
dutasteride	Preferred	Generic	01/01/18	Male only	90 Day Supply Required		
finasteride	Preferred	Generic	10/01/11	Male only	90 Day Supply Required		
prazosin	Preferred	Generic	12/01/18	Male only			
silodosin	Preferred	Generic	09/01/20	Male only			
tamsulosin	Preferred	Generic	01/01/12	Male only	90 Day Supply Required		
terazosin	Preferred	Generic	10/01/11	Male only	90 Day Supply Required		

Non Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
Avodart	Non Preferred	Brand	01/01/18	Male only	Medication Coverage Exception		
Cardura	Non Preferred	Brand	04/01/12	Male only	Medication Coverage Exception		
Cardura XL	Non Preferred	Brand	04/01/12	Male only	Medication Coverage Exception		
Cialis 5mg	Non Preferred	Brand	06/01/20	Male only	Cialis Prior Auth form		
dutasteride/tamsulosin	Non Preferred	Generic	10/01/11	Male only	Medication Coverage Exception		
Entadfi	Non Preferred	Brand	02/01/23	Male only	Medication Coverage Exception		
Flomax	Non Preferred	Brand	10/01/11	Male only	Medication Coverage Exception		
Jalyn	Non Preferred	Brand	10/01/11	Male only	Medication Coverage Exception		
Minipress	Non Preferred	Brand	12/01/18	Male only	Medication Coverage Exception		
Proscar	Non Preferred	Brand	10/01/11	Male only	Medication Coverage Exception		
Rapaflo	Non Preferred	Brand	09/01/20	Male only	Medication Coverage Exception		
tadalafil 5mg	Non Preferred	Generic	06/01/20	Male only	Cialis Prior Auth form		

Utah Medicaid Preferred Drug List - Effective January 1, 2024

Pulmonary Hypertension

Endothelin Antagonists

Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
ambrisentan	Preferred	Generic	01/01/23		Pulmonary Arterial HTN		
bosentan	Preferred	Generic	01/01/24		Pulmonary Arterial HTN		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Letairis	Non Preferred	Brand	01/01/23		Pulmonary Arterial HTN		
Opsumit	Non Preferred	Brand	10/01/13		Pulmonary Arterial HTN		
Tracleer	Non Preferred	Brand	01/01/24		Pulmonary Arterial HTN		

Phosphodiesterase-5 Enzyme (PDE-5) Inhibitors

Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
sildenafil	Preferred	Generic	09/01/13		Pulmonary Arterial HTN		
tadalafil	Preferred	Generic	01/01/20		Pulmonary Arterial HTN		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Adcirca	Non Preferred	Brand	01/01/20		Pulmonary Arterial HTN		
Revatio	Non Preferred	Brand	09/01/13		Pulmonary Arterial HTN		
Tadliq	Non Preferred	Brand	10/01/22		Pulmonary Arterial HTN		

Prostacyclins

Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
epoprostenol	Preferred	Generic	06/01/12		Pulmonary Arterial HTN		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Flolan	Non Preferred	Brand	06/01/12		Pulmonary Arterial HTN		
Orenitram	Non Preferred	Brand	04/02/14		Pulmonary Arterial HTN		
Remodulin	Non Preferred	Brand	10/01/19		Pulmonary Arterial HTN	Remodulin	
treprostinil	Non Preferred	Brand	10/01/19		Pulmonary Arterial HTN	Remodulin	
Tyvaso	Non Preferred	Brand	06/01/12		Pulmonary Arterial HTN		
Uptravi	Non Preferred	Brand	01/15/16		Pulmonary Arterial HTN		
Veletri	Non Preferred	Brand	06/01/12		Pulmonary Arterial HTN		
Ventavis	Non Preferred	Brand	01/01/14		Pulmonary Arterial HTN		

Utah Medicaid Preferred Drug List - Effective January 1, 2024

Respiratory

Monoclonal Antibodies for Asthma

Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
Cinqair	Preferred	Brand	01/01/21		Monoclonal Antibodies for Asthma and Other Indications		
Dupixent	Preferred	Brand	01/01/22		Monoclonal Antibodies for Asthma and Other Indications		Included in more than one class
Fasenra	Preferred	Brand	01/01/21		Monoclonal Antibodies for Asthma and Other Indications		
Xolair	Preferred	Brand	01/01/21		Monoclonal Antibodies for Asthma and Other Indications		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Cibinqo	Non Preferred	Brand	03/01/22		Monoclonal Antibodies for Asthma and Other Indications		
Nucala	Non Preferred	Brand	01/01/21		Monoclonal Antibodies for Asthma and Other Indications		
Tezspire	Non Preferred	Brand	03/01/22		Monoclonal Antibodies for Asthma and Other Indications		

Asthma & COPD - Anticholinergics

Preferred Drugs	Status	Type	Last Update	Limits	Mandatory 3-Month	Brand Required	Additional Note
Atrovent HFA	Preferred	Brand	04/01/12	2 inhalers/30 days			
ipratropium	Preferred	Generic	04/01/12	2 inhalers/30 days			
Spiriva	Preferred	Brand	01/01/20	1 inhaler/30 days		Spiriva	
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Incruse Ellipta	Non Preferred	Brand	01/01/15	1 inhaler/30 days	Medication Coverage Exception		
Lonhala Magnair	Non Preferred	Brand	03/01/18	1 inhaler/30 days	Medication Coverage Exception		
tiotropium	Non Preferred	Generic	09/01/23	1 inhaler/30 days	Medication Coverage Exception	Spiriva	
Tudorza Pressair	Non Preferred	Brand	01/01/20	1 inhaler/30 days	Medication Coverage Exception		
Yupelri	Non Preferred	Brand	01/01/22		Medication Coverage Exception		

Asthma & COPD - Short Acting Beta Agonists (SABA)

Preferred Drugs	Status	Type	Last Update	Limits	Mandatory 3-Month	Brand Required	Additional Note
albuterol nebulizer	Preferred	Generic	01/01/13				
levalbuterol nebulizer	Preferred	Generic	05/15/16				
ProAir HFA	Preferred	Brand	01/01/20	2 inhalers/30 days		ProAir HFA	
Proventil HFA	Preferred	Brand	01/01/24	2 inhalers/30 days		Proventil HFA	
Ventolin HFA	Preferred	Brand	05/01/20	2 inhalers/30 days		Ventolin HFA	

Utah Medicaid Preferred Drug List - Effective January 1, 2024

Non Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
albuterol HFA	Non Preferred	Generic	05/01/19	2 inhalers/30 days	Medication Coverage Exception	Ventolin or ProAir	
levalbuterol HFA	Non Preferred	Generic	01/01/24	2 inhalers/30 days	Medication Coverage Exception		
ProAir Digihaler	Non Preferred	Brand	10/01/19	2 inhalers/30 days	Medication Coverage Exception		
ProAir RespiClick	Non Preferred	Brand	01/01/21	2 inhalers/30 days	Medication Coverage Exception		
Xopenex HFA	Non Preferred	Brand	01/01/23	2 inhalers/30 days	Medication Coverage Exception		
Asthma & COPD - Long Acting Beta Agonists (LABA)							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Serevent Diskus	Preferred	Brand	09/28/09	1 inhaler/30 days			
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
arformoterol	Non Preferred	Generic	07/01/21		Medication Coverage Exception	Brovana	
Brovana	Non Preferred	Brand	01/01/16		Medication Coverage Exception	Brovana	
formoterol	Non Preferred	Generic	07/01/21		Medication Coverage Exception	Perforomist	
Perforomist	Non Preferred	Brand	01/01/20		Medication Coverage Exception	Perforomist	
Striverdi	Non Preferred	Brand	01/01/21	1 inhaler/30 days	Medication Coverage Exception		
Asthma & COPD - Corticosteroids							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Arnuity Ellipta	Preferred	Brand	01/01/19	1 inhaler/30 days			
budesonide nebulizer	Preferred	Brand	01/01/21				
Pulmicort Flexhaler	Preferred	Brand	01/01/13	1 inhaler/30 days			
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Alvesco	Non Preferred	Brand	01/01/19	1 inhaler/30 days	Medication Coverage Exception		
Armonair	Non Preferred	Brand	09/01/17	1 inhaler/30 days	Medication Coverage Exception		
Asmanex	Non Preferred	Brand	01/01/15	1 inhaler/30 days	Medication Coverage Exception		
fluticasone HFA	Non Preferred	Generic	12/01/22	1 inhaler/30 days	Medication Coverage Exception		
Pulmicort nebulizer	Non Preferred	Brand	01/01/21	1 inhaler/30 days	Medication Coverage Exception		
Qvar	Non Preferred	Brand	01/01/19	1 inhaler/30 days	Medication Coverage Exception		

Utah Medicaid Preferred Drug List - Effective January 1, 2024

Asthma & COPD - Leukotriene Receptor Antagonists							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
montelukast chewable	Preferred	Generic	01/01/13				
montelukast tablet	Preferred	Generic	01/01/13				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Accolate	Non Preferred	Brand	01/01/18		Medication Coverage Exception		
montelukast granules	Non Preferred	Generic	01/01/13		Medication Coverage Exception		
Singulair	Non Preferred	Brand	01/01/13		Medication Coverage Exception		
zafirlukast	Non Preferred	Generic	01/01/18		Medication Coverage Exception		
zileuton CR	Non Preferred	Generic	10/15/15		Medication Coverage Exception		
Zyflo CR	Non Preferred	Brand	10/15/15		Medication Coverage Exception		
Asthma & COPD - Oral Beta Agonists							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
albuterol syrup	Preferred	Generic	01/01/19				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
albuterol tablet	Non Preferred	Generic	01/01/19		Medication Coverage Exception		
terbutaline	Non Preferred	Generic	01/01/19		Medication Coverage Exception		
Asthma & COPD - Combination Products							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Advair	Preferred	Brand	06/01/19	1 inhaler/30 days		Advair	
Combivent	Preferred	Brand	01/01/21	2 inhalers/30 days			
Dulera	Preferred	Brand	05/23/11	1 inhaler/30 days			
ipratropium/albuterol	Preferred	Generic	01/01/14	2 inhalers/30 days			
Symbicort	Preferred	Brand	01/01/13	1 inhaler/30 days		Symbicort	

Utah Medicaid Preferred Drug List - Effective January 1, 2024

Non Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
AirDuo	Non Preferred	Brand	09/01/19	1 inhaler/30 days	Medication Coverage Exception	AirDuo	
Airsupra	Non Preferred	Brand	09/01/23	1 inhaler/30 days	Medication Coverage Exception		
Breo Ellipta	Non Preferred	Brand	01/01/19	1 inhaler/30 days	Medication Coverage Exception	Breo Ellipta	
budesonide/formoterol	Non Preferred	Generic	07/01/20	1 inhaler/30 days	Medication Coverage Exception	Symbicort	
fluticasone/salmeterol	Non Preferred	Generic	09/01/19	1 inhaler/30 days	Medication Coverage Exception	Advair	
fluticasone/salmeterol	Non Preferred	Generic	05/01/17	1 inhaler/30 days	Medication Coverage Exception	AirDuo	
fluticasone/vilanterol	Non Preferred	Generic	12/01/22	1 inhaler/30 days	Medication Coverage Exception	Breo Ellipta	
Asthma & COPD - LABA/LAMA Combinations							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
Anoro Ellipta	Preferred	Brand	09/01/17	1 inhaler/30 days			
Stiolto	Preferred	Brand	01/01/22	1 inhaler/30 days			
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Bevespi	Non Preferred	Brand	01/01/22	1 inhaler/30 days	Medication Coverage Exception		
Breztri	Non Preferred	Brand	08/01/20	1 inhaler/30 days	Medication Coverage Exception		
Duaklir	Non Preferred	Brand	02/01/20	1 inhaler/30 days	Medication Coverage Exception		
Trelegy Ellipta	Non Preferred	Brand	11/01/17	1 inhaler/30 days	Medication Coverage Exception		
Cystic Fibrosis: CFTR Modulators							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Kalydeco	Preferred	Brand	01/01/21		Cystic Fibrosis CFTR Modulators		
Orkambi	Preferred	Brand	01/01/21		Cystic Fibrosis CFTR Modulators		
Trikafta	Preferred	Brand	01/01/21		Cystic Fibrosis CFTR Modulators		
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
Symdeko	Non Preferred	Brand	01/01/21		Cystic Fibrosis CFTR Modulators		
Cystic Fibrosis: Inhaled Aminoglycosides							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
tobramycin 300mg/5ml nebulizer	Preferred	Generic	01/01/22				

Utah Medicaid Preferred Drug List - Effective January 1, 2024

Non Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
Arikayce	Non Preferred	Brand	11/01/18		Medication Coverage Exception		
Bethkis	Non Preferred	Brand	01/01/20		Medication Coverage Exception		
Kitabis Pak	Non Preferred	Brand	01/01/22		Medication Coverage Exception		
Tobi nebulizer	Non Preferred	Brand	01/01/16		Medication Coverage Exception		
Tobi Podhaler capsule	Non Preferred	Brand	01/01/18		Medication Coverage Exception		
tobramycin 300mg/4ml nebulizer	Non Preferred	Generic	01/01/24		Medication Coverage Exception		

Urinary

Short Acting Antispasmodics

Preferred Drugs	Status	Type	Last Update	Limits	Mandatory 3-Month	Brand Required	Additional Note
bethanechol	Preferred	Generic	01/01/20				
oxybutynin	Preferred	Generic	09/28/09				
trospium	Preferred	Generic	01/01/24				

Non Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
Detrol	Non Preferred	Brand	09/28/09		Medication Coverage Exception		
flavoxate	Non Preferred	Generic	09/28/09		Medication Coverage Exception		
tolterodine	Non Preferred	Generic	09/28/09		Medication Coverage Exception		

Long Acting Antispasmodics

Preferred Drugs	Status	Type	Last Update	Limits	Mandatory 3-Month	Brand Required	Additional Note
oxybutynin ER	Preferred	Generic	02/01/10				
Oxytrol Rx	Preferred	Brand	01/01/19				
solifenacin	Preferred	Generic	08/01/20				
Toviaz	Preferred	Brand	09/28/09				

Non Preferred Drugs	Status	Type	Last Update	Limits	Required Prior Authorization Form	Brand Required	Additional Note
darifenacin	Non Preferred	Generic	04/01/16		Medication Coverage Exception		
Detrol LA	Non Preferred	Brand	02/01/10		Medication Coverage Exception		
Ditropan XL	Non Preferred	Brand	01/01/12		Medication Coverage Exception		
fesoterodine	Non Preferred	Generic	08/01/22		Medication Coverage Exception		
Gelnique	Non Preferred	Brand	05/01/17		Medication Coverage Exception		
Gemtesa	Non Preferred	Brand	02/01/21		Medication Coverage Exception		
Myrbetriq	Non Preferred	Brand	05/09/13		Medication Coverage Exception		

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Drug / Product Name	Status	Type	Updated	Limits	PA Form / 3-Month Req'd	Brand Req'd	Additional Note
tolterodine ER	Non Preferred	Generic	01/01/14		Medication Coverage Exception		
trospium ER	Non Preferred	Generic	10/01/13		Medication Coverage Exception		
Vesicare	Non Preferred	Brand	08/01/20		Medication Coverage Exception		
Vitamin D Analogs							
Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Mandatory 3-Month**	**Brand Required**	**Additional Note**
calcitriol capsule	Preferred	Generic	01/01/18				
calcitriol injection	Preferred	Generic	05/01/22				Covered under medical benefit using appropriate HCPCS
doxercalciferol injection	Preferred	Generic	05/01/22				Covered under medical benefit using appropriate HCPCS
paricalcitol injection	Preferred	Generic	05/01/22				Covered under medical benefit using appropriate HCPCS
Rocaltrol solution	Preferred	Brand	01/01/18			Rocaltrol	
vitamin D 125mg (50,000 units)	Preferred	Generic	01/01/15				
Non Preferred Drugs	**Status**	**Type**	**Last Update**	**Limits**	**Required Prior Authorization Form**	**Brand Required**	**Additional Note**
calcitriol solution	Non Preferred	Generic	01/01/15		Medication Coverage Exception	Rocaltrol	
doxercalciferol capsule	Non Preferred	Generic	01/01/15		Medication Coverage Exception		
Drisdol	Non Preferred	Brand	11/01/16		Medication Coverage Exception		
Hectorol	Non Preferred	Brand	01/01/18		Medication Coverage Exception		
paricalcitol capsule	Non Preferred	Generic	01/01/15		Medication Coverage Exception		
Rocaltrol capsule	Non Preferred	Brand	01/01/18		Medication Coverage Exception		
Zemplar	Non Preferred	Brand	01/01/15		Medication Coverage Exception		

Utah Medicaid Covered Over-the-Counter Drugs - Effective January 1, 2024

• **Nursing Home Members** - OTC products are not covered through the outpatient pharmacy benefit program for members residing in nursing homes.

Anti-Fungals

Drugs	Updated	Limits	Mandatory 3-Month	Additional Note
clotrimazole 1% topical cream, vaginal cream	12/01/20			
miconazole 2% vaginal cream	04/01/17			
miconazole 4% vaginal cream	04/01/17			

1st Generation Antihistamines

Drugs	Updated	Limits	Mandatory 3-Month	Additional Note
chlorpheniramine 4mg tablet	04/01/17			
diphenhydramine 12.5mg chew	06/01/21			
diphenhydramine 12.5mg/5ml liquid	04/01/17			
diphenhydramine 25mg capsule	04/01/17			
diphenhydramine 25mg tablet	04/01/17			
diphenhydramine 50mg capsule	04/01/17			

2nd Generation Antihistamines

Drugs	Updated	Limits	Mandatory 3-Month	Additional Note
cetirizine 10 mg tablet	04/01/17		90 Day Supply Required	
cetirizine 5mg tablet	04/01/17			
cetirizine 5mg/5ml solution	04/01/17			
loratadine 10mg tablet	04/01/17		90 Day Supply Required	
loratadine 5mg chewable tablet	04/01/17			
loratadine 5mg/5ml solution	04/01/17			

Contraceptives

Emergency

Drugs	Updated	Limits	Covered Generic Products
levonorgestrel 1.5 mg tablet	07/01/23	4 tabs per 30 days	Curae, Econtra, FallBack, Her Style, My Choice, My Way, New Day, Opcicon, Option 2,Take Action

Non-Emergency

Products	Updated	Limits	Mandatory 3-Month	Additional Note
condoms - female	04/01/17			
condoms - male	04/01/17			
nonoxynol-9 spermicides	04/01/17			

Utah Medicaid Covered Over-the-Counter Drugs - Effective January 1, 2024

Dermatological

Corticosteroids

Drugs	Updated	Limits	Mandatory 3-Month	Additional Note
hydrocortisone 0.5% cream	04/01/17			
hydrocortisone 0.5% ointment	04/01/17			
hydrocortisone 1% cream	04/01/17			
hydrocortisone 1% ointment	04/01/17			

Anti-Lice

Drugs	Updated	Limits	Mandatory 3-Month	Additional Note
permethrin 1% liquid	04/01/17			
permethrin 1% lotion	04/01/17			
pyrethrins/piperonyl butoxide 0.33%/4% shampoo	04/01/17			
Vanalice 0.3-3.5% gel	01/01/20			

Fever Reducers and Pain Relievers

Acetaminophen

Drugs	Updated	Limits	Mandatory 3-Month	Additional Note
acetaminophen 160mg/5ml liquid	04/01/17			
acetaminophen 160mg/5ml suspension	04/01/17			
acetaminophen 160mg/5ml solution	04/01/17			
acetaminophen 120mg suppository	04/01/17			
acetaminophen 325mg suppository	04/01/17			
acetaminophen 650mg suppository	04/01/17			
acetaminophen 160mg chewable tablet	04/01/17			
acetaminophen 160mg dispersible tablet	04/01/17			
acetaminophen 325mg tablet	04/01/17			
acetaminophen 500mg capsule	04/01/17			
acetaminophen 500mg tablet	04/01/17			
acetaminophen 650mg tablet	04/01/17			

Aspirin

Drugs	Last	Limits	Mandatory 3-Month	Additional Note
aspirin 81mg tablet	04/01/17			
aspirin 81mg chewable tablet	04/01/17		90 Day Supply Required	
aspirin 81mg oral disintegrating tablet	04/01/17			
aspirin 81mg enteric coated tablet	04/01/17		90 Day Supply Required	
aspirin 325mg enteric coated tablet	04/01/17			
aspirin 325mg tablet	04/01/17			

Utah Medicaid Covered Over-the-Counter Drugs - Effective January 1, 2024

Non-Steroidal Anti-Inflammatorys (NSAIDs)				
Drugs	**Updated**	**Limits**	**Mandatory 3-Month**	**Additional Note**
ibuprofen 100mg/5ml suspension	04/01/17			
ibuprofen 50mg/1.25ml suspension	04/01/17			
ibuprofen 100mg chewable tablet	01/01/19			
ibuprofen 200mg tablet	04/01/17			
naproxen Na 220mg tablet	04/01/17			

Gastrointestinal (GI)

Anti-Diarrheals				
Drugs	**Updated**	**Limits**	**Mandatory 3-Month**	**Additional Note**
loperamide 2mg capsule	04/01/17	240 caps per 30 days		
loperamide 2mg tablet	04/01/17	240 tabs per 30 days		
loperamide 1mg/7.5ml suspension	04/01/17			

Laxatives - Bulk				
Drugs	**Updated**	**Limits**	**Mandatory 3-Month**	**Additional Note**
psyllium	04/01/17			

Laxatives - Osmotic				
Drugs	**Updated**	**Limits**	**Mandatory 3-Month**	**Additional Note**
polyethylene glycol 3350 powder	04/01/17	1054g per 30 days		

Laxatives - Saline				
Drugs	**Updated**	**Limits**	**Mandatory 3-Month**	**Additional Note**
mag hydroxide 400mg/ml suspension	11/01/18			

Laxatives - Surfactant				
Drugs	**Updated**	**Limits**	**Mandatory 3-Month**	**Additional Note**
docusate calcium 240mg capsules	04/01/17			
docusate Na 100mg, 200mg capsules	01/01/19		90 Day Supply Required	
docusate Na 50mg/5ml liquid	04/01/17			

Laxatives - Stimulant				
Drugs	**Updated**	**Limits**	**Mandatory 3-Month**	**Additional Note**
bisacodyl 10mg suppository	04/01/17			
bisacodyl EC 5mg tablets	04/01/17			
sennosides 8.6mg tablets	01/01/19			
sennosides 8.8mg/5ml syrup	12/01/23			
sennosides/docusate 8.6/50mg tablets	01/01/19			

Utah Medicaid Covered Over-the-Counter Drugs - Effective January 1, 2024

Ulcer Drugs - Antacids				
Drugs	**Updated**	**Limits**	**Mandatory 3-Month**	**Additional Note**
aluminum hydroxide/mag carbonate 160/104mg chewable	04/01/17			
aluminum hydroxide/mag carbonate 95/358mg/15ml suspension	04/01/17			
aluminum hydroxide/mag hydroxide/simethicone 200/200/25mg chewable	04/01/17			
aluminum hydroxide/mag hydroxide/simethicone 200/200/20mg/5ml susp	04/01/17			
aluminum hydroxide/mag hydroxide/simethicone 400/400/40mg/5ml susp	04/01/17			
calcium carbonate 1000mg chewable	04/01/17			
Ulcer Drugs - Stomach Acid Reducers				
Drugs	**Updated**	**Limits**	**Mandatory 3-Month**	**Additional Note**
famotidine 10mg tablet	06/01/21			
famotidine 20mg tablet	04/01/17			
Opioid Overdose Treatments				
Drugs	**Updated**	**Limits**	**Mandatory 3-Month**	**Additional Note**
naloxone nasal spray	12/01/23			
Smoking Deterrents				
Drugs	**Updated**	**Limits**	**Mandatory 3-Month**	**Additional Note**
nicotine 2mg gum	04/01/17			
nicotine 4mg gum	04/01/17			
nicotine 2mg lozenge	04/01/17			
nicotine 4mg lozenge	04/01/17			
nicotine 7mg/24hr patch	04/01/17			
nicotine 14mg/24hr patch	04/01/17			
nicotine 21mg/24hr patch	04/01/17			
Supplements				
Iron				
Drugs	**Updated**	**Limits**	**Mandatory 3-Month**	**Additional Note**
ferrous gluconate 325mg (36mg elemental Fe) tablet	04/01/17			
ferrous sulfate drops 75 mg/ml (15 mg/ml elemental Fe) liquid	04/01/17			
ferrous sulfate 220mg/5ml (44mg/5ml elemental Fe) liquid	04/01/17			
ferrous sulfate 325mg (65mg elemental fe) tablet	01/01/19		90 Day Supply Required	
ferrous sulfate CR 325mg (65mg elemental fe) tablet	04/01/17		90 Day Supply Required	

Utah Medicaid Additional Brand Required Over Generic Drugs - Effective January 1, 2024

• **Policy:** Drugs listed on this list or on the PDL as preferred, are exceptions to Utah Medicaid's Mandatory Generic Drug Policy.

Preferred Brand Name Drugs	Non-Preferred Generic Drugs	Updated	Limits	Prior Auth	Additional Note
Afinitor	everolimus	10/01/20			
Azopt	brinzolamide	07/01/21			
Bidil	isosorbide dinitrate/hydralazine	05/01/22			
Biltricide	praziquantel	Not Available			
Buphenyl	sodium phenylbutyrate	Not Available		PA Required	Rare Disease Medication Form
Carafate suspension	sucralfate suspension	06/01/19			
Cellcept suspension	mycophenolate suspension	Not Available			
Condylox gel	podofilox gel	01/01/24			
DDAVP	desmopressin	09/01/23			
Demser	metyrosine	08/01/20			
Fareston	toremifene	02/01/19			
Glumetza	Metformin ER 24HR Modified Release	08/01/23			
Glyset	miglitol	Not Available			
Hemabate	carboprost	03/01/22			
Hepsera	adefovir	Not Available			
Keveyis	dishlorphenamide	02/01/23			
Mephyton	phytonadione	11/01/18			
Mycamine	micafungin	05/01/20			
Nexavar	sorafenib	07/01/22			
Niaspan	niacin ER	Not Available			
Nuvaring	etonogestrel/ethinyl estradiol vaginal ring	02/01/20			84 Day Supply Required
Orfadin	nitisinone cap	06/01/21			
Proglycem	diazoxide	04/01/20			
Rapamune solution	sirolimus sol	02/01/19			
Revlimid	lenalidomide	04/01/22			
Riomet	metformin solution	04/01/21			
Samsca	tolvaptan	09/01/21			
Sensipar	cinacalcet	Not Available			
Sorilux foam	calcipotriene foam	Not Available			

Utah Medicaid Additional Brand Required Over Generic Drugs - Effective January 1, 2024

Preferred Brand Name Drugs	Non-Preferred Generic Drugs	Updated	Limits	Prior Auth	Additional Note
Sutent	sunitinib	09/01/22			
Syprine	trientine	Not Available			
Tarceva	erlotinib	06/01/19			
Tekturna	aliskiren	04/01/19			
Torisel	temsirolimus	10/01/20			
Tykerb	lapatinib	11/01/20			
Tyrosint	levothyroxine cap	12/01/20			
Valstar	valrubicin	05/01/19			
Xyrem	sodium oxybate	06/01/23			
Zavesca	miglustat	02/01/19			
Zyclara	imiquimod 3.75%	09/01/18			
Zytiga	abiraterone	12/01/18			

Utah Medicaid Additional 3 Month Supply Required Drugs- Effective January 1, 2024

• **Policy:** Utah Medicaid has instituted a mandatory 3 month supply for maintenance medications, following a two-month window for dose titration and stabilization.

• **Copays:** For a 3 month supply, Utah Medicaid fee for service members who are subject to cost-sharing will pay a single copay.

• **Day Supply:** 3 Month supply is defined as a 90 day supply. Exceptions to this are hormonal contraceptives. For continuous cycle contraceptives it is defined as 91 days; for all other hormonal contraceptives it is defined as 84 days.

• **Dispensing Fees:** Pharmacies will receive a single dispensing fee on prescriptions filled for a 3 Month supply.

• **Exemptions:** Mandatory three month policy applies to most members. Exemptions from this program as determined based on the member Category of Aid. Note: The mandatory 3 Month policy does not apply to Indian Health Service providers, or Medicaid members receiving long term services and supports in nursing facilities, intermediate care facilities, or home and community based waiver programs. While not mandatory, 3 Month supply fills remains optional for these groups.

• **Exceptions**: Requests for exceptions may be submitted by the prescriber through Prior Authorization.

Drugs	Strength(s)	Status	Type	Updated
amiodarone hydrochloride	200mg	Mandatory Generic Policy Applies	Generic	08/01/18
amlodipine/benazepril	2.5/10mg, 5/10mg, 5/20mg, 5/40mg, 10/20mg, 10/40mg	Mandatory Generic Policy Applies	Generic	08/01/18
anastrozole	1mg, 2mg	Mandatory Generic Policy Applies	Generic	08/01/18
aspirin chew & EC tablet	81mg	Mandatory Generic Policy Applies	Generic	07/01/16
clonidine tablet	0.1mg, 0.2mg, 0.3mg	Mandatory Generic Policy Applies	Generic	07/01/16
contraceptives	barrier, injectable, progestin only, transdermal, vaginal	Mandatory Generic Policy Applies	Brand/ Generic	05/01/19
dapsone tablet	25mg, 100mg	Mandatory Generic Policy Applies	Generic	08/01/18
dicyclomine	20mg	Mandatory Generic Policy Applies	Generic	07/01/16
docusate Na	100mg, 250mg	Mandatory Generic Policy Applies	Generic	07/01/16
ferrous sulfate	325mg	Mandatory Generic Policy Applies	Generic	07/01/16
fludrocortisone	0.1mg	Mandatory Generic Policy Applies	Generic	08/01/21
folic acid	1mg	Mandatory Generic Policy Applies	Generic	07/01/16
isoniazid tablet	100mg, 300mg	Mandatory Generic Policy Applies	Generic	08/01/18
isoniazid syrup	50mg/5ml	Mandatory Generic Policy Applies	Generic	08/01/18
letrozole	2.5mg	Mandatory Generic Policy Applies	Generic	07/01/16
levothyroxine	25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 300mcg	Mandatory Generic Policy Applies	Generic	08/01/21
medroxyprogesterone	2.5mg, 5mg, 10mg	Mandatory Generic Policy Applies	Generic	08/01/18
metformin	500mg, 850mg, 1000mg	Mandatory Generic Policy Applies	Generic	07/01/16
metformin ER (except modified release)	500mg, 750mg, 1000mg	Mandatory Generic Policy Applies	Generic	08/01/23
norethindrone acetate	5mg	Mandatory Generic Policy Applies	Generic	08/01/21
pediatric vitamins	ADC, multi- w/o Fl & Fe	Mandatory Generic Policy Applies	Brand/ Generic	05/01/19
Prempro	0.3/1.5mg, 0.45/1.5mg, 0.625/2.5mg, 0.625/5mg	Mandatory Generic Policy Applies	Brand	08/01/18
segesterone/ethinyl estradiol	0.15/0.013mg per 24 hr	Mandatory Generic Policy Applies	Brand	Not available
tamoxifen	10mg, 20mg	Mandatory Generic Policy Applies	Generic	08/01/18
trihexyphenidyl	2mg, 5mg	Mandatory Generic Policy Applies	Generic	02/01/18

Utah Medicaid Additional Drug Limits - Effective January 1, 2024

Antineoplastics

Generic Name Drugs	Brand Name Drugs	Updated	Limits	Additional Note
apalutamide	Erleada	Not Available	Male only	
bicalutamide	Casodex	Not Available	Male only	
darolutamide	Nubeqa	Not Available	Male only	
enzalutamide	Xtandi	Not Available	Male only	
exemestane	Aromasin	Not Available	Female only	
flutamide		Not Available	Male only	
leuprolide	Eligard	Not Available	Male only	
nilutamide		Not Available	Male only	

Central Nervous System - Smoking Deterrents

Generic Name Drugs	Brand Name Drugs	Updated	Limits	Additional Note
Nicotine Replacement Products	All	Not Available	12 years and older	
Varenicline	Chantix	04/01/19	16 years and older	

Contraceptives

Generic Name Drugs	Brand Name Drugs	Updated	Limits	Additional Note
drospirenone	Slynd	Not Available	Female only	
etonogestrel/ethinyl estradiol ring	Nuvaring	Not Available	Female only	
lactic/citric/potassium vaginal gel	Phexxi	Not Available	Female only	
levonorgestrel/ethinyl estradiol patch	Twirla	Not Available	Female only	
norelgestromin/ethinyl estradiol patch		Not Available	Female only	
norethindrone		Not Available	Female only	

Cough and Cold Preparations

Generic Name Drugs	Brand Name Drugs	Updated	Limits	Additional Note
codeine/guaifenesin combinations		11/01/21	12 years and older	

COVID-19 Tests

Products		Updated	Limits	Additional Note
COVID-19 Tests		02/01/22	8 tests /30 days	FDA EUA OTC, DTC, and RX tests are listed on FDA's In Vitro Diagnostics EUA webpage: www.fda.gov/medical-devices/coronavirus-disease-2019-covid-19-emergency-use-authorizations-medical-devices/in-vitro-diagnostics-euas

Emergency Contraceptives

Generic Name Drugs	Brand Name Drugs	Updated	Limits	Additional Note
Ulipristal	Ella	Not Available	2 kits /30 days	

Utah Medicaid Additional Drug Limits - Effective January 1, 2024

Gastrointestinal (GI) - Antidiarrheals

Generic Name Drugs	Brand Name Drugs	Updated	Limits	Additional Note
diphenoxylate/atropine	Lomotil	05/01/23	Cumulative limit: 240 tab /30 days	
loperamide		05/01/23	Cumulative limit: 240 tab /30 days	

Hematopoietic Growth Factors

Generic Name Drugs	Brand Name Drugs	Updated	Limits	Additional Note
eltrombopag	Promacta	11/01/18	Cumulative limit: 30 tab /30 days	

Migraine Agents

Generic Name Drugs	Brand Name Drugs	Updated	Limits	Additional Note
butalbital/apap	Allzital	10/01/19	Cumulative limit: 20 units /30 days	Restricted to members age 18 and older.
butalbital/apap/caf	Fioricet, Esgic	10/01/19	Cumulative limit: 20 units /30 days	Restricted to members age 18 and older.
butalbital/apap/caf/codeine		10/01/19	Cumulative limit: 20 units /30 days	Restricted to members age 18 and older.
butalbital/asa/caf	Fiorinal	10/01/19	Cumulative limit: 20 units /30 days	Restricted to members age 18 and older.
butalbital/asa/caf/codeine	Fiorinal/codeine	10/01/19	Cumulative limit: 20 units /30 days	Restricted to members age 18 and older.

Minerals and Vitamins

Generic Name Drugs	Brand Name Drugs	Updated	Limits	Additional Note
Fluoride		Not Available	5 years and under	
Pediatric vitamins		Not Available	5 years and under	

Progesterones

Generic Name Drugs	Brand Name Drugs	Updated	Limits	Additional Note
hydroxyprogesterone caproate	Makena	Not Available	Female only	
medroxyprogesterone tablet	Provera	Not Available	Female only	
norethindrone tablet	Aygestin	Not Available	Female only	
progesterone capsule	Prometrium	Not Available	Female only	
progesterone injection	Depo-Provera	Not Available	Female only	

Utah Medicaid Prior Authorizations - Effective January 1, 2024

• **Pharmacy Prior Authorization Forms:** Can be found on the Utah Medicaid website. https://medicaid.utah.gov/pharmacy/prior-authorization
• **Submission:** Fax completed and signed form with documentation, including chart notes, letter of medical necessity and laboratory results to 855-828-4992.
• **Substitution:** Authorizations will be processed for the preferred Generic/Brand equivalent unless specified "Do Not Substitute".

Non Drug Specific PA Forms

Form	Notes	Updated
Exception to 3 Month Supply		05/01/23
Medication Coverage Exception Request	Incorporates Brand Name, Combination Products, Dosing Kits, Non-Preferred Medications, Off-Label Use, Quantity/Dose/Age Limit Exceptions, and Step Therapy Requests	10/01/23
New to Market Drug		07/01/23
Rare Disease Medications- Medications that require prior authorization but do not belong to another PA class due to the disease or indication being uncommon, including but not limited to:	Abecma, Adakveo, Adcetris, Adzynma, Aldurazyme, Ammonul, Amondys 45, Amvuttra, Aralast, Atgam, Ayvakit, Berinert, Besremi, Breyanzi, Brineura, Buphenyl, Bylvay, Carbaglu, Carvykti, Cerdelga, Cerezyme, Cinryze, Cuvrior, Daybue, Dojolvi, Elaprase, Elelyso, Elfabrio, Empaveli, Enjaymo, Enspryng, Evkeeza, Exondys 51, Fabrazyme, Filspari, Firazyr, Galafold, Gamifant, Givlaari, Glassia, Haegarda, Imcivree, Isturisa, Jakafi, Joenja, Kalbitor, Kanuma, Kymriah, Lamzede, Lumizyme, Mepsevii, Myalept, Naglazyme, Nexavar, Nexviazyme, Nuedexta, Nulibry, Onpattro, Opfolda, Orladeyo, Oxbryta, Oxlumo, Palinzyq, Pheburane, Pombiliti, Prolastin, Provenge, Ravicti, Reblozyl, Ruconest, Ryplazim, sodium benzoate/sodium phenylacetate, Pyrukynd, Soliris, Spevigo, Strensiq, Sutent, Sylvant, Takhzyro, Tavneos, Tecartus, Tegsedi, Tepezza, Terlivaz, Ultomiris, Uplizna, Veopoz, Vijoice, Viltepso, Vimizim, Voxzogo, Vpriv, Vyjuvek, Vyondys 53, Xenpozyme, Yescarta, Zemaira, Zynteglo	01/01/24

Drug Class or Disease Specific PA Forms

• **Policy:** Non-Preferred products, per Utah Medicaid's PDL, require trial and failure of a preferred product or the prescriber must demonstrate medical necessity.

Form	Products	Notes	Updated
ADHD Stimulants			04/01/23
Androgens			10/01/23
Antiemetics	Akynzeo, Aloxi, Anzemet, Aponvie, aprepitant, Cinvanti, Emend, fosaprepitant, granisetron, palonosetron, Sancuso, Sustol,		10/01/23
Antipsychotics in Children			04/01/23
Anti-vascular Endothelial Growth Factor Therapy	Avastin, Beovu, Cimerli, Cyramza, Eylea, Lucentis, Macugen, Mvasi, Susvimo, Vabysmo, Zaltrap, Zirabev	Covered under medical benefit using appropriate HCPCS	03/01/23

Utah Medicaid Prior Authorizations - Effective January 1, 2024

Form	Products	Notes	Updated
Botulinum Toxin	Botox, Dysport, Myobloc, Xeomin	Covered under medical benefit using appropriate HCPCS	05/01/23
Buprenorphine & Buprenorphine/Naloxone	Bunavail, buprenorphine, buprenorphine/naloxone, Suboxone,		06/01/23
CGRP Antagonist	Aimovig, Ajovy, Emgality, Nurtec, Qulipta, Ubrelvy, Vyepti		12/01/23
Continuous Glucose Monitors	Dexcom, FreeStyle Libre, Guardian		05/01/23
Cystic Fibrosis CFTR Modulators	Kalydeco, Orkambi, Symdeko, Trikafta		06/01/23
Gonadotropin-Releasing Hormone	Camsevi, Eligard, Fensolvi, Firmagon, Lupron, Orgovyx, Supprelin, Synarel, Trelstar, Triptodur	Orilissa has a separate PA form	03/01/23
Growth Hormone			07/01/23
Hepatitis C			10/01/23
Hormone Therapy for Gender Dysphoria			01/01/24
Immunoglobulin Therapy			01/01/24
Monoclonal Antibodies for Asthma and Other Indications	CinQair, Dupixent, Fasenra, Nucala, Tezspire, Xolair		02/01/23
Ophthalmic Corticosteroid Intravitreal Implants/Injection	Iluvien, Ozurdex, Retisert, Triesence, Xipere, Yutiq	Covered under medical benefit using appropriate HCPCS	08/01/23
Opioid and Opioid Benzodiazepine Combination			05/01/23
PAMORAs			08/01/23
Parathyroid Hormone Analogs	Evenity (romosozumab-aqqg), Forteo (teriparatide), Tymlos (abaloparatide)		01/01/24
PCSK9 Inhibitors	Praluent, Repatha		02/01/23
Pulmonary Arterial Hypertension (PAH)			05/01/23
Wakefulness Promoting Agents	Nuvigil (armodafinil), Provigil (modafinil), Sunosi (solriamfetol), Wakix (pitolisant)		08/01/23

Drug Specific PA Forms

Brand Name	Generic Name	Notes	Updated
Abilify Mycite	aripiprazole tablets with sensor		07/01/23
Aduhelm	aducanumab-avwa		01/01/24
Braftovi, Mektovi	encorafenib and binimetinib		10/01/23

Utah Medicaid Prior Authorizations - Effective January 1, 2024

Brand Name	Generic Name	Notes	Updated
Cabenuva	cabotegravir/rilpivirine extended-release injectable suspension		08/01/23
Cialis	tadalafil		05/01/23
Novarel, Pregnyl	Chorionic Gonadotropin		06/01/23
Doptelet	avatrombopag		10/01/23
Emflaza	deflazacort		10/01/23
Epidiolex	cannabidiol		07/01/23
Evrysdi, Spinraza	risdiplam, nusinersen		12/01/23
Hemgenix	etranacogene dezaparvovec-drlb		12/01/23
Hemlibra	emicizumab		09/01/23
Hetlioz	tasimelteon		02/01/23
Humulin R U-500	concentrated insulin human injection		10/01/23
Krystexxa	Pegloticase		09/01/23
Leqembi	lecanemab-irmb		06/01/23
Lucemyra	lofesidine hydrochloride		07/01/23
Luxturna	voretigene neparvovec-rzyl		10/01/23
Mavenclad	cladribine		12/01/23
Methadone	Methadone	Treatment of chronic pain only	05/01/23
Mifeprex	mifepristone		06/01/23
Nuplazid	pimavanserin		07/01/23
Oralair	Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Blue Grass Mixed Pollens Allergen Extract		07/01/23
Orilissa	elagolix		07/01/23
Palforzia	Peanut (Arachis hypogaea) Allergen Powder-dnfp		10/01/23
Restasis, Cequa	Ophthalmic Cyclosporine		09/01/23
Reyvow	lasmiditan		01/01/24
Roctavian	valoctocogene roxaparvovec		10/01/23
Rukobia	fostemsavir		12/01/23
Samsca, Jynarque	tolvaptan		12/01/23

Utah Medicaid Prior Authorizations - Effective January 1, 2024

Brand Name	Generic Name	Notes	Updated
Spravato	esketamine nasal spray		05/01/23
Sunlenca	lenacapavir		02/01/23
Synagis	Palivizumab		12/01/23
Trodelvy	sacituzumab govitecan		12/01/23
Verquvo	vericiguat		05/01/23
Vyjuvek	beremagene geperpavec-svdt		12/01/23
Xifaxan	rifaximin		12/01/23
Xyrem, Xywav	(sodium oxybate), (calcium, magnesium, potassium, and sodium oxybates)		12/01/23
Zolgensma	onasemnogene abeparvovec-xioi		06/01/23
Zulresso	brexanolone	Covered under medical benefit using appropriate HCPCS	12/01/23

Utah Medicaid Ultra High Cost Drugs - Effective January 1, 2024

• **Policy:** Drugs listed on this list are considered Ultra High Cost and are carved out to Fee For Service Medicaid.

Brand Name	Generic Name	Updated	HCPCS or CPT Code	PA Form	Population and Dx Codes
Casgevy	exagamglogene autotemcel	01/01/24	TBD	TBD	Sickle Cell Disease (SCD) in patients 12 years and older with recurrent vaso-occlusive crises
Elevidys	delandistrogene moxeparvovec-rokl	08/01/23	TBD	Elevidys	Ambulatory pediatric patients aged 4 through 5 years with Duchenne muscular dystrophy (DMD) with a confirmed mutation in the DMD gene
Hemgenix	etranacogene dezaparvovec-drlb	07/01/23	J1411	TBD	Adults with Hemophilia B (congenital Factor IX deficiency)
Lyfgenia	lovotibeglogene autotemcel	01/01/24	TBD	TBD	Sickle Cell Disease (SCD) in patients 12 years and older with a history of vaso-occlusive events
Roctavian	valoctocogene roxaparvovec-rvox	08/01/23	TBD	Roctavian	Adults with severe hemophilia A (congenital factor VIII deficiency with factor VIII activity < 1 IU/dL) without pre-existing antibodies to adeno-associated virus serotype 5
Skysona	elivaldogene autotemcel	09/01/23	TBD	TBD	Boys aged 4-17 years with Early, active cerebral adrenoleukodystrophy (CALD)
Zolgensma	onasemnogene abeparvovec-xioi	07/01/23	J3399	Zolgensma	Children <2yrs of age with Spinal Muscular Atrophy (SMA)
Zynteglo	Betibeglogene autotemcel	09/01/23	TBD	TBD	Adult and pediatric patients with β-thalassemia who require regular red blood cell (RBC) transfusions.