Formulary Exception Criteria

EXPRESS SCRIPTS®

STANDARD FORMULARY EXCEPTION CRITERIA

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
ACE-Inhibitor/CCB Combination Product	Lotrel	amlodipine/benazepril capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Acne Vulgaris Agents (Topical)	Fabior and authorized generic	tazarotene 0.1% foam	Other diagnoses (e.g., acne vulgaris). Approve if the patient meets the following (A and B): A. Patient has tried one of tazarotene cream (Tazorac cream, generics) or tazarotene gel (Tazorac gel, generics), if one is formulary. If none are formulary, approve; AND B. Patient has tried a topical tretinoin-containing product. Note: Examples of topical retinoid products include tretinoin cream (Retin-A cream, generics), tretinoin gel (Retin-A gel, generics). Psoriasis. Approve if the patient has tried one of tazarotene cream (Tazorac cream, generics) or tazarotene gel (Tazorac gel, generics), if one is formulary. If none are formulary, approve.	1 year	Yes	
Acne Vulgaris Agents (Topical)	Cabtreo	clindamycin phosphate, adapalene and benzoyl peroxide topical gel	Approve if the patient meets BOTH of the following (A and B): A. Patient has concomitantly tried ALL three of the following products **[documentation required]**: 1) a topical benzoyl peroxide product, 2) a topical tretinoin-containing or adapalene-containing product, and 3) a topical clindamycin-containing product; AND B. According to the prescriber, there is a significant clinical concern such that the patient is unable to continue to use the products in criterion A.	1 year	Yes	
Acne Vulgaris Agents (Topical)	Winlevi	clascoterone cream 1%	Acne Vulgaris in a patient ≥ 12 years of age. Approve if the patient meets the following (A and B): A. Patient has tried at least one prescription topical retinoid **[documentation required]**; AND Note: Examples of a prescription topical retinoid are adapalene (Differin generic), Aklief (trifarotene 0.005% cream), tazarotene 0.1% cream (Tazorac 0.1% cream, generic), tazarotene 0.1% gel (Tazorac 0.1% gel, generic), and tretinoin. B. Patient has tried at least three other prescription non-retinoid topical therapies **[documentation required]**. Note: Topical retinoids do not count. Examples of other prescription non-retinoid topical therapies for acne include: dapsone gel (Aczone, generic), Azelex (azelaic acid 20% cream), topical clindamycin, topical erythromycin, and topical minocycline (Amzeeq [minocycline 4% foam]). For combination products, each active chemical entity counts as one trial. Example: If one prescription product has 2 non-retinoids, this would fulfill a trial of 2 non-retinoid topical therapies.	1 year	Yes	
Acne Vulgaris Agents (Topical)	Acanya Gel	benzoyl peroxide 2.5% and clindamycin phosphate 1.2% gel	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Acne Vulgaris Agents (Topical)	Atralin	tretinoin gel (0.05%)	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Acne Vulgaris Agents (Topical)	Clindagel 1% gel	clindamycin 1% gel	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Acne Vulgaris Agents (Topical)	Retin-A Micro 0.1% & 0.04% gel	tretinoin 0.1% & 0.04% gel	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Acne Vulgaris Agents (Topical)	Veltin	clindamycin phosphate and tretinoin gel	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Actinic Keratosis Agents (Topical)	Klisyri	tirbanibulin ointment 1%	Approve if the patient has tried two of the following products: diclofenac 3% gel, a fluorouracil-containing product (e.g., fluorouracil cream, Carac, fluorouracil topical solution), or an imiquimod-containing product (e.g., imiquimod 5% cream, Zyclara).	1 year	Yes	
Actinic Keratosis Agents (Topical)	Carac and authorized generic 0.5%	fluorouracil 0.5% cream	Approve if the patient has tried one of the following products, if formulary: Tolak, Fluoroplex, fluorouracil 2% solution, fluorouracil 5% solution, or fluorouracil 5% cream (Efudex, generics). If none are formulary, approve.	1 year	Yes	
Actinic Keratosis Agents (Topical)	Zyclara 2.5% and 3.75%	imiquimod 2.5% and 3.75% cream	Approve if the patient has tried imiquimod 5% cream (Aldara, generics), if formulary. If imiquimod 5% cream (Aldara, generics) is non-formulary, approve.	1 year	Yes	

Formulary Exception Criteria

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Allergen Immunotherapy	Palforzia	peanut [Arachis hypogaea] allergen powder-dnfp for oral administration	See standard *Allergen Immunotherapy – Palforzia Prior Authorization Policy* criteria.	1 year	Yes	
Alpha and beta-blocker	Coreg	carvedilol tablet	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Alpha1 Proteinase Inhibitors	Aralast NP	alpha1-proteinase inhibitor [human] lyophilized powder	Alpha1-Antitrypsin Deficiency with Emphysema (or Chronic Obstructive Pulmonary Disease); Alpha1-Antitrypsin Deficiency-Associated Panniculitis: Approve if the patient has tried two formulary alternatives from the following list, if formulary (or one if one is formulary): Glassia, Prolastin-C (powder or liquid), or Zemaira. If none are formulary, approve.	1 year	Yes	
Alpha1 Proteinase Inhibitors	Glassia	alpha1-proteinase inhibitor [human] solution	Alpha1-Antitrypsin Deficiency with Emphysema (or Chronic Obstructive Pulmonary Disease); Alpha1-Antitrypsin Deficiency-Associated Panniculitis: Approve if the patient has tried two formulary alternatives from the following list, if formulary (or one if one is formulary): Aralast NP, Prolastin-C (powder or liquid), or Zemaira. If none are formulary, approve.	1 year	Yes	
Alpha1 Proteinase Inhibitors	Zemaira	alpha1-proteinase inhibitor [human] lyophilized powder	Alpha1-Antitrypsin Deficiency with Emphysema (or Chronic Obstructive Pulmonary Disease); Alpha1-Antitrypsin Deficiency-Associated Panniculitis: Approve if the patient has tried two formulary alternatives from the following list, if formulary (or one if one is formulary): Aralast NP, Glassia, or Prolastin-C (powder or liquid). If none are formulary, approve.	1 year	Yes	
Alpha-2 Agonists	Lucemyra	lofexidine tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Alpha-adrenergic Agonist	Nexiclon XR and authorized generic	clonidine ER tablet and authorized generic	Approve if the patient tried and is unable to use both clonidine immediate-release tablets AND clonidine transdermal patches.	1 year	Yes	
Aluminum Chloride Agents	Drysol	aluminum chloride 20% topical solution	Hyperhidrosis in the axillae, palms, or soles. Approve if the patient has tried, for at least 4 weeks, and experienced inadequate efficacy with one over-the-counter aluminum-containing product (such as Certain Dri, Bromi-lotion) **[documentation required]**.	1 year	Yes	
Alzheimer's Agent - Amyloid beta-directed antibody	Leqembi	lecanemab-irmb intravenous infusion	No exceptions are recommended. Due to safety concerns and the lack of clinically significant efficacy data, an exception is not recommended for Leqembi. (NOTE: It is not appropriate to use standard global criteria for this medication; Denial reason is: No exceptions are recommended. There are safety concerns and a lack of clinically significant efficacy data with use of Leqembi.)	N/A	Yes	
Alzheimer's Agent - Amyloid beta-directed antibody	Kisunla	donanemab-azbt intravenous infusion	No exceptions are recommended. Due to safety concerns and the lack of clinically significant efficacy data, an exception is not recommended for Kisunla. (NOTE: It is not appropriate to use standard global criteria for this medication; Denial reason is: No exceptions are recommended. There are safety concerns and a lack of clinically significant efficacy data with use of Kisunla.)	N/A	Yes	
Alzheimer's Disease Agents	Namenda XR	memantine extended-release capsule	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Amyloidoisis-associated Polyneuropathy Agents	Onpattro	patisiran for intravenous use	Approve if the patient meets the following criteria (A and B): A. Polyneuropathy of Hereditary Transthyretin-Mediated Amyloidosis (hATTR). Approve if the patient meets ALL of the following (i, ii, iii, and iv): i. Patient is ≥18 years of age; AND ii. Patient has a transthyretin (TTR) pathogenic variant as confirmed by genetic testing; AND iii. Patient has symptomatic polyneuropathy; AND Note: Examples of symptomatic polyneuropathy include reduced motor strength/coordination, and impaired sensation (e.g., pain, temperature, vibration, touch). Examples of assessments for symptomatic disease include history and clinical exam, electromyography, or nerve conduction velocity testing. iv. The medication is prescribed by or in consultation with a neurologist, geneticist, or a physician who specializes in the treatment of amyloidosis; AND B. The patient meets one of the following criteria (i, iii, or iii): i. Patient has tried one of Amvuttra or Wainua, if formulary; OR ii. If neither Amvuttra nor Wainua is formulary; OR iii. Patient has already been started on Onpattro.	1 year	Yes	Yes

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Amyloidoisis-associated Polyneuropathy Agents	Wainua	eplontersen subcutaneous injection	Approve if the patients meets the following criteria (A and B): A. Polyneuropathy of Hereditary Transthyretin–Mediated Amyloidosis (hATTR). Approve if the patient meets ALL of the following (i, ii, iii, iv, and v): i. Patient is ≥ 18 years of age; AND ii. Patient has a transthyretin (TTR) pathogenic variant as confirmed by genetic testing; AND iii. Patient has symptomatic polyneuropathy; AND Note: Examples of polyneuropathy include reduced motor strength/coordination, and impaired sensation (e.g., pain, temperature, vibration, touch). Examples of assessments for symptomatic disease include history and clinical exam, electromyography, or nerve conduction velocity testing. iv. Patient does not have a history of liver transplantation; AND v. The medication is prescribed by or in consultation with a neurologist, geneticist, or a physician who specializes in the treatment of amyloidosis; AND B. The patient meets one of the following criteria (i, ii, or iii): i. Patient has tried Amvuttra, if formulary; OR ii. If Amvuttra is non-formulary; OR iii. Patient has already been started on Wainua.	1 year	Yes	Yes
Analgesics - Butalbital-Containing Products	Bupap tablet	butalbital 50 mg, acetaminophen 300 mg tablet	Approve if the patient has tried one other formulary butalbital-containing product, if one is formulary (e.g., butalbital/acetaminophen capsule or tablet, butalbital/acetaminophen/caffeine capsule or tablet, butalbital/acetaminophen/caffeine/codeine capsule, butalbital/aspirin/caffeine capsule or tablet, butalbital/aspirin/caffeine/codeine capsule). If none are formulary, approve.	1 year	Yes	
Angiotensin Converting Enzyme (ACE) Inhibitors	Qbrelis	lisinopril oral solution	**1.** Approve if the patients has tried lisinopril tablets (Prinivl, Zestril, generics), if formulary. If lisinopril tablets (Prinivil, Zestril, generics) are non-formulary, approve. **2.** Approve if the patient cannot swallow or has difficulty swallowing tablets.	1 year	Yes	
Angiotensin Converting Enzyme (ACE) Inhibitors	Epaned	enalapril maleate powder for oral solution, enalapril maleate oral solution	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Angiotensin Receptor Blockers	Valsartan oral solution (previously Prexxartan)	valsartan oral solution	**1.** Direct the patient to valsartan tablets. **2.** Approve if the patient is unable to or has difficulty swallowing oral tablets.	1 year	Yes	
Angiotensin Receptor Blockers (ARBs) and Combination Products	Edarbi	azilsartan	**1.** Approve if the patient has tried five of the following, if five are formulary (or four if four are formulary or three if three are formulary or two if two are formulary; or one if only one is formulary): candesartan (Atacand, generics), irbesartan (Avapro, generics), olmesartan (Benicar, generics), losartan (Cozaar, generics), valsartan (Diovan, generics), telmisartan (Micardis, generics), or eprosartan. If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement **2.** Patients recently hospitalized (and discharged within 30 days) for a cardiovascular event (e.g., myocardial infarction [MI], hypertensive emergency) who has already been started and stabilized on Edarbi: approve.	1 year	Yes	
Angiotensin Receptor Blockers (ARBs) and Combination Products	Edarbyclor	azilsartan and chlorthalidone tablets	**1.** Approve if the patient has tried five of the following formulary angiotensin receptor blocker/diuretic combination products, if five are formulary, or four if four are formulary, or three if three are formlary, or two are formulary, or one if only one is formulary): candesartan-hydrochlorothiazide (Atacand HCT, generics), irbesartan-hydrochlorothiazide (Avalide, generics), losartan-hydrochlorothiazide (Hyzaar, generics), telmisartan-hydrochlorothiazide (Micardis HCT, generics), valsartan-hydrochlorothiazide (Diovan HCT, generics), olmesartan-hydrochlorothiazide (Benicar HCT, generics). **2.** Approve if the patient has tried chlorthalidone AND Edarbi, if Edarbi is formulary. If Edarbi is non-formulary, approve if the patient has tried five of the following formulary angiotensin receptor blockers (ARBs), if five are formulary or four if four are formulary or three if three are formulary, or two if only two are formulary; or one if only one is formulary): candesartan (Atacand, generics), irbesartan (Avapro, generics), olmesartan (Benicar, generics), losartan (Cozaar, generics), valsartan (Diovan, generics), telmisartan (Micardis, generics), or eprosartan. If none are formulary, approve.	1 year	Yes	
Angiotensin Receptor Blockers (ARBs) and Combination Products	Atacand	candesartan cilexetil tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Angiotensin Receptor Blockers (ARBs) and Combination Products	Atacand HCT	candesartan/hydrochlorothiazide tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Angiotensin Receptor Blockers (ARBs) and Combination Products	Avalide	irbesartan/hydrochlorothiazide tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Angiotensin Receptor Blockers (ARBs) and Combination Products	Avapro	irbesartan tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	

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Angiotensin Receptor Blockers (ARBs) and Combination Products	AZOR	amlodipine besylate/olmesartan medoxomil tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Angiotensin Receptor Blockers (ARBs) and Combination Products	Benicar	olmesartan medoxomil tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Angiotensin Receptor Blockers (ARBs) and Combination Products	Benicar HCT	olmesartan/hydrochlorothiazide tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Angiotensin Receptor Blockers (ARBs) and Combination Products	Cozaar	losartan tablet	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Angiotensin Receptor Blockers (ARBs) and Combination Products	Diovan	valsartan tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Angiotensin Receptor Blockers (ARBs) and Combination Products	Diovan HCT	valsartan/hydrochlorothiazide tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Angiotensin Receptor Blockers (ARBs) and Combination Products	Exforge	valsartan/amlodipine tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Angiotensin Receptor Blockers (ARBs) and Combination Products	Exforge HCT	valsartan/amlodipine/hydrochlorothiazide tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Angiotensin Receptor Blockers (ARBs) and Combination Products	Hyzaar	losartan/hydrochlorothiazide tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Angiotensin Receptor Blockers (ARBs) and Combination Products	Micardis	telmisartan tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Angiotensin Receptor Blockers (ARBs) and Combination Products	Micardis HCT	telmisartan/hydrochlorothiazide tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Angiotensin Receptor Blockers (ARBs) and Combination Products	Tribenzor	olmesartan/amlodipine/hydrochlorothiazide tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	

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Anti-arrhythmic agents	Norpace and disopyramide capsules	disopyramide phosphate capsules	**1.** Approve if the patient has tried two other anti-arrhythmic agents (e.g., amiodarone, quinidine, sotalol). **2.** Approve if the patient has already been started on therapy with disopyramide (Norpace, generics) or Norpace CR.	1 year	Yes	Yes
Anti-arrhythmic agents	Norpace CR	disopyramide extended-release capsule	**1.** Approve if the patient has tried two other anti-arrhythmic agents (e.g., amiodarone, quinidine, sotalol). **2.** Approve if the patient has already been started on therapy with disopyramide (Norpace, generics) or Norpace CR.	1 year	Yes	Yes
Antibiotics (Inhaled)	TOBI	tobramycin solution for inhalation	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Antibiotics (Oral)	Doryx DR 80 mg and authorized generic	doxycycline hyclate delayed-release tablets	**1.** Direct patient to other doxycycline products. **2.** Approve if, per the prescriber, the 80 mg tablet is required to meet the prescribed dosing requirement.	1 year	Yes	
Antibiotics (Oral)	Doryx MPC	doxycycline hyclate tablet, delayed-release	**1.** Direct patient to other doxycycline products. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use a generic doxycycline product.	1 year	Yes	
Antibiotics (Oral)	Likmez	metronidazole oral suspension	**1.** Direct the patient to metronidazole tablets. **2.** Approve if the patient is unable to swallow tablets or has difficulty swallowing tablets.	1 year	Yes	
Antibiotics (Oral)	Sivextro	tedizolid phosphate tablets	**1.** Approve if the patient has tried linezolid tablets or oral suspension (Zyvox, generics), if formulary. If none are formulary, approve. **2.** Approve if the patient is currently taking a medication that interacts with linezolid (Zyvox, generics) [e.g., monoamine oxidase inhibitors {MAOIs} or selective serotonin reuptake inhibitors {SSRIs}]. **3.** Approve if the patient is being treated for an organism that is resistant to linezolid (Zyvox, generics), but sensitive to Sivextro. **4.** Approve if the patient has been started on a course of therapy with Sivextro (to allow for completion of a course of therapy).	1 year	Yes	
Antibiotics (Oral)	Firvanq and authorized generic vancomycin oral solution	vancomycin oral solution	**1.** Approve if the patient has tried vancomycin capsules (Vancocin oral capsule, generics) or vancomycin oral solution (Vancocin oral solution, generics), if formulary. If neither are formulary, approve. **2.** If the patient is unable to swallow or has difficulty swallowing capsules, approve if the patient has tried vancomycin oral solution (Vancocin oral solution, generics), if formulary. If vancomycin oral solution is non-formulary, approve.	1 year	Yes	
Antibiotics (Oral)	Minolira and authorized generic	minocycline ER tablet	Approve if the patient has tried minocycline extended-release tablets (Solodyn, generics), if formulary. If none are formulary, approve.	1 year	Yes - Authorized generic	
Antibiotics (Oral)	Ximino and authorized generic	minocycyline ER capsule	Approve if the patient has tried minocycline extended-release tablets (Solodyn, generics), if formulary. If none are formulary, approve	1 year	Yes	
Antibiotics (Oral)	Nitrofurantoin 50 mg/5 ml suspension (brand)	nitrofurantoin 50 mg/5 ml suspension	**1.** Direct to nitrofurantoin 25 mg/5 ml oral suspension. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use the nitrofurantoin 25 mg/5 ml oral suspension.	1 year	Yes	
Antibiotics (Oral)	Doryx 50 mg, 200 mg	doxycycline hyclate delayed-release tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Anticoagulants (Oral)	Pradaxa	dabigatran etexilate mesylate capsules	**1.** Approve if the patient has tried one of dabigatran capsules, Eliquis, Savaysa, or Xarelto, if one is formulary **[documentation required]**. If none are formulary, approve. **2.** Patient is less than (<) 18 years of age: approve if the patient has tried Xarelto (tablets or oral suspension) **[documentation required]**, if formulary. If neither are formulary, approve. **3.** Patients currently receiving Pradaxa for treatment of thrombosis (e.g., deep vein thrombosis [DVT] or pulmonary embolism [PE]), approve. **4.** Patients currently receiving Pradaxa for prophylaxis of DVT or PE after orthopedic surgery (e.g., hip or knee replacement surgery), approve.	1 year	Yes	
Anticoagulants (Oral)	Pradaxa oral pellets	dabigatran oral pellets	**1.** Regardless of the patient's age, approve if the patient is currently receiving Pradaxa (oral pellets or tablets) for treatment of thrombosis (e.g., deep vein thrombosis [DVT] or pulmonary embolism [PE]). **2.** Patient is ≥ 8 years of age and < 12 years of age, approve if the patient meets one of the following (A or B): A. Patient has tried dabigatran capsules (Pradaxa, generics) **[documentation required]**, if formulary. If dabigatran capsules (Pradaxa, generics) are non-formulary, approve; OR B. Patient is not able to swallow capsules, approve if the patient has tried Xarelto (tablets or oral suspension) **[documentation required]**, if formulary. If neither are formulary, approve. **3.** Patient is < 8 years of age, approve if the patient has tried Xarelto (tablets or oral suspension) **[documentation required]**, if formulary. If neither are formulary, approve.	1 year	Yes	
Anticoagulants (Oral)	Savaysa	edoxaban tablets	**1.** Approve if the patient has tried one of the following, if one is formulary: dabigatran (Pradaxa, generics), Xarelto, or Eliquis **[documentation required]**. If none are formulary, approve. **2.** Patients currently receiving Savaysa for treatment of thrombosis (e.g., deep vein thrombosis [DVT] or pulmonary embolism [PE]), approve. **3.** Patients using Savaysa for treatment of DVT or PE associated with cancer: approve if the patient has tried Eliquis **[documentation required]**, if formulary. If Eliquis is non-formulary, approve. **4.** Patients currently receiving Savaysa for prophylaxis of DVT or PE after orthopedic surgery (e.g., hip replacement surgery), approve.	1 year	Yes	
Antidepressants - Other	Forfivo XL and authorized generic	bupropion hydrochloride extended-release tablets	**1.** Patient is directed to bupropion hydrochloride XL 150 mg and/or 300 mg tablets (Wellbutrin XL, generics). **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use the buproprion hydrochloride XL 150 mg and/or 300 mg tablets (Wellbutrin XL, generics).	1 year	Yes	
Antidepressants - Other	Aplenzin	bupropion hydrobromide extended-release tablets	Approve if the patient has tried one product from the following list: bupropion hydrochloride extended-release tablets (Wellbutrin XL, generics), if formulary. If bupropion hydrochloride extended-release tablets (Wellbutrin XL, generics) are non-formulary, approve.	1 year	Yes	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Antidepressants - Other	Wellbutrin SR	bupropion HCl tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Antidepressants - Other	Wellbutrin XL	bupropion XL tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Antiemetic Agents - Substance P/Neurokinin-1 (NK1) receptor antagonists (Injectable)	Cinvanti IV	aprepitant injectable emulsion	**1.** Approve if the patient has tried ONE of fosaprepitant dimeglumine injection (IV) [Emend IV, generics] or Focinvez IV, if formulary. If neither are formulary, approve. **2.** In patients with hypersensitivities to polysorbate 80, approve if the patient has tried Focinvez IV, if formulary. If Focinvez IV is non-formulary, approve. **3.** Approve if the patient has already started Cinvanti IV to complete all cycles in the current course of chemotherapy.	1 year	Yes	
Antiemetic Agents - Substance P/Neurokinin-1 (NK1) receptor antagonists (Injectable)	Emend IV	fosaprepitant dimeglumine injection	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Antiemetic Agents - Substance P/Neurokinin-1 (NK1) receptor antagonists (Injectable)	Focinvez IV	fosaprepitant intravenous infusion	**1.** Approve if the patient has tried ONE of generic fosaprepitant dimeglumine injection (IV) [Emend IV, generics] or Cinvanti IV, if formulary. If neither are formulary, approve. **2.** Patients < 18 years of age, approve if the patient has tried fosaprepitant dimeglumine IV (Emend IV, generics), if formulary. If fosaprepitant dimeglumine IV (Emend IV, generics) are non-formulary, approve. **3.** In patients with hypersensitivities to polysorbate 80, approve if the patient has tried Cinvanti IV, if formulary. If Cinvanti IV is non-formulary, approve. **4.** Approve if the patient has already started Focinvez IV to complete all cycles in the current course of chemotherapy.	1 year	Yes	
Antiemetic Agents - Combination Substance P/NK1 receptor antagonist and serotonin (5-HT3) receptor antagonist. (Oral)	Akynzeo capsules	netupitant/palonsetron capsules	Approve if the patient meets ONE of the following (1 or 2): **1.** Patient meets BOTH of the following (A and B): A. Patient has tried two formulary oral or transdermal serotonin 5-HT3 receptor antagonists from the following list (if two are formulary or one if one is formulary): ondansetron oral (generics), granisetron oral (generics), or Sancuso; AND B. Patient has tried one oral formulary Substance P/NK1 antagonists from the following list: aprepitant capsules (Emend, generics) or Varubi tablets, if one is formulary; OR Note: If there are no formulary 5-HT3 receptor antagonists, approve. If there are no Substance P/NK1 antagonists, approve. **2.** Approve if the patient has already started Akynzeo to complete all cycles in the current course of chemotherapy.	1 year	Yes	
Antiemetics - Serotonin (5-HT3) Receptor Antagonists (Oral)	ondansetron ODT 16 mg (brand)	ondansetron ODT 16 mg	Approve if the patient has tried ondansetron ODT 4 mg or ondansetron ODT 8 mg AND is unable to continue to use these products. If both ondansetron ODT 4 mg and ondansetron ODT 8 mg are non-formulary, approve.	1 year	Yes	
Antiemetics - Serotonin Receptor Antagonists (Oral and Inejctable)	Anzemet tablets	dolasetron tablets	**1.** Approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with BOTH of the following: 1) granisetron tablets (generics) and 2) ondansetron tablets (generics), if formulary (or only one if one is formulary). If neither are formulary, approve. **2.** Patient < 18 years of age, approve if the patient tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with ondansetron tablets (generics), if formulary. If ondansetron tablets (generics) are non-formulary, approve. 3. Approve if the patient has already started Anzemet to complete all cycles in the current course of chemotherapy.	1 year	Yes	
Antiemetics and Antivertigo Agents	Emend oral suspension	aprepitant oral suspension	**1.** Approve if the patient has tried one formulary alternative from the following list: aprepitant capsules (Emend, generics) or Varubi tablets. If none are formulary, approve. **2.** Patients ≥ 12 and <18 years of age: approve if the patient has tried aprepitant capsules (Emend, generics), if formulary. If aprepitant capsules (Emend, generics) are non-formulary, approve. **3.** Patients < 12 years of age: approve. **4.** Patients who cannot swallow or have difficulty swallowing capsules, approve. **5.** Approve if the patient has already started Emend oral suspension to complete all cycles in the current course of chemotherapy.	1 year	Yes	
Antiemetics and Antivertigo Agents	Bonjesta	doxylamine succinate and pyridoxine hydrochloride extended-release tablets	Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with doxylamine-pyridoxine (Diclegis, generics), if formulary. If doxylamine-pyridoxine (Diclegis, generics) are non-formulary, approve if the patient has tried doxylamine AND pyridoxine (Vitamin B6).	1 year	Yes	
Antiemetics and Antivertigo Agents	Emend capsules and Emend Trifold Pack	aprepitant oral capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Antifungals (Oral)	Tolsura	itraconazole capsules	**1.** Approve if the patient has tried one of itraconazole capsules (Sporanox, generics) or itraconazole oral solution (Sporanox liquid, generics). **NOTE:** A trial of either the conventional intraconazole capsules or intraconazole solution would count toward meeting criteria regardless of the formulary status of the product. **2.** Patient has been started on a current course of therapy with Tolsura (for a non-oncychomycosis diagnosis): approve to complete the current course. **3.** Deny: If the patient is requesting Tolsura for a diagnosis of onychomycosis. **NOTE:** If the patient is requesting Tolsura for a diagnosis of onychomycosis, the request should be denied regardless of what the patient has tried for the current condition or if the patient has already been started on the product.	1 year	Yes	
Antifungals (Oral)	Noxafil tablets	posaconazole delayed-release tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Antifungals (Topical)	Ecoza foam	econazole nitrate topical foam	**1.** Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with four topical antifungals. **2.** If the patient has an occluded fungal infection, such as intertrigo or erosio interdigitalis blastomycetica, approve if the patient has tried and, according to the prescriber has experienced inadequate efficacy OR a significant intolerance with two topical antifungals. Note: Examples of topical antifungals include: naftifine 1% or 2% cream or 1% gel (Naftin, generics), Naftin 2% gel, Lotrimin Ultra (over-the-counter [OTC]), clotrimazole 1% cream (OTC formulation), econazole 1% cream, ketoconazole 2% cream or foam (Extina, generics), Oxistat 1% lotion, oxiconazole 1% cream (Oxistat, generics), Ertaczo 2% cream, Exelderm 1% cream or solution, ciclopirox 0.77% cream or gel (generics), Mentax 1% cream, Xolegel 2% gel.	1 year	Yes	
Antifungals (Topical)	Ertaczo	sertaconazole nitrate 2% cream	**1.** Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with four topical antifungals. **2.** If the patient has an occluded fungal infection, such as intertrigo or erosio interdigitalis blastomycetica, approve if the patient has tried and, according to the prescriber has experienced inadequate efficacy OR a significant intolerance with two topical antifungals. Note: Examples of topical antifungals include: naftifine 1% or 2% cream or 1% gel (Naftin, generics), Naftin 2% gel, Lotrimin Ultra (over-the-counter [OTC]), clotrimazole 1% cream (OTC formulation), econazole 1% cream, ketoconazole 2% cream or foam (Extina, generics), Oxistat 1% lotion, oxiconazole 1% cream (Oxistat, generics), Ecoza foam, Exelderm 1% cream or solution, ciclopirox 0.77% cream or gel (generics), Mentax 1% cream, Xolegel 2% gel.	1 year	Yes	
Antifungals (Topical)	Exelderm and authorized generic (sulconazole nitrate 1%)	sulconazole nitrate 1% (cream and solution)	**1.** Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with four topical antifungals. **2.** If the patient has an occluded fungal infection, such as intertrigo or erosio interdigitalis blastomycetica, approve if the patient has tried and, according to the prescriber has experienced inadequate efficacy OR a significant intolerance with two topical antifungals. Note: Example of topical antifungals include: naftifine 1% or 2% cream or 1% gel (Naftin, generics), Naftin 2% gel, Lotrimin Ultra (over-the-counter [OTC]), clotrimazole 1% cream (OTC formulation), econazole 1% cream, Ecoza 1% foam, ketoconazole 2% cream or foam (Extina, generics), Oxistat 1% lotion, oxiconazole 1% cream (Oxistat, generics), Ertaczo 2% cream, ciclopirox 0.77% cream or gel (generics), Luzu 1% cream, Mentax 1% cream, Xolegel 2% gel.	1 year	Yes - Authorized generic only	
Antifungals (Topical)	Luzu and authorized generic (luliconazole 1% cream)	luliconazole 1% cream	**1.** Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with four topical antifungals. **2.** If the patient has an occluded fungal infection, such as intertrigo or erosio interdigitalis blastomycetica, approve if the patient has tried and, according to the prescriber has experienced inadequate efficacy OR a significant intolerance with two topical antifungals. Note: Examples of topical antifungals include: naftifine 1% or 2% cream or 1% gel (Naftin, generics), Naftin 2% gel, Lotrimin Ultra (over-the-counter [OTC]), clotrimazole 1% cream (OTC formulation), econazole 1% cream, Ecoza 1% foam, ketoconazole 2% cream or foam (Extina, generics), Oxistat 1% lotion, oxiconazole 1% cream (Oxistat, generics), Ertaczo 2% cream, Exelderm 1% cream or solution, ciclopirox 0.77% cream or gel (generics), Mentax 1% cream, Xolegel 2% gel.	1 year	Yes	
Antifungals (Topical)	Oxistat lotion	oxiconazole nitrate lotion	**1.** Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with four topical antifungals. **2.** If the patient has an occluded fungal infection, such as intertrigo or erosio interdigitalis blastomycetica, approve if the patient has tried and, according to the prescriber has experienced inadequate efficacy OR a significant intolerance with two topical antifungals. Note: Examples of topical antifungals include: naftifine 1% or 2% cream or 1% gel (Naftin, generics), Naftin 2% gel, Lotrimin Ultra (over-the-counter [OTC]), clotrimazole 1% cream (OTC formulation), econazole 1% cream, ketoconazole 2% cream or foam (Extina, generics), oxiconazole 1% cream (Oxistat, generics), Ertaczo 2% cream, Exelderm 1% cream or solution, ciclopirox 0.77% cream or gel (generics), Mentax 1% cream, Xolegel 2% gel.	1 year	Yes	
Antifungals (Topical)	Xolegel	ketoconazole 2% gel	**1.** Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with four topical antifungals. **2.** If the patient has an occluded fungal infection, such as intertrigo or erosio interdigitalis blastomycetica, approve if the patient has tried and, according to the prescriber has experienced inadequate efficacy OR a significant intolerance with two topical antifungals. Note: naftifine 1% or 2% cream or 1% gel (Naftin, generics), Naftin 2% gel, Lotrimin Ultra (over-the-counter [OTC]), clotrimazole 1% cream (OTC formulation), econazole 1% cream, Ecoza 1% foam, ketoconazole 2% cream or foam (Extina, generics), Oxistat 1% lotion, oxiconazole 1% cream (Oxistat, generics), Ertaczo 2% cream, Exelderm 1% cream or solution, ciclopirox 0.77% cream or gel (generics), Luzu 1% cream, Mentax 1% cream.	1 year	Yes	
Antifungals (Topical)	Oxistat Cream	oxiconazole nitrate cream	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Antihistamines (oral) - First-generation	carbinoxamine maleate 4 mg/5 ml oral suspension (brand) [authorized generic of Karbinal ER] and Karbinal ER	carbinoxamine maleate 4 mg/5 ml oral suspension	**1.** Approve if the patient has tried five oral antihistamines (e.g., clemastine, diphenhydramine, chlorpheniramine, carbinoxamine [generic], hydroxyzine, cetirizine, loratadine). Note: OTC products would count toward meeting the requirement. **2.** If the patient is unable to swallow or has difficulty swallowing solid dosage forms, approve if the patient has tried at least two oral liquid antihistamines (e.g., carbinoxamine solution [generic], diphenhydramine solution, hydroxyzine solution or syrup, clemastine syrup, cetirizine solution, or loratadine solution or syrup). Note: OTC products would count toward meeting the requirement.	1 year	Yes	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Antimuscarinic Agents	Transderm-Scop	scopolamine patches	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Antiparkinson Drugs	Gocovri ER	amantadine extended-release capsules	Approve if the patient has tried one product from the following list: amantadine capsules, amantadine tablets, or amantadine oral solution AND meets one of the following (A or B): A. Patient derived benefit from immediate-release amantadine, but had intolerable adverse events, as determined by the prescriber **[documentation required]**; OR B. Patient could not achieve a high enough dosage to gain adequate benefit, as determined by the prescriber **[documentation required]**.	1 year	Yes	
Antiparkinson Drugs	Osmolex ER	amantadine extended-release tablets	Approve if the patient has tried one product from the following list: amantadine capsules, amantadine tablets, or amantadine oral solution AND meets one of the following (A or B): A. Patient derived benefit from immediate-release amantadine, but had intolerable adverse events, as determined by the prescriber **[documentation required]**; OR B. Patient could not achieve a high enough dosage to gain adequate benefit, as determined by the prescriber **[documentation required]**.	1 year	Yes	
Antiparkinson Drugs - Carbidopa and/or Levodopa Agents	Dhivy	carbidopa and levodopa immediate-release tablets	Approve if dose prescribed cannot be obtained withcarbidopa-levodopa tablets (Sinemet, generics) or half-tablets. Note: Dhivy can be split into a ¼ of a tablet (i.e., 6.25 mg of carbidopa and 25 mg of levodopa).	N/A	Yes	
Antiparkinson Drugs – Carbidopa and/or Levodopa Agents	Vyalev	foslevodopa-foscarbidopa subcutaneous infusion	**1.** Approve if the patient has tried one of the following: Crexont capsules, Rytary capsules, or carbidopa-levodopa extended-release tablets, if formulary. If none are formulary, approve. **2.** Approve if the patient is unable to swallow oral dosage forms or has difficulty swallowing oral dosage forms. **3.** Approve if the patient has already been started on therapy with Vyalev.	1 year	Yes	
Antiparkinson Drugs - Inhibitor of Monoamine Oxidase Type B Inhibitors	Xadago	safinamide tablets	**1.** Approve if the patient has tried two products from the following list, if formulary (or one if one is formulary): selegiline tablets/capsules, rasagiline tablets (Aziliect, generics), or Zelapar. If none are formulary, approve. **2.** Patients already started on Xadago, approve.	1 year	Yes	Yes
Antiparkinson Drugs - Inhibitor of Monoamine Oxidase Type B Inhibitors	Zelapar	selegiline orally disintegrating tablets	**1.** Approve if the patient has tried one product from the following list, if formulary (or one if one is formulary): selegiline tablets/capsules, rasagiline tablets (Azilect, generics), or Xadago. If none are formulary, approve. **2.** Approve if the patient cannot swallow or has difficulty swallowing selegiline tablets.	1 year	Yes	
Antiparkinson Drugs – Apomorphine products	Apokyn	apomorphine injection	See standard *Parkinsons Disease Apokyn Prior Authorization Policy* criteria	1 year	Yes	
Antiplatelet Agents	Plavix	clopidogrel bisulfaste tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Antiprotozoals (Oral)	Alinia tablets	nitazoxanide tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Antipsychotics (Long-Acting Injectables) – Risperidone or Paliperidone Based	Invega Hafyera	paliperidone palmitate extended-release injectable suspension	**1.** Approve if the patient has been established on therapy with Invega Sustenna for ≥ 4 months OR Invega Trinza for ≥ one 3-month cycle AND the prescriber attests the patient requires an extended dosing interval due to a demonstrated significant concern for non-adherence with a 4-week or 3-month dosing interval. **NOTE**: Invega Sustenna/Invega Trinza Formulary Exception Criteria will apply. **2.** Approve if the patient has already been started on therapy with Invega Hafyera.	1 year	Yes	Yes
Antipsychotics (Oral)	Quetiapine 150 mg tablets	quetiapine 150 mg tablet	**1.** Direct to quetiapine 50 mg and/or quetiapine 100 mg tablets. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use the quetiapine 50 mg and/or 100 mg tablet.	1 year	Yes	
Antipsychotics (Oral)	Fanapt	iloperidone tablets and titration pack	**1.** Approve if the patient has tried two oral antipsychotics (e.g., risperidone tablets/orally disintegrating tablets [ODT]{Risperdal, generics}, olanzapine tablets/ODT [Zyprexa/Zydis, generics], quetiapine tablets [Seroquel, generics], quetiapine extended-release tablets [Seroquel XR, generics], aripiprazole tablets [Abilify, generics], paliperidone ER tablets [Invega, generics], ziprasidone capsules [Geodon, generics], Latuda tablets, Rexulti tablets, Vraylar capsules, asenapine sublingual tablets [Saphris, generics], Caplyta). **2.** Approve if the patient is currently taking Fanapt. **3.** Approve if the patient has taken Fanapt at any time in the past.	1 year	Yes	Yes
Antipsychotics (Oral)	Latuda	lurasidone tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Antipsychotics (Oral)	Abilify	aripiprazole tablets and oral solution	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Antipsychotics (Oral)	Saphris	asenapine sublingual tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Antipsychotics (Oral)	Seroquel	quetiapine fumarate tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Antipsychotics (Oral)	Seroquel XR	quetiapine fumarate extended-release tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Antiseizure Medications	Eprontia	topiramate oral solution	Approve if the patient has tried and cannot take topiramate sprinkle capsules (Topamax Sprinkle capsules, generics). If topiramate sprinkle capsules (Topamax Sprinkle capsules, generics) are non-formulary, approve.	1 year	Yes	
Antiseizure Medications	Fintepla	fenfluramine oral solution	See standard *Antiepileptics – Fintepla Prior Authorization Policy* criteria.	1 year	Yes	Yes
Antiseizure Medications	Primidone 125 mg (brand)	primidone 125 mg tablet	Approve if the patient's prescribed dose cannot be obtained with primidone 50 mg or 250 mg tablets. Note: The patient is NOT required to split the 250 mg tablets in half.	1 year	Yes	
Antiseizure Medications	Vigafyde	vigabatrin oral solution	Approve if the patient tried and cannot take vigabatrin granules for oral solution (Sabril powder for solution, generics), if formulary. If vigabatrin granules for oral solution (Sabril powder for solution, generics) is non-formulary, approve.	1 year	Yes	
Antiseizure Medications	Motpoly XR	lacosamide extended-release capsules	Approve if the patient is unable to use lacosamide immediate-release tablets (Vimpat tablets, generics), if formulary. If lacosamide immediate-release tablets (Vimpat tablets, generics) are non-formulary, approve.	1 year	Yes	
Antiseizure Medications	Zonisade oral suspension	zonisamide oral suspension	Approve if the patient is unable to swallow or has difficulty swallowing zonisamide capsules. If zonisamide capsules are non-formulary, approve.	1 year	Yes	
Antiseizure Medications	Banzel	rufinamide tablets and oral suspension	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Antiseizure Medications	Keppra	levetiracetam tablets and solution	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Antiseizure Medications	Keppra XR	levetiracetam exteended-release tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Antiseizure Medications	Lamictal	lamotrigine tablets and chewable tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Antiseizure Medications	Lamictal ODT	lamotrigine oral disintegrating tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Antiseizure Medications	Lamictal XR	lamotrigine extended-release tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Antiseizure Medications	Onfi	clobazam tablets and suspension	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Antiseizure Medications	Sabril	vigabatrin tablets and powder packet	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Antiseizure Medications	Topamax	topiramate tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Antiseizure Medications	Trileptal	oxcarbazepine tablets and suspension	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Antiseizure Medications	Vimpat	lacosamide tablets and oral solution and vials	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Antiseizure Medications	Zonegran	zonisamide capsule	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Antiseizure Medications - Buccal	Libervant	diazepam buccal film strips	**1.** Approve if the patient has tried diazepam rectal gel (Diastat, generics), if formulary. If diazepam rectal gel (Diastat, generics) is non-formulary, approve. Note: If the patient has tried a benzodiazepine nasal spray (e.g., Valtoco or Nayzilam), this would satisfy the requirement for approval. **2.** If the patient's caregiver is unable to administer diazepam rectal gel (Diastat, generics), approve.	1 year	Yes	
Antivirals (Oral)	Sitavig	acyclovir buccal tablets	Approve if the patient has tried two of the following: acyclovir capsules/tablets, famciclovir tablets (generics), valacyclovir tablets (Valtrex, generics), penciclovir 1% cream (Denavir, generics), Xerese 5%/1% cream, acyclovir 5% cream (Zovirax 5% cream, generics), or over-the-counter (OTC) Abreva 10% cream.	1 year	Yes	
Antivirals (Oral)	Valtrex	valacyclovir HCl caplets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Antivirals (Topical)	Xerese	acyclovir and hydrocortisone cream, 5%/1%	Approve if the patient has tried two of the following: acyclovir capsules/tablets, famciclovir tablets (generics), valacyclovir tablets (Valtrex, generics), acyclovir 5% cream (Zovirax 5% cream, generics), penciclovir 1% cream (Denavir, generics), Sitavig tablets, or over-the-counter (OTC) Abreva 10% cream.	1 year	Yes	
Antivirals (Topical)	Zovirax ointment	acyclovir 5% ointment	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Aromatase inhibitor	Arimidex	anastrozole tablets	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. 1. For brand Arimidex requests, approve one of the following (A or B): A) The patient meets both of the following (i and ii): i. The requested brand non-formulary drug is being prescribed for the primary prevention of breast cancer for a post-menopausal patient aged 35 years or greater who is at increased risk of breast cancer and at low risk for adverse medication effects and who does NOT have a current or previous diagnosis of breast cancer or ductal carcinoma in situ (DCIS); AND ii. The patient meets one of the following (a or b): a. According to the prescriber, the brand product is being requested because the preferred bioequivalent generic product would not be as medically appropriate for the patient as the requested brand non-formulary drug; OR b. According to the prescriber, other formulary alternatives would not be as medically appropriate for the patient as the requested non-formulary drug.* B) The patient meets both of the following (i and ii): i. The requested brand non-formulary drug is being prescribed for a use OTHER THAN the primary prevention of breast cancer for a post-menopausal patient aged 35 years or greater who is at increased risk of breast cancer and at low risk for adverse medication effects and who does NOT have a current or previous diagnosis of breast cancer or ductal carcinoma in situ (DCIS); AND ii. The Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**. **2.** For generic anastrozole requests,** approve if the requested non-formulary drug is being prescribed for the primary prevention of breast cancer for a post-menopausal patient aged 35 years or greater who is at increased risk of breast cancer and at low risk for adverse medication effects and who does NOT have a current or previous diagnosis of breast cancer or ductal carcinoma in situ (DCIS) AND, according to the prescriber, other formulary alternatives would not be as medically appropriate for the patient as the requested non-formulary drug. *Applicable for clients who are not using Multi-Source Brand criteria. **Note: When compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required, these products would be reviewed under the Standard Commercial Default Criteria.	1 year	MSB Exclusion *This criteria applies only to the NPF	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Benign Prostatic Hyperplasia – Combination Agents	Entadfi	finasteride 5 mg and tadalafil 5 mg capsules	Benign Prostatic Hyperplasia (BPH). Approve if, according to the prescriber, the patient has a clinical reason they cannot take finasteride 5 mg and tadalafil 5 mg as separate agents.	1 year	Yes	
Benign Prostatic Hyperplasia (Alpha Blockers and 5-Alpha Reductase Inhibitors)	Avodart	dutasteride capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Benign Prostatic Hyperplasia (Alpha Blockers and 5-Alpha Reductase Inhibitors)	Rapaflo	silosodin capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Benign Prostatic Hyperplasia (Alpha Blockers and 5-Alpha Reductase Inhibitors)	Uroxatral	alfuzosin tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Benzodiazepines	Loreev XR	lorazepam extended-release capsules	**1.** Direct the patient to use lorazepam tablets. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use lorazepam immediate-release tablets.	1 year	Yes	
Benzodiazepines	Klonopin	clonazepam tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Benzodiazepines	Valium	diazepam tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Benzodiazepines	Xanax	alprazolam tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Benzodiazepines	Xanax XR	alprazolam entended-release tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Benzodiazepines	Doral and authorized generic	quazepam tablets	Approve if the patient has tried estazolam or lorazepam, if formulary. If neither are formulary, approve.	1 year	Yes	
Benzodiazepines and Combination Products	Librax	chlordiazepoxide/clidinium bromide capsules	Approve if the patient has tried clidinium-chlordiazepoxide capsules. If clidinium-chlordiazepoxide capsules are non-formulary, approve.	1 year	Yes *This criteria applies only to the NPF	
Beta-Blocker Products	Bystolic	nebivolol tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Beta-Blocker and Beta-Blocker Combination Products	Inderal XL	propranolol hydrochloride capsule, extended release	**1.** Direct the patient to propranolol extended-release capsules. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use generic propranolol extended-release capsules.	1 year	Yes	
Beta-Blocker and Beta-Blocker Combination Products	Innopran XL	propranolol hydrochloride capsule, extended release	**1.** Direct the patient to propranolol extended-release capsules. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use generic propranolol extended-release capsules.	1 year	Yes	
Beta-Blocker and Beta-Blocker Combination Products	Kapspargo Sprinkle	metoprolol succinate extended-release capsules	**1.** Approve if the patient has tried metoprolol succinate extended-release tablets, if formulary. If non-formulary, approve. **2.** If the patient requires a dosage form which can be opened and sprinkled for alternative administration (e.g., for patients unable to swallow capsules, for nasogastric tube administration), approve.	1 year	Yes	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Beta-Blocker and Beta-Blocker Combination Products	Inderal LA	propranolol HCl capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Beta-Blocker and Beta-Blocker Combination Products	Toprol XL	metoprolol succinate extended-release tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Bone Modifiers - Other	Evenity	romosozumab-aqqg injection for subcutaneous use	**1**. Approve if patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one of the following products: an oral bisphosphonate (e.g., alendronate [Fosamax, Fosamax Plus D, generics], ibandronate tablets [Boniva, generics], alendronate oral solution, Binosto, risedronate [Actonel, Atelvia, generics], a teriparatide product (i.e., Forteo, teriparatide), Tymlos, or Prolia. **2**. Patient has already tried ibandronate injection (Boniva IV) or zoledronic acid injection (Reclast): approve. **3**. According to the prescriber, patient has severe renal impairment or chronic kidney disease: approve. Note: An example of severe renal impairment is a creatinine clearance < 35 mL/min). **4**. Patients who have had an osteoporotic fracture or a fragility fracture: approve. **5**. Patients who cannot swallow or has difficulty swallowing tablets, cannot remain in an upright position (post oral bisphosphonate administration), or has a pre-existing gastrointestinal medical condition: approve. Note: Examples of pre-existing gastrointestinal medical conditions include esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia].	1 year	Yes	
Bone Modifiers - Other	Prolia	denosumab injection for subcutaneous use	**1**. Approve if patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one of the following products: an oral bisphosphonate (e.g., alendronate [Fosamax, Fosamax Plus D, generics], ibandronate tablets [Boniva, generics], alendronate oral solution, Binosto, risedronate [Actonel, Atelvia, generics, a teriparatide product (i.e., Forteo, teriparatide), Tymlos, or Evenity. **2**. Patient has already tried ibandronate injection (Boniva IV) or zoledronic acid injection (Reclast): approve. **3.** According to the prescriber, the patient has severe renal impairment or chronic kidney disease: approve Note: An example of severe renal impairment is a creatinine clearance < 35 mL/minute. **4**. Patients who have had an osteoporotic fracture or a fragility fracture: approve. **5**. Patients who cannot swallow or has difficulty swallowing tablets, cannot remain in an upright position post oral bisphosphonate administration, or has a pre-existing gastrointestinal medical condition: approve. Note: Examples of pre-existing gastrointestinal medical conditions include esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying (stricture, achalasia). **6**. Treatment of bone loss (to increase bone mass) in patients with nonmetastatic prostate cancer at high risk for fracture who are receiving androgen deprivation therapy OR has undergone bilateral orchiectomy): approve. Note: Examples of androgen deprivation therapy are: Lupron Depot [leuprolide for depot suspension], Eligard [leuprolide acetate for injectable suspension], Trelstar (triptorelin pamoate suspension injection), Zoladex (goserelin implant), Orgovyx (relugolix tablets). **7**. Treatment of bone loss in patients with prostate cancer receiving androgen deprivation therapy: approve. Note: Examples of androgen deprivation therapy include Lupron Depot [leuprolide for depot suspension], Eligard [leuprolide acetate for injectable suspension], Trelstar (triptorelin pamoate suspension injection), Zoladex (goserelin implant), Orgovyx (relugolix tablets). **8**. Treatment of bone loss (to increase bone mass) in patients with breast cancer at high risk for fracture receiving adjuvant aromatase inhibitor therapy: approve. Note: Examples of aromatase inhibitor therapy are anastrozole (Arimidex, generics), letrozole (Femara, generics), or exemestane (Aromasin, generics). **9**. Treatment to increase bone mineral density in patients with breast cancer: approve.	1 year	Yes	
Bone Modifiers - Other	Forteo	teriparatide injection	Approve if the patient has tried generic teriparatide (generic Forteo), if formulary. If generic teriparatide (generic Forteo) is non-formulary or if generic teriparatide (generic Forteo) is being requested, approve if the patient meets one of the following (1, 2, or 3): **1.** Approve if the patient has tried brand teriparatide, if formulary. If brand teriparatide is non-formulary, approve if patient has tried Tymlos, if formulary. If Tymlos is non-formulary, approve. **2.** Approve if the patient has tried brand teriparatide, if formulary. If brand teriparatide is non-formulary, patients with glucocorticoid-induced osteoporosis (GIO): approve. Note: For approvals above under criteria (1 and 2): Use of teriparatide (Forteo [generics] or teriparatide) exceeding 2 years during a patient's lifetime, approve if the patient is at high risk for fracture as determined by the prescriber. **3.** Approve if the patient has tried brand teriparatide, if formulary. If brand teriparatide is non-formulary, approve if the patient has a diagnosis of chronic hypoparathyroidism	1 year	Yes - Forteo brand	
Botulinum Toxin Products	Daxxify	daxibotulinumtoxinA-lanm for injection	Cervical Dystonia in a patient ≥ 18 years of age. Note: Cervical dystonia is also referred to as spasmodic torticollis. **1.** Approve if the patient has tried ONE of Botox, Dysport, or Xeomin, if formulary. If none are formulary, approve. **2.** Patient has a sensitivity or allergy to cow's milk protein, approve if the patient has tried one of Botox or Xeomin, if formulary. If neither are formulary, approve. **3.** Approve if the patient has already been started on therapy with Daxxify. Daxxify is not covered in the following situations: Cosmetic Uses. Note: Examples of cosmetic uses include facial rhytides, frown lines, glabellar wrinkling, horizontal neck rhytides, mid and lower face and neck rejuvenation, platsymal bands, or rejuvenation of the periorbital region.	1 year	Yes	Yes

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Botulinum Toxin Products	Xeomin	incobotulinumtoxinA for injection	Blepharospasm in a patient ≥ 18 years of age. Note: This includes blepharospasm associated with dystonia, benign essential blepharospasm, seventh (VII) nerve disorders. **1.** Approve if the patient has tried Botox, if formulary. If Botox is non-formulary, approve. **2.** Approve if the patient has already been started on therapy with Xeomin. Cervical Dystonia in a patient ≥ 18 years of age. Note: Cervical dystonia is also referred to as spasmodic torticollis. **1.** Approve if the patient has tried one of Botox, Dysport, or Daxxify, if formulary. If none are formulary, approve. **2.** Patient has a sensitivity or allergy to cow's milk protein, approve if the patient has tried one of Botox or Daxxify, if formulary. If neither are formulary approve. **3.** Approve if the patient has already been started on therapy with Xeomin. Spasticity, upper limb, in a patient ≥ 2 years of age. **1.** Approve if the patient has tried one of Botox or Dysport, if formulary. If neither are formulary, approve. **2.** Patient has a sensitivity or allergy to cow's milk protein, approve if the patient has tried Botox, if formulary. If Botox is non-formulary approve. 3. Approve if the patient has already been started on therapy with Xeomin. Sialorrhea, Chronic, in a patient ≥ 2 years of age. **1.** Approve if the patient has tried Myobloc, if formulary. If Myobloc is non-formulary, approve. **2.** Patient < 18 years of age, approve. **3.** Approve if the patient has already been started on therapy with Xeomin. Xeomin is not covered in the following situations: Cosmetic Uses. Note: Examples of cosmetic uses include facial rhytides, frown lines, glabellar wrinkling, horizontal neck rhytides, mid and lower face and neck rejuvenation, platsymal bands, or rejuvenation of the periorbital region.	1 year	Yes	Yes
Botulinum Toxin Products - Botox	Botox (NOT cosmetic) (1 of 2)	onabotulinumtoxinA for injection	Hyperhidrosis, Primary Axillary , in a patient ≥ 18 years of age. Approve if the patient has tried at least one prescription topical agent for axillary hyperhidrosis. Note: Examples of prescription topical agents for the treatment of axillary hyperhidrosis include Drysol (aluminum chloride 20% topical solution), Qbrexza (glycopyrronium cloth 2.4% for topical use), Sofdra (glycopyrronium 12.45% topical gel). Hyperhidrosis, Primary Palmar/Plantar and Facial , in a patient ≥ 18 years of age. Approve if the patient has tried at least one topical agent for the treatment of hyperhidrosis (e.g., aluminum chloride). Migraine Headache Prevention in a patient ≥ 18 years of age. **1.** Approve if the patient has tried one of Aimovig, Ajovy, Emgality, Vyepti, or Qulipta **[documentation required]**, if formulary. If none are formulary, approve. **2.** Approve if the patient has already been started on therapy with Botox. Blepharospasm in a patient ≥ 12 years of age. Note: This includes blepharospasm associated with dystonia, benign essential blepharospasm, seventh (VII) nerve disorders. **1.** Approve if the patient has tried Xeomin, if formulary. If Xeomin is non-formulary, approve. **2.** If the patient is < 18 years of age, approve. **3.** Approve if the patient has already been started on therapy with Botox. Strabismus in a patient ≥ 12 years of age: Approve. Note: Common types of strabismus include esotropia, exotropia, hypertropia, hypotropia. Cervical Dystonia in a patient ≥ 18 years of age. Note: Cervical dystonia is also referred to as spasmodic torticollis. **1.** Approve if the patient has tried one of Dysport, Xeomin, or Daxxify, if formulary. If none are formulary, approve. **2.** Patient has a sensitivity or allergy to cow's milk protein, approve if the patient has tried one of Xeomin or Daxxify, if formulary. If neither are formulary, approve. **3.** Approve if the patient has already been started on therapy with Botox. Spasticity, Limb(s), in a patient ≥ 2 years of age. **1.** Approve if the patient has tried one of Dysport or Xeomin, if formulary. If neither are formulary, approve. **2.** Patients with lower limb spasticity, approve if the patient has tried Dysport. If Dysport is non-formulary, approve. a. Patient has a sensitivity or allergy to cow's milk protein, approve. **3.** Patient has a sensitivity or allergy to cow's milk protein, approve if the patient has tried Xeomin, if formulary. If Xeomin is non-formulary, approve. **4.** Approve if the patient has already been started on therapy with Botox.	1 year	Yes	Yes

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Botulinum Toxin Products - Botox	Botox (NOT cosmetic) [2 of 2]	onabotulinumtoxinA for injection (continued)	<u>Sialorrhea, Chronic, in a patient ≥ 18 years of age</u>. **1.** Approve if the patient has tried one of Dysport, Xeomin, or Myobloc, if formulary. If none are formulary, approve. **2.** Patient has a sensitivity or allergy to cow's milk protein, approve if the patient has tried one of Xeomin or Myobloc, if formulary. If neither are formulary, approve. **3.** Approve if the patient has already been started on therapy with Botox. <u>Anal Fissure, Chronic, in a patient ≥ 18 years of age</u>. **1.** Approve if the patient has tried Dysport, if formulary. If Dysport is non-formulary, approve. **2.** Patient has a sensitivity or allergy to cow's milk protein, approve. **3.** Approve if the patient has already been started on therapy with Botox. <u>Hemifacial Spasm in a patient ≥ 18 years of age</u>. **1.** Approve if the patient has tried Dysport, if formulary. If Dysport is non-formulary, approve. **2.** Patient has a sensitivity or allergy to cow's milk protein, approve. **3.** Approve if the patient has already been started on therapy with Botox. <u>Oromandibular Dystonia in a patient ≥ 18 years of age.</u> 1. Approve if the patient has tried Dysport, if formulary. If Dysport is non-formulary, approve. 2. Approve if the patient has already been started on therapy with Botox. <u>Neurogenic Detrusor Overactivity in patient ≥ 5 years of age; Overactive Bladder with Symptoms of Urge Urinary Incontinence, Urgency, and Frequency in a patient ≥ 18 years of age; Urinary Incontinence Due to Detrusor Overactivity Associated with a Neurological Condition in a patient ≥ 18 years of age; Achalasia in a patient ≥ 18 years of age; Essential Tremor in a patient ≥ 18 years of age; Hyperhidrosis, Gustatory (also referred to as Frey's Syndrome) in a patient ≥ 18 years of age; Dystonia, Focal Upper Limb in a patient ≥ 18 years of age; Laryngeal Dystonia (Spasmodic Dysphonia) in a patient ≥ 18 years of age</u>: Approve. <u>Botox is not covered in the following situations: Cosmetic Uses</u>. <u>Note</u>: Examples of cosmetic uses include facial rhytides, frown lines, glabellar wrinkling, horizontal neck rhytides, mid and lower face and neck rejuvenation, platsymal bands, or rejuvenation of the periorbital region.	1 year (continued)	Yes	
Bowel Evacuants – Low Volume – Polyethylene Glycol (PEG)-based Preparations	Plenvu	polyethylene glycol; electrolytes; ascorbic acid powder for solution	<u>Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required</u>. Approve if the patient meets one of the following criteria (i <u>or</u> ii): i. Patient has tried PEG3350/Ascorbic Acid powder packet (Moviprep, generics). If PEG3350/Ascorbic Acid powder packet (Moviprep, generics) are non-formulary, approve; OR ii. Patients with phenylketonuria. OR <u>Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required</u>. Approve if the patient meets one of the following criteria (i, ii, <u>or</u> iii): i. Patient has tried PEG3350/Ascorbic Acid powder packet (Moviprep, generics). If PEG3350/Ascorbic Acid powder packet (Moviprep, generics) are non-formulary, approve; OR ii. Patients with phenylketonuria; OR iii. Patient meets both of the following (a <u>and</u> b): a. The requested non-formulary drug is being prescribed for bowel preparation as part of a colorectal cancer screening procedure in a patient between the ages of 45 years and 75 years old; AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 month	Yes	
Bowel Evacuants – Low Volume – Polyethylene Glycol (PEG)-based Preparations	Moviprep	PEG-3350, sodium sulfate, sodium chloride, potassium chloride, sodium ascorbate, ascorbic acid	<u>Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required</u>. **NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**. OR <u>Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required</u>. Approve one of the following (A <u>or</u> B): A. The patient meets both of the following (i <u>and</u> ii): i. The requested non-formulary drug is being prescribed for bowel preparation as part of a colorectal cancer screening procedure in a patient between the ages of 45 years and 75 years old; AND ii. According to the prescriber, the brand product is being requested because the preferred bioequivalent generic product would not be as medically appropriate for the patient as the requested brand non-formulary drug; OR B. The patient meets both of the following (i <u>and</u> ii): i. The requested non-formulary drug is being prescribed for a use OTHER THAN bowel preparation as part of a colorectal cancer screening procedure in a patient between the ages of 45 years and 75 years old; AND ii. The Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Bowel Evacuants – Low Volume – Sodium Picosulfate-based Preparations	Clenpiq	sodium picosulfate; magnesium oxide; anhydrous citric acid solution	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **1.** Approve if the patient meets one of the following (a or b): a. Patient has tried one of the following, if formulary: 1) PEG3350/Ascorbic Acid powder pack (Moviprep, generic) OR 2) Sod Sul-Potass Sul-Magnesium sol prep kit (Suprep, generic). If neither are formulary, approve; OR b. Patient is < 12 years of age. **2.** If only PEG3350/Ascorbic Acid powder (Moviprep, generic) is formulary, approve if the patient meets one of the following criteria (a, b, c, or d): a. Patient has tried PEG3350/Ascorbic Acid powder packet (Moviprep, generics). If PEG3350/Ascorbic Acid powder packet (Moviprep, generics) are non-formulary, approve; OR b. The patient is less than 18 years of age; OR c. Patients with phenylketonuria; OR d. Patients with glucose-6-phosphate dehydrogenase deficiency. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient meets one of the following (a or b): a. Patient has tried one of the following, if formulary: 1) PEG3350/Ascorbic Acid powder pack (Moviprep, generic) OR 2) Sod Sul-Potass Sul-Magnesium sol prep kit (Suprep, generic). If neither are formulary, approve; OR b. Patient is < 12 years of age. **2.** If only PEG3350/Ascorbic Acid powder (Moviprep, generic) is formulary, approve if the patient meets one of the following criteria (a, b, c, or d): a. Patient has tried PEG3350/Ascorbic Acid powder packet (Moviprep, generics). If PEG3350/Ascorbic Acid powder packet (Moviprep, generics) are non-formulary, approve; OR b. The patient is less than 18 years of age; OR c. Patients with phenylketonuria; OR d. Patients with glucose-6-phosphate dehydrogenase deficiency. **3.** Patient meets both of the following (a and b): a. The requested non-formulary drug is being prescribed for bowel preparation as part of a colorectal cancer screening procedure in a patient between the ages of 45 years and 75 years old; AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 month	Yes	
Bowel Evacuants – Low Volume – Sodium Sulfate-Based Preparations	Suprep	magnesium sulfate; potassium sulfate; sodium sulfate solution	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve one of the following (A or B): A. The patient meets both of the following (i and ii): i. The requested non-formulary drug is being prescribed for bowel preparation as part of a colorectal cancer screening procedure in a patient between the ages of 45 years and 75 years old; AND ii. According to the prescriber, the brand product is being requested because the preferred bioequivalent generic product would not be as medically appropriate for the patient as the requested brand non-formulary drug; OR B. The patient meets both of the following (i and ii): i. The requested non-formulary drug is being prescribed for a use OTHER THAN bowel preparation as part of a colorectal cancer screening procedure in a patient between the ages of 45 years and 75 years old; AND ii. The Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Bowel Evacuants – Low Volume – Polyethylene Glycol (PEG)-based Preparations	Suflave	polyethylene glycol 3350, sodium sulfate, potassium chloride, magnesium sulfate, and sodium chloride for oral solution	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **1.** Approve if the patient has tried one of the following, if formulary: 1) PEG3350/Ascorbic Acid powder pack (Moviprep, generic) OR 2) Sod Sul-Potass Sul-Magnesium sol prep kit (Suprep, generic). If neither are formulary, approve. **2.** If only PEG3350/Ascorbic Acid powder (Moviprep, generic) is formulary, approve if the patient meets one of the following criteria (a, b, or c): a. Patient has tried PEG3350/Ascorbic Acid powder packet (Moviprep, generics). If PEG3350/Ascorbic Acid powder packet (Moviprep, generics) are non-formulary, approve; OR b. Patients with phenylketonuria; OR c. Patients with glucose-6-phosphate dehydrogenase deficiency. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient has tried one of the following, if formulary: 1) PEG3350/Ascorbic Acid powder pack (Moviprep, generic) OR 2) Sod Sul-Potass Sul-Magnesium sol prep kit (Suprep, generic). If neither are formulary, approve. **2.** If only PEG3350/Ascorbic Acid powder (Moviprep, generic) is formulary, approve if the patient meets one of the following criteria (a, b, or c): a. Patient has tried PEG3350/Ascorbic Acid powder packet (Moviprep, generics). If PEG3350/Ascorbic Acid powder packet (Moviprep, generics) are non-formulary, approve; OR b. Patients with phenylketonuria; OR c. Patients with glucose-6-phosphate dehydrogenase deficiency. **3.** Patient meets both of the following (a and b): a. The requested non-formulary drug is being prescribed for bowel preparation as part of a colorectal cancer screening procedure in a patient between the ages of 45 years and 75 years old; AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 month	Yes	
Bowel Evacuants – Low Volume – Sodium Sulfate-based Preparations	Sutab	sodium sulfate, magnesium sulfate, and potassium chloride tablets	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **1.** Approve if the patient has tried one of the following, if formulary: 1) PEG3350/Ascorbic Acid powder pack (Moviprep, generic) OR 2) Sod Sul-Potass Sul-Magnesium sol prep kit (Suprep, generic). If neither are formulary, approve. **2.** If only PEG3350/Ascorbic Acid powder (Moviprep, generic) is formulary, approve if the patient meets one of the following criteria (a, b, or c): a. Patient has tried PEG3350/Ascorbic Acid powder packet (Moviprep, generics). If PEG3350/Ascorbic Acid powder packet (Moviprep, generics) are non-formulary, approve; OR b. Patients with phenylketonuria; OR c. Patients with glucose-6-phosphate dehydrogenase deficiency. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient has tried one of the following, if formulary: 1) PEG3350/Ascorbic Acid powder pack (Moviprep, generic) OR 2) Sod Sul-Potass Sul-Magnesium sol prep kit (Suprep, generic). If neither are formulary, approve. **2.** If only PEG3350/Ascorbic Acid powder (Moviprep, generic) is formulary, approve if the patient meets one of the following criteria (a, b, or c): a. Patient has tried PEG3350/Ascorbic Acid powder packet (Moviprep, generics). If PEG3350/Ascorbic Acid powder packet (Moviprep, generics) are non-formulary, approve; OR b. Patients with phenylketonuria; OR c. Patients with glucose-6-phosphate dehydrogenase deficiency. **3.** Patient meets both of the following (a and b): a. The requested non-formulary drug is being prescribed for bowel preparation as part of a colorectal cancer screening procedure in a patient between the ages of 45 years and 75 years old; AND b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 month	Yes	
Calcium Channel Blockers (CCBs)	Conjupri and levamlodipine	levamlodipine tablets	**1.** Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with four formulary products from the following list: amlodipine, felodipine, nifedipine LA, nisoldipine (if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary). **2.** If the patient is < 18 years of age, approve if the patient has tried amlodipine, if formulary. If amlodipine is non-formulary, approve.	1 year	Yes	
Calcium Channel Blockers (CCBs)	Katerzia	amlodipine oral suspension	**1.** Direct the patient to amlodipine tablets. **2.** If the patient is unable to swallow or has difficulty swallowing amlodipine tablets, approve if the patient has tried Norliqva oral solution, if formulary. If Norliqva oral solution is non-formulary, approve..	1 year	Yes	
Calcium Channel Blockers (CCBs)	Norliqva	amlodipine oral solution	**1.** Direct the patient to amlodipine tablets. **2.** If the patient is unable to swallow or has difficulty swallowing amlodipine tablets, approve if the patient has tried Katerzia oral suspension, if formulary. If Katerzia oral suspension is non-formulary, approve.	1 year	Yes	
Calcium Channel Blockers (CCBs)	Norvasc	amlodipine tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Cancer (Oral) – FMS-Like Tyrosine Kinase 3 Inhibitors for AML	Vanflyta	quizartinib tablets	FLT3-ITD Mutation-positive Acute Myeloid Leukemia. **1.** Approve if the patient has tried Rydapt. If Rydapt is non-formulary, approve. **2.** If Vanflyta is being used in the maintenance setting, approve. Note: The maintenance setting is therapy after consolidation chemotherapy. **3.** If, according to the prescriber, the patient has or is at risk for pulmonary toxicity, approve. **4.** Approve if the patient has already been started on Vanflyta therapy.	1 year	Yes	Yes

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Cancer (Oral) – Isocitrate Dehydrogenase-1 Inhibitors	Rezlidhia	olutasidenib capsules	Acute myeloid leukemia with isocitrate dehydrogenase-1 (IDH1) mutation positive disease in a patient ≥ 18 years of age. **1.** Approve if the patient has tried Tibsovo. If Tibsovo is non-formulary, approve. **2.** Approve if the patient has QTc prolongation OR is or will be taking medications that can prolong the QTc interval. **3.** Patients with Guillain-Barre, approve. **4.** Approve if the patient has already been started on Rezlidhia therapy.	1 year	Yes	Yes
Cancer (Oral) - Kinase Inhibitor of Vascular Endothelial Growth Factor Receptor	Fruzaqla	fruquintinib capsules	Appendiceal, Colon, or Rectal Cancer in a patient ≥ 18 years of age. **1.** Approve if the patient has tried Lonsurf. If Lonsurf is non-formulary, approve. **2.** According to the prescriber, the patient has or is at risk of myelosuppression, approve. **3.** Approve if the patient has already been started on therapy with Fruzaqla.	1 year	Yes	Yes
Cancer Agent – Multiple Myeloma Nuclear Export Inhibitor	Xpovio	selinexor tablets	**1.** Multiple Myeloma: Approve if the patient meets one of the following (i, ii, or iii): i. Patient has tried at least FOUR prior regimens for multiple myeloma; OR ii. Patient meets both of the following (a and b): a) Patient has tried at least ONE prior regimen for multiple myeloma; AND b) The medication will be taken in combination with bortezomib; OR iii. Patient meets both of the following (a and b): a) Patient has tried at least ONE prior regimen for multiple myeloma; AND b) The medication will be taken in combination with Darzalex (daratumumb infusion), Darzlaex Faspro (daratumumab and hyaluronidase-fihj injection), Kyprolis, or Pomalyst (pomalidomide capsules). Note: Examples of prior regimens include bortezomib/Revlimid (lenalidomide capsules)/dexamethasone, Kyprolis (carfilzomib infusion) / Revlimid/ dexamethasone, Darzalex (daratumumab injection)/bortezomib or Kyprolis/dexamethasone, or other regimens containing a proteasome inhibitor, immunomodulatory drug, and/or anti-CD38 monoclonal antibody. **2.** Diffuse Large B-Cell Lymphoma: approve if the patient has been treated with at least TWO prior systemic therapies. Note: This includes patients with histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma. **3.** Multiple Myeloma, Diffuse Large B-Cell Lymphoma: If the patient has already been started on Xpovio, approve.	1 year	Yes	Yes
Cancer Agent (Oral)	Targretin capsule	bexarotene capsule	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Cancer Agents – (Injectable) - Docetaxel intravenous infusion	Docivyx	docetaxel intravenous infusion	Approve if the patient has tried generic docetaxel. If generic decetaxel is non-formulary, approve.	1 year	Yes	
Cancer Agents - Acute myeloid leukemia (AML) Agents	Onureg	azacitadine tablets	Acute Myeloid Leukemia: Approve if the patient meets ONE of the following (1 OR 2): 1. Patient is ≥ 18 years of age and using the medication for post-remission maintenance; OR 2. The patient has been started on therapy with Onureg. Peripheral T-Cell Lymphoma: Approve.	1 year	Yes	Yes
Cancer Agents – Bendamustine Agents	Vivimusta	bendamustine hydrochloride intravenous infusion	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with one of bendamustine vial (Treanda, generics), Bendeka, bendamustine hydrochloride injection, or Belrapzo. If none are formulary, approve. **NOTE**: A trial of the requested agent would NOT count toward this requirement.	1 year	Yes	
Cancer Agents - Bevacizumab-containing Agents	Alymsys	bevacizumab-maly injection for intravenous infusion	**1.** Approve if the patient meets BOTH of the following (A and B): A. The patient has tried three of the following: Avastin, Mvasi, Vegzelma, or Zirabev, if three are formulary (or two if two are formulary or one if one is formulary). If none are formulary, approve; AND B. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. **2.** Patient has already been started on therapy with Alymsys: Approve.	1 year	Yes	Yes
Cancer Agents - Bevacizumab-containing Agents	Avastin	bevacizumab injection for intravenous use	**1.** Approve if the patient meets BOTH of the following (A and B): **A**. The patient has tried three of the following: Alymsys, Mvasi, Vegzelma, or Zirabev, if three are formulary (or two if two are formulary or one if one is formulary). If none are formulary, approve; AND **B**. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. **2**. Patient has already been started on therapy with Avastin: Approve.	1 year	Yes	Yes
Cancer Agents - Bevacizumab-containing Agents	Vegzelma	bevacizumab-adcd intravenous infusion	**1.** Approve if the patient meets BOTH of the following (A and B): A. The patient has tried three of the following: Alymsys, Avastin, Mvasi, or Zirabev, if three are formulary (or two if two are formulary or one if one is formulary). If none are formulary, approve; AND B. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. **2.** Patient has already been started on therapy with Vegzelma: Approve.	1 year	Yes	Yes

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Cancer Agents – Bispecific Antibodies for B-Cell Lymphomas	Columvi	glofitamab intravenous infusion	Diffuse Large B-Cell Lymphoma. Note: Examples of diffuse large B-cell lymphoma (DLBCL) include DLBCL not otherwise specified, high-grade B-cell lymphoma, and DLBCL arising from indolent lymphoma. Approve if the patient meets ONE of the following (1 or 2): **1.** Patient has tried Epkinly. If Epkinly is non-formulary, approve; OR **2.** Patient has already been started on therapy with Columvi. Human Immunodeficiency Virus (HIV)-Related B-Cell Lymphomas Note: HIV-related B-cell lymphomas includes HIV-related diffuse large B-cell lymphoma (DLBCL), primary effusion lymphoma, and human herpes virus-8 (HHV8) positive DLBCL. :Post-Transplant Lymphoproliferative Disorders: Approve.	1 year	Yes	Yes
Cancer Agents – Bispecific Antibodies for B-Cell Lymphomas	Epkinly	epcoritamab-bysp subcutaneous injection	Diffuse Large B-Cell Lymphoma. Note: Examples of diffuse large B-cell lymphoma (DLBCL) include DLBCL not otherwise specified, DLBCL arising from indolent lymphoma, and high-grade B-cell lymphoma. Approve if the patient meets ONE of the following: (1, 2, 3, or 4): **1.** Patient has tried Columvi. If Columvi is non-formulary, approve; OR **2.** Patient is not a candidate for Gazyva (obinutuzumab); OR **3.** Patient is unable to obtain and/or maintain intravenous access; OR **4.** Patient has already been started on therapy with Epkinly. Follicular Lymphoma. Approve if the patient meets ONE of the following: (1, 2, or 3): **1.** Patient has tried Lunsumio. If Lunsumio is non-formulary, approve; OR **2.** Patient is unable to obtain and/or maintain intravenous access; OR **3.** Patient has already been started on therapy with Epkinly. Human Immunodeficiency Virus (HIV)-Related B-Cell Lymphomas Note: HIV-related B-cell lymphomas includes HIV-related diffuse large B-cell lymphoma (DLBCL), primary effusion lymphoma, and human herpes virus-8 (HHV8) positive DLBCL. :Post-Transplant Lymphoproliferative Disorders: Approve.	1 year	Yes	Yes
Cancer Agents - Bruton Tyrosine Kinase Inhibitors	Jaypirca	pirtobrutinib tablets	Mantle cell lymphoma. **1.** Approve if the patient has tried one of Brukinsa or Calquence. If neither are formulary, approve. **2.** Patient has already been started on Jaypirca therapy, approve. Chronic Lymphocytic Leukemia, Small Lymphocytic Lymphoma. **1.** Approve if the meets BOTH of the following (A and B): A. Patient has tried one of Brukinsa or Calquence; AND Note: If the patient had tried Imbruvia, this would also satisfy criterion A. Note: If neither Brukinsa nor Calquence are formulary, would still need to meet criterion B. B. Patient meets one of the following (i or ii): i. Patient has tried Venclexta; OR Note: If Venclexta is non-formulary, would still need to meet criterion A. ii. Patient is not a candidate for rituximab or Gazyva (obinutuzumab). **2.** Patient has already been started on Jaypirca therapy, approve. Richter's Transformation to Diffuse Large B-Cell Lymphoma; Marginal Zone Lymphoma: Approve. Note: Marginal zone lymphoma includes gastric mucosa-associated lymphoid tissue (MALT) lymphoma, non-gastric MALT lymphoma, nodal marginal zone lymphoma, and splenic marginal zone lymphoma.	1 year	Yes	Yes
Cancer Agents - Kirsten rat sarcoma (KRAS) inhibitor	Krazati	adagrasib tablets	Non-Small Cell Lung Cancer - KRAS G12C-mutated. **1.** Approve if the patient has tried Lumakras. If Lumakras is non-formulary, approve. **2.** Patient with brain metastases, approve. **3.** Approve if the patient has already been started on therapy with Krazati. Colon or Rectal Cancer - KRAS G12C-mutated: Approve.	1 year	Yes	Yes
Cancer Agents - NSCLC (Oral) -MET receptor tyrosine kinase inhibitor	Tepmetko	tepotinib tablets	Non-Small Cell Lung Cancer (NSCLC) with mesenchymal-epithelial transition (MET) exon 14 skipping alterations or high-level MET amplification: **1.** Approve if the patient has tried Tabrecta. If Tabrecta is non-formulary, approve. **2.** Approve if the patient has already been started on Tepmetko.	1 year	Yes	Yes
Cancer Agents - PARP inhibitor/Prostate Cancer Agent	Akeega	niraparib and abiraterone acetate tablets	BRCA-mutated Prostate Cancer. **1.** Approve if the patient has tried ONE of the following: 1) Lynparza +/- abiraterone or 2) Talzenna plus Xtandi. Note: If either medication in the regimens above are non-formulary, then that regimen does not need to be tried. Note: If Lynparza is non-formulary, approve. **2.** Approve if the patient has already been started on therapy with Akeega.	1 year	Yes	Yes

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Cancer Agents - PARP Inhibitors (oral)	Rubraca	rucaparib tablets	**1.** Ovarian, Fallopian Tube, or Primary Peritoneal Cancer in the Maintenance setting (after complete or partial response to chemotherapy): Approve if the patient meets one of the following criteria (A or B): A) Patient has tried one of Zejula or Lynparza. If neither are formulary, approve; OR B) Patient has already started on Rubraca. **2.** Prostate cancer: Approve if the patient meets one of the following criteria (A or B): A) Patient has tried Lynparza. If Lynparza is non-formulary, approve; OR B) Patient has already started on Rubraca. **3.** Uterine Leiomyosarcoma: Approve if the patient meets one of the following (A or B): A) Patient has tried one of Zejula or Lynparza. If neither is formulary, approve; OR B) Patient has already started on Rubraca. **4.** Pancreatic Adenocarcinoma: approve.	1 year	Yes- 7/1	Yes
Cancer Agents - PARP Inhibitors (oral)	Zejula	niraparib capsules and tablets	**1.** Ovarian, Fallopian Tube, or Primary Peritoneal Cancer in the Maintenance setting (after complete or partial response to chemotherapy): Approve if the patient meets one of the following (A or B): A) Patient meets one of the following (i or ii): i. Patient has tried Lynparza **[documentation required]**. If Lynparza is non-formulary, approve; OR ii. Patient has already been started on therapy with Zejula; OR B) Patient meets both of the following (i and ii): i. Patient has had a complete or partial response to first-line platinum-based chemotherapy; AND ii. Patient does not have a BRCA mutation **[documentation required]**. **2.** Uterine Leiomyosarcoma: Approve if the patient meets one of the following (A or B): A) Patient has tried one of Rubraca or Lynparza **[documentation required]**. If neither is formulary, approve; OR B) Patient has already started on Zejula.	1 year	Yes - 7/1	Yes
Cancer Agents - Prostate Cancer (Oral)	Zytiga	abiraterone acetate tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Cancer Agents - Renal Cell Carcinoma (Oral)	Fotivda	tivozanib capsules	Renal Cell Carcinoma. Approve if the patient meets one of the following (1, 2, or 3): **1.** Patient has tried one of Inlyta, Lenvima, or Cabometyx. If none are formulary, approve; OR **2.** If there are toxicity concerns with a trial of Lenvima (and other concomitantly given medications), according to the prescriber, approve if the patient has tried Inlyta or Cabometyx. If neither are formulary, approve; OR **3.** Patient has already been started on therapy with Fotivda.	1 year	Yes	Yes
Cancer Agents - Renal Cell Carcinoma (Oral)	Afinitor Disperz	everolimus tablets for oral suspension	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Cancer Agents - Renal Cell Carcinoma (Oral)	Afinitor tablet	everolimus tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Cancer Agents - Trastuzumab-containing Agents	Herceptin	trastuzumab for intravenous injection	**1.** Approve if the patient meets BOTH of the following (a and b): a. Patient has tried three products from the following list (if three are formulary or two if two are formulary or one if one is formulary): Kanjinti, Trazimera, Ogivri, Ontruzant, or Herzuma; AND Note: If none are formulary, approve. b. Patient cannot continue to use each of the alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. **2.** If the patient has already been started on therapy with Herceptin, approve.	1 year	Yes	Yes
Cancer Agents - Trastuzumab-containing Agents	Herceptin Hylecta	trastuzumab and hyaluronidase-oysk for subcutaneous use	**1.** Approve if the patient has tried one product from the following list (if one is formulary): Herceptin intravenous, Kanjinti, Trazimera, Ogivri, Ontruzant, or Herzuma. If none are formulary, approve. **2.** Approve if the patient is unable to obtain and/or maintain intravenous access. **3.** If the patient has already been started on therapy with Herceptin Hylecta, approve.	1 year	Yes	Yes
Cancer Agents - Trastuzumab-containing Agents	Herzuma	trastuzumab-pkrb for intravenous injection	**1.** Approve if patient meets BOTH of the following (a and b): a. Patient has tried three products from the following list (if three are formulary or two if two are formulary or one if one is formulary): Herceptin intravenous, Kanjinti, Ogivri, Ontruzant, or Trazimera; AND Note: If none are formulary, approve. b. Patient cannot continue to use each of the alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. **2.** If the patient has already been started on therapy with Herzuma, approve.	1 year	Yes	Yes
Cancer Agents - Trastuzumab-containing Agents	Ogivri	trastuzumab- dkst intravenous injection	**1.** Approve if the patient meets BOTH of the following (a and b): a. Patient has tried three products from the following list (if three are formulary or two if two are formulary or one if one is formulary): Herceptin intravenous, Trazimera, Kanjinti, Ontruzant, or Herzuma; AND Note: If none are formulary, approve. b. Patient cannot continue to use each of the alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. **2.** If the patient has already been started on therapy with Ogivri, approve.	1 year	Yes	Yes

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Cancer Agents - Trastuzumab-containing Agents	Ontruzant	trastuzumab-dttb for intravenous injection	**1.** Approve if the patient meets BOTH of the following (a and b): a. Patient has tried three products from the following list (if three are formulary or two if two are formulary or one if one is formulary): Kanjinti, Trazimera, Ogivri, Herzuma, or Herceptin intravenous; AND Note: If none are formulary, approve. b. Patient cannot continue to use each of the alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. **2.** If the patient has already been started on therapy with Ontruzant, approve.	1 year	Yes	Yes
Cancer Agents - Tyrosine Kinase Inhibitors	Qinlock	ripretinib tablets	Gastrointestinal stromal tumor. **1.** Approve if the patient has been previously treated with at least two other kinase inhibitors. Note: Examples of kinase inhibitors are imatinib (Gleevec), sunitinib (Sutent), Stivarga, sorafenib (Nexavar), pazopanib (Votrient), Tasigna, Sprycel, Ayvakit. **2.** Approve if the patient has already been started on therapy with Qinlock. Melanoma, Cutaneous. **1.** Approve if the patient meets all of the following (A, B and C): A. Patient has metastatic or unresectable disease; AND B. Patient has an activating KIT mutation; AND C. Patient has tried at least one systemic regimen. Note: Examples of a systemic regimen include: Opdivo (nivolumab intravenous infusion) + Yervoy (ipilimumab intravenous infusion), Opdivo + Opdualag (nivolumab/relatlimab-rmbw intravenous infusion), Keytruda (pembrolizumab intravenous infusion), Opdivo, Tafinlar (dabrafenib capsules) + Mekinist (trametinib tablets), Zelboraf (vemurafenib tablets) + Cotellic (cobimetinib tablets), Braftovi (encorafenib capsules) + Mektovi (binimetinib tablets). **2.** Approve if the patient has already been started on therapy with Qinlock.	1 year	Yes	Yes
Cancer Agents - Tyrosine Kinase Inhibitors	Gleevec	imatinib tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Carbonic Anhydrase Inhibitors	Keveyis and generics (including dichlorphenamide tablets, Ormalvi)	dichlorphenamide tablets	Approve if the patient has tried one of dichlorphenamide tablets or Ormalvi, if formulary. If BOTH dichlorphenamide tablets and Ormalvi are non-formulary, or generic dichlorphenamide or Ormalvi is being requested, approve if the patient meets one of the following (1 or 2): **1.** For the treatment of primary hyperkalemic periodic paralysis (HyperPP), primary hypokalemic periodic paralysis (HypoPP), and related variants: approve if the patient has tried one of acetazolamide tablets (generics) or acetazolamide ER capsules, if one is formulary. If neither are formulary, approve. **2.** For the treatment of primary hyperkalemic periodic paralysis (HyperPP), primary hypokalemic periodic paralysis (HypoPP), and related variants: approve if the patient has been started on therapy with Keveyis, Ormalvi or dichlorphenamide.	1 year	Yes - brand only	Yes
Cardiovascular Medications - Other	Aspruzyo Sprinkle	ranolazine extended-release granules	**1.** Approve if the patient meets one of the following (A or B): A. Patient is unable to or has difficulty swallowing ranolazine extended-release tablets (Ranexa, generics); OR B. Patient requires administration by nasogastric or gastrostomy/gastric tube. **2.** If ranolazine extended-release tablets (Ranexa, generics) are non-formulary, approve if the patient meets one of the following (A, B, or C): A. Patient has tried two of the following: beta blockers, calcium-channel blockers, or nitrates; OR Note: Two products in the same class would satisfy this criterion. B. Patient has difficulty swallowing oral dosage forms and is unable to try a beta-blocker, calcium-channel blocker, or a nitrate; OR C. Patient has already been started on a ranolazine product (e.g., Ranexa, Aspruzyo Sprinkle).	1 year	Yes	
Cardiovascular Medications - Other	Corlanor	ivabradine tablets and solution	If requesting brand Corlanor tablets or Corlanor solution, approve if the patient meets ONE of the following (1 or 2): **1.** Patient has tried and cannot take generic ivabradine tablets; OR **2.** Patient cannot swallow or has difficulty swallowing tablets, approve Corlanor solution. If requesting generic ivabradine tablets or generic ivabradine tablets are non-formulary, approve if the patient meets ONE of the following (1, 2, or 3): **1.** Patient has tried, or is currently receiving a beta-blocker (e.g., bisoprolol, carvedilol, metoprolol) OR the patient has a contraindication to beta-blockers; OR **2.** Heart failure due to dilated cardiomyopathy, approve if the patient is < 18 years of age; OR **3.** Patient has already been started on Corlanor or ivabradine.	1 year	Yes	Yes
Cardiovascular Medications - Other	BiDil	isosorbide dinitrate and hydralazine tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Cardiovascular Medications - Other	Tikosyn	dofetilide capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Central Nervous System Non-Stimulants	Onyda XR	clonidine hydrochloride extended-release oral suspension	**1.** Approve if the patient has tried clonidine ER tablets (generic of Kapvay), if formulary. If clonidine ER tablets (generic of Kapvay) is non-formulary, approve. **2.** Approve if the patient is unable to swallow tablets or has difficulty swallowing tablets.	1 year	Yes	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Central Nervous System Non-Stimulants	Intuniv	guanfacine HCl tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Central Nervous System Non-Stimulants	Strattera	atomoxetine HCl capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Central Nervous System Stimulants – Amphetamine Products	Dyanavel XR suspension	amphetamine extended-release oral suspension	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with three products (or two if two are formulary or one if one is formulary) from the following list: 1) amphetamine mixed extended-release (Er) capsules (Adderall XR, generics), or 2) Adzenys XR ODT tablets, or 3) lisdexamfetamine capsules (Vyvanse capsule, generics) or lisdexamfetamine chewable tablets (Vyvanse chewable tablet, generics). If none are formulary, approve.	1 year	Yes	
Central Nervous System Stimulants – Amphetamine Products	Dyanavel XR tablets	amphetamine extended-release tablets	**1.** Approve if the patient has tried Dyanavel XR oral suspension, if formulary. **2.** If Dyanavel XR oral suspension is non-formulary, approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with three products (or two if two are formulary or one if one is formulary) from the following list: 1) amphetamine mixed extended-release (Er) capsules (Adderall XR, generics), or 2) Adzenys XR ODT tablets, or 3) lisdexamfetamine capsules (Vyvanse capsule, generics) or lisdexamfetamine chewable tablets (Vyvanse chewable tablet, generics). If none are formulary, approve.	1 year	Yes	
Central Nervous System Stimulants – Amphetamine Products	Adderall	dextroamphetamine/amphetamine tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Central Nervous System Stimulants – Amphetamine Products	Adderall XR	dextroamphetamine/amphetamine extended-release capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Central Nervous System Stimulants – Amphetamine Products	Evekeo	amphetamine sulfate tablet	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Central Nervous System Stimulants – Methylphenidate Products	Quillivant XR	methylphenidate hydrochloride for extended-release oral suspension	**1.** Approve if the patient has tried QuilliChew ER tablets, if formulary. If QuilliChew ER tablets are non-formulary, approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with four products (or three if three are formulary, or two if two are formulary, or one if one is formulary) from the following list: 1) dexmethylphenidate extended-release capsules (Focalin XR, generics), 2) methylphenidate extended-release capsules (Aptensio XR, generics), 3) Jornay PM, 4) Azstarys. **2.** If the patient cannot swallow solid oral dosage forms or has difficulty swallowing solid oral dosage forms AND the patient is unable to ingest the prescribed dosage when using a product that can be opened and sprinkled on food, approve.	1 year	Yes	
Central Nervous System Stimulants – Methylphenidate Products	QuilliChew ER	methylphenidate HCl extended-release chewable tablets	Approve if the patient has tried Quillivant XR suspension, if formulary. If Quillivant XR suspension is non-formulary, approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with four products (or three if three are formulary, or two if two are formulary, or one if one is formulary) from the following list: 1) dexmethylphenidate extended-release capsules (Focalin XR, generics), 2) methylphenidate extended-release capsules (Aptensio XR, generics), 3) Jornay PM, 4) Azstarys.	1 year	Yes	
Central Nervous System Stimulants – Methylphenidate Products	Relexxii and authorized generic	methylphenidate ER tablet	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with five products (or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary) from the following list: 1) dexmethylphenidate extended-release capsules (Focalin XR, generics), 2) methylphenidate extended-release capsules (Aptensio XR, generics), 3) Jornay PM, or 4) Azstarys or 5) QuilliChew ER tablets or Quillivant XR suspension. Note: QuilliChew ER tablets and Quillivant XR suspension count as one alternative.	1 year	Yes	
Central Nervous System Stimulants – Methylphenidate Products	Aptensio XR	methylphenidate hydrochloride XR capsule	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Central Nervous System Stimulants – Methylphenidate Products	Concerta	methylphenidate hcl extended-release tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Central Nervous System Stimulants – Methylphenidate Products	Focalin and Focalin XR	dexmethylphenidate tablets and extended-release capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Central Nervous System Stimulants – Methylphenidate Products	Ritalin	methylphenidate tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Central Nervous System Stimulants – Methylphenidate Products	Ritalin LA	methylphenidate long-acting capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Central Nervous System Stimulants –Amphetamine Products	Xelstrym	dextroamphetamine transdermal system	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with three products, if formulary (or two if two are formulary or one if one is formulary) from the following list: 1) amphetamine mixed extended-release (Er) capsules (Adderall XR, generics), 2) Adzenys XR-ODT tablets, 3) lisdexamfetamine capsules (Vyvanse capsule, generics) or lisdexamfetamine chewable tablets (Vyvanse chewable tablet, generics) 4) Dyanavel XR oral suspension, or 5) dextroamphetamine extended-release capsules. If none are formulary, approve.	1 year	Yes	
Central Nervous System/Autonomic Drugs	Northera and generic droxidopa capsules	droxydopa capsules	Neurogenic Orthostatic Hypotension. Approve if the patient has tried two of the following products: 1) midodrine tablets, 2) fludrocortisone tablets, 3) dihydroergotamine injection/nasal spray, 4) indomethacin capsules/injection, 5) pyridostigmine tablets, or 6) atomoxetine.	1 year	Yes	
Central Nervous System/Autonomic Drugs	Sodium oxybate oral solution (AG to Xyrem) by AMNEAL	sodium oxybate oral solution	Cataplexy Treatment in Patients with Narcolepsy: Direct the patient to one of 1) Xyrem (brand) OR 2) sodium oxybate oral solution (by Hikma), if formulary. If neither are formulary, approve if the patient meets (1 or 2): **1.** Patients ≥ 18 years of age: approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with one of Lumryz, Xywav, or Wakix, if formulary. If none are formulary, approve. **2.** Patients ≥ 7 years of age and < 18 years of age: approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one of Lumryz or Xywav, if formulary. If neither are formulary, approve. Excessive Daytime Sleepiness in Patients with Narcolepsy: Direct the patient to one of 1) Xyrem (brand) OR 2) sodium oxybate oral solution (by Hikma), if formulary. If neither are formulary, approve if the patient (≥ 7 years of age) has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with one of Lumryz, Xywav, or Wakix, if formulary. If none are formulary, approve.	1 year	Yes	
Central Nervous System/Autonomic Drugs	Xyrem (brand)	sodium oxybate oral solution	Cataplexy Treatment in Patients with Narcolepsy: Direct the patient to one of 1) sodium oxybate oral solution (authorized generic of Xyrem) [by Hikma] OR 2) sodium oxybate oral solution (authorized generic of Xyrem) [by Amneal], if formulary. If neither are formulary, approve if the patient meets (1 or 2): **1.** Patients ≥ 18 years of age: approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with one of Lumryz, Xywav, or Wakix, if formulary. If none are formulary, approve. **2.** Patients ≥ 7 years of age and < 18 years of age: approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one of Lumryz or Xywav, if formulary. If neither are formulary, approve. Excessive Daytime Sleepiness in Patients with Narcolepsy: Direct the patient to one of 1) sodium oxybate oral solution (authorized generic of Xyrem) [by Hikma] OR 2) sodium oxybate oral solution (authorized generic of Xyrem) [by Amneal], if formulary. If neither are formulary, approve if the patient(≥ 7 years of age) has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with one of Lumryz, Xywav, or Wakix, if formulary. If none are formulary, approve.	1 year	Yes	
Chagas Disease Agents	Lampit	nifurtimox tablets	**1.** Approve if the patient has tried benznidazole, if formulary. If benznidazole is non-formulary, approve. **2.** Approve if the patient is less than 2 years of age. **3.** Approve if the patient has already started on therapy with Lampit.	1 year	Yes	Yes
Chelating Agents	Exjade	deferasirox tablets for oral suspension	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Chelating Agents	Jadenu	deferasirox tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Chelating Agents	Jadenu Sprinkles	deferasirox oral granules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Chelating Agents - Wilson's Disease	Cuprimine	penicillamine capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Chelating Agents - Wilson's Disease	trientine 500 mg capsules	trientine 500 mg capsules	Approve if the patient has tried generic trientine 250 mg capsules, if formulary. If generic trientine 250 mg capsules are non-formulary, approve if the patient meets one of the following: **1.** Approve if the patient has tried one penicillamine product: penicillamine (Cuprimine, generics) or penicillamine (Depen, generics), if one is formulary. If neither are formulary, approve. **2.** Approve if per the prescriber, the patient is intolerant to penicillamine or the patient has clinical features indicating the potential for intolerance to penicillamine (i.e., history of any renal disease, congestive splenomegaly causing severe thrombocytopenia, autoimmune tendency). **3.** Approve if, per the prescriber, the patient has a contraindication to penicillamine. **4.** Approve if the patient has neurological manifestations of Wilson's Disease. **5.** Approve if the patient is pregnant. **6.** Approve if the patient has been started on therapy with a trientine product.	1 year	Yes	
Chelating Agets - Wilson's Disease	Cuvrior	trientine tetrahydrochloride 300 mg tablets	Approve if the patient has tried trientine capsules (Syprine, generics), if formulary. If trientine capsules (Syprine, generics) are non-formulary, approve if the patient meets one of the following: **1.** Approve if the patient has tried one penicillamine product: penicillamine (Cuprimine, generics) or penicillamine (Depen, generics), if one is formulary. If neither are formulary, approve. **2.** Approve if per the prescriber, the patient is intolerant to penicillamine or the patient has clinical features indicating the potential for intolerance to penicillamine (i.e., history of any renal disease, congestive splenomegaly causing severe thrombocytopenia, autoimmune tendency). **3.** Approve if, per the prescriber, the patient has a contraindication to penicillamine. **4.** Approve if the patient has neurological manifestations of Wilson's Disease. **5.** Approve if the patient is pregnant. **6.** Approve if the patient has been started on therapy with a trientine product or Cuvrior.	1 year	Yes	
Colchicine Agents	Lodoco	colchicine 0.5 mg tablets	Atherosclerotic Disease. Approve if the patient meets ALL of the following (1, 2, 3, and 4): **1.** Patient is ≥ 18 years of age; AND **2.** Lodoco is being added onto a background regimen(s) of other atherosclerotic disease medication(s) **[documentation required]**; AND Note: Examples of medications recommended in guideline-directed therapy for patients with atherosclerotic disease can include aspirin, antiplatelet agents (e.g., clopidogrel, Brilinta [ticagrelor tablets]), anticoagulants, lipid-lowering agents (e.g., statins such as atorvastatin and rosuvastatin), beta blockers, angiotensin-converting enzyme inhibitors, and/or angiotensin receptor blockers. **3.** Patient has a creatinine clearance ≥ 50 mL/min; AND **4.** Patient has tried colchicine 0.6 mg tablets or capsules **[documentation required]**.	1 year	Yes	
Colony Stimulating Factors	Rolvedon	eflapegrastim-xnst subcutaneous injection	Cancer in a Patient ≥ 18 Years of Age Receiving Myelosuppressive Chemotherapy. Approve if the patient has tried one pegfilgrastim product **[documentation required]**. Note: Pegfilgrastim products are Neulasta, Fulphila, Fylnetra, Nyvepria, Udenyca, Stimufend, and Ziextenzo. Note: If no pegfilgrastim products are formulary, approve.	1 year	Yes	
Colony Stimulating Factors - Filgrastim	Granix	tbo-filgrastim subcutaneous injection	**1.** Approve if the patient meets BOTH of the following (a and b): a. Patient has tried four of the following products, if formulary (or three if three are formulary, or two if two are formulary, or one if one is formulary): Nypozi, Releuko, Neupogen, Nivestym, or Zarxio **[documentation required]**; AND Note: If none are formulary, approve. b. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. **2.** Patients requiring a dose < 180 mcg: approve if the patient meets the following (a and b): a. Patient has tried one of Neupogen or Nivestym **[documentation required]**, if formulary; AND Note: If neither are formulary, approve. b. Patient cannot continue to use the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. **3.** Patients who initiated therapy with Granix and requires further medication to complete the current cycle of chemotherapy: approve for 30 days OR the length of the chemotherapy cycle. Note: A cycle is the time from the start of a round of chemotherapy until the next round of chemotherapy is started. Typically cycles are 21 or 28 days in length; however, they can be shorter or longer depending on the chemotherapy regimen. .	1 year	Yes	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Colony Stimulating Factors - Filgrastim	Neupogen	filgrastim intravenous or subcutaneous injection	**1.** Approve if the patient meets BOTH of the following (a and b): a. Patient has tried four of the following products, if formulary (or three if three are formulary, or two if two are formulary, or one if one is formulary): Nypozi, Releuko, Zarxio, Nivestym, or Granix **[documentation required]**; AND Note: If none are formulary, approve. b. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. **2.** Patients who require administration by intravenous infusion: approve if the patient meets the following (a and b): a. Patient has tried one of Nypozi, Releuko, Zarxio, or Nivestym **[documentation required]**, if formulary; AND Note: If none are formulary, approve. b. Patient cannot continue to use the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. Note: If Nivestym is non-formulary and the patient requires a dose of < 180 mcg, approve. **3.** Patients requiring a dose < 180 mcg: approve if the patient meets the following (a and b): a. Patient has tried one of Nivestym or Granix **[documentation required]**; AND Note: If neither are formulary, approve. b. Patient cannot continue to use the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. Note: If the only formulary alternative is Granix and the patient requires intravenous administration, approve. **4.** Patients who initiated therapy with Neupogen and requires further medication to complete the current cycle of chemotherapy: approve for 30 days OR the length of the chemotherapy cycle. Note: A cycle is the time from the start of a round of chemotherapy until the next round of chemotherapy is started. Typically cycles are 21 or 28 days in length; however, they can be shorter or longer depending on the chemotherapy regimen.	1 year	Yes	
Colony Stimulating Factors - Filgrastim	Releuko	filgrastim-ayow subcutaneous or intravenous injection (biosimilar to Neupogen)	**1.** Approve if the patient meets BOTH of the following (a and b): a. Patient has tried four of the following products, if formulary (or three if three are formulary, or two if two are formulary, or one if one is formulary): Nypozi, Nivestym, Neupogen, Granix, or Zarxio **[documentation required]**; AND Note: If none are formulary, approve. b. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. **2.** Patients who require administration by intravenous infusion: approve if the patient meets BOTH of the following (a and b): a. Patient has tried one of Nypozi, Nivestym, Neupogen, or Zarxio **[documentation required]**, if formulary; AND Note: If none are formulary, approve. b. Patient cannot continue to use the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. **3.** Patients who initiated therapy with Releuko and requires further medication to complete the current cycle of chemotherapy: approve for 30 days OR the length of the chemotherapy cycle. Note: A cycle is the time from the start of a round of chemotherapy until the next round of chemotherapy is started. Typically cycles are 21 or 28 days in length; however, they can be shorter or longer depending on the chemotherapy regimen.	1 year	Yes	
Colony Stimulating Factors - Filgrastim	Zarxio	filgrastim-sndz subcutaneous or intravenous injection (biosimilar to Neupogen)	**1.** Approve if the patient meets BOTH of the following (a and b): a. The patient has tried four of the following products, if formulary (or three if three are formulary, or two if two are formulary, or one if one is formulary): Nypozi, Releuko, Neupogen, Nivestym, or Granix **[documentation required]**; AND Note: If none are formulary, approve. b. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. **2.** Patients who require administration by intravenous infusion: approve if the patient has meets the following (a and b): a. Patient has tried one of Nypozi, Releuko, Neupogen, or Nivestym **[documentation required]**, if formulary; AND Note: If none are formulary, approve. b. Patient cannot continue to use the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. **3.** Patients who initiated therapy with Zarxio and requires further medication to complete the current cycle of chemotherapy: approve for 30 days OR the length of the chemotherapy cycle. Note: A cycle is the time from the start of a round of chemotherapy until the next round of chemotherapy is started. Typically cycles are 21 or 28 days in length; however, they can be shorter or longer depending on the chemotherapy regimen.	1 year	Yes	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Colony Stimulating Factors - Pegfilgrastim	Fylnetra	pegfilgrastim-pbbk subcutaneous injection	Approve if the patient meets BOTH of the following (a and b): a. The patient has tried five of the following, if five are formulary (or four if there are formulary or three if three are formulary or two if two are formulary or one if one is formulary): Neulasta, Fulphila, Udenyca, Ziextenzo, Nyvepria, or Stimufend **[documentation required]**; AND Note: If none are formulary, approve. b. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction.	1 year	Yes	
Colony Stimulating Factors - Pegfilgrastim	Neulasta	pegfilgrastim subcutaneous injection	Approve if the patient meets BOTH of the following (a and b): a. The patient has tried five of the following, if five are formulary (or four if four are formulary or three if three are formulary or two if two are formulary or one if one is formulary): Fulphila, Udenyca, Ziextenzo, Nyvepria, Fylnetra, or Stimufend **[documentation required]**; AND Note: If none are formulary, approve. b. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction.	1 year	Yes	
Colony Stimulating Factors - Pegfilgrastim	Nyvepria	pegfilgrastim-apgf subcutaneous injection	Approve if the patient meets BOTH of the following (a and b): a. The patient has tried five of the following, if five are formulary (or four if four are formulary or three if three are formulary or two if two are formulary or one if one is formulary): Neulasta, Fulphila, Udenyca, Ziextenzo, Fylnetra, or Stimufend **[documentation required]**; AND Note: If none are formulary, approve. b. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction.	1 year	Yes	
Colony Stimulating Factors - Pegfilgrastim	Stimufend	pegfilgrastim-fpgk	Approve if the patient meets BOTH of the following (a and b): a. The patient has tried five of the following, if five are formulary (or four if four are formulary or three if three are formulary or two if two are formulary or one if one is formulary): Neulasta, Nyvepria, Fulphila, Udenyca, Ziextenzo, or Fylnetra **[documentation required]**; AND Note: If none are formulary, approve. b. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction.	1 year	Yes	
Colony Stimulating Factors - Pegfilgrastim	Udenyca	pegfilgrastim-cbqv subcutaneous injection	Approve if the patient meets BOTH of the following (a and b): a. The patient has tried five of the following, if five are formulary (or four if four are formulary or three if three are formulary or two if two are formulary or one if one is formulary): Neulasta, Fulphila, Ziextenzo, Nyvepria, Fylnetra, or Stimufend **[documentation required]**; AND Note: If none are formulary, approve. b. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction.	1 year	Yes	
Complement Inhibitors	PiaSky	crovalimab-akkz intravenous infusion and subcutaneous injection	Paroxysmal nocturnal hemoglobinuria in a patient ≥ 13 years of age. **1.** Approve if the patient has tried one of Soliris or Ultomiris, if formulary. If neither are formulary, approve. **2.** Patient < 18 years of age, approve if the patient has tried Ultomiris, if formulary. If Ultomiris is non-formulary, approve. **3.** Patient is unable to maintain intravenous access, approve. **4.** Patient has already been started on therapy with PiaSky, approve.	1 year	Yes	Yes
Complement Inhibitors - Complement C5 inhibitor	Zilbrysq	zilucoplan subcutaneous injection	Anti-acetylcholine receptor antibody positive generalized myasthenia gravis in a patient ≥ 18 years of age. Approve if the patient meets one of the following (1 or 2): **1.** Patient meets BOTH of the following (A and B): A. Patient meets one of the following (i or ii): i. Patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with one of Soliris or Ultomiris, if formulary; OR ii. Patient is unable to obtain intravenous access; AND Note: If neither are formulary, would still need to meet criterion B. B. Patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with one of Vyvgart intravenous, Vyvgart Hytrulo, or Rystiggo, if formulary; OR Note: If none are formulary, would still need to meet criterion A. Note: If there are no formulary alternatives from criterion A or B, approve. **2.** Approve if the patient has already been started on therapy with Zilbrysq.	1 year	Yes	Yes
Constipation Agents	Relistor	methylnaltrexone bromide tablets	Approve if the patient has tried two products from the following list: Movantik, Symproic, or Amitiza (lubiprostone), if two are formulary or one if one is formulary. If none are formulary, approve if the patient has tried two laxative agents (e.g., bisacodyl-containing products, senna-containing products, milk of magnesia, lactulose).	1 year	Yes	
Constipation Agents – Chronic Idiopathic Constipation Agents	Motegrity	prucalopride tablets	Patient ≥ 18 years of age. Approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with BOTH products from the following list: Linzess AND Trulance **[documentation required]**, if two are formulary or one if one is formulary. If neither are formulary, approve.	1 year	Yes	
Constipation Agents – Chronic Idiopathic Constipation Agents/Irritable Bowel Syndrome	Amitiza	lubiprostone capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Constipation Agents – Irritable Bowel Syndrome	Ibsrela	tenapanor tablets	Patient ≥ 18 years of age. Approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with BOTH products from the following list: Linzess AND Trulance, if two are formulary or one if one is formulary. If neither are formulary, approve.	1 year	Yes	
Contraceptives	NuvaRing	etonogestrel/ethinyl estradiol vaginal ring	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **NOTE**: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the patient meets one of the following criteria (i or ii): i. The requested brand non-formulary drug is being prescribed primarily for the prevention of pregnancy AND, according to the prescriber, the brand product is being requested because the preferred bioequivalent generic product would not be as medically appropriate for the patient as the requested brand non-formulary drug; OR ii. The requested brand non-formulary drug is being prescribed for a use OTHER THAN primarily for the prevention of pregnancy AND the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Contraceptives	Phexxi	L-lactic acid, citric acid, and potassium bitartrate vaginal gel	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. Approve if the patient has tried or is unable to tolerate THREE other barrier methods of contraception, such as diaphragms, condoms, spermicides (over-the-counter), or sponges. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the patient meets one of the following (i or ii): i. Patient has tried or is unable to tolerate THREE other barrier methods of contraception, such as diaphragms, condoms, spermicides (over-the-counter), or sponges; OR ii. The requested non-formulary drug is being prescribed primarily for the prevention of pregnancy and other barrier methods of contraception would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year	Yes	
Contraceptives	Twirla	levonorgestrel and ethinyl estradiol transdermal system	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. Approve if the patient has tried five other contraceptive agents (e.g., oral contraceptive tablets, Xulane [contraceptive patch], Annovera [contraceptive ring]), NuvaRing or generics [contraceptive ring]). Note: A trial of five different oral contraceptive agents would meet the requirement. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the patient meets one of the following (i or ii): i. The patient has tried five other contraceptive agents (e.g., oral contraceptive tablets, Xulane [contraceptive patch], Annovera [contraceptive ring]), NuvaRing or generics [contraceptive ring]); OR Note: A trial of five different oral contraceptive agents would meet the requirement. ii. The requested non-formulary drug is being prescribed primarily for the prevention of pregnancy AND other contraceptive agents would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year	Yes	
Contraceptives – Oral	Slynd	drospirenone tablet	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. Approve if the patient has tried one progesterone-only contraceptive containing norethindrone. Note: Examples of progesterone-only contraceptives containing norethindrone include Camila, Deblitane, Emzahh, Errin, Nora-BE, norethindrone, Heather, Jencycla, Lyza, Sharobel, Tulana, Lyleq, Incassia. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the patient meets one of the following criteria (i or ii): i. Patient has tried one progesterone-only contraceptive containing norethindrone; OR Note: Examples of progesterone-only contraceptives containing norethindrone include Camila, Deblitane, Emzahh, Errin, Nora-BE, norethindrone, Heather, Jencycla, Lyza, Sharobel, Tulana, Lyleq, Incassia. ii. The requested non-formulary drug is being prescribed primarily for the prevention of pregnancy and other progesterone-only contraceptives containing norethindrone would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year	Yes	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Contraceptives – Oral	Balcoltra	ethinyl estradiol 0.02 mg; levonorgestrel 0.1 mg; ferrous bisglycinate tablet	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **NOTE**: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the patient meets one of the following criteria (i or ii): i. The requested brand non-formulary drug is being prescribed primarily for the prevention of pregnancy AND, according to the prescriber, the brand product is being requested because the preferred bioequivalent generic product would not be as medically appropriate for the patient as the requested brand non-formulary drug; OR ii. The requested brand non-formulary drug is being prescribed for a use OTHER THAN primarily for the prevention of pregnancy AND the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Contraceptives – Oral	Femlyv	norethindrone acetate and ethinyl estradiol orally disintegrating tablets	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **1.** Approve if the patient has tried four other oral contraceptive agents. **2.** If the patient is unable to swallow tablets or has difficulty swallowing tablets, approve if the patient has tried one oral chewable birth control product (e.g., Finzala, Mibelas, Charlotte, Wymzya, Kaitlib, Layolis). OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient has tried four other oral contraceptive agents. **2.** If the patient is unable to swallow tablets or has difficulty swallowing tablets, approve if the patient has tried one oral chewable birth control product (e.g., Finzala, Mibelas, Charlotte, Wymzya, Kaitlib, Layolis). **3.** The requested non-formulary drug is being prescribed primarily for the prevention of pregnancy and other oral contraceptive agents would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year	Yes	
Contraceptives – Oral	Lo Loestrin FE	ethinyl estradiol 0.01 mg; norethindrone acetate 1 mg; ferrous fumarate tablet	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. Approve if the patient has tried two other oral contraceptive agents. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the patient meets one of the following criteria (i or ii): i. Patient has tried two other oral contraceptive agents; OR ii. The requested non-formulary drug is being prescribed primarily for the prevention of pregnancy and other oral contraceptive agents would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year	Yes	
Contraceptives – Oral	Loestrin and Loestrin FE	ethinyl estradiol/norethindrone and ferrous fumarate tablets	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **NOTE**: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the patient meets one of the following criteria (i or ii): i. The requested brand non-formulary drug is being prescribed primarily for the prevention of pregnancy AND, according to the prescriber, the brand product is being requested because the preferred bioequivalent generic product would not be as medically appropriate for the patient as the requested brand non-formulary drug; OR ii. The requested brand non-formulary drug is being prescribed for a use OTHER THAN primarily for the prevention of pregnancy AND the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Contraceptives – Oral	Minastrin 24 FE	norethindrone - ethinyl estradiol - iron chewable tablets	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **NOTE**: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the patient meets one of the following criteria (i or ii): i. The requested brand non-formulary drug is being prescribed primarily for the prevention of pregnancy AND, according to the prescriber, the brand product is being requested because the preferred bioequivalent generic product would not be as medically appropriate for the patient as the requested brand non-formulary drug; OR ii. The requested brand non-formulary drug is being prescribed for a use OTHER THAN primarily for the prevention of pregnancy AND the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Contraceptives – Oral	Mircette	desogestrel - ethinyl estradiol and ethinyl estradiol tablets	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **NOTE**: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the patient meets one of the following criteria (i or ii): i. The requested brand non-formulary drug is being prescribed primarily for the prevention of pregnancy AND, according to the prescriber, the brand product is being requested because the preferred bioequivalent generic product would not be as medically appropriate for the patient as the requested brand non-formulary drug; OR ii. The requested brand non-formulary drug is being prescribed for a use OTHER THAN primarily for the prevention of pregnancy AND the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Contraceptives – Oral	Natazia	dienogest; estradiol valerate tablet	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. Approve if the patient has tried four other oral contraceptive agents. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the patient meets one of the following criteria (i or ii): i. Patient has tried four other oral contraceptive agents; OR ii. The requested non-formulary drug is being prescribed primarily for the prevention of pregnancy and other oral contraceptive agents would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year	Yes	
Contraceptives – Oral	Nextstellis	estetrol and drospirenone tablets	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. Approve if the patient has tried four other oral contraceptive agents. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the patient meets one of the following criteria (i or ii): i. Patient has tried four other oral contraceptive agents; OR ii. The requested non-formulary drug is being prescribed primarily for the prevention of pregnancy and other oral contraceptive agents would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year	Yes	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Contraceptives – Oral	Quartette	levonorgestrel-ethinyl estradiol and ethinyl estradiol tablets	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **NOTE**: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the patient meets one of the following criteria (i or ii): i. The requested brand non-formulary drug is being prescribed primarily for the prevention of pregnancy AND, according to the prescriber, the brand product is being requested because the preferred bioequivalent generic product would not be as medically appropriate for the patient as the requested brand non-formulary drug; OR ii. The requested brand non-formulary drug is being prescribed for a use OTHER THAN primarily for the prevention of pregnancy AND the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Contraceptives – Oral	Safyral	drospirenone/ethinyl estradiol-levomefolate tablets	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **NOTE**: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the patient meets one of the following criteria (i or ii): i. The requested brand non-formulary drug is being prescribed primarily for the prevention of pregnancy AND, according to the prescriber, the brand product is being requested because the preferred bioequivalent generic product would not be as medically appropriate for the patient as the requested brand non-formulary drug; OR ii. The requested brand non-formulary drug is being prescribed for a use OTHER THAN primarily for the prevention of pregnancy AND the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Contraceptives – Oral	Seasonique	levonorgestrel-ethinyl estradiol and ethinyl estradiol tablets	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **NOTE**: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the patient meets one of the following criteria (i or ii): i. The requested brand non-formulary drug is being prescribed primarily for the prevention of pregnancy AND, according to the prescriber, the brand product is being requested because the preferred bioequivalent generic product would not be as medically appropriate for the patient as the requested brand non-formulary drug; OR ii. The requested brand non-formulary drug is being prescribed for a use OTHER THAN primarily for the prevention of pregnancy AND the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Contraceptives – Oral	Taytulla	norethindrone and ethinyl estradiol and ferrous fumarate capsules	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **NOTE**: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the patient meets one of the following criteria (i or ii): i. The requested brand non-formulary drug is being prescribed primarily for the prevention of pregnancy AND, according to the prescriber, the brand product is being requested because the preferred bioequivalent generic product would not be as medically appropriate for the patient as the requested brand non-formulary drug; OR ii. The requested brand non-formulary drug is being prescribed for a use OTHER THAN primarily for the prevention of pregnancy AND the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Contraceptives – Oral	Tyblume	levonorgestrel 0.1 mg and ethinyl estradiol 0.02 mg tablets	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. Approve if the patient has tried four other oral contraceptive agents. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the patient meets one of the following criteria (i or ii): i. Patient has tried four other oral contraceptive agents; OR ii. The requested non-formulary drug is being prescribed primarily for the prevention of pregnancy and other oral contraceptive agents would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year	Yes	
Contraceptives – Oral	Yasmin	ethinyl estradiol/ drospirenone tablets	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **NOTE**: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the patient meets one of the following criteria (i or ii): i. The requested brand non-formulary drug is being prescribed primarily for the prevention of pregnancy AND, according to the prescriber, the brand product is being requested because the preferred bioequivalent generic product would not be as medically appropriate for the patient as the requested brand non-formulary drug; OR ii. The requested brand non-formulary drug is being prescribed for a use OTHER THAN primarily for the prevention of pregnancy AND the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Corticosteroid (oral) - Eosinophilic Esophagitis Agent	Eohilia	budesonide oral suspension	Eosinophilic Esophagitis in a patient ≥ 11 years of age. **1.** Approve if the patient has tried budesonide inhalation suspension (Pulmicort Respules, generic) that was made into a slurry or suspension and swallowed (not inhaled). **2.** Approve if the patient has already been started on a 12-week course of therapy with Eohilia (to allow for completion of up to a 12-week course of therapy).	1 year	Yes	
Corticosteroids (Oral)	Alkindi Sprinkle	hydrocortisone oral granules	**1.** Approve if the patient has tried and cannot take hydrocortisone tablets. **2.** Approve if the patient cannot swallow or has difficulty swallowing hydrocortisone tablets. **3.** Approve if the patient's dose cannot be obtained using whole hydrocortisone tablets.	1 year	Yes	
Corticosteroids (Oral)	Hemady	dexamethasone 20 mg tablets	Approve if the patient has tried generic dexamethasone tablets, if formulary. If dexamethasone tablets are non-formulary, approve.	1 year	Yes	
Corticosteroids (Rectal Formulations)	Anusol-HC suppository	hydrocortisone acetate suppository	Approve if the patient has tried hydrocortisone acetate suppositories. If hydrocortisone acetate suppositories are non-formulary, approve.	1 year	Yes *This criteria applies only to the NPF	
Corticosteroids (Rectal Formulations)	Hydrocortisone-pramoxine suppository	hydrocortisone-pramoxine suppository 25-18 mg	Approve if the patient has tried one of 1) hydrocortisone acetate suppositories or 2) a rectal topical product containing hydrocortisone and pramoxine (e.g., topical foam, topical cream).	1 year	Yes	
Corticosteroids (Rectal Formulations)	Proctofoam-HC	pramoxine hydrochloride hydrocortisone acetate aerosol, foam	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with pramoxine-hydrocortisone cream.	1 year	Yes	
Corticosteroids (Rectal Formulations)	Cortifoam	hydrocortisone acetate aerosol foam	**1.** Approve if the patient has tried budesonide foam (Uceris foam, generics), if formulary. If budesonide foam (Uceris foam, generics) are non-formulary, approve if the patient has tried one corticosteroid enema from the following list (if one is formulary): Cortenema or hydrocortisone enema. If neither are formulary, approve. **2.** Patients who are unable to retain a corticosteroid enema: approve if the patient has tried budesonide foam (Uceris foam, generics), if formulary. If budesonide foam (Uceris foam, generics) are non-formulary, approve.	1 year	Yes	
Corticosteroids (Topical)	Impoyz	clobetasol propionate cream, 0.025%	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with five unique, generic prescription-strength topical corticosteroid products. Note: Examples of topical steroid products include: desoximetasone, triamcinolone, betamethasone, clobetasol, fluocinonide, mometasone, halcinonide, diflorasone. NOTE: The products must be chemically unique.	1 year	Yes	
Corticosteroids (Topical)	Sernivo spray	betamethasone dipropionate spray 0.05%	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with five unique, generic prescription-strength topical corticosteroid products. Note: Examples of topical steroid products include: desoximetasone, triamcinolone, betamethasone, clobetasol, fluocinonide, mometasone, halcinonide. NOTE: The five products must be chemically unique.	1 year	Yes	
Corticosteroids (Topical)	Verdeso	desonide foam	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with five unique, generic prescription-strength topical corticosteroid products. Note: Examples of topical steroid products include: desonide, alclometasone dipropionate, betamethasone valerate, fluocinolone acetonide, triamcinolone, flurandrenolide, hydrocortisone butyrate. **NOTE**: The five products must be chemically unique (i.e., a trial of desoximetasone 0.05% and 0.25% would NOT fulfill the requirement).	1 year	Yes	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Corticosteroids (Topical)	Anusol-HC cream	hydrocortisone acetate cream	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Corticosteroids (Topical)	Locoid	hydrocortisone butyrate cream, lotion, ointment, solution	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Corticosteroids (Topical)	Locoid Lipocream	hydrocortisone butyrate 0.1% cream	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Corticosteroids (Topical)	Topicort spray	desoximetasone spray	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Corticosteroids (Topical)	Vanos	fluocinonide 0.1% cream	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Cushing's - Cortisol Synthesis Inhibitor	Isturisa	osilodrostat tablets	Cushing's Disease in a patient ≥ 18 years of age. Approve if the patient meets one of the following (A or B): A. Patient has tried, or is currently taking, one of Signifor or Signifor LAR. If neither are formulary, approve; OR B. Patient has already been started on Isturisa. Endogenous Cushing's Syndrome in a patient ≥ 18 years of age. Note: This includes patients awaiting surgery and patients awaiting therapeutic response after pituitary radiotherapy. Approve if the patient meets one of the following (A or B): A. Patient has tried, or is currently taking, one of Signifor, Signifor LAR, ketoconazole, Metoprione (metyrapone capsules), Recorlev, or Korlym. If none are formulary, approve; OR B. Patient has already been started on Isturisa. Note: A trial of any of the products above would count toward meeting criteria regardless of the formulary status of the product.	1 year	Yes	
Cushing's - Cortisol Synthesis Inhibitor	Recorlev	levoketoconazole tablets	Endogenous Cushing's Syndrome in a patient ≥ 18 years of age. Note: This includes patients awaiting surgery and patients awaiting therapeutic response after pituitary radiotherapy. 1. Approve if the patient meets the following (A and B): A. Patient has tried ketoconazole; AND B. Patient has tried, or is currently taking, two of Isturisa or Metopirone (metyrapone). If neither Isturisa nor Metopirone are formulary, approve if the patient has tried ketoconazole. If both or one of Isturisa or Metopirone (metyrapone) are formulary, then one of those agents AND ketoconazole would need to be tried. Note: A trial of any of the products above would count toward meeting criteria regardless of the formulary status of the product. 2. If the patient has already been started on Recorlev, approve if the patient has tried ketoconazole.	1 year	Yes	
Cushing's -Cortisol Receptor Blocker	Korlym	mifepristone 300 mg tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Cystinuria Agents	Thiola	tiopronin tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Diabetes - Oral Sulfonylurea	Glimepiride 3 mg (brand)	glimepiride 3 mg	Approve if the patient cannot use one of the following: generic glimepiride 1mg, 2mg, or 4 mg. If generic glimepiride is non-formulary, approve.	1 year	Yes	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Diabetes Agents - Dipeptidyl Peptidase-4 (DPP-4) Inhibitor Combination Products	Zituvimet XR	sitagliptin and metformin hydrochloride extended-release tablets	Approve if the patient has tried Janumet XR, if formulary. If Janumet XR is non-formulary, approve if the patient meets ONE of the following (1 or 2): **1.** Approve if the patient has tried three metformin-DPP-4 inhibitor combination products from the following list (if three are formulary, or two if two are formulary, or one if one is formulary): Janumet (NOT XR), alogliptin and metformin tablets, Jentadueto, Jentadueto XR, Kazano, or saxagliptin plus metformin extended-release tablets (Kombiglyze XR, generics). If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics) AND two of the following, if two are formulary (or one if only one is formulary): saxagliptin tablets (Onglyza, generics), Januvia, Tradjenta, or alogliptin tablets (Nesina, authorized generics). If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics). Note: Jentadueto and Jentadueto XR would count as one alternative. Alogliptin/metformin tablets and Kazano would count as one alternative. **2.** Patients with a history of heart failure (HF) or renal impairment: approve if the patient has tried Janumet (NOT XR). If Janumet (NOT XR) is non-formulary, approve if the patient has tried metformin (Glucopage, Glucophage ER, generics) AND Januvia, if formulary. If Januvia is non-formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics). Note: A brand product and its generic or authorized generic would count as one alternative.	1 year	Yes	
Diabetes Agents - Dipeptidyl Peptidase-4 (DPP-4) Inhibitor Combination Products	sitagliptin and metformin hydrochloride tablets and Zituvimet	sitagliptin and metformin hydrochloride tablets 50-1000; 50-500	Approve if the patient has tried Janumet, if formulary. If Janumet is non-formulary, approve if the patient meets ONE of the following (1 or 2): **1.** Approve if the patient has tried three metformin-DPP-4 inhibitor combination products from the following list (if three are formulary, or two if two or formulary or one if one is formulary): alogliptin and metformin tablets, Janumet XR, Jentadueto, Jentadueto XR, Kazano, or saxagliptin plus metformin extended-release tablets (Kombiglyze XR, generics). If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics) AND two of the following, if two are formulary (or one if only one is formulary): saxagliptin tablets (Onglyza, generics), Januvia, Tradjenta, or alogliptin (Nesina, authorized generics). If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics). Note: Jentadueto and Jentadueto XR would count as one alternative. Alogliptin/metformin tablets and Kazano would count as one alternative. **2.** Patients with a history of heart failure (HF) or renal impairment: approve if the patient has tried Janumet XR. If Janumet XR is non-formulary, approve if the patient has tried metformin (Glucopage, Glucophage ER, generics) AND Januvia, if formulary. If Januvia is non-formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics). Note: A brand product and its generic or authorized generic would count as one alternative.	1 year	Yes	
Diabetes Agents - Dipeptidyl Peptidase-4 (DPP-4) Inhibitor Combination Products	Jentadueto	linagliptin and metformin tablets	**1.** Approve if the patient has tried three metformin-DPP-4 inhibitor combination products from the following list (if three are formulary, or two if two are formulary, or one if one is formulary): Jentadueto XR, alogliptin and metformin tablets, Janumet, Janumet XR, Kazano, or saxagliptin plus metformin extended-release tablets (Kombiglyze XR, generics). If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics) AND two of the following, if two are formulary (or one if only one is formulary): alogliptin tablets (Nesina, authorized generics), Tradjenta, saxagliptin tablets (Onglyza, generics), or Januvia. If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics). Note: Janumet and Janumet XR would count as one alternative. Alogliptin/metformin tablets and Kazano would count as one alternative. **2.** Patients with a history of heart failure (HF) or renal impairment: approve if the patient has tried ONE of Jentadueto XR, Janumet or Janumet XR, if one is formulary. If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics) AND one of the following, if one is formulary: Januvia or Tradjenta. If neither are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics). Note: A brand product and its generic or authorized generic would count as one alternative.	1 year	Yes	
Diabetes Agents - Dipeptidyl Peptidase-4 (DPP-4) Inhibitor Combination Products	Jentadueto XR	linagliptin and metformin extended-release tablets	**1.** Approve if the patient has tried three metformin-DPP-4 inhibitor combination products from the following list: (if three are formulary, or two if two are formulary, or one if one is formulary): Jentadueto (NOT XR), alogliptin and metformin tablets, Janumet, Janumet XR, Kazano, saxagliptin plus metformin extended-release tablets (Kombiglyze XR, generics). If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics) AND two of the following, if two are formulary (or one if only one is formulary): alogliptin tablets (Nesina, authorized generics), Tradjenta, saxagliptin tablets (Onglyza, generics), or Januvia. If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics). Note: Janumet and Janumet XR would count as one alternative. Alogliptin/metformin tablets and Kazano would count as one alternative. **2.** Patients with a history of heart failure or renal impairment: approve if the patient has tried one of Jentadueto (NOT XR), Janumet or Janumet XR, if formulary. If **n**one are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics) AND one of the following, if one is formulary: Januvia or Tradjenta. If neither are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics). Note: A brand product and its generic or authorized generic would count as one alternative	1 year	Yes	
Diabetes Agents - Dipeptidyl Peptidase-4 (DPP-4) Inhibitor Combination Products	Kazano and authorized generic	alogliptin and metformin tablets	Approve if the patient has tried three metformin-DPP-4 inhibitor combination products from the following list (if three are formulary, or two if two are formulary, or one if one is formulary): Jentadueto, Jentadueto XR, Janumet, Janumet XR, or saxagliptin plus metformin extended-release tablets (Kombiglyze XR, generics). If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics) AND two of the following, if two are formulary (or one if only one is formulary): saxagliptin tablets (Onglyza, generics), alogliptin tablets (Nesina, authorized generics), Tradjenta, or Januvia. If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics). Note: Jentadeuto and Jentadueto XR would count as one alternative. Janumet and Janumet XR would count as one alternative. A brand product and its generic or authorized generic would count as one alternative.	1 year	Yes	
Diabetes Agents - Dipeptidyl Peptidase-4 (DPP-4) Inhibitor Combination Products	Kombiglyze XR	saxagliptin plus metformin extended-release tablets	If requesting brand Kombiglyze XR: Approve if the patient has tried generic Kombiglyze XR tablets (saxagliptin plus metformin ER tablets), if formulary. If requesting brand Kombiglyze XR and generic Kombiglyze XR tablets (saxagliptin plus metformin ER tablets) are non-formulary (or if requesting generic Kombiglyze), approve if the patient has tried three metformin-DPP-4 inhibitor combination products from the following list (if three are formulary, or two if two are formulary, or one if one is formulary): alogliptin and metformin tablets, Jentadueto, Jentadueto XR, Kazano, Janumet, or Janumet XR. If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics) AND two of the following, if two are formulary (or one if only one is formulary): alogliptin tablets (Nesina, authorized generics), saxagliptin tablets (Onglyza, generic), Tradjenta, or Januvia. If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics). Note: Jentadueto and Jentadueto XR would count as one alternative. Alogliptin/metformin tablets and Kazano would count as one alternative. Janumet and Janumet XR would count as one alternative. A brand product and its generic or authorized generic would count as one alternative.	1 year	Yes	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Diabetes Agents - Dipeptidyl Peptidase-4 (DPP-4) Inhibitor Combination Products	Oseni and authorized generic	alogliptin and pioglitazone tablets	Approve if the patient has tried pioglitazone (Actos, generics) AND two of the following, if two are formulary (or one if only one is formulary): saxagliptin (Onglyza, generics), alogliptin tablets (Nesina, authorized generics), Tradjenta, or Januvia. If none are formulary, approve if the patient has tried pioglitazone (Actos, generics). Note: A brand product and its generic or authorized generic would count as one alternative. **NOTE:** A trial of Oseni or is authorized generic would not count toward this requirement.	1 year	Yes - Authorized generic only	
Diabetes Agents - Dipeptidyl Peptidase-4 (DPP-4) Inhibitor/ Sodium Glucose Co-Transporter-2 (SGLT-2) Inhibitors	Steglujan	ertugliflozin/ sitagliptin tablets	**1.** Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with both Qtern and Glyxambi, if formulary **[documentation required]**. If one is formulary, try one, if neither are formulary, approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with three formulary SGLT-2 inhibitors (or two if two are formulary or one if one is formulary) **[documentation required]** AND three formulary DPP-4 inhibitors (or two if two are formulary or one if one is formulary) **[documentation required]**. **2.** Patient with a history of heart failure or renal impairment: Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with Glyxambi, if formulary **[documentation required]**. If Glyxambi is not formulary, approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with one of Farxiga or Jardiance, if formulary **[documentation required]**, AND one of Tradjenta or Januvia, if formulary **[documentation required]**. If Farxiga and Jardiance are both non-formulary, approve. If Tradjenta and Januvia are both non-formulary, approve. Note: SGLT-2 inhibitors: Brenzavvy, Farxiga, Invokana, Jardiance, Steglatro. DPP-4 inhibitors: Januvia, Nesina (alogliptin), Onglyza (saxagliptin), Tradjenta. Note: If the patient has tried a combination product containing the DPP-4 inhibitor or the SGLT-2 inhibitor, this would count as a trial of the respective product. A trial of the request agent would NOT count toward this requirement.	1 year	Yes	
Diabetes Agents - Dipeptidyl Peptidase-4 (DPP-4) Inhibitor/ Sodium Glucose Co-Transporter-2 (SGLT-2) Inhibitors	Qtern	dapagliflozin/ saxagliptin tablets	Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with both Glyxambi and Steglujan, if formulary. If one is formulary, try one, if neither are formulary, approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with three formulary SGLT-2 inhibitors (or two if two are formulary or one if one is formulary) AND three formulary DPP-4 inhibitors (or two if two are formulary or one if one is formulary). SGLT-2 inhibitors: Brenzavvy, Farxiga, Invokana, Jardiance, Steglatro. DPP-4 inhibitors: Januvia, Nesina (alogliptin), Onglyza (saxagliptin), Tradjenta. Note: If the patient has tried a combination product containing a DPP-4 inhibitor or an SGLT-2 inhibitor, this would count as a trial of the respective product. A trial of the request agent would NOT count toward this requirement.	1 year	Yes	
Diabetes Agents - Dipeptidyl Peptidase-4 (DPP-4) Inhibitors	Zituvio and authorized generic sitagliptin	sitagliptin 100 mg, 50 mg, 25 mg tablets	Approve if the patient has tried Januvia, if formulary. If Januvia is non-formulary, approve if the patient meets one of the following (1 or 2): **1.** Approve if the patient has tried three products from the following list (if three are formulary or two if two are formulary, or one if only one is formulary): saxagliptin (Onglyza, generics), Tradjenta, or alogliptin tablets (Nesina, authorized generics). If none are formulary, approve. Note: Saxagliptin and Onglyza count as one alternative. Alogliptin and Nesina count as one alternative. **2.** Patients with a history of heart failure or a history of renal impairment: approve if the patient has tried Tradjenta, if formulary. If Tradjenta is non-formulary, approve.	1 year	Yes	
Diabetes Agents - Dipeptidyl Peptidase-4 (DPP-4) Inhibitors	Nesina and authorized generic	alogliptin tablets	Approve if the patient has tried three products from the following list (if three are formulary or two if two are formulary, or one if only one is formulary): saxagliptin (Onglyza, generics), Tradjenta, or a sitagliptin product (Januvia or Zituvio). If none are formulary, approve. Note: Saxagliptin and Onglyza count as one alternative. Januvia and Zituvio would count as one alternative.	1 year	Yes	
Diabetes Agents - Dipeptidyl Peptidase-4 (DPP-4) Inhibitors	Onglyza	saxagliptin tablets	If requesting brand Onglyza: Approve if the patient has tried saxagliptin tablets (generic for Onglyza), if formulary. If requesting brand Onglyza and generic saxagliptin tablets are non-formulary (or if requesting generic Onglyza), approve if the patient has tried three products from the following list (if three are formulary or two if two are formulary, or one if only one is formulary): alogliptin tablets (Nesina, authorized generics), Tradjenta, or a sitagliptin product (Januvia or Zituvio). If none are formulary, approve. Note: Alogliptin and Nesina count as one alternative. Januvia and Zituvio count as one alternative.	1 year	Yes	
Diabetes Agents - Dipeptidyl Peptidase-4 (DPP-4) Inhibitors	Tradjenta	linagliptin tablets	**1.** Approve if the patient has tried three products from the following list (if three are formulary or two if two are formulary, or one if only one is formulary): alogliptin tablets (Nesina, authorized generics), saxagliptin (Onglyza, generics), or a sitagliptin product (Januvia or Zituvio). If none are formulary, approve. Note: Alogliptin and Nesina count as one alternative. Saxagliptin and Onglyza count as one alternative. Januvia and Zituvio count as one alternative. **2.** Patients with a history of heart failure or a history of renal impairment: Approve if the patient has tried a stiagliptin product (Januvia or Zituvio), if formulary. If neither Januvia nor Zituvio is formulary, approve.	1 year	Yes	
Diabetes Agents - Glucagon-Like Peptide-1 (GLP-1) Agonists	Victoza and authorized generic	liraglutide (rDNA origin) injection	Type 2 Diabetes Mellitus. **1.** Approve if the patient has tried both Ozempic and Trulicity **[documentation required]**, if formulary (or one if one is formulary). If neither are formulary, approve. **2.** If the patient is less than 18 years of age, approve if the patient has tried Trulicity **[documentation required]**, if formulary. If Trulicity is non-formulary, approve.	1 year	Yes	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Diabetes Agents - Insulin (Basal)	Basaglar	Insulin glargine U-100 KwikPen	Approve if the patient has tried one of Rezvoglar, Lantus, Semglee (YFGN), or Insulin Glargine (YFGN), if formulary. If none of the above are formulary, see, 1, 2, and 3 below. Type 2 Diabetes (Initial user and a patient Currently Receiving Basaglar) [and all others]. **1.** If all the following products: Rezvoglar, Lantus, Semglee (YFGN), Insulin Glargine (YFGN) are non-formulary, approve if the patient meets the following (a and b): a. Patient has tried one of Toujeo or Insulin glargine U300, if formulary; AND b. Patient has tried one of Tresiba or Insulin Degludec; if formulary. Note: If the patient has tried any product from a. or b. regardless of formulary status, that criterion would be satisfied. Note: If there are no formulary products in a or b, approve. Type 1 Diabetes (initial user). **2.** If the patient has Type 1 diabetes and all the following products: Rezvoglar, Lantus, Semglee (YFGN), Insulin Glargine (YFGN) are non-formulary, approve if the patient meets (a and b): a. Patient has tried one of Toujeo or Insulin glargine U300, if formulary; AND b. Patient has tried one of Tresiba or Insulin Degludec, if formulary. Note: If the patient has tried any product from a. or b. regardless of formulary status, that criterion would be satisfied. Note: If there are no formulary products in a or b, approve. Type 1 Diabetes, Continuation of Therapy with Basaglar. **3.** If all the following products: Rezvoglar, Lantus, Semglee (YFGN), Insulin Glargine (YFGN) are non-formulary, the patient has Type 1 diabetes, and the patient is currently taking Basaglar, approve if the patient has tried one of Toujeo or Insulin glargine U300, if formulary. If neither are formulary, approve. Note: If the patient has tried either product above, regardless of formulary status, the criterion would be satisfied.	1 year	Yes	
Diabetes Agents - Insulin (Basal)	Levemir	insulin detemir U-100 vial and FlexTouch pen	Type 2 Diabetes (Initial user and a patient Currently Receiving Levemir); AND Type 1 Diabetes (Initial user) [and all others]. **1.** Approve if the patient meets the following (a and b): a. Patient has tried one of Tresiba or Insulin Degludec, if formulary; AND Note: If the patient has tried any product from a. regardless of formulary status, criterion a. would be satisfied. b. Patient has tried one of Rezvoglar, Toujeo, Basaglar, Lantus, Insulin Glargine (YFGN), or Semglee (YFGN), if formulary. Note: If the patient has tried any product from b. regardless of formulary status, criterion b. would be satisfied. Note: If there are no formulary products in a or b, approve. **2.** Patients < 6 years of age: approve if the patient has tried one of Tresiba or Insulin Degludec, if formulary. If neither are formulary, approve. Note: If the patient has tried either product listed in 2. regardless of formulary status, criterion 2. would be satisfied. **3.** Pregnant patients: approve. Type 1 Diabetes, Continuation of Therapy with Levemir. **4.** If the patient has Type 1 diabetes and is currently taking Levemir, approve.	1 year	Yes	
Diabetes Agents - Insulin (Basal)	Semglee (non YFGN)	insulin glargine U-100 vial and pen	**1.** Patient is directed to use Semglee (YFGN) [brand] or Insulin glargine-YFGN, if formulary. **2.** If neither are formulary, approve if the patient has tried one of Rezvoglar, Lantus, or Basaglar, if formulary. If Rezvoglar, Lantus, and Basaglar are non-formulary, approve. Note: If the patient has tried any product from 2. regardless of formulary status, criterion 2 would be satisfied.	1 year	Yes	
Diabetes Agents - Insulin (Basal)	Basaglar Tempo Pen	Insulin glargine U-100 Tempo Pen	Approve if the patient meets the following (1, 2, and 3): **1.** Patient will use or is using Basaglar Tempo Pen with the Tempo Smart Button; AND **2.** Patient has tried a basal insulin pen; AND **3.** Patient was unable to adhere to a regimen using a standard basal insulin pen, according to the prescriber **[documentation required]**. Note: Document the specific issue(s) with adherence that would be solved by the use of a Tempo Pen.	6 months	Yes	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Diabetes Agents - Insulin (Basal)	Insulin glargine U300	insulin glargine U-300 SoloStar pen	Direct to Toujeo (brand), if formulary. If Toujeo (brand) is non-formulary, approve if the patient meets (1, 2, 3 or 4): Type 2 Diabetes, (initial user) OR taking Toujeo/Insulin glargine U300 < 100 Units/injection (all others taking < 100 units/injection). **1.** Approve if the patient meets the following (a and b): a. Patient has tried one of Tresiba or Insulin Degludec, if formulary; AND Note: If the patient has tried any product from a. regardless of formulary status, criterion a. would be satisfied. b. Patient has tried one of Rezvoglar, Basaglar, Lantus, Semglee (YFGN), or Insulin glargine (YFGN), if formulary. Note: If the patient has tried any product from b. regardless of formulary status, criterion b would be satisfied. Note: If there are no formulary products in a or b, approve. Type 2 Diabetes, Continuation of Therapy with Toujeo or Insulin glargine U300 ≥ 100 units per injection (and all others taking ≥ 100 units/injection). **2.** Patients currently taking Toujeo or Insulin glargine U300 dose of ≥ 100 units per injection, approve if the patient has tried one of Tresiba U-200 or Insulin Degludec U-200, if formulary. If neither are formulary, approve. Note: If the patient has tried either product listed in 2. regardless of formulary status, criterion 2 would be satisfied. Note: A patient who has previously tried Tresiba U-100 is not required to try Tresiba U-200. Type 1 Diabetes (initial user). **3.** Patients with Type 1 diabetes- approve if the patient meets the following (a and b): a. Patient has tried one of Tresiba or Insulin Degludec, if formulary; AND Note: If the patient has tried any product from a. regardless of formulary status, criterion a would be satisfied. b. Patient has tried one of Rezvoglar, Basaglar, Lantus, Semglee (YFGN), or Insulin Glargine (YFGN), if formulary. Note: If the patient has tried any product from b. regardless of formulary status, criterion b would be satisfied. Note: If there are no formulary products in a or b, approve. Type 1 Diabetes, Continuation of Therapy with Toujeo or Insulin glargine U300. **4.** Patients with Type 1 diabetes currently taking Toujeo or Insulin glargine U300- approve if the patient meets the following (a or b): a. Patient has tried one of Rezvoglar, Basaglar, Semglee (YFGN), Insulin Glargine (YFGN), or Lantus, if formulary. If none are formulary, approve; OR Note: If the patient has tried any product from a. regardless of formulary status, criterion a would be satisfied. b. Patient is currently receiving a Toujeo or Insulin glargine U300 dose of ≥ 100 units per injection.	1 year	Yes	
Diabetes Agents - Insulin (Basal)	Lantus and Insulin glargine (by Winthrop, A-S Medication)	insulin glargine U-100 vial and SoloStar device	**1.** Patient is directed to use Semglee (YFGN) or Insulin glargin (YFGN) [authorized generic of Semglee {YFGN}], if formulary. If neither are formulary, approve. **2.** Approve if the patient has tried and cannot use Semglee (YFGN) or Insulin glargine (YFGN) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**. Note: If the patient had a trial of Insulin glargine (YFGN) and cannot use due to a formulation difference, an additional trial of Semglee (YFGN) would not be required and vice-versa, regardless of the formulary status of these products.	1 year	Yes	
Diabetes Agents - Insulin (Basal)	Rezvoglar	insulin glargine-aglr 100 units/mL Kwikpen	**1.** Patient is directed to use Semglee (YFGN) or Insulin glargine (YFGN) [authorized generic of Semglee {YFGN}], if formulary. If neither are formulary, approve. **2.** Approve if the patient has tried and cannot use Semglee (YFGN) or Insulin glargine (YFGN) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**. Note: If the patient had a trial of Insulin glargine (YFGN) and cannot use due to a formulation difference, an additional trial of Semglee (YFGN) would not be required and vice-versa, regardless of the formulary status of these products.	1 year	Yes	
Diabetes Agents – Insulin (Basal)	Insulin Degludec	insulin degludec vial and FlexTouch pen U-100 and U-200	Patient is directed to use Tresiba (brand), if formulary. If Tresiba (brand) is non-formulary, approve if the patient meets 1, 2, 3, or 4 below: All patients < 6 years (Type 1, Type 2, all others). **1.** Patients < 6 years of age: approve. Type 2 Diabetes (Initial user and a Patient Currently Receiving Tresiba) [and all others]. 2. Approve if the patient has tried one of Rezvoglar, Toujeo, Insulin glargine U300, Basaglar, Lantus, Semglee (YFGN), Insulin Glargine (YFGN), if formulary. Note: If the patient has tried any product above regardless of formulary status, this criterion would be satisfied. Note: If there are no formulary products in this criterion, approve. Type 1 Diabetes (Initial user). **3.** Patients with Type 1 diabetes- approve if the patient has tried one formulary product from the following list: Rezvoglar, Basaglar, Lantus, Semglee (YFGN), Insulin Glargine (YFGN), Toujeo, or Insulin glargine U300. If none are formulary, approve. Note: If the patient has tried any product from 3. regardless of formulary status, criterion 3 would be satisfied. Type 1 Diabetes, Continuation of therapy with Insulin Degludec or Tresiba. **4.** If the patient has Type 1 diabetes and is currently taking Tresiba or Insulin Degludec, approve.	1 year	Yes	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Diabetes Agents – Insulin (Basal) and Glucagon-Like Peptide-1 (GLP-1) Agonist Combination	Xultophy	insulin degludec/liraglutide injection	Approve if the patient has tried Soliqua, if formulary. If Soliqua is non-formulary, approve if the patient has tried two formulary basal insulins (if two are formulary or one if one is formulary): a glargine product (Basaglar, Lantus, Insulin Glargine [YFGN], Semglee [YFGN], Toujeo, Insulin glargine U300), or a degludec product (Tresiba or Insulin Degludec) AND three formulary glucagon-like peptide-1 (GLP-1) agonists (if three are formulary, or two if two are formulary or one if one is formulary): an exenatide product (Bydureon BCise, Byetta), Ozempic, Trulicity, or Victoza. If none of the basal insulin products or none of the GLP-1 agonists are formulary, approve. Note: Lantus, Insulin Glargine (YFGN), Semglee (YFGN), Basalgar, Toujeo, and Insulin glargine U300 would count as one alternative. Note: Tresiba and Insulin Degludec would count as one alternative. Note: Bydureon BCise and Byetta would count as one alternative.	1 year	Yes	
Diabetes Agents - Insulin (Human)	Novolin 70/30 Flexpen and Relion Novolin 70/30 Flexpen	insulin, 70/30 pen	**1.** Approve if the patient has tried Humulin 70/30 Kwikpens or Humulin 70/30 vials, if formulary. If both Humulin 70/30 Kwikpens and Humulin 70/30 vials are non-formulary, approve. **2.** If only Humulin 70/30 vials are formulary, approve in patients who are visually impaired, disabled (unable to draw up dose because of arthritis or otherwise physically disabled), or have coordination issues.	1 year	Yes	
Diabetes Agents - Insulin (Human)	Novolin 70/30 vials and Relion Novolin 70/30 vials	insulin, 70/30 vials	Approve if the patient has tried Humulin 70/30 vials or Humulin 70/30 Kwikpens, if formulary. If both Humulin 70/30 vials and Humulin 70/30 Kwikpens are non-formulary, approve.	1 year	Yes	
Diabetes Agents - Insulin (Human)	Novolin N Flexpen and Relion Novolin N Flexpen	insulin, NPH pen	**1.** Approve if the patient has tried Humulin N Kwikpens or Humulin N vials, if formulary. If both Humulin N Kwikpens and Humulin N vials are non-formulary, approve. **2.** If only Humulin N vials are formulary, approve in patients who are visually impaired, disabled (unable to draw up dose because of arthritis or otherwise physically disabled), or have coordination issues.	1 year	Yes	
Diabetes Agents - Insulin (Human)	Novolin N vials and Relion Novolin N vials	insulin, NPH vials	Approve if the patient has tried Humulin N vials or Humulin N Kwikpens, if formulary. If both Humulin N vials and Humulin N Kwikpens are non-formulary, approve.	1 year	Yes	
Diabetes Agents - Insulin (Human)	Novolin R Flexpen and Relion Novolin R U-100 Flexpen	insulin, regular pen	**1.** Approve if the patient has tried Humulin R U-100 vials, if formulary. If Humulin R U-100 vials are non-formulary, approve. **2.** Approve in patients who are visually impaired, disabled (unable to draw up dose because of arthritis or otherwise physically disable), or have coordination issues.	1 year	Yes	
Diabetes Agents - Insulin (Human)	Novolin R R U-100 vials and Relion Novolin R vials	insulin, regular vials	Approve if the patient has tried Humulin R U-100 vials, if formulary. If Humulin R U-100 vials are non-formulary, approve.	1 year	Yes	
Diabetes Agents - Insulin (Rapid-Acting and Other)	Admelog	insulin lispro vial, SoloStar (prefilled pen)	Approve if the patient meets one of the following (1 or 2): **1.** Patient meets all of the following (A, B, and C): A. Patient has tried Apidra, if formulary; AND B. Patient has tried one of the following, if formulary: Insulin Lispro (authorized generic of Humalog), Humalog, or Lyumjev; AND Note: If the patient has tried any product from B. regardless of formulary status, criterion B would be satisfied. C. Patient has tried one of the following, if formulary: NovoLog, or Insulin Aspart (authorized generic of NovoLog), or Fiasp; OR Note: If the patient has tried any product from C. regardless of formulary status, criterion C would be satisfied. Note: If no products in A, B, or C are formulary, approve. **2.** Patient is using an insulin pump that is not compatible with the formulary alternative(s), approve.	1 year	Yes	
Diabetes Agents - Insulin (Rapid-Acting and Other)	Apidra	insulin glulisine vial/Solostar (prefilled pen)	Approve if the patient meets one of the following (1 or 2): **1.** Patient meets both of the following (A and B): A. Patient has tried one of the following, if formulary: Insulin Lispro (authorized generic of Humalog), Humalog, Lyumjev, or Admelog; AND Note: If the patient has tried any product from A. regardless of formulary status, criterion A would be satisfied. B. Patient has tried one of the following, if formulary: NovoLog or Insulin Aspart (authorized generic of NovoLog), or Fiasp; OR Note: If the patient has tried any product from B. regardless of formulary status, criterion B would be satisfied. Note: If no products in A or B are formulary, approve. **2.** Patient is using an insulin pump that is not compatible with the formulary alternative(s), approve.	1 year	Yes	
Diabetes Agents - Insulin (Rapid-Acting and Other)	NovoLog and authorized generic (insulin aspart) and Relion Novolog	insulin aspart syringe, cartridge/Flexpen (prefilled syringe)/vial	Approve if the patient meets one of the following (1 or 2): **1.** Approve if the patient meets all of the following (A, B, and C): A. Patient has tried Apidra, if formulary; AND B. Patient has tried Fiasp, if formulary; AND C. Patient has tried one of following, if formulary: Insulin Lispro (authorized generic of Humalog), Humalog, Lyumjev, or Admelog; OR Note: If the patient has tried any product from C. regardless of formulary status, criterion C would be satisfied. Note: If no products in A, B, or C are formulary, approve. **2.** Patient is using an insulin pump that is not compatible with the formulary alternative(s), approve.	1 year	Yes	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Diabetes Agents - Insulin (Rapid-Acting and Other)	Humalog	insulin lispro syringe, cartridge/Kwikpen/vial 100 units/mL, and Kwikpen 200 units/mL	**1.** If the patient is requesting Humalog vial 100 units/mL or Humalog Kwikpen 100 units/mL, direct the patient to Insulin Lispro (authorized generic of Humalog), if formulary. If Insulin Lispro (authorized generic of Humalog) is non-formulary, then approve if the patient meets one of the following (A or B): A. Patient meets all of the following (i, ii, and iii): i. Patient has tried Apidra, if formulary; AND ii. Patient has tried one of the following, if formulary: NovoLog, Insulin Aspart (authorized generic of NovoLog), or Fiasp; AND Note: If the patient has tried any product from ii. regardless of formulary status, criterion ii would be satisfied. iii. Patient has tried one of Admelog or Lyumjev, if formulary; OR Note: If the patient has tried any product from iii. regardless of formulary status, criterion iii would be satisfied. Note: If no products in i, ii, or iii are formulary, approve. B. Patient is using an insulin pump that is not compatible with the formulary alternative(s), approve. **2.** If the patient is requesting Humalog cartridge, Humalog KwikPen U-200, or Tempo Pen, approve if the patient has tried Insulin Lispro (authorized generic of Humalog), if formulary. If Insulin Lispro (authorized generic of Humalog) is non-formulary, then approve if the patient meets all of the following (A, B, and C): A. Patient has tried Apidra, if formulary; AND B. Patient has tried one of the following, if formulary: NovoLog, Insulin Aspart (authorized generic of NovoLog), or Fiasp; AND Note: If the patient has tried any product from B. regardless of formulary status, criterion B would be satisfied. C. Patient has tried one of Admelog or Lyumjev, if formulary. Note: If the patient has tried any product from C. regardless of formulary status, criterion C would be satisfied. Note: If no products in A, B, or C are formulary, approve.	1 year	Yes - vial only	
Diabetes Agents - Insulin (Rapid-Acting and Other)	Insulin Lispro JR	Insulin lispro JR	Direct the patient to Humalog JR (brand). If Humalog JR (brand) is non-formulary, approve if the patient meets the following (A or B): A. Patient meets the following (i, ii, and iii): i. Patient has tried Apidra, if formulary; AND ii. Patient has tried one of the following, if formulary: Novolog, Insulin Aspart (authorized generic of Novolog), or Fiasp; AND iii. Patient has tried Admelog, if formulary; OR B. Patient requires ½ unit dosing. Note: If no products in A i, ii, or iii are formulary, approve. Note: The same product with different dosage forms count as one alternative (e.g., Fiasp vial, Fiasp Flextouch, Fiasp penfil would all count as one alternative).	1 year	Yes	
Diabetes Agents - Insulin (Rapid-Acting and Other)	Fiasp	insulin aspart injection vial, pen, cartridge, PumpCart	Approve if the patient meets one of the following (1 or 2): **1.** Patient meets all of the following (A, B, and C): A. Patient has tried Apidra, if formulary; AND B. Patient has tried one of the following, if formulary: Insulin Lispro (authorized generic of Humalog), Humalog, Lyumjev, or Admelog; AND Note: If the patient has tried any product from B. regardless of formulary status, criterion B would be satisfied. C. Patient has tried one of the following, if formulary: NovoLog or Insulin Aspart (authorized generic of NovoLog); OR Note: If the patient has tried any product from C. regardless of formulary status, criterion C would be satisfied. Note: If no products in A, B, or C are formulary, approve. **2.** Patient is using an insulin pump that is not compatible with the formulary alternative(s), approve.	1 year	Yes	
Diabetes Agents - Insulin (Rapid-Acting and Other)	Afrezza	insulin human [rDNA origin] inhalation powder	Approve if the patient meets the following (A, B, C and D): A. Patient has tried Apidra, if formulary; AND B. Patient has tried Fiasp, if formulary; AND C. Patient has tried one of the following, if formulary: NovoLog or Insulin Aspart (authorized generic); AND D. Patient has tried one of the following, if formulary: Insulin Lispro (authorized generic), Humalog, or Admelog. Note: If no products in A, B, C, or D are formulary, approve. Note: The same product with different dosage forms count as one alternative (e.g., Humalog vial and Humalog Kwikpen would count as one alternative).	1 year	Yes	
Diabetes Agents - Insulin (Rapid-Acting and Other)	Insulin Lispro Mix 75/25	75% Insulin lispro protamine/25% insulin lispro Kwikpen	Direct the patient is Humalog 75/25 (brand), if formulary. If Humalog 75/25 (brand) is non-formulary, approve if the patient has tried one of Novolog 70/30 or Insulin Aspart Protamine-Insulin Aspart Mix, if formulary. If neither are formulary, approve.	1 year	Yes	
Diabetes Agents - Insulin (Rapid-Acting and Other)	NovoLog 70/30 and authorized generic (insulin aspart protamine-insulin aspart) and Relion Novolog 70/30	insulin aspart protamine/insulin aspart, Flexpen (prefilled syringe)/vial	Approve if the patient has tried Humalog 75/25, if formulary. If Humalog 75/25 is non-formulary, approve.	1 year	Yes	
Diabetes Agents - Other	metformin immediate release 625 mg	metformin immediate-release tablet 625 mg	Approve if the patient had inadequate efficacy OR significant intolerance with metformin 500 mg, 850 mg, or 1000 mg immediate-release tablets.	1 year	Yes	
Diabetes Agents - Other	Glumetza	metformin extended-release tablets	Approve if the patient has tried BOTH one metformin immediate-release tablet product AND two other formulary metformin extended-release products (if two are formulary or one if one is formulary): metformin extended-release tablets or Fortamet (brand or generic). **NOTE:** A trial of Glumetza would NOT count toward this requirement.	1 year	Yes	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Diabetes Agents - Sodium Glucose Co-Transporter-2 (SGLT-2) Inhibitor Combination Products	dapagliflozin-metformin ER tablets	dapagliflozin-metformin ER tablets	Direct to Xigduo XR (brand), if formulary. If Xigduo XR (brand) is non-formulary: Approve if the patient has tried two formulary alternatives from the following list, if formulary (or one if one is formulary): Synjardy, Synjardy XR, or Segluromet. If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics) AND three formulary alternatives from the following list, if formulary (or three if three are formulary or two if two are formulary or one if one is formulary): Farxiga, Jardiance, or Steglatro. Note: Synjardy and Synjardy XR would count as one alternative.	1 year	Yes	
Diabetes Agents - Sodium Glucose Co-Transporter-2 (SGLT-2) Inhibitor Combination Products	Invokamet	canagliflozin and metformin tablets	Approve if the patient has tried four formulary alternatives from the following list, if formulary (or three if three are formulary or two if two are formulary or one if one is formulary): Invokamet XR, Synjardy, Synjardy XR, Segluromet, or Xigduo XR. If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics) AND four formulary alternatives from the following list, if formulary (or three if three are formulary or two if two are formulary or one if only one is formulary): Farxiga, Invokana, Jardiance, or Steglatro. Note: Synjardy and Synjardy XR would count as one alternative.	1 year	Yes	
Diabetes Agents - Sodium Glucose Co-Transporter-2 (SGLT-2) Inhibitor Combination Products	Invokamet XR	canagliflozin and metformin extended-release tablets	Approve if the patient has tried four formulary alternatives from the following list, if formulary (or three if three are formulary or two if two are formulary or one if one is formulary): Invokamet (not XR), Synjardy, Synjardy XR, Xigduo XR, or Segluromet. If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics) AND four formulary alternatives from the following list, if formulary (or three if three are formulary or two if two are formulary or one if one is formulary): Farxiga, Invokana, Jardiance, or Steglatro. Note: Synjardy and Synjardy XR would count as one alternative.	1 year	Yes	
Diabetes Agents - Sodium Glucose Co-Transporter-2 (SGLT-2) Inhibitor Combination Products	Segluromet	ertugliflozine and metformin tablets	Approve if the patient has tried two formulary alternatives from the following list (or one if only one is formulary): Synjardy, Synjardy XR, or Xigduo XR. If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics) AND three formulary alternatives from the following list, if formulary (or two if two are formulary or one if one is formulary: Farxiga, Steglatro, or Jardiance. Note: Synjardy and Synjardy XR would count as one alternative.	1 year	Yes	
Diabetes Agents - Sodium Glucose Co-Transporter-2 (SGLT-2) Inhibitors	dapagliflozin tablets (authorized generic of Farxiga)	dapagliflozin tablets	Direct to Farxiga (brand), if formulary. If Farxiga (brand) is non-formulary: Approve if the patient has tried, according to the prescriber, and experienced inadequate efficacy OR significant intolerance with Jardiance, if formulary. If Jardiance is non-formulary, approve.	1 year	Yes	
Diabetes Agents - Sodium Glucose Co-Transporter-2 (SGLT-2) Inhibitors	Inpefa	sotagliflozin tablets	Patients with one of the following: 1) Heart Failure OR 2) Type 2 diabetes, Chronic Kidney Disease (CKD), and Other cardiovascular (CV) risk factors. Approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with BOTH Farxiga and Jardiance, if formulary (or one if one is formulary). If neither are formulary, approve.	1 year	Yes	
Diabetes Agents - Sodium Glucose Co-Transporter-2 (SGLT-2) Inhibitors	Invokana	canagliflozin tablets	**1.** Approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with BOTH products from the following list (or one if only one is formulary): Farxiga and Jardiance. If neither are formulary, approve. **2.** If Invokana is being used for glycemic control and the patient's estimated glomerular filtration rate is less than 45 mL/minute, approve if the patient has tried and, according to the prescriber, experienced inadequate efficacy OR significant intolerance with Jardiance, if formulary. If Jardiance is non-formulary, approve. **3.** If the patient has diabetic kidney disease, approve if the patient has tried and, according to the prescriber, experienced inadequate efficacy OR significant intolerance with Farxiga, if formulary. If Farxiga is non-formulary, approve.	1 year	Yes	
Diabetes Agents - Sodium Glucose Co-Transporter-2 (SGLT-2) Inhibitors	Steglatro	ertugliflozin tablets	Approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with BOTH products from the following list (or one if only one is formulary): Farxiga and Jardiance. If neither are formulary, approve.	1 year	Yes	
Diabetes Agents - Sodium Glucose Co-Transporter-2 (SGLT-2) Inhibitors	Brenzavvy	bexagliflozin tablets	**1.** Approve if the patient has tried BOTH Farxiga AND Jardiance, if both are formulary (or one if one is formulary). If neither are formulary, approve. **2.** If the patient's estimated glomerular filtration rate is less than 45 mL/minute, approve if the patient has tried Jardiance, if formulary. If Jardiance is non-formulary, approve.	1 year	Yes	
Diabetes Agents – Sulfonylurea	glipizide 2.5 mg	glipizide 2.5 mg	Approve if the patient's prescribed dose cannot be obtained with glipizide 5 mg. Note: The patient is NOT required to split the 5 mg tablets in half.	1 year	Yes	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Diabetic Pen Needles	Pen needles by Arkray, Home Aide Diagnostics, HTL-Strefa, Nipro Diagnostics, Novo Nordisk, Owen Mumford, Simple Diagnostics, Ultimed, all other diabetic pen needles that are not BD	Pen needles by Arkray, Home Aide Diagnostics, HTL-Strefa, Nipro Diagnostics, Novo Nordisk, Owen Mumford, Simple Diagnostics, Ultimed, all other diabetic pen needles that are not BD	**1.** Approve if the patient has tried one formulary pen needle. If none are formulary, approve. **2.** Approve if the prescriber states the patient requires a needle of the requested length and/or gauge which is not available as a formulary product. Note: NPF prefers BD products.	1 year	Yes	
Diabetic Supplies	Diabetic Supplies	Blood glucose meters/test strips/control solutions	**1.** Approve if the patient has tried one formulary meter/test strip/control solution. If none are formulary, approve. **2.** Patients using an insulin pump/meter system that is not compatible with one of the available formulary alternatives: approve. **3.** If the request is for Freestyle Precision Neo strips for use in a Freestyle Libre reader, approve. **4.** Patients who are blind or significantly visually impaired who are requesting a meter with audio capabilities: approve if the patient has tried one other formulary meter with audio capabilities. If there are no formulary meters with audio capabilities, approve. Note: Meters with audio capabilities include Advocate (Redi-Code plus speaking meter), Arkray (Glucocard Expression, Glucocard Shine Express), Foracare (Fora D40D, Fora D40G, For a Gtel, Fora Premium V10 BLE, Fora Test N' Go Advance Voice, Fora Tn'G Voice, Fora V30), Oak Tree Health (EasyMax V, Fortiscare V3), Omnis Health (Embrace Talk), Prodigy (Prodigy Autocode, Prodigy Voice), Relion Premier Voice.	1 year	Yes - certain diabetic supplies	
Diabetic Supplies – Continuous Glucose Monitoring Systems	Other continuous glucose monitoring systems (receiver/reader, transmitter, sensor) [That are NOT Dexcom 6 or Freestyle Libre 2 or Freestyle Libre 3], this includes Bigfoot Unity Program Kit	Other continuous glucose monitoring systems (receiver/reader, transmitter, sensor) [That are NOT Dexcom 6 or Freestyle Libre 2 or Freestyle Libre 3]	Patient meets the following *Diabetes – Continuous Glucose Monitoring Systems Prior Authorization Policy* criteria AND Patient meets ONE of the following (1 or 2): **1.** Approve if the patient has tried BOTH of the following systems, if formulary: 1) Freestyle Libre 2 or Freestyle Libre 3 AND 2) Dexcom G6 or Dexcom G7. If none are formulary, approve. Note: If only a Freestyle Libre product is formulary and the patient has tried a different Freestyle Libre product (e.g., Freestyle Libre 10- or 14 day- product), approve. Note: If only a Dexcom product is formulary and the patient has tried a different Dexcom product (e.g., Dexcom G4 or G5), approve. **2.** If the patient is using an insulin pump system that is not compatible with one of the formulary alternatives: approve.	1 year	Yes - Bigfoot Unity Program Kit	
Diabetic Supplies – Other	Tempo Refill Kit	Tempo Lancets, strips, and Pen needles	Approve if the patient meets the following (1, 2, and 3): **1.** Patient will use or is using this product concomitantly with a Tempo Insulin Pen; AND **2.** Patient has tried standard insulin products; AND **3.** Patient was unable to adhere to a regimen using standard insulin products, according to the prescriber **[documentation required]**. Note: Document the specific issue(s) with adherence that would be solved by the use of a Tempo product.	6 months	Yes	
Diabetic Supplies – Other	Tempo Smart Button	Tempo Smart Button	Approve if the patient meets the following (1, 2, and 3): **1.** Patient will use or is using this product concomitantly with a Tempo Insulin Pen; AND **2.** Patient has tried standard insulin products; AND **3.** Patient was unable to adhere to a regimen using standard insulin products, according to the prescriber **[documentation required]**. Note: Document the specific issue(s) with adherence that would be solved by the use of a Tempo product.	6 months	Yes	
Diabetic Supplies – Other	Tempo Welcome Kit	Tempo Smart Button; Tempo Blood Glucose Monitoring System, Lancets, Strips, and Pen needles	Approve if the patient meets the following (1, 2, and 3): **1.** Patient will use or is using this product concomitantly with a Tempo Insulin Pen; AND **2.** Patient has tried standard insulin products; AND **3.** Patient was unable to adhere to a regimen using standard insulin products, according to the prescriber **[documentation required]**. Note: Document the specific issue(s) with adherence that would be solved by the use of a Tempo product.	6 months	Yes	
Diabetic Syringes	Syringes by Arkray, Home Aide Diagnostics, HTL-Strefa, Nipro Diagnostics, Novo Nordisk, Owen Mumford, Simple Diagnostics, Ultimed, all other syringes that are not BD	Syringes by Arkray, Home Aide Diagnostics, HTL-Strefa, Nipro Diagnostics, Novo Nordisk, Owen Mumford, Simple Diagnostics, Ultimed, all other syringes that are not BD	**1.** Approve if the patient has tried one formulary syringe. If none are formulary, approve. **2.** Approve if the prescriber states the patient requires a needle of the requested length and/or gauge which is not available as a formulary product. Note: NPF prefers BD products	1 year	Yes	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Direct Renin Inhibitors	Tekturna	aliskiren tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Duchenne Muscular Dystrophy (DMD) Agents	Amondys 45	casimersen intravenous	No exceptions are recommended. The effectiveness of Amondys 45 has not been established at this time. (NOTE: It is not appropriate to use standard global criteria for this medication; Denial reason is: No exceptions are recommended. The effectiveness of Amondys 45 has not been established at this time.)	N/A	Yes	
Duchenne Muscular Dystrophy (DMD) Agents	Exondys 51	eteplirsen injection for intravenous use	No exceptions are recommended. The effectiveness of Exondys 51 has not been established at this time. (NOTE**:** It is not appropriate to use standard global criteria for this medication; Denial reason is: No exceptions are recommended. The effectiveness of Exondys 51 has not been established at this time.)	N/A	Yes	
Duchenne Muscular Dystrophy (DMD) Agents	Viltepso	viltolarsen injection for intravenous infusion	No exceptions are recommended. The effectiveness of Viltepso has not been established at this time. (NOTE: It is not appropriate to use standard global criteria for this medication; Denial reason is: No exceptions are recommended. The effectiveness of Viltepso has not been established at this time.)	N/A	Yes	
Duchenne Muscular Dystrophy (DMD) Agents	Vyondys 53	golodirsen injection for intravenous use	No exceptions are recommended. The effectiveness of Vyondys 53 has not been established at this time. (NOTE: It is not appropriate to use standard global criteria for this medication; Denial reason is: No exceptions are recommended. The effectiveness of Vyondys 53 has not been established at this time.)	N/A	Yes	
Duchenne Muscular Dystrophy (DMD) Agents	Brand Emflaza (tablets and oral suspension)	deflazacort tablets and oral suspension	See standard *Muscular Dystrophy – Deflazacort Preferred Specialty Management Policy* criteria.	See PSM duration	Yes	
Duchenne Muscular Dystrophy (DMD) Agents	Agamree	vamorolone oral suspension	See standard *Muscular Dystrophy – Agamree Prior Authorization Policy* criteria.	1 year	Yes	
Duchenne Muscular Dystrophy (DMD) Agents	Elevidys	delandistrogene moxeparvovec-rokl intravenous infusion	No exceptions are recommended. The effectiveness of Elevidys has not been established at this time. (NOTE: It is not appropriate to use standard global criteria for this medication; Denial reason is: No exceptions are recommended. The effectiveness of Elevidys has not been established at this time.)	N/A	Yes	
Duchenne Muscular Dystrophy (DMD) Agents - Histone Deacetylase Inhibitor	Duvyzat	givinostat oral suspension	See standard *Muscular Dystrophy – Duvyzat Prior Authorization Policy* criteria	See PA duration	Yes	
Endocrine Drugs – Repository Corticotropin	Cortrophin Gel (Purified)	repository corticotropin subcutaneous or intramuscular injection	No exceptions are recommended. There is a lack of updated clinical efficacy data and potential safety concerns with long-term use. (NOTE: It is not appropriate to use standard global criteria for this medication; Denial reason is: No exceptions are recommended. There is a lack of updated clinical efficacy data and insufficient information to determine clinically meaningful benefits.)	N/A	Yes	
Endocrine Drugs - Miscellaneous	Samsca	tolvaptan tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Endocrine Drugs - Miscellaneous	Sensipar	cinacalcet tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Endothelin Receptor Antagonist	Tryvio	aprocitentan tablets	Approve if the patient has tried, or is currently receiving, at least three other antihypertensive agents for the treatment of hypertension from at least three of the following pharmacological classes **[documentation required]** (i, ii, iii, iv, v, vi, vii, viii, ix, x). Note: A combination product from two or more different classes would count as an alternative from each class. i. Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB); Note: Examples of ACE inhibitors include benazepril, captopril, enalapril, fosinopril, lisinopril, moexipril, perindopril, ramipril, and trandolapril. Examples of ARBs include azilsartan, candesartan, eprosartan, irbesartan, losartan, olmesartan, telmisartan, and valsartan. ii. Non-dihydropyridine calcium channel blocker; Note: Examples include diltiazem and verapamil. iii. Dihydropyridine calcium channel blocker; Note: Examples include amlodipine, felodipine, isradipine, nicardipine, nifedipine, and nisoldipine. iv. Diuretic; Note: Examples of thiazide diuretics include chlorthalidone, chlorothiazide, hydrochlorothiazide, indapamide, and metolazone. Examples of potassium-sparing diuretics are amiloride and triamterene. v. Mineralocorticoid receptor antagonist; Note: Examples of mineralocorticoid receptor antagonists include eplerenone and spironolactone. vi. Beta-blocker; Note: Examples of beta blockers include acebutolol, atenolol, betaxolol, bispoprolol, carvedilol, metoprolol, nadolol, nebivolol, pindolol, propranolol, and timolol. vii. Alpha-adrenergic blocker; Note: Examples of alpha-adrenergic blockers are doxazosin, prazosin, and terazosin. viii. Central alpha-adrenergic agonist; Note: Examples of central alpha-adrenergic agonists are clonidine, guanfacine, and methyldopa. ix. Direct vasodilator; Note: Examples of direct vasodilators are hydralazine and minoxidil. x. Direct renin inhibitor. Note: An example of a direct renin inhibitor is aliskiren.	1 year	Yes	
Epinephrine Self-Administered Injectables	epinephrine auto-injector	epinephrine 0.15 mg, 0.3 mg auto-injector authorized generic (Amneal Pharmace, Avkare, A-S Medication)	Approve if the patient has tried one product from the following list, if one is formulary: epinephrine auto-injector (EpiPen/EpiPen Jr., generics). If none are formulary, approve.	1 year	Yes	
Erectile Dysfunction Agents - Phosphodiesterase Type 5 (PDE-5) Inhibitors	Cialis	tadalafil tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Erectile Dysfunction Agents - Phosphodiesterase Type 5 (PDE-5) Inhibitors	Viagra	sildenafil tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Erythropoiesis-Stimulating Agents (ESAs)	Aranesp	darbepoetin alfa	Approve if the patient has tried one product from the following list: Epogen, Procrit or Retacrit **[documentation required]**, if one is formulary. If none are formulary, approve.	1 year	Yes	
Erythropoiesis-Stimulating Agents (ESAs)	Epogen	epoetin alfa	**1.** Approve if the patient meets the following criteria (A and B): A. Patient meets the following criteria (i and ii): i. Patient has tried both products from the following list, if formulary (or one if only one is formulary): Procrit and Retacrit **[documentation required]**; AND Note: If neither are formulary, would still need to meet criteria B, if Aranesp is formulary. ii. Patient cannot continue to use each formulary alternative due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction; AND B. Patient has tried Aranesp, if formulary **[documentation required]**. Note: If none of the following products are formulary: Aranesp, Procrit, and Retacrit, approve. **2.** Pediatric patients with anemia due to cancer chemotherapy; Patients undergoing surgery requesting agent for the reduction of allogeneic red blood cell transfusion; Patients with anemia and human immunodeficiency virus (HIV) infection who are receiving zidovudine: Patient meets the following criteria (i and ii): i. Patient has tried both products from the following list, if formulary (or one if only one is formulary): Procrit and Retacrit **[documentation required]**; AND Note: If neither are formulary, approve. ii. Patient cannot continue to use each formulary alternative due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction.	1 year	Yes	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Erythropoiesis-Stimulating Agents (ESAs)	Mircera	methoxy polyethylene glycol-epoetin beta solution for injection	Approve if the patient meets the following criteria (1 AND 2): 1. Patient has tried one epoetin alpha product from the following list, if formulary: Epogen, Procrit, or Retacrit **[documentation required]**; AND Note: If none are formulary, would still need to meet criteria 2, if Aranesp is formulary. 2. Patient has tried Aranesp, if formulary **[documentation required]**. Note: If none of the following products are formulary: Aranesp, Epogen, Procrit, and Retacrit, approve. Note: The requirements are that one epoetin alpha product and Aranesp have been tried, if both are formulary. If only epoetin alpha product(s) is/are formulary and the patient has tried an epoetin alpha product, then the request should be approved.	1 year	Yes	
Estrogen and Estrogen Combination Products (Topical)	Elestrin	estradiol gel 0.06%	Approve if the patient meets BOTH of the following (A and B): A. Patient has tried one formulary non-patch topical estradiol product: Estrogel, estradiol gel (transdermal) [Divigel, generics] Evamist, if one is formulary; AND B. Patient has tried one estradiol patch (e.g., estradiol patch [Climara, Vivelle Dot generics], Minivelle [generics). Note: If no transdermal gels or sprays are formulary, the patient would still need to try an estradiol patch.	1 year	Yes	
Estrogen and Estrogen Combination Products (Topical)	Estrogel	estradiol gel 0.06%	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Estrogen and Estrogen Combination Products (Topical)	Climara Pro	estradiol/ levonorgestrel patch	Approve if the patient has tried CombiPatch, if formulary. If CombiPatch is non-formulary, approve if the patient has tried one oral estrogen/progestin combination product (e.g., estradiol/norethindrone [Activella, generics], Prempro, Premphase, ethinyl estradiol/norethindrone acetate [Femhrt, generics], Prefest, Angeliq).	1 year	Yes	
Estrogen and Estrogen Combination Products (Topical)	Divigel	estradiol gel 0.1%	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Estrogen and Estrogen Combination Products (Topical)	Minivelle	estradiol transdermal patch	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.		MSB Exclusion *This criteria applies only to the NPF	
Estrogen and Estrogen Combination Products (Topical)	Vivelle-Dot	estradiol transdermal patch	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Estrogen Combination Products (Oral)	Bijuva	estradiol 1 mg and progesterone 100 mg capsules	Approve if the patient meets the following (A, B and C): A. Patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one product from the following list, if formulary: Activella (including generics of Activella: Mimvey, Amabelz, and estradiol-norethindrone); AND B. Patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one product from the following list: Femhrt (including generics of Femhrt: Jinteli, Fyavolv, norethindrone-ethinyl estradiol); AND C. Patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one of Premphase or Prempro, if formulary. Note: If none are formulary in A, B and C, approve. If none are formulary in A, B, or C, the other(s) would still need to be tried.	1 year	Yes	
Estrogen Combination Products (Oral)	Premphase	conjugated estrogens//medroxyprogesterone tablets	Approve if the patient meets the following (A, B, and C): A. Patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one product from the following list, if formulary: Femhrt (including generics of Femhrt: Jinteli, Fyavolv, norethindrone-ethinyl estradiol); AND B. Patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one product from the following list, if formulary: Activella (including generics of Activella: Mimvey, Amabelz, and estradiol-norethindrone); AND C. Patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with Bijuva. Note: If none are formulary in A, B, and C, approve. If none are formulary in A, B, or C, the other(s) would still need to be tried.	1 year	Yes	
Estrogen Combination Products (Oral)	Prempro	conjugated estrogens/ medroxyprogesterone tablets	Approve if the patient meets the following (A, B, and C): A. Patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one product from the following list, if formulary: Femhrt (including generics of Femhrt: Jinteli, Fyavolv, norethindrone-ethinyl estradiol); AND B. Patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one product from the following list, if formulary: Activella (including generics of Activella: Mimvey, Amabelz, and estradiol-norethindrone); AND C. Patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with Bijuva. Note: If none are formulary in A, B, and C, approve. If none are formulary in A, B, or C, the other(s) would still need to be tried.	1 year	Yes	
Estrogen Products (Oral)	Menest	esterified estrogens tablets	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with two products (or one if one is formulary) from the following list: estradiol tablets (Estrace, generics) and Premarin tablets. If neither are formulary, approve.	1 year	Yes	
Estrogen Products (Oral)	Premarin	conjugated estrogens tablets	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with two products (or one if one is formulary) from the following list: estradiol tablets (Estrace, generics) and Menest tablets. If neither are formulary, approve.	1 year	Yes	
Estrogen Products (Vaginal)	Femring	estradiol vaginal ring (0.05 mg and 0.10 mg)	Approve if the patient has tried two formulary alternatives from the following list (or one if only one is formulary): Imvexxy vaginal insert, Premarin cream, estradiol 0.01% cream (Estrace Cream, generics), Estring vaginal ring, estradiol vaginal tablet (e.g., Yuvafem, Vagifem, generics), estradiol patch (Climara, generics), estradiol patch (Vivelle Dot, generics), Menostar patch, estradiol tablets (Estrace, generics), Menest tablets, or Premarin tablets. If none are formulary, approve.	1 year	Yes	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Estrogen Products (Vaginal)	Estring	estradiol 2 mg vaginal ring	**1.** Approve if the patient has tried two formulary alternatives from the following list (or one if only one is formulary): Imvexxy vaginal insert, Femring vaginal ring, Premarin Cream, estradiol 0.01% cream (Estrace Cream, generics), or estradiol vaginal tablet (e.g., Yuvafem, Vagifem, generics). If none are formulary, approve. **2.** If according to the prescriber, the patient requires a low-dose vaginal product, approve if the patient has tried one of Imvexxy vaginal insert or estradiol vaginal tablets (e.g., Yuvagen, Vagifem, generics), if formulary. If neither are formulary, approve.	1 year	Yes	
Estrogen Products (Vaginal)	Imvexxy	estradiol vaginal insert	**1.** Approve if the patient has tried two formulary alternatives from the following list (or one if only one is formulary): Premarin vaginal cream, Femring vaginal ring, estradiol 0.01% cream (Estrace Cream, generics), Estring vaginal ring, or estradiol vaginal tablet (e.g., Yuvafem, Vagifem, generics). If none are formulary, approve. **2.** If according to the prescriber, the patient requires a low-dose vaginal product, approve if the patient has tried one of Estring or estradiol vaginal tablets (e.g., Yuvagen, Vagifem, generics), if formulary. If neither are formulary, approve.	1 year	Yes	
Estrogen Products (Vaginal)	Estrace Cream	estradiol cream	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Estrogen Products (Vaginal)	Vagifem	estradiol vaginal tablet	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Factor Deficiency Agents and Related Products	NovoSeven RT	Factor VIIa (recombinant) powder for injection	**1.** Hemophilia A with Inhibitors; Hemophilia B with Inhibitors: Approve if the patient meets the following criteria (a, b, c, or d): a. The patient has tried Sevenfact, if formulary. If Sevenfact is non-formulary, approve; OR b. The patient is less than 12 years of age; OR c. The patient has an allergy to rabbits or rabbit-derived products; OR d. The patient is currently receiving NovoSeven RT or has received NovoSeven RT in the past. **2.** Congenital Factor VII Deficiency, approve. **3.** Glanzmann's Thrombasthenia, approve. **4.** Hemophilia, Aquired, approve.	1 year	Yes	Yes
Fc receptor blocker	Rystiggo	rozanolixizumab-noli subcutaneous infusion	Generalized Myasthenia Gravis, anti-acetylcholine receptor antibody positive in a patient ≥18 years of age. **1.** Approve if the patient has tried one of Vyvgart intravenous or Vyvgart Hytrulo, if formulary. If neither are formulary, approve. **2.** If the patient is unable to obtain and/or maintain intravenous access, approve if the patient has tried Vyvgart Hytrulo, if formulary. If Vyvgart Hytrulo is non-formulary, approve. **3.** Approve if the patient has already been started on therapy with Rystiggo. Generalized Myasthenia Gravis, anti-muscle-specific tyrosine kinase antibody-positive in a patient ≥ 18 years of age. Approve.	1 year	Yes	Yes
Fenofibrates	Antara, Lipofen and authorized generics	fenofibrate capsules or tablets	Approve if the patient has tried three other formulary fenofibrate products (e.g., TriCor or generic, Lipofen, Fenoglide or generic, Trilipix or generic, generic fenofibrate capsule/ tablets, Fibricor or generic, generic fenofibric acid tablets) or two if only two are formulary, or one if only one is formulary. If none are formulary approve the requested agent.	1 year	Yes	
Fenofibrates	Tricor	fenofibrate tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Fentanyl Transmucosal Products	Fentora and authorized generic	fentanyl buccal tablet	See *Opioids Transmucosal – Fentora FE*	1 year	Yes	
Fertility Agents – Follitropin Ovulatory Stimulants	Follistim AQ	follitropin beta	**1.** Approve if the patient has tried one product from the following list: Gonal-F/Gonal-F RFF, if formulary. If Gonal-F/Gonal-F RFF is non-formulary, approve. **2.** Patient has been started on a current cycle of therapy with Follistim AQ: approve to complete the current cycle.	1 year	Yes	
Fertility Agents – Gonadotropin-Releasing Hormone (GnRH) Antagonists	ganirelix injection	ganirelix acetate injection	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Gabapentin and Gabapentin-Like Medications	Lyrica	pregabalin capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Gabapentin and Gabapentin-Like Medications	Lyrica CR	pregabalin controlled-release capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Gabapentin and Gabapentin-Like Medications	Neurontin	gabapentin tablet, capsule and solution	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Gastrointestinal Drugs - Miscellaneous	Dartisla ODT	glycopyrrolate orally disintegrating tablets	**1.** Direct to glycopyrrolate tablets. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use glycopyrrolate tablets.	1 year	Yes	
Gastrointestinal Drugs - Miscellaneous	Mytesi	crofelemer delayed-release tablets	For the symptomatic relief of non-infectious diarrhea in adult patients with Human immunodeficiency virus (HIV) or Acquired immunodeficiency syndrome (AIDS): Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with both diphenoxylate-atropine tablets AND loperamide.	1 year	Yes	
Gastrointestinal Drugs - Miscellaneous	Carafate	sulcralfate tablets and oral suspension	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Gastrointestinal Drugs - Miscellaneous	Cuvposa	glycopyrrolate oral solution	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Gastroparesis Agents	Gimoti	metoclopramide nasal spray	No exceptions are recommended. Due to insufficient clinical efficacy data, approval is not recommended for Gimoti. (**NOTE**: It is not appropriate to use standard global criteria for this medication; Denial reason is: No exceptions are recommended. Due to insufficient clinical efficacy data, approval is not recommended.)	N/A	Yes	
Gaucher Disease Medications	Elelyso	taliglucerase alfa for injection	**1**. Patients with Gaucher Disease Type 1, approve if the patient has tried one product from the following list: Cerezyme or Vpriv, if formulary. If neither are formulary, approve. Note: Type 1 Gaucher disease is also known as non-neuronopathic Gaucher disease. **2**. Patients with Gaucher Disease Type 3, approve if the patient has tried one product from the following list: Cerezyme or Vpriv, if formulary. If neither are formulary, approve. Note: Type 3 Gaucher disease is also known as chronic neuronopathic Gaucher disease. **3**. Patients with Gaucher Disease Type I or Type 3 currently established on treatment with Elelyso: approve.	1 year	Yes	Yes
Gaucher Disease Medications	Vpriv	velaglucerase alfa for injection	**1**. Patients with Gaucher Disease Type 1, approve if the patient has tried one product from the following list: Cerezyme or Elelyso, if formulary. If neither are formulary, approve. Note: Type 1 Gaucher disease is also known as non-neuronopathic Gaucher disease. **2**. Patients with Gaucher Disease Type 3, approve if the patient has tried one product from the following list: Cerezyme or Elelyso, if formulary. If neither are formulary, approve. Note: Type 3 Gaucher disease is also known as chronic neuronopathic Gaucher disease. **3**. Patients with Gaucher Disease Type 1 or Type 3 currently established on treatment with Vpriv: approve.	1 year	Yes	Yes
Gaucher Disease Medications	Zavesca	miglustat capsules	**NOTE**: A multisource Brand product is being requested. See standard *Gaucher Disease – Substrate Reduction Therapy Preferred Specialty Management Policy* criteria	1 year	MSB Exclusion *This criteria applies only to the NPF	
Glucose-Elevating Drugs	Zegalogue	dasiglucagon subcutaneous injection	Approve if the patient has tried Gvoke and Baqsimi, if formulary (or one if one is formulary). If neither are formulary, approve.	1 year	Yes	
Glucose-Elevating Drugs	GlucaGen/GlucaGen HypoKit	glucagon, human recombinant for injection	**1.** Approve if the patient has tried two products from the following list: Baqsimi intranasal, Gvoke, or Zegalogue, if formulary (or only one if one is formulary). If none are formulary, approve. **2.** If the patient is ≥ 4 years of age but < 6 years of age, approve if the patient has tried Baqsimi or Gvoke, if formulary. If neither are formulary, approve. **3.** If the patient is ≥ 2 years of age but < 4 years of age, approve if the patient has tried Gvoke, if formulary. If Gvoke is non-formulary, approve. **4.** If the patient is < 2 years of age, approve.	1 year	Yes	
Glucose-Elevating Drugs	Glucagon/Glucagon Emergency Kit	glucagon/glucagon Emergency Kit	**1.** Approve if the patient has tried two products from the following list: Baqsimi intranasal, Gvoke, or Zegalogue, if formulary (or only one if one is formulary). If none are formulary, approve. **2.** If the patient is ≥ 4 years of age but < 6 years of age, approve if the patient has tried Baqsimi or Gvoke, if formulary. If neither are formulary, approve. **3.** If the patient is ≥ 2 years of age but < 4 years of age, approve if the patient has tried Gvoke, if formulary. If Gvoke is non-formulary, approve. **4.** If the patient is < 2 years of age, approve.	1 year	Yes	
Gonadotropin-Releasing Hormone (GnRH) Analogs - CPP	Lupron Depot-Ped	leuprolide acetate for depot suspension	Central Precocious Puberty; Gender-Dysphoric/Gender-Incongruent Persons; Persons Undergoing Gender Reassignment (Female-To-Male or Male-To-Female). **1.** Approve if the patient has tried both Triptodur and Fensolvi, if formulary (or one if one is formulary) **[documentation required]**. If neither are formulary, approve. **2.** Patients < 2 years of age, approve.	1 year	Yes	
Gonadotropin-Releasing Hormone (GnRH) Analogs - CPP	Supprelin LA	histrelin subcutaneous [SC] implant	Approve if the patient has tried one of Fensolvi, Lupron Depot-Ped, or Triptodur, if one is formulary. If none are formulary, approve.	1 year	Yes	
Gonadotropin-Releasing Hormone (GnRH) Analogs - Prostate Cancer	Leuprolide Depot 22.5 mg (formerly Lutrate Depot)	leuprolide acetate 22.5 mg for depot suspension	Prostate Cancer: Approve if patient has tried Lupron Depot 22.5 mg, if formulary. If Lupron Depot, 22.5 mg is non-formulary, approve if the patient meets (1 or 2): 1. Approve if the patient has tried one of Camcevi, Eligard, Firmagon, Trelstar, or Orgovyx, if formulary. If none are formulary, approve. 2. Patient who has already been started on therapy with Leuprolide Depot, approve if the patient has tried one of Camcevi or Eligard, if formulary. If neither are formulary, approve. Head and Neck Cancer – Salivary Gland Tumors: Approve if the patient has tried one of Camcevi, Eligard, or Lupron Depot. If none are formulary, approve.	1 year	Yes	Yes

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Gonadotropin-Releasing Hormone (GnRH) Analogs - Prostate Cancer	Camcevi	leuprolide injectable emulsion for subcutaneous use	Prostate Cancer. **1.** Approve if the patient has tried one of the following: leuprolide depot 22.5 mg (formerly Lutrate), Lupron Depot (7.5 mg, 22.5 mg, 30 mg, or 45 mg), Eligard, Firmagon, Trelstar or Orgovyx. If none are formulary, approve. **2.** Patients currently receiving therapy with Camcevi, approve if the patient has tried one of Lupron Depot or Eligard. If neither are formulary, approve. Head and Neck Cancer – Salivary Gland Tumors. Approve if the patient has tried one of Lupron Depot or Eligard. If neither are formulary, approve.	1 year	Yes	Yes
Gonadotropin-Releasing Hormone (GnRH) Analogs - Prostate Cancer	Trelstar	triptorelin pamoate for injectable suspension	Prostate Cancer: **1.** Approve if the patient has tried one of the following: leuprolide depot 22.5 mg (formerly Lutrate), Camcevi, Lupron Depot (7.5 mg, 22.5 mg, 30 mg, or 45 mg), Eligard, Firmagon, or Orgovyx. If none are formulary, approve. **2.** If only leuprolide depot 22.5 mg (formerly Lutrate) is formulary and the prescriber prefers monthly dosing, approve the patient has tried one of Lupron Depot 7.5 mg, Eligard, or Firmagon. If none are formulary, approve. 3. Patients currently receiving therapy with Trelstar: approve.	1 year	Yes	Yes
Gout Medications	Colcrys	colchicine tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Gout Medications	Uloric	febuxostat tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Growth Hormone Products	Humatrope	somatropin injection	Growth hormone deficiency (GHD) in children, Turner syndrome, GHD in adults, Prader Willi syndrome, Idiopathic short stature in children, Children with chronic kidney disease, Short Stature Homeobox-Containing Gene deficiency, Children Born Small for Gestational Age or with Intrauterine Growth Restriction, Noonan syndrome, Short bowel syndrome: Approve if the patient meets BOTH of the following (1 and 2): **1.** Patient has tried five of the following (if five are formulary, or four if four are formulary, or three if three are formulary, or two if only two are formulary, or one if only one is formulary): Genotropin, Norditropin Flexpro, Nutropin AQ, Omnitrope, Saizen, or Zomacton **[documentation required]**; AND Note: If none are formulary, approve. **2.** Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	Yes	
Growth Hormone Products	Norditropin Flexpro	somatropin injection	Growth hormone deficiency (GHD) in children, Turner syndrome, GHD in adults, Prader Willi syndrome, Idiopathic short stature in children, Children with chronic kidney disease, Short Stature Homeobox-Containing Gene deficiency, Children Born Small for Gestational Age or with Intrauterine Growth Restriction, Noonan syndrome, Short bowel syndrome: Approve if the patient meets BOTH of the following (1 and 2): **1.** Patient has tried five of the following (if five are formulary, or four if four are formulary, or three if three are formulary, or two if only two are formulary, or one if only one is formulary): Genotropin, Humatrope, Nutropin AQ, Omnitrope, Saizen, or Zomacton **[documentation required]**; AND Note: If none are formulary, approve. **2.** Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	Yes	
Growth Hormone Products	Nutropin AQ Nuspin	somatropin injection	Growth hormone deficiency (GHD) in children, Turner syndrome, GHD in adults, Prader Willi syndrome, Idiopathic short stature in children, Children with chronic kidney disease, Short Stature Homeobox-Containing Gene deficiency, Children Born Small for Gestational Age or with Intrauterine Growth Restriction, Noonan syndrome, Short bowel syndrome: Approve if the patient meets BOTH of the following (1 and 2): **1.** Patient has tried five of the following (if five are formulary, or four if four are formulary, or three if three are formulary, or two if only two are formulary, or one if only one is formulary): Genotropin, Humatrope, Norditropin Flexpro, Omnitrope, Saizen, or Zomacton **[documentation required]**; AND Note: If none are formulary, approve. **2.** Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	Yes	
Growth Hormone Products	Saizen/SaizenPrep	somatropin injection	Growth hormone deficiency (GHD) in children, Turner syndrome, GHD in adults, Prader Willi syndrome, Idiopathic short stature in children, Children with chronic kidney disease, Short Stature Homeobox-Containing Gene deficiency, Children Born Small for Gestational Age or with Intrauterine Growth Restriction, Noonan syndrome, Short bowel syndrome: Approve if the patient meets BOTH of the following (1 and 2): **1.** Patient has tried five of the following (if five are formulary, or four if four are formulary, or three if three are formulary, or two if only two are formulary, or one if only one is formulary): Genotropin, Humatrope, Norditropin Flexpro, Nutropin AQ, Omnitrope, or Zomacton **[documentation required]**; AND Note: If none are formulary, approve. **2.** Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	Yes	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Growth Hormone Products	Zomacton (formerly Tev-Tropin)	somatropin injection	Growth hormone deficiency (GHD) in children, Turner syndrome, GHD in adults, Prader Willi syndrome, Idiopathic short stature in children, Children with chronic kidney disease, Short Stature Homeobox-Containing Gene deficiency, Children Born Small for Gestational Age or with Intrauterine Growth Restriction, Noonan syndrome, Short bowel syndrome: Approve if the patient meets BOTH of the following (1 and 2): **1.** Patient has tried five of the following (if five are formulary, or four if four are formulary, or three if three are formulary, or two if only two are formulary, or one if only one is formulary): Genotropin, Humatrope, Norditropin Flexpro, Nutropin AQ, Omnitrope, or Saizen **[documentation required]**;AND Note: If none are formulary, approve. **2.** Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	Yes	
Growth Hormone Products – Weekly Dosed	Skytrofa	lonapegsomatropin-tcgd subcutaneous injection	**1.** Growth hormone deficiency in a patient ≥ 2.5 years of age to < 3 years of age, approve if the patient has tried Sogroya for 6 months OR experienced an intolerance with Sogroya, if formulary. If Sogroya is non-formulary, approve if the patient meets criteria #3. **2.** Growth hormone deficiency in patients ≥ 3 years of age to < 18 years of age, approve if the patient has tried one of Sogroya or Ngenla for 6 months OR experienced an intolerance with the respective agent, if one is formulary. **3.** If neither Sogroya nor Ngenla are formulary (in patients ≥ 2.5 years of age to < 18 years of age) OR the patient is ≥ 1 year of age and < 2.5 years of age, approve if the patient meets ONE of the following (A or B): A. Patient has been able to adhere to somatropin product(s) administered daily AND has experienced inadequate efficacy (i.e., patient has tried for 12 months and has a growth rate of less than 2 cm per year) **[documentation required]** with ONE product from the following list: Genotropin, Humatrope, Norditropin Flexpro, Nutropin AQ, Omnitrope, Saizen, or Zomacton; OR B. Patient meets BOTH of the following (i and ii): i. Patient has tried TWO of the following products: Genotropin, Humatrope, Norditropin Flexpro, Nutropin AQ, Omnitrope, Saizen, or Zomacton **[documentation required]**; AND ii. Patient cannot continue to use each of the TWO products due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**. Note: Meeting the criteria above with a trial of any daily growth hormone product(s) would count toward meeting the requirements regardless of formulary status. Note: If there is only ONE growth hormone product on a formulary, then the patient would NOT be required to try TWO products- only ONE.	1 year	Yes	
Growth Hormone Products – Weekly Dosed	Sogroya	somapacitan-beco subcutaneous injection	**1.** Growth hormone deficiency in patients ≥ 2.5 years of age to < 3 years of age, approve if the patient has tried Skytrofa for 6 months OR experienced an intolerance with Skytrofa, if formulary. If Skytrofa is non-formulary, approve if the patient meets criteria #3. **2.** Growth hormone deficiency in patients ≥ 3 years of age to < 18 years of age, approve if the patient has tried one of Skytrofa or Ngenla for 6 months OR experienced an intolerance with the respective agent, if one is formulary. **3.** If neither Skytrofa nor Ngenla are formulary (in patients ≥ 2.5 years of age to < 18 years of age) , approve if the patient meets ONE of the following (A or B): A. Patient has been able to adhere to somatropin product(s) administered daily AND has experienced inadequate efficacy (i.e., patient has tried for 12 months and has a growth rate of less than 2 cm per year) **[documentation required]** with ONE product from the following list: Genotropin, Humatrope, Norditropin Flexpro, Nutropin AQ, Omnitrope, Saizen, or Zomacton; OR B. Patient meets BOTH of the following (i and ii): i. Patient has tried TWO of the following products: Genotropin, Humatrope, Norditropin Flexpro, Nutropin AQ, Omnitrope, Saizen, or Zomacton **[documentation required]**; AND ii. Patient cannot continue to use each of the TWO products due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**. Note: Meeting the criteria above with a trial of any daily growth hormone product(s) would count toward meeting the requirements regardless of formulary status. Note: If there is only ONE growth hormone product on a formulary, then the patient would NOT be required to try TWO products- only ONE. **4.** Adults with growth hormone deficiency (patients ≥ 18 years of age). Approve if the patient meets BOTH of the following (A and B): A. Patient has tried TWO of the following products: Genotropin, Humatrope, Norditropin Flexpro, Nutropin AQ, Omnitrope, Saizen, or Zomacton **[documentation required]**; AND B. Patient cannot continue to use each of the TWO products due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**. Note: Meeting the criteria above with a trial of any daily growth hormone product(s) would count toward meeting the requirements regardless of formulary status. Note: If there is only ONE growth hormone product on a formulary, then the patient would NOT be required to try TWO products- only ONE.	1 year	Yes	
Head Lice Treatments (Topical)	Natroba	spinosad topical suspension	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Helicobacter Pylori Agents	Pylera	bismuth subcitrate potassium, metronidazole plus tetracycline capsules	If requesting brand Pylera: Approve if the patient has tried generic Pylera (bismuth-metronidazole-tetracycline 140-125-125), if formulary. If requesting brand Pylera and generic Pylera (bismuth-metronidazole-tetracycline 140-125-125), is non-formulary (or if requesting generic Pylera), approve if the patient meets ONE of the following (A or B): A. The patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with TWO different regimens of single-entity products (e.g., clarithromycin + amoxicillin + proton pump inhibitor [e.g., omeprazole, lansoprazole]; bismuth-containing product + tetracycline + metronidazole + proton pump inhibitor [e.g., omeprazole, lansoprazole]; Voquezna + amoxicillin +/- clarithromycin); OR B. The patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with any TWO pre-packaged products (e.g., amoxicillin/clarithromycin/lansoprazole [Prevpac, generics], Omeclamox-Pak, Voquezna Pak, or Talicia).	1 month	Yes	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Hematology Agents - Miscellaneous	Rytelo	imetelstat intravenous injection	Myelodysplastic Syndromes with Transfusion-Dependent Anemia who are relapsed, refractory or ineligible for erythropoiesis-stimulating agents. **1.** Approve if the patient tried Reblozyl, if formulary. If Reblozyl is non-formulary, approve. **2.** Approve if the patient meets ALL of the following (A, B, and C): A. Patient does NOT have a deletion 5q [del(5q)]; AND B. Patient has ring sideroblasts < 15% (or ring sideroblasts < 5% with an SF3B1 pathogenic variant); AND C. Patient has tried or has a poor probability to respond to immunosuppressive therapy. **3.** Approve if the patient has already been started on therapy with Rytelo.	1 year	Yes	Yes
Hematopoietic/Thrombopoietic Agents	Aphexda	motixafortide subcutaneous injection	Peripheral blood stem cell mobilization for collection and subsequent autologous transplantation in patients with Multiple myeloma. **1.** Approve if the patient has tried plerixafor injection (Mozobil, generics), if formulary. If plerixafor injection (Mozobil, generics) are non-formulary, approve. **2.** Approve if the patient has already started therapy with Aphexda.	1 year	Yes	
Hemophilia - Factor IX Products (recombinant extended half-life products)	Rebinyn	coagulation Factor IX [recombinant], glycoPEGylated for IV injection	**1.** Approve if the patient has tried one product from the following list (if one is formulary): Alprolix or Idelvion. If neither are formulary, approve. **2.** Approve if the patient is currently receiving Rebinyn or has received Rebinyn in the past.	1 year	Yes	Yes
Hemophilia - Factor IX Products (recombinant standard half-life products)	Ixinity	coagulation factor IX [recombinant] solution for intravenous injection	**1.** Approve if the patient has tried one product from the following list (if one is formulary): Rixubis or BeneFIX. If neither are formulary, approve. **2.** Approve if the patient is currently receiving Ixinity or has received Ixinity in the past.	1 year	Yes	Yes
Hemophilia - Factor IX Products (recombinant standard half-life products)	Rixubis	coagulation factor IX [recombinant]	**1.** Approve if the patient has tried one of BeneFIX or Ixinity, if formulary. If neither are formulary, approve. **2.** Approve if the patient is currently receiving Rixubis or has received Rixubis in the past.	1 year	Yes	Yes
Hemophilia - Factor VIII Products (recombinant standard half-life)	Nuwiq	antihemophilic factor [recombinant] for intravenous injection	**1.** Patient has tried two formulary recombinant Factor VIII products from the following list (if two are formulary, or one if one is formulary): Advate, Recombinate, Kogenate FS, Xyntha, Novoeight, Kovaltry, Afstyla. If none are formulary, approve. **2.** Patient is currently receiving Nuwiq or has received Nuwiq in the past: approve	1 year	Yes	Yes
Hemophilia - Factor VIII Products (recombinant standard half-life)	Recombinate	antihemophilic factor [recombinant] injection	**1.** Patient has tried two formulary recombinant Factor VIII products from the following list (if two are formulary or one if one is formulary): Advate, Kogenate FS, Xyntha, Novoeight, Nuwiq, Kovaltry, Afstyla. If none are formulary, approve. **2.** Patient is currently receiving Recombinate or has received Recombinate in the past: approve.	1 year	Yes	Yes
Hemophilia Gene Therapy	Beqvez	fidanacogene elaparvovec-dzkt intravenous infusion	Patient meets the following standard *Hemophilia – Gene Therapy – Beqvez Prior Authorization Policy* criteria AND Patient meets ONE of the following (1 or 2): **1.** If Hemgenix is non-formulary, approve; OR **2.** Hemgenix is not available at the treatment facility or treatment center in which the patient is enrolled to receive the gene therapy, approve. If the patient does not meet 1 or 2 above, direct the patient to Hemgenix. All reviews (approvals and denials) will be forwarded to the Medical Director for evaluation.	See PA Duration	Yes	
Hepatitis B Agents	Baraclude tablets	entecavir tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Hepatitis C - Oral Agents	Sovaldi 200 mg tablets and oral pellets	sofosbuvir tablets and oral pellets	If Epclusa (brand) is formulary: **1.** Genotype 2 or 3 Chronic Hepatitis C Virus, Pediatric Patient (≥ 3 Years of Age and < 18 Years of Age) – New Start: Sovaldi is not approved. Offer to review for Epclusa (brand only) using the standard Hepatitis C – Epclusa PA Policy criteria. **2.** Patient Continuing Therapy with Sovaldi: Refer to the standard Hepatitis C – Sovaldi PA Policy criteria. If Epclusa (brand) is non-formulary and sofosbuvir/velpatasvir is formulary: 1. Genotype 2 or 3 Chronic Hepatitis C Virus, Pediatric Patient (≥ 3 Years of Age and < 18 Years of Age) – New Start. Approve for the duration specified in the standard Hepatitis C – Sovaldi PA Policy criteria if the patient has met the standard Hepatitis Sovaldi PA Policy criteria. **2.** Patient Continuing Therapy with Sovaldi. Refer to the standard Hepatitis C – Sovaldi PA Policy criteria. If neither Epclusa (brand) nor sofosbuvir/velpatasvir are formulary, approve.	Varies	Yes	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Hepatitis C - Oral Agents	Sovaldi 400 mg tablets	sofosbuvir tablets	If Epclusa (brand) is formulary: **1.** Genotype 2 or 3 Chronic Hepatitis C Virus, Pediatric Patient (≥ 3 Years of Age and < 18 Years of Age) – New Start: Sovaldi is not approved. Offer to review for Epclusa (brand only) using the standard Hepatitis C – Epclusa PA Policy criteria. **2.** Patient Continuing Therapy with Sovaldi: Refer to the standard Hepatitis C – Sovaldi PA Policy criteria. If Epclusa (brand) is non-formulary and sofosbuvir/velpatasvir is formulary: **1.** Genotype 2 or 3 Chronic Hepatitis C Virus, Pediatric Patient (≥ 3 Years of Age and < 18 Years of Age) – New Start. Sovaldi is not approved. Offer to review for sofosbuvir/velpatasvir 400 mg/100 mg tablets (generic only) using the standard Hepatitis C – Epclusa PA Policy criteria. **2.** Patient Continuing Therapy with Sovaldi. Refer to the standard Hepatitis C – Sovaldi PA Policy criteria. If neither Epclusa (brand) nor sofosbuvir/velpatasvir are formulary, approve.	Varies	Yes	
Hepatitis C - Oral Agents	sofosbuvir/velpatasvir (Authorized generic for Epclusa) 400 mg/100 mg tablets	sofosbuvir/velpatasvir tablets 400 mg/100 mg tablets	Patient is directed to use Epclusa. If Epclusa is non-formulary, approve.	24 weeks	Yes	
Hepatitis C - Oral Agents	Mavyret	glecaprevir/ pibrentasvir tablets and oral pellets	See *Hepatitis C Virus Direct Acting Antivirals Preferred Specialty Management (PSM) for National Preferred Formulary and Basic Formulary (Mavyret Criteria)*	Up to 16 weeks	Yes	
Hepatitis C - Oral Agents	ledipasvir/sofosbuvir tablets 90 mg/400 mg (Authorized generic for Harvoni)	ledipasvir/sofosbuvir tablets 90 mg/400 mg	Patient is directed to use Harvoni 90 mg/400 mg. If Harvoni 90 mg/400 mg is non-formulary, approve.	24 weeks	Yes	
Hereditary Angioedema – Acute Treatment	Firazyr	icatibant injection for subcutaneous use	See standard *Hereditary Angioedema – Icatibant Preferred Specialty Management Policy* criteria.	1 year	Yes	
Hereditary Angioedema Products – IV C1 Esterase Products	Berinert	C1 esterase inhibitor [human] powder for intravenous injection	See Hereditary Angioedema Medications - Berinert FE	1 year	Yes	
HMG-CoA Reductase Inhibitors and Combination Products	Roszet and authorized generic	rosuvastatin and ezetimibe	Approve if the patient meets the following criteria (A and B): A. Patient has tried ezetimibe; AND B. Patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with atorvastatin (Lipitor, generics) or rosuvastatin (Crestor, generics). If neither of atorvastatin (Lipitor, generics) nor rosuvastatin (Crestor, generics) are formulary, approve.	1 year	Yes - Authorized generic only	
HMG-CoA Reductase Inhibitors and Combination Products	Altoprev	lovastatin extended-release tablets	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with five statins from the following list (if five are formulary or four if four are formulary or three if three are formulary or two if only two are formulary, or one if only one is formulary): lovastatin, atorvastatin (Lipitor, generics), rosuvastatin (Crestor, generics), fluvastatin (Lescol/XL, generics), a pitavastatin product (Livalo, Zypitamag), pravastatin (Pravachol), or simvastatin (Zocor, generics). If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** 1. Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with five statins from the following list (if five are formulary or four if four are formulary or three if three are formulary or two if only two are formulary, or one if only one is formulary): lovastatin, atorvastatin (Lipitor, generics), rosuvastatin (Crestor, generics), fluvastatin (Lescol/XL, generics), a pitavastatin product (Livalo, Zypitamag), pravastatin (Pravachol), or simvastatin (Zocor, generics). If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement. **2.** The patient meets both of the following (i and ii): i. The requested non-formulary drug is being prescribed for the primary prevention of cardiovascular disease (CVD) for an adult aged 40 to 75 years who has one or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking) and an estimated 10-year CVD event risk of 10% or greater and who does NOT have a history of (or signs or symptoms of) CVD (for example: symptomatic coronary artery disease, ischemic stroke); AND ii. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year	Yes	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
HMG-CoA Reductase Inhibitors and Combination Products	Atorvaliq	atorvastatin calcium oral suspension	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **1.** Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with three statins from the following list (if three are formulary or two if only two are formulary, or one if only is formulary): lovastatin, rosuvastatin (Crestor, generics), atorvastatin (Lipitor, generics), fluvastatin (Lescol/XL, generics), a pitavastatin product (Livalo, Zypitamag), pravastatin (Pravachol), or simvastatin (Zocor, generics). If none are formulary, approve. **2.** Patients who cannot swallow or have difficulty swallowing tablets or capsules, approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with three statins from the following list (if three are formulary or two if only two are formulary, or one if only is formulary): lovastatin, rosuvastatin (Crestor, generics), atorvastatin (Lipitor, generics), fluvastatin (Lescol/XL, generics), a pitavastatin product (Livalo, Zypitamag), pravastatin (Pravachol), or simvastatin (Zocor, generics). If none are formulary, approve. **2.** Patients who cannot swallow or have difficulty swallowing tablets or capsules, approve. **3.** The patient meets both of the following (i and ii): i. The requested non-formulary drug is being prescribed for the primary prevention of cardiovascular disease (CVD) for an adult aged 40 to 75 years who has one or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking) and an estimated 10-year CVD event risk of 10% or greater and who does NOT have a history of (or signs or symptoms of) CVD (for example: symptomatic coronary artery disease, ischemic stroke); AND ii. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year	Yes	
HMG-CoA Reductase Inhibitors and Combination Products	Crestor	rosuvastatin tablets	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve one of the following (A or B): A. The patient meets both of the following (i and ii): i. The requested brand non-formulary drug is being prescribed for the primary prevention of cardiovascular disease (CVD) for an adult aged 40 to 75 years who has one or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking) and an estimated 10-year CVD event risk of 10% or greater and who does NOT have a history of (or signs or symptoms of) CVD (for example: symptomatic coronary artery disease, ischemic stroke); AND ii. According to the prescriber, the brand product is being requested because the preferred bioequivalent generic product would not be as medically appropriate for the patient as the requested brand non-formulary drug; OR B. The patient meets both of the following (i and ii): i. The requested brand non-formulary drug is being prescribed for a use OTHER THAN the primary prevention of cardiovascular disease (CVD) for an adult aged 40 to 75 years who has one or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking) and an estimated 10-year CVD event risk of 10% or greater and who does NOT have a history of (or signs or symptoms of) CVD (for example: symptomatic coronary artery disease, ischemic stroke); AND ii. The Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
HMG-CoA Reductase Inhibitors and Combination Products	Ezallor Sprinkle	rosuvastatin capsules	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **1.** Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with three statins from the following list (if three are formulary or two if only two are formulary, or one if only is formulary): lovastatin, rosuvastatin (Crestor, generics), atorvastatin (Lipitor, generics), fluvastatin (Lescol/XL, generics), a pitavastatin product (Livalo, Zypitamag), pravastatin (Pravachol), or simvastatin (Zocor, generics). If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement. **2.** Patients who cannot swallow or have difficulty swallowing tablets or capsules, approve. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. **1.** Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with three statins from the following list (if three are formulary or two if only two are formulary, or one if only is formulary): lovastatin, rosuvastatin (Crestor, generics), atorvastatin (Lipitor, generics), fluvastatin (Lescol/XL, generics), a pitavastatin product (Livalo, Zypitamag), pravastatin (Pravachol), or simvastatin (Zocor, generics). If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement. **2.** Patients who cannot swallow or have difficulty swallowing tablets or capsules, approve. **3.** The patient meets both of the following (i and ii): i. The requested non-formulary drug is being prescribed for the primary prevention of cardiovascular disease (CVD) for an adult aged 40 to 75 years who has one or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking) and an estimated 10-year CVD event risk of 10% or greater and who does NOT have a history of (or signs or symptoms of) CVD (for example: symptomatic coronary artery disease, ischemic stroke); AND ii. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 year	Yes	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
HMG-CoA Reductase Inhibitors and Combination Products	Lipitor	atorvastatin tablets	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve one of the following (A or B): A. The patient meets both of the following (i and ii): i. The requested brand non-formulary drug is being prescribed for the primary prevention of cardiovascular disease (CVD) for an adult aged 40 to 75 years who has one or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking) and an estimated 10-year CVD event risk of 10% or greater and who does NOT have a history of (or signs or symptoms of) CVD (for example: symptomatic coronary artery disease, ischemic stroke); AND ii. According to the prescriber, the brand product is being requested because the preferred bioequivalent generic product would not be as medically appropriate for the patient as the requested brand non-formulary drug; OR B. The patient meets both of the following (i and ii): i. The requested brand non-formulary drug is being prescribed for a use OTHER THAN the primary prevention of cardiovascular disease (CVD) for an adult aged 40 to 75 years who has one or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking) and an estimated 10-year CVD event risk of 10% or greater and who does NOT have a history of (or signs or symptoms of) CVD (for example: symptomatic coronary artery disease, ischemic stroke); AND ii. The Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
HMG-CoA Reductase Inhibitors and Combination Products	Zocor	simvastatin tablets	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve one of the following (A or B): A. The patient meets both of the following (i and ii): i. The requested brand non-formulary drug is being prescribed for the primary prevention of cardiovascular disease (CVD) for an adult aged 40 to 75 years who has one or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking) and an estimated 10-year CVD event risk of 10% or greater and who does NOT have a history of (or signs or symptoms of) CVD (for example: symptomatic coronary artery disease, ischemic stroke); AND ii. According to the prescriber, the brand product is being requested because the preferred bioequivalent generic product would not be as medically appropriate for the patient as the requested brand non-formulary drug; OR B. The patient meets both of the following (i and ii): i. The requested brand non-formulary drug is being prescribed for a use OTHER THAN the primary prevention of cardiovascular disease (CVD) for an adult aged 40 to 75 years who has one or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking) and an estimated 10-year CVD event risk of 10% or greater and who does NOT have a history of (or signs or symptoms of) CVD (for example: symptomatic coronary artery disease, ischemic stroke); AND ii. The Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
HMG-CoA Reductase Inhibitors and Combination Products	Vytorin	ezetimibe/simvastatin tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Human Chorionic Gonadotropin, HCG Agents	chorionic gonadotropin	chorionic gonadotropin 10,000 unit powder for intramuscular injection	**1.** Approve if the patient has tried one product from the following list (if one is formulary): Pregnyl, Novarel or Ovidrel. If none are formulary, approve. **2.** For a diagnosis of cryptorchidism or hypogonadism, approve if the patient has tried Pregnyl or Novarel, if formulary. If neither are formulary, approve. **3.** For a diagnosis related to infertility or induction of ovulation, approve a one-time fill if the patient may be at risk of missing the optimal administration timeframe window of the product (in order to avoid disruption of the current fertility medication cycle).	1 year	Yes	
Human Immunideficiency Virus (HIV-1) - Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs)	Pifeltro	doravirine tablets	**1.** Approve if the patient has tried one non-nucleoside reverse transcriptase inhibitor (NNRTI) or a NNRTI-containing product (e.g., Sustiva, Edurant, Delstrigo, Complera, Odefsey, Atripla, Symfi, Smyfi Lo). **2.** Patients already started on therapy with Pifeltro, approve.	1 year	Yes	Yes

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Human Immunideficiency Virus (HIV-1) – Protease Inhibitor (PI) Based Agents	Prezcobix	darunavir and cobicistat tablets	**1.** Approve if the patient has tried one protease inhibitor (PI) or a PI-containing product (e.g., Aptivus, atazanavir [Reyataz, generics], Viracept, ritonavir [Norvir, generics], fosamprenavir, Prezista, Evotaz, lopinavir-ritonavir [Kaletra, generics]). **2.** Approve if, according to the prescriber, the patient meets BOTH of the following (A and B): A. Patient has a history of Apretude (cabotegravir extended-release injectable suspension) for pre-exposure prophylaxis (PrEP); AND B. Patient meets ONE of the following (i or ii): i. Results of resistance testing are not available; OR ii. Patient has integrase strand-transfer inhibitor (INSTI) resistance. **3.** If the patient, according to the prescriber, needs to begin antiretroviral therapy urgently, approve. **4.** Approve if the patient has already been started on therapy with Prezcobix.	1 year	Yes	Yes
Human Immunodeficiency Virus (HIV) – Specialized	Rukobia	fostemsavir extended-release tablets	Human Immunodeficiency Virus (HIV) infection, multi-drug treatment-resistant. **1.** Approve if the patient has tried Sunlenca or is concomitantly receiving Sunlenca, if formulary. If Sunlenca is non-formulary, approve. **2.** Approve if the patient has exhausted at least FOUR of the following antiretroviral classes defined as elimination of all antiretrovirals within a given class due to demonstrated or projected resistance to the agent(s) in that class OR due to significant intolerance (FOUR of a, b, c, d, e, or f): a) Nucleoside reverse transcriptase inhibitor; OR Note: Examples of nucleoside reverse transcriptase inhibitors include abacavir, didanosine, emtricitabine, lamivudine, stavudine, tenofovir disoproxil fumarate, tenofovir alafenamide, zidovudine. b) Non-nucleoside reverse transcriptase inhibitor; OR Note: Examples of non-nucleoside reverse transcriptase inhibitor include delaviridine, efavirenz, etravirine, nevirapine, nevirapine XR, rilpivirine. c) Protease inhibitor; OR Note: Examples of protease inhibitors include atazanavir, darunavir, fosamprenavir, indinavir, nelfinavir, ritonavir, saquinavir, tipranavir. d) Fusion inhibitor; OR Note: Examples of fusion inhibitors include Fuzeon (enfuviritide for injection). e) Integrase strand transfer inhibitor; OR Note: Examples of integrase strand transfer inhibitors include raltegravir, dolutegravir, elvitegravir. f) CCR5 antagonist. Note: Examples of CCR5 antagonists include Selzentry (maraviroc tablets). **3.** Approve if the patient has already been started on Rukobia therapy.	1 year	Yes	Yes
Human Immunodeficiency Virus (HIV-1) - integrase strand transfer inhibitor (INSTI) Combination Products	Stribild	elvitegravir/ cobicistat/ emtricitabine/ tenofovir tablets	**1.** Approve if the patient has tried Biktarvy, if formulary. If Biktarvy is non-formulary, approve. **2.** Approve if the patient has tried one integrase strand transfer inhibitor (INSTI) or an INSTI-containing product (e.g., Genvoya, Tivicay, Triumeq, Juluca, Isentress or Intress-HD). **3.** Patients already started on therapy with Stribild: approve.	1 year	Yes	Yes
Human Immunodeficiency Virus (HIV-1) - Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTI)-Based Combination Products	Complera	emtricitabline/rilpivirine/tenofovir disoproxil fumarate (TDF) tablets	**1.** Approve if the patient has tried Odefsey, if formulary. If Odefsey is non-formulary, approve if the patient has tried one of the following products: Biktarvy, Genvoya, Stribild, Triumeq, Symtuza, efavirenz-emtricitabine-tenofovir disoproxil fumarate (Atripla, generics), efavirenz-lamivudine-tenofovir (Symfi, Symfi Lo, generics), if formulary. If none are formulary, approve. **2.** Approve if the patient is currently taking single-entity or combination products containing emtricitabine, rilpivirine, and tenofovir disoproxil fumarate and is requesting Complera for a single-table regimen. **3.** Patients already started on therapy with Complera: approve.	1 year	Yes	Yes
Human Immunodeficiency Virus (HIV-1) - Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTI)-Based Combination Products	Delstrigo	doravirine/lamivudine/ tenofovir disoproxil fumarate tablets	**1.** Approve if the patient has tried one of the following products: Biktarvy, Genvoya, Odefsey, Stribild, Complera, Triumeq, Symtuza, efavirenz-lamivudine-tenofovir (Symfi, Symfi Lo, generics), if formulary. If none are formulary, approve. **2.** Patient < 18 years of age AND weighing ≥ 35 kg (77 pounds), approve if the patient has tried one of Biktarvy, Genvoya, Odefsey, Stribild, Complera, or efavirenz-lamivudine-tenofovir (Symfi Lo, generics), if formulary. If none are formulary, approve. **3.** Approve if the patient is currently taking single-entity or combination products containing doravirine, lamivudine, and tenofovir disoproxil fumarate and is requesting Delstrigo for a single tablet regimen. **4.** Patients already started on therapy with Delstrigo, approve.	1 year	Yes	Yes

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Human Immunodeficiency Virus (HIV-1) - Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTI)-Based Combination Products	Atripla	efavirenz 600 mg, emtricitabine 200 mg, tenofovir disoproxil fumarate 300 mg tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	Yes
Human Immunodeficiency Virus (HIV-1) – NRTI Based Combination Products	Truvada	emtricitabine/ tenofovir tablets	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required. **NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**. OR Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required. Approve if the patient meets one of the following criteria (i or ii): i. The requested brand non-formulary drug is being prescribed for HIV Pre-Exposure Prophylaxis (PrEP) AND, according to the prescriber, the brand product is being requested because the preferred bioequivalent generic product would not be as medically appropriate for the patient as the requested brand non-formulary drug; OR ii. The requested brand non-formulary drug is being prescribed for a use OTHER THAN HIV Pre-Exposure Prophylaxis (PrEP) AND the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Hyaluronic Acid Derivatives	Durolane	hyaluronic acid intraarticular injection	**1.** Approve if the patient has tried five formulary intra-articular hyaluronic acid products from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Euflexxa, Gel-One, Gel-Syn, GenVisc 850, Hyalgan, Monovisc, Orthovisc, Supartz FX, Synvisc, Synvisc-One, Hymovis, Visco-3, Synojoynt, Triluron, or Trivisc **[documentation required]**. If none are formulary, approve Durolane. **2.** Patient has a known allergy to avian or avian-derived products (e.g., eggs, feathers): approve if the patient has tried five formulary products from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Euflexxa, Orthovisc, Monovisc, Hymovis, Gel-Syn, GenVisc 850, Synojoynt, or Trivisc **[documentation required]**. If none are formulary, approve Durolane.	1 year	Yes	
Hyaluronic Acid Derivatives	Euflexxa	sodium hyaluronate injection	**1.** Approve if the patient has tried five formulary intra-articular hyaluronic acid products from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Durolane, Gel-One, Gel-Syn, GenVisc 850, Hyalgan, Monovisc, Orthovisc, Supartz FX, Synvisc, Synvisc-One, Hymovis, Visco-3, Synojoynt, Triluron, or Trivisc **[documentation required]**. If none are formulary, approve Euflexxa. **2.** Patient has a known allergy to avian or avian-derived products (e.g., eggs, feathers): approve if the patient has tried five formulary products from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Orthovisc, Monovisc, Hymovis, Durolane, Gel-Syn, GenVisc 850, Synojoynt, or Trivisc **[documentation required]**. If none are formulary, approve Euflexxa. **3.** Patients who have already been started on an injection series with Euflexxa: approve to complete the series. Note: If the patient has received all the injections in a completed series (for each targeted joint), refer to criteria above.	1 year	Yes	
Hyaluronic Acid Derivatives	Gel-One	hyaluronate gel injection	Approve if the patient has tried five formulary intra-articular hyaluronic acid products from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Durolane, Euflexxa, Gel-Syn, GenVisc 850, Hyalgan, Monovisc, Orthovisc, Supartz FX, Synvisc, Synvisc-One, Hymovis, Visco-3, Synojoynt, Triluron, or Trivisc **[documentation required]**. If none are formulary, approve Gel-One.	1 year	Yes	
Hyaluronic Acid Derivatives	Gel-Syn-3	sodium hyaluronate injection	**1.** Approve if the patient has tried five formulary intra-articular hyaluronic acid products from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Durolane, Euflexxa, Gel-One, GenVisc 850, Hyalgan, Hymovisc, Monovisc, Orthovisc, Supartz FX, Synvisc, Synvisc-One, Visco-3, Synojoynt, Triluron, or Trivisc **[documentation required]**. If none are formulary, approve Gel-Syn. **2.** Patient has a known allergy to avian or avian-derived products (e.g., eggs, feathers): approve if the patient has tried five formulary products from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Orthovisc, Monovisc, Durolane, Euflexxa, Hymovis, GenVisc 850, Synojoynt, or Trivisc **[documentation required]**. If none are formulary, approve Gel-Syn. **3.** Patients who have already been started on an injection series with Gel-Syn: approve to complete the series. Note: If the patient has received all the injections in a completed series (for each targeted joint), refer to criteria above.	1 year	Yes	
Hyaluronic Acid Derivatives	GenVisc 850	sodium hyaluronate injection	**1.** Approve if the patient has tried five formulary intra-articular hyaluronic acid products from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Durolane, Euflexxa, Gel-One, Gel-Syn, Hyalgan, Monovisc, Orthovisc, Supartz FX, Synvisc, Synvisc-One, Hymovis, Visco-3, Synojoynt, Triluron, or Trivisc **[documentation required]**. If none are formulary, approve GenVisc 850. **2.** Patient has a known allergy to avian or avian-derived products (e.g., eggs, feathers): approve if the patient has tried five formulary product from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Orthovisc, Monovisc, Durolane, Gel-Syn, Hymovis, Euflexxa, Synojoynt, or Trivisc **[documentation required]**. If none are formulary, approve GenVisc 850. **3.** Patients who have already been started on an injection series with Genvisc 850: approve to complete the series. Note: If the patient has received all the injections in a completed series (for each targeted joint), refer to criteria above.	1 year	Yes	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Hyaluronic Acid Derivatives	Hyalgan	sodium hyaluronate injection	**1.** Approve if the patient has tried five formulary intra-articular hyaluronic acid products from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Durolane, Euflexxa, Gel-One, Gel-Syn, GenVisc 850, Monovisc, Orthovisc, Supartz FX, Synvisc, Synvisc-One, Hymovis, Visco-3, Synojoynt, Triluron, or Trivisc **[documentation required]**. If none are formulary, approve Hyalgan. **2.** Patients who have already been started on an injection series with Hyalgan: approve to complete the series. Note: If the patient has received all the injections in a completed series (for each targeted joint), refer to criteria above.	1 year	Yes	
Hyaluronic Acid Derivatives	Hymovis	hyaluronic acid injection	**1.** Approve if the patient has tried five formulary intra-articular hyaluronic acid products from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Durolane, Euflexxa, Gel-One, Gel-Syn, GenVisc 850, Hyalgan, Monovisc, Orthovisc, Supartz FX, Synvisc, Synvisc-One, Visco-3, Synojoynt, Triluron, or Trivisc **[documentation required]** If none are formulary, approve Hymovis. **2.** Patient has a known allergy to avian or avian-derived products (e.g., eggs, feathers): approve if the patient has tried five formulary products from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Orthovisc, Monovisc, Durolane, Euflexxa, Gel-Syn, GenVisc 850, Synojoynt, or Trivisc **[documentation required]**. If none are formulary, approve Hymovis. **3.** Patients who have already been started on an injection series with Hymovis: approve to complete the series. Note: If the patient has received all the injections in a completed series (for each targeted joint), refer to criteria above.	1 year	Yes	
Hyaluronic Acid Derivatives	Supartz FX	sodium hyaluronate injection	**1.** Approve if the patient has tried five formulary intra-articular hyaluronic acid products from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Durolane, Euflexxa, Gel-One, Gel-Syn, GenVisc 850, Hyalgan, Monovisc, Orthovisc, Synvisc, Synvisc-One, Hymovis Visco-3, Synojoynt, Triluron, or Trivisc **[documentation required]**. If none are formulary, approve Supartz FX. **2.** Patients who have already been started on an injection series with Supartz FX: approve to complete the series. Note: If the patient has received all the injections in a completed series (for each targeted joint), refer to criteria above.	1 year	Yes	
Hyaluronic Acid Derivatives	Synojoynt	sodium hyaluronate injection	**1.** Approve if the patient has tried five formulary intra-articular hyaluronic acid product from the following list ((if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Durolane, Euflexxa, Gel-One, Gel-Syn, GenVisc 850, Hyalgan, Monovisc, Orthovisc, Supartz FX, Synvisc, Synvisc-One, Hymovis, Trivisc, Triluron, or Visco-3 **[documentation required]**. If none are formulary, approve. **2.** Patient has a known allergy to avian or avian-derived products (e.g., eggs, feathers): approve if the patient has tried five formulary products from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Durolane, Euflexxa, Orthovisc, Monovisc, Hymovis, Gel-Syn, Trivisc, or GenVisc 850 **[documentation required]**. If none are formulary, approve. **3.** Patients who have already been started on an injection series with Synojoynt: approve to complete the series. Note: If the patient has received all the injections in a completed series (for each targeted joint), refer to criteria above.	1 year	Yes	
Hyaluronic Acid Derivatives	Synvisc	sodium hyaluronate injection	**1.** Approve if the patient has tried five other formulary intra-articular hyaluronic acid products from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Durolane, Euflexxa, Gel-One, Gel-Syn, GenVisc 850, Hyalgan, Monovisc, Orthovisc, Supartz FX, Synvisc-One, Hymovis Visco-3, Synojoynt, Triluron, or Trivisc **[documentation required]**. If none are formulary, approve Synvisc. **2.** Patients who have already been started on an injection series with Synvisc: approve to complete the series. Note: If the patient has received all the injections in a completed series (for each targeted joint), refer to criteria above.	1 year	Yes	
Hyaluronic Acid Derivatives	Synvisc-One	sodium hyaluronate injection	Approve if the patient has tried five formulary intra-articular hyaluronic acid products from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Durolane, Euflexxa, Gel-One, Gel-Syn, GenVisc 850, Hyalgan, Monovisc, Orthovisc, Supartz FX, Synvisc, Hymovis Visco-3, Synojoynt, Triluron, or Trivisc **[documentation required]**. If none are formulary, approve Synvisc-One.	1 year	Yes	
Hyaluronic Acid Derivatives	Triluron	sodium hyaluronate 1% injection	**1.** Approve if the patient has tried five formulary alternatives from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Durolane, Euflexxa, Gel-One, Gel-Syn, GenVisc 850, Hyalgan, Monovisc, Orthovisc, Supartz FX, Synvisc, Synvisc-One, Hymovis, Synojoynt, Visco-3, or Trivisc **[documentation required]**. If none are formulary, approve. **2.** Patients who have already been started on an injection series with Triluron: approve to complete the series. Note: If the patient has received all the injections in a completed series (for each targeted joint), refer to criteria above.	1 year	Yes	
Hyaluronic Acid Derivatives	Trivisc	sodium hyaluronate injection	**1.** Approve if the patient has tried five formulary intra-articular hyaluronic acid product from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Durolane, Euflexxa, Gel-One, Gel-Syn, GenVisc 850, Hyalgan, Monovisc, Orthovisc, Supartz FX, Synvisc, Synvisc-One, Hymovis, Synojoynt, Triluron, or Visco-3 **[documentation required]**. If none are formulary, approve Trivisc. **2.** Patient has a known allergy to avian or avian-derived products (e.g., eggs, feathers): approve if the patient has tried five formulary products from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Durolane, Euflexxa, Orthovisc, Monovisc, Hymovis, Gel-Syn, Synojoynt, or GenVisc 850 **[documentation required]**. If none are formulary, approve Trivisc. **3.** Patients who have already been started on an injection series with Trivisc: approve to complete the series. Note: If the patient has received all the injections in a completed series (for each targeted joint), refer to criteria above.	1 year	Yes	
Hyaluronic Acid Derivatives	Visco-3	sodium hyaluronate injection	**1.** Approve if the patient has tried five formulary alternatives from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if one is formulary): Durolane, Euflexxa, Gel-One, Gel-Syn, GenVisc 850, Hyalgan, Monovisc, Orthovisc, Supartz FX, Synvisc, Synvisc-One, Hymovis, Synojoynt, Triluron, or Trivisc **[documentation required]**. If none are formulary, approve Visco-3. **2.** Patients who have already been started on an injection series with Visco-3: approve to complete the series. Note: If the patient has received all the injections in a completed series (for each targeted joint), refer to criteria above.	1 year	Yes	
Hyperlipidemia - Proprotein Convertase Subtilisin Kexin Type 9 (PCSK9) Inhibitors and Related Agents	Leqvio	inclisiran subcutaneous injection	Established Cardiovascular Disease; Heterozygous Familial Hypercholesterolemia; Primary Hyperlipidemia (all diagnoses in a patient ≥ 18 years of age). Approve if the patient has tried Repatha or Praluent, if formulary. If neither are formulary, approve.	1 year	Yes	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Hyperlipidemia - Proprotein Convertase Subtilisin Kexin Type 9 (PCSK9) Inhibitors and Related Agents	Praluent	alirocumab injection for subcutaneous use	See *Proprotein Convertase Subtilisin Kexin Type 9 Related Products Care Value Policy* criteria **For Praluent only**	1 year	Yes	
Hypolipoproteinemics	Welchol packets and tablets	colesevelam packets and tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Hypolipoproteinemics	Zetia	ezetimibe tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Hypoxia-Inducible Factor Prolyl Hydroxylase Inhibitor	Jesduvroq	daprodustat tablets	Treatment of anemia due to chronic kidney disease in a patient ≥ 18 years of age. Approve if the patient meets BOTH of the following (1 and 2): **1.** Patient has been receiving dialysis for at least 4 months; AND **2.** Patient meets ONE of the following (A or B): A. If Vafseo is formulary, patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with Vafseo; OR B. If Vafseo is non-formulary, patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with one of the following: an epoetin alfa product or Aranesp or Mircera. Note: Examples of epoetin alfa products are Procrit, Epogen, and Retacrit.	1 year	Yes	
Hypoxia-Inducible Factor Prolyl Hydroxylase Inhibitor	Vafseo	vadadustat tablets	Treatment of anemia due to chronic kidney disease in a patient ≥ 18 years of age. Approve if the patient meets the following (1 and 2): **1.** Patient has been receiving dialysis for at least 3 consecutive months; AND **2.** Patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with one of the following: an epoetin alfa product or Aranesp or Mircera. Note: Examples of epoetin alfa products are Procrit, Epogen, and Retacrit.	1 year	Yes	
Idiopathic Pulmonary Fibrosis Agents	Pirfenidone 534 mg tablet	pirfenidone 534 mg tablet	Idiopathic pulmonary fibrosis. Patient meets both of the following (i and ii): i. Patient has tried generic pirfenidone tablets; AND Note: True generic tablets are available in 267 mg tablets. ii. Patient cannot continue to use generic pirfenidone tablets due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent product which, per the prescriber, would result in a significant allergy or serious adverse reaction.	1 year	Yes	
Idiopathic Pulmonary Fibrosis Agents	Esbriet	pirfenidone tablets and capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Immune Globulins - Intravenous (IVIG) and Subcutaneous (SCIG)	Gammaked	immune globulin injection (human), 10%	**1.** If using via the subcutaneous (SC) route: approve if the patient has tried three products from the following list, if formulary (or two if two are formulary or one if one is formulary): Cuvitru, Hizentra, Xembify, Cutaquig, Gamunex-C or Gammagard Liquid. If none are formulary, approve. **2.** If using via the intravenous (IV) route: approve if the patient has tried three formulary IVIG products from the following list, if formulary (or two if two are formulary or one if only one is formulary): Alyglo, Asceniv, Bivigam, Flebogamma DIF, Gammagard Liquid, Gammagard S/D, Gammaplex, Gamunex-C, Octagam, Privigen or Panzyga. If none are formulary, approve.	1 year	Yes	
Immune Globulins - Subcutaneous (SCIG)	Cutaquig	Immune globulin subcutaneous [human] 16.5% solution	Primary Immunodeficiencies: Note: Examples of primary immunodeficiences include, but are not limited to, congenital agammaglobulinemia, X-linked agammaglobulinemia, severe combined immunodeficiency, common variable immunodeficiency. Approve if the patient has tried three products from the following list, if formulary (or two if two are formulary or one if one is formulary): Cuvitru, Hizentra, Xembify, Gamunex-C, Gammagard Liquid, or Gammaked. If none are formulary, approve.	1 year	Yes	
Immunological Agents	Cinqair	reslizumab for intravenous injection	Asthma with an eosinophilic phenotype. Approve if the patient meets one of the following (A or B): **A.** Initial therapy in a patient ≥ 18 years of age: Patient has tried one formulary alternative from the following list: Nucala or Fasenra. If neither is formulary, approve if the patient has tried Dupixent. If Dupixent is non-formulary, approve; OR **B.** Patient has already been started on therapy with Cinqair.	1 year	Yes	Yes
Immunosuppressant Agents	Envarsus XR	tacrolimus extended-release tablets	**1.** Approve if the patient has tried and cannot take tacrolimus immediate-release capsules (Prograf, generics), if formulary. If tacrolimus immediate-release capsules (Prograf, generics) are non-formulary, approve. **2.** Approve if the patient has the CYP3A5*1 allele. Note: The CYP3A5*1 allele is a gene variant determined by testing that may confer faster metabolism of certain medications. **3.** If the patient has already started on therapy with Envarsus XR, approve.	1 year	Yes	Yes

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Immunosuppressant Agents – Methotrexate Injections	Otrexup	methotrexate injection for subcutaneous use; 10mg, 12.5 mg, 15 mg, 17.5 mg, 20 mg, 22.5 mg, 25 mg	Approve if the patient has tried Rasuvo, if formulary. If Rasuvo is non-formulary, approve if, according to the prescriber, the patient and caregiver are unable to administer methotrexate injection (NOT including Otrexup or Rasuvo).	1 year	Yes	
Immunosuppressant Agents – Oral Methotrexate Agents	Xatmep	methotrexate 2.5 mg/mL oral solution	Approve if the patient has tried Jylamvo, if formulary. If Jylamvo is non-formulary, approve if the patient meets one of the following (1 or 2): **1.** Patient cannot swallow or has difficulty swallowing oral methotrexate tablets; OR **2.** The dose prescribed cannot be obtained using whole methotrexate tablets.	1 year	Yes	
Immunosuppressant Agents – Oral Methotrexate Agents	Jylamvo	methotrexate 2 mg/mL oral solution	Approve if the patient has tried Xatmep, if formulary. If Xatmep is non-formulary, approve if the patient meets one of the following (1 or 2): **1.** Patient cannot swallow or has difficulty swallowing oral methotrexate tablets; OR **2.** The dose prescribed cannot be obtained using whole methotrexate tablets.	1 year	Yes	
Inflammatory Bowel Agents	Dipentum	olsalazine capsule	Approve if the patient has tried two products from the following list (if two are formulary, or one if one is formulary): mesalamine delayed-release tablets (Asacol HD, generics), sulfasalazine (generics), mesalamine delayed-release tablets (Lialda, generics), mesalamine delayed-release capsule (Delzicol, generics), balsalazide (Colazal, generics), mesalamine extended-release capsules (Apriso, generics) or Pentasa. If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.	1 year	Yes	
Inflammatory Bowel Agents	Canasa	mesalamine rectal suppository	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Inflammatory Bowel Agents	Delzicol	mesalamine delayed-release capsule	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Inflammatory Bowel Agents	Lialda	mesalamine delayed-release tablet	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Inflammatory Conditions	Sovuna	hydroxychloroquine sulfate 200 mg, 300 mg	**1.** Direct to generic hydroxychloroquine tablets. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use generic hydroxychloroquine tablets.	1 year	Yes	
Inflammatory Conditions	Plaquenil	hydroxychloroquine sulfate tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Inflammatory Conditions – Infused Non-TNF Biologics	Orencia IV	abatacept injection for intravenous use	Juvenile Idiopathic Arthritis; Psoriatic Arthritis; Rheumatoid Arthritis. **1.** Patient has tried at least one biologic: Approve. Examples: a tocilizumab product (e.g., Actemra intravenous [IV] or subcutaneous), a sarilumab product (Kevzara), an etanercept product (e.g., Enbrel, biosimilars), an adalimumab product (e.g., Humira, biosimilars), a certolizumab pegol product (e.g., Cimzia), a golimumab product (e.g., Simponi Aria or subcutaneous), an infliximab IV product (e.g., Remicade, biosimilars), a rituximab product (e.g., Rituxan intravenous, biosimilars), a secukinumab product (e.g., Cosentyx IV or SC), an ixekizumab product (e.g., Taltz), a guselkumab product (e.g., Tremfya), or a ustekizumab product (e.g., Stelara SC). If none are formulary, approve. **2.** According to the prescriber, the patient previously experienced a serious infection: Approve. **3.** Patient is currently taking Orencia intravenous or subcutaneous: Approve if the patient has been established on Orencia intravenous or subcutaneous for ≥ 3 months. **4.** Patient has been started on Orencia intravenous or subcutaneous for < 3 months: Refer to the appropriate criteria above. Graft-Versus-Host Disease – Prevention: Approve.	1 year	Yes	Yes
Inflammatory Conditions – Infused Non-TNF Biologics	Entyvio SC	vedolizumab for subcutabeous injection	See standard Inflammatory Conditions (Entyvio SC) Preferred Specialty Management Policy for National Preferred, High Performance, and Basic Formularies 1) Choice, Alternate, 2) Legacy OR FLEX Formulary policies.	See PSM duration	Yes	Yes

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Inflammatory Conditions – Infused Non-TNF Biologics – Tocilizumab Intravenous Agents	Tofidence IV	tocilizumab-bavi intravenous infusion	If Actemra IV AND Tyenne IV are both formulary (or one is formulary) [For all indications except COVID]: Approve if the patient meets ONE of the following (1 or 2): **1.** Patient meets BOTH of the following (A and B): A. Patient has tried BOTH Actrema IV and Tyenne IV (if both are formulary or one if one is formulary); AND B. Patient cannot continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. **2.** Patient has already been started on therapy with Tofidence. If both Actemra IV AND Tyenne IV are non-formulary: Polyarticular Juvenile Idiopathic Arthritis; Rheumatoid Arthritis. **1.** Patient has tried at least one biologic: Approve. Examples: an abatacept product (e.g., Orencia intravenous [IV] or subcutaneous), a sarilumab product (e.g., Kevzara), an etanercept product (e.g., Enbrel, biosimilars), an adalimumab product (e.g., Humira, biosimilars), a certolizumab pegol product (e.g., Cimzia), a golimumab product (e.g., Simponi Aria or subcutaneous), an infliximab IV product (e.g., Remicade, biosimilars), a rituximab product (e.g., Rituxan intravenous, biosimilars). If none are formulary, approve. **2.** Patient is currently taking a tocilizumab product (e.g., Actemra IV or SC or Tyenne IV or Tofidence IV): Approve if the patient has been established on a tocilizumab product (e.g., Actemra IV or SC or Tyenne IV or Tofidence IV) for ≥ 90 days. If both Actemra IV and Tyenne IV are non-formulary: Giant Cell Arteritis; Polymyalgia Rheumatica; Systemic Juvenile Idiopathic Arthritis, Castleman's Disease, Still's Disease, Chimeric Antigen Receptor (CAR) T Cell-Induced Severe or Life-Threatening Cytokine Release Syndrome, or Inflammatory Arthritis Associated with Checkpoint Inhibitor Therapy: Approve. Note: Examples of checkpoint inhibitors are Keytruda (pembrolizumab intravenous infusion), Opdivo (nivolumab intravenous infusion), Yervoy (ipilimumab intravenous infusion), Tecentriq (atezolizumab intravenous infusion), Bavencio (avelumab intravenous infusion), Imfinzi (durvalumab intravenous infusion), and Libtayo (cemiplimab-rwlc intravenous infusion). COVID-19 (Coronavirus Disease 2019) – Hospitalized Patient. Note: Tocilizumab intravenous is indicated for COVID-19 only in hospitalized patients. Note: This includes requests for cytokine release syndrome in a patient hospitalized with COVID-19. Note: For a patient who is hospitalized, forward all requests to the Medical Director.	1 year	Yes	Yes
Inflammatory Conditions - Infused TNF antagonists	Avsola	Infliximab- axxq for intravenous use	Patient meets the following: *Inflammatory Conditions – Infliximab Intravenous Products Prior Authorization Policy* criteria AND 1. Approve if the patient meets BOTH of the following (a and b): a. Patient has tried Inflectra; AND b. Patient cannot continue to use Inflectra due to a formulation difference in the inactive ingredients(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. 2. Conditions other than Plaque psoriasis; Hidradenitis suppurativa, Pyoderma gangrenosum: Approve if the patient has already started on therapy with Avsola. Note: An approval will be entered for Inflectra if the Infliximab Intravenous Products Prior Authorization criteria are met, but the remaining criteria are not met.	See PA duration	Yes	Yes

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Inflammatory Conditions - Infused TNF antagonists	Remicade and authorized generic infliximab	infliximab injection for intravenous use	Patient meets the following: *Inflammatory Conditions – Infliximab Intravenous Products Prior Authorization Policy* criteria AND Psoriatic arthritis. 1. Approve if the patient meets BOTH of the following (a and b): a. Patient has tried Inflectra; AND b. Patient cannot continue to use Inflectra due to a formulation difference in the inactive ingredients(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. 2. Approve if the patient has already been started on therapy with Remicade. Rheumatoid arthritis; Ankylosing spondylitis; Juvenile idiopathic arthritis; Crohn's disease; Ulcerative colitis. 1. Approve if the patient meets BOTH of the following (a and b): a. Patient has tried Inflectra; AND b. Patient cannot continue to use Inflectra due to a formulation difference in the inactive ingredients(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. 2. Approve if the patient has started therapy with Remicade AND has already been switched among the infliximab products in the past (e.g., switched from Remicade to Avsola or Remicade to Inflectra, or vice versa). Plaque psoriasis; Hidradenitis suppurativa, Pyoderma gangrenosum. 1. Approve if the patient meets BOTH of the following (a and b): a. Patient has tried Inflectra; AND b. Patient cannot continue to use Inflectra due to a formulation difference in the inactive ingredients(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. All other off-labeled indications in the *Inflammatory Conditions – Infliximab Intravenous Products Prior Authorization Policy* criteria. 1. Approve if the patient meets BOTH of the following (a and b): a. Patient has tried Inflectra; AND b. Patient cannot continue to use Inflectra due to a formulation difference in the inactive ingredients(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. 2. Approve if the patient has started therapy with Remicade AND has already been switched among the infliximab products in the past (e.g., switched from Remicade to Avsola or Remicade to Inflectra, or vice versa). 3. Approve if the patient has already been started on therapy with Remicade AND according to the prescriber, the patient has life- or organ-threatening disease (e.g., blindness). Note: An approval will be entered for Inflectra if the Infliximab Intravenous Products Prior Authorization criteria are met, but the remaining criteria are not met.	See PA duration	Yes	Yes
Inflammatory Conditions - Infused TNF antagonists	Renflexis	Infliximab-abda for intravenous use	Patient meets the following: *Inflammatory Conditions – Infliximab Intravenous Products Prior Authorization Policy* criteria AND 1. Approve if the patient meets BOTH of the following (a and b): a. Patient has tried Inflectra; AND b. Patient cannot continue to use Inflectra due to a formulation difference in the inactive ingredients(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. 2. Conditions other than Plaque psoriasis; Hidradenitis suppurativa, Pyoderma gangrenosum: Approve if the patient has already started on therapy with Renflexis. Note: An approval will be entered for Inflectra if the Infliximab Intravenous Products Prior Authorization criteria are met, but the remaining criteria are not met.	See PA duration	Yes	Yes
Inflammatory Conditions – Janus Kinase Inhibitors	Olumiant	baricitinib tablets	See standard Inflammatory Conditions (Olumiant) Preferred Specialty Management Policy for National Preferred, High Performance, and Basic Formularies 1) Choice, Alternate, 2) Legacy OR FLEX Formulary policies.	See PSM duration	Yes	Yes

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Inflammatory Conditions – SC Non-TNF Biologics	Cosentyx IV	secukinumab for intravenous injection	Approve if the patient has tried Cosentyx subcutaneous, if formulary, AND the patient is unable to continue to use a subcutaneous dosage form. If Cosentyx subcutaneous is non-formulary: Ankylosing Spondylitis; Psoriatic Arthritis. Approve if the patient meets ONE of the following (1 or 2): **1.** Patient meets BOTH of the following (A and B): A. Patient has tried Taltz, if formulary; AND Note: If Taltz is non-formulary, would still need to meet criterion B. B. Patient has tried at least one other biologic. Examples of other biologics: an adalimumab product (e.g.,Humira, biosimilars), a certolizumab pegol product (e.g., Cimzia), an etanercept product (e.g., Enbrel, biosimilars), an infliximab product (e.g., Remicade, biosimilars), a golimumab product (e.g., Simponi Aria or subcutaneous), or an abatacept product (e.g., Orencia intravenous or subcutaneous). If none are formulary, approve. **2.** Patient is currently receiving Cosentyx (intravenous (IV) or subcutaneous (SC): Patient has been established on Cosentyx (IV or SC) for ≥ 90 days, approve. Note: If the patient has been on Cosentyx (IV or SC) for < 90 days, refer to criterion #1. Non-Radiographic Spondyloarthritis. Approve if the patient meets ONE of the following (1 or 2): **1.** Approve if the patient has tried Taltz, if formulary; OR Note: If Taltz is non-formulary, approve. **2.** Patient is currently receiving Cosentyx (intravenous (IV) or subcutaneous (SC): Patient has been established on Cosentyx (IV or SC) for ≥ 90 days, approve. Note: If the patient has been on Cosentyx (IV or SC) for < 90 days, refer to criterion #1.	1 year	Yes	Yes
Inflammatory Conditions – SC Non-TNF Biologics	Ilumya	tildrakizumab SC injection	See standard *Inflammatory Conditions (**Ilumya**) Preferred Specialty Management Policy for National Preferred, High Performance, and Basic Formularies 1) Choice, Alternate, 2) Legacy OR FLEX Formulary* policies.	See PSM duration	Yes	Yes
Inflammatory Conditions – SC Non-TNF Biologics	Kevzara	sarilumab subcutaneous injection	See standard *Inflammatory Conditions (**Kevzara**) Preferred Specialty Management Policy for National Preferred, High Performance, and Basic Formularies 1) Choice, Alternate, 2) Legacy OR FLEX Formulary* policies.	See PSM duration	Yes	Yes
Inflammatory Conditions – SC Non-TNF Biologics	Kineret	anakinra SC injection	See standard *Inflammatory Conditions (**Kineret**) Preferred Specialty Management Policy for National Preferred, High Performance, and Basic Formularies 1) Choice, Alternate, 2) Legacy OR FLEX Formulary* policies.	See PSM duration	Yes	Yes
Inflammatory Conditions – SC Non-TNF Biologics	Orencia for SC use	abatacept injection for subcutaneous use	See standard *Inflammatory Conditions (**Orencia SC**) Preferred Specialty Management Policy for National Preferred, High Performance, and Basic Formularies 1) Choice, Alternate, 2) Legacy OR FLEX Formulary* policies.	See PSM duration	Yes	Yes
Inflammatory Conditions – SC Non-TNF Biologics	Bimzelx	bimekizumab-bkzx subcutaneous injection	See standard *Inflammatory Conditions (**Bimzelx**) Preferred Specialty Management Policy for National Preferred, High Performance, and Basic Formularies 1) Choice, Alternate, 2) Legacy OR FLEX Formulary* policies.	See PSM duration	Yes	Yes
Inflammatory Conditions – SC Non-TNF Biologics	Siliq	brodalumab for subcutaneous injection	See standard *Inflammatory Conditions (**Siliq**) Preferred Specialty Management Policy for National Preferred, High Performance, and Basic Formularies 1) Choice, Alternate, 2) Legacy OR FLEX Formulary* policies.	See PSM duration	Yes	Yes
Inflammatory Conditions – SC TNF Antagonists	Simponi SC	golimumab subcutaneous injection	See standard *Inflammatory Conditions (**Simponi SC**) Preferred Specialty Management Policy for National Preferred, High Performance, and Basic Formularies 1) Choice, Alternate, 2) Legacy OR FLEX Formulary* policies.	See PSM duration	Yes	Yes
Inflammatory Conditions – SC TNF Antagonists	Cimzia	certolizumab powder for injection	See standard *Inflammatory Conditions (**Cimzia**) Preferred Specialty Management Policy for National Preferred, High Performance, and Basic Formularies 1) Choice, Alternate, 2) Legacy OR FLEX Formulary* policies.	See PSM duration	Yes	Yes
Inflammatory Conditions – SC TNF Antagonists - Adalimumab Agents	Yuflyma and adalimumab-aaty	adalimumab-aaty subcutaneous injection	See standard *Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for National Preferred, High Performance, and Basic Formularies 1) Choice, 2) Alternate, 3) Legacy OR FLEX Formulary* policies.	See PSM duration	Yes	
Inflammatory Conditions – SC TNF Antagonists - Adalimumab Agents	Yusimry	adalimumab-aqvh subcutaneous injection	See standard *Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for National Preferred, High Performance, and Basic Formularies 1) Choice, 2) Alternate, 3) Legacy OR FLEX Formulary* policies.	See PSM duration	Yes	
Inflammatory Conditions – SC TNF Antagonists - Adalimumab Agents	Abrilada	adalimumab-afzb subcutaneous injection	See standard *Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for National Preferred, High Performance, and Basic Formularies 1) Choice, 2) Alternate, 3) Legacy OR FLEX Formulary* policies.	See PSM duration	Yes	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Inflammatory Conditions – SC TNF Antagonists - Adalimumab Agents	Adalimumab-fkjp	adalimumab-fkjp subcutaneous injection (unbranded version of Hulio)	See standard *Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for National Preferred, High Performance, and Basic Formularies 1) Choice, 2) Alternate, 3) Legacy OR FLEX Formulary* policies.	See PSM duration	Yes	
Inflammatory Conditions – SC TNF Antagonists - Adalimumab Agents	Amjevita	adalimumab-atto subcutaneous injection	See standard *Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for National Preferred, High Performance, and Basic Formularies 1) Choice, 2) Alternate, 3) Legacy OR FLEX Formulary policies.*	See PSM duration	Yes	
Inflammatory Conditions – SC TNF Antagonists - Adalimumab Agents	Hadlima	adalimumab-bwwd subcutaneous injection	See standard *Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for National Preferred, High Performance, and Basic Formularies 1) Choice, 2) Alternate, 3) Legacy OR FLEX Formulary* policies.	See PSM duration	Yes	
Inflammatory Conditions – SC TNF Antagonists - Adalimumab Agents	Hulio	adalimumab-fkjp subcutaneous injection	See standard *Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for National Preferred, High Performance, and Basic Formularies 1) Choice, 2) Alternate, 3) Legacy OR FLEX Formulary* policies.	See PSM duration	Yes	
Inflammatory Conditions – SC TNF Antagonists - Adalimumab Agents	Humira	adalimumab injection	See standard *Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for National Preferred, High Performance, and Basic Formularies 1) Choice, 2) Alternate, 3) Legacy OR FLEX Formulary* policies.	See PSM duration	Yes	
Inflammatory Conditions – SC TNF Antagonists - Adalimumab Agents	Hyrimoz	adalimumab-adaz subcutaneous injection	See standard Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for National Preferred, High Performance, and Basic Formularies 1) Choice, 2) Alternate, 3) Legacy OR FLEX Formulary policies.	See PSM duration	Yes	
Inflammatory Conditions – SC TNF Antagonists - Adalimumab Agents	Idacio and adalimumab-aacf	adalimumab-aacf subcutaneous injection	See standard *Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for National Preferred, High Performance, and Basic Formularies 1) Choice, 2) Alternate, 3) Legacy OR FLEX Formulary* policies.	See PSM duration	Yes	
Interferons	Besremi	ropeginterferon alfa-2b-njft subcutaneous injection	See *Oncology (Injectable) – Besremi Prior Authorization Policy* criteria.	1 year	Yes	
Iron Replacement (Injectable)	Monoferric	ferric derisomaltose injection for intravenous use	Approve if the patient has tried three products from the following list (if three are formulary, or two if two are formulary, or one if one is formulary): Venofer, sodium ferric gluconate complex (Ferrlecit, generics), or Injectafer. If none are formulary, approve.	1 year	Yes	
Iron Replacement (Injectable)	Feraheme	ferumoxytol injection	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Irritable Bowel Syndrome Agents	Lotronex	alosetron tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.		MSB Exclusion *This criteria applies only to the NPF	
Isotretinoin Products	Absorica LD	isotretinoin capsules low dose	Approve if the patient has tried three of the following: isotretinoin capsules (Absorica [not LD]), Accutane, Amnesteem, Claravis, or Zenatane, if formulary (or two if two are formulary or one if one is formulary). If none are formulary, approve.	1 year	Yes	
Leukotriene Pathway Inhibitors	Singulair tablets	montelukast sodium tablets, chewable tablets, granules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Long-Acting Beta-Agonists (Inhalers)	Serevent Diskus	salmeterol xinafoate inhalation powder	**1.** Approve if the patient has tried Striverdi Respimat, if formulary. If Striverdi is non-formulary, approve. **2.** Patient who is unable to coordinate breath and actuation with a metered-dose inhaler (MDI): approve. **3.** Patient with asthma: Approve if the patient is using Serevent Diskus concomitantly with an inhaled corticosteroid or an inhaled corticosteroid-containing product. **4.** Patient with exercise induced bronchospasm without asthma: approve. Note: A patient with exercise-induced bronchospasm and asthma should be referred to criterion #3.	1 year	Yes	
Long-Acting Beta-Agonists (nebulized)	Perforomist	formoterol fumarate inhalation solution	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Long-Acting Muscarinic Antagonist (LAMA)/Long-Acting Beta-Agonist (LABA) Combination Inhalers	Bevespi Aerosphere	glycopyrrolate and formoterol fumarate inhalation aerosol	**1.** Approve if the patient has tried three of Anoro Ellipta, Duaklir Pressair, or Stiolto Respimat, if three are formulary, or two if two are formulary, or one if one is formulary. If none are formulary, approve. **2.** If the patient has a low inspiratory flow rate and is unable to use a dry powder inhaler (DPI), approve if the patient has tried Stiolto Respimat, if formulary. If Stiolto Respimat is non-formulary, approve.	1 year	Yes	
Long-Acting Muscarinic Antagonist (LAMA)/Long-Acting Beta-Agonist (LABA) Combination Inhalers	Duaklir Pressair	aclidinium bromide and formoterol fumarate inhalation powder	**1.** Approve if the patient has tried three of Anoro Ellipta, Bevespi Aerosphere, or Stiolto Respimat, if three are formulary, or two if two are formulary or one if one is formulary. If none are formulary, approve. **2.** If the patient is unable to coordinate breath and actuation with a metered-dose inhaler (MDI), approve if the patient has tried Anoro Ellipta, if formulary. If Anoro Ellipta is non-formulary, approve.	1 year	Yes	
Long-Acting Opioids (Oral)	Nucynta ER	tapentadol extended-release tablets	**1.** Approve if the patient has tried three other oral long-acting opioid products. For example: morphine sulfate controlled-release/extended-release capsules or tablets [MS Contin, Kadian, generics], OxyContin, oxycodone ER tablets [generics], Xtampza ER, hydromorphone extended-release tablets [Exalgo, generics], oxymorphone extended-release tablets, or hydrocodone ER (Zohydro ER, Hysingla ER, generics). **2.** Patient is intolerant or allergic to morphine: approve if the patient has tried one product from the following list (if one is formulary): hydrocodone ER (Zohydro ER, Hysingla ER, generics), OxyContin, Xtampza ER, or oxycodone ER tablets (generics). If none are formulary, approve. **3.** Patient has renal insufficiency: approve if the patient has tried one product from the following list (if one is formulary): hydrocodone ER (Zohydro ER, Hysingla ER, generics), OxyContin, Xtampza ER, or oxycodone ER tablets (generics). If none are formulary, approve.	1 year	Yes	
Long-Acting Opioids (Oral)	oxycodone ER	oxycodone extended-release tablets	**1.** Approve if the patient has tried three other oral long-acting opioid products. For example: morphine sulfate controlled-release/extended-release capsules or tablets [MS Contin, Kadian, generics], hydromorphone extended-release tablets [Exalgo, generics], oxymorphone extended-release, Nucynta ER, hydrocodone ER (Zohydro ER, Hysingla ER, generics), OxyContin, or Xtampza ER. **2.** Patient is intolerant or allergic to morphine: approve if the patient has tried one product from the following list (if one is formulary): Nucynta ER, hydrocodone ER (Zohydro ER, Hysingla ER, generics), Xtampza ER, or OxyContin. If none are formulary, approve. **3.** Patient has renal insufficiency: approve if the patient has tried one product from the following list (if one is formulary): Nucynta ER, hydrocodone ER (Zohydro ER, Hysingla ER, generics), Xtampza ER, or OxyContin. If none are formulary, approve. **4.** Patients ≥ 11 years and < 18 years of age: approve if the patient has tried OxyContin, if formulary. If Oxycontin is non-formulary, approve.	1 year	Yes	
Long-Acting Opioids (Oral)	Xtampza ER	oxycodone extended-release capsules (with DETERx)	**1.** Approve if the patient has tried three other oral long-acting opioid products. For example: morphine sulfate controlled-release/extended-release capsules or tablets [MS Contin, Kadian, generics], hydromorphone extended-release tablets [Exalgo, generics], oxymorphone extended-release, Nucynta ER, hydrocodone ER (Zohydro ER, Hysingla ER, generics), OxyContin, or oxycodone ER tablets [generics]. **2.** Patient is intolerant or allergic to morphine: approve if the patient has tried one product from the following list (if one is formulary): Nucynta ER, hydrocodone ER (Zohydro ER, Hysingla ER, generics), oxycodone ER tablets (generics), or OxyContin. If none are formulary, approve. **3.** Patient has renal insufficiency: approve if the patient has tried one product from the following list (if one is formulary): Nucynta ER, hydrocodone ER (Zohydro ER, Hysingla ER, generics), oxycodone ER tablets (generics), or OxyContin. If none are formulary, approve.	1 year	Yes	
Long-Acting Opioids (Transdermal)	Butrans	buprenorphine transdermal system	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Loop diuretics	Soaanz	torsemide tablets	Approve if the patient has tried three products from the following list, if formulary (or two if two are formulary or one if one is formulary): torsemide tablets, bumetanide (Bumex, generics), furosemide (Lasix, generics). If none are formulary, approve.	1 year	Yes	
Loop diuretics	Furoscix	furosemide subcutaneous injection by on-body infusor	For the treatment of congestion due to fluid overload in a patient ≥ 18 years of age with chronic heart failure. Approve if the patient has tried at least one loop diuretic **[documentation required]** or the patient is currently taking a loop diuretic. Note: Examples of loop diuretics include furosemide, bumetanide, torsemide.	30 days	Yes	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Low Molecular Weight Heparins and Related Agents	Lovenox	enoxaparin sodium injection (syringe/vial)	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Metabolic Agents	Cystadane	betaine trimethylglycine powder for solution	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Metabolic Agents - Phenylbutyrate Agents	Ravicti	glycerol phenylbutyrate oral liquid	Patient meets the following: *Metabolic Disorders – Phenylbutyrate Products Prior Authorization Policy* criteria AND Patient meets one of the following (1, 2, 3, or 4): **1.** Approve if the patient has tried two of the following, if two are formulary (or one if only one is formulary): Olpruva and Pheburane **[documentation required]**. If neither are formulary, approve; OR **2.** Patient has a feeding tube: Approve if the patient has tried sodium phenylbutyrate powder for oral administration (Buphenyl powder, generic) **[documentation required]**, if formulary. If sodium phenylbutyrate powder for oral administration (Buphenyl powder, generic) is non-formulary, approve; OR **3.** Patient is < 20 kg: approve if the patient meets one of the following (a or b): a. Patient has tried Pheburane **[documentation required]**, if formulary. If Pheburane is non-formulary, approve; OR b. Patient is NOT eating solid food AND does NOT have a feeding tube (e.g., young infant): Approve; OR **4.** Patient is on a sodium-restricted diet OR, according to the prescriber, a high sodium diet is contraindicated **[documentation required]**: Approve.	See PA duration	Yes	
Metabolic Disorder Agent	Rivfloza	nedosiran subcutaneous injection	Primary Hyperoxaluria Type 1 in a patient ≥ 9 years of age. **1.** Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with Oxlumo, if formulary. If Oxlumo is non-formualry, approve. **2.** Approve if the patient has already been started on therapy with Rivfloza.	1 year	Yes	Yes
Metabolic Disorders – Cysteamine Ophthalmic Products	Cystadrops	cysteamine ophthalmic solution	Cystinosis with Corneal Cysteine Crystal Deposits: Approve, if the patient has tried Cystaran, if formulary. If Cystaran is non-formulary, approve.	1 year	Yes	
Migraine – Ergotamine Agents	Trudhesa	dihydroergotamine mesylate nasal spray	Approve if the patient has tried dihydroergotamine nasal spray (Migranal, generics), if formulary. If dihydroergotamine nasal spray (Migranal, generics) are non-formulary, approve if the patient meets one of the following (A or B): A. Patient meets one of the following (i or ii): i. Patient has tried one of sumatriptan nasal spray (Imitrex Nasal Spray, generics), Tosymra, or Onzetra Xsail, if formulary; OR ii. Patient has tried Zomig Nasal Spray or zolmitriptan nasal spray, if formulary: OR Note: If no products from i. or ii. are formulary, approve. B. Patient has already experienced inadequate efficacy or a contraindication with a triptan product.	1 year	Yes	
Migraine Agent – Treatment Medications - Calcitonin gene-related peptide (CGRP) receptor antagonist	Zavzpret	zavegepant nasal spray	Approve if the patient meets the following (A and B): A. Patient meets one of the following (i or ii): i. Patient has tried both Nurtec ODT AND Ubrelvy, if both are formulary (or only one if one is formulary); OR ii. If the patient is unable to swallow or has difficulty swallowing tablets, the patient has tried Nurtec ODT, if formulary. If Nurtec ODT is non-formulary, criteria A is met; AND Note: The patient would still need to meet criteria B even if criteria A is met. B. Patient meets one of the following (i or ii): i. Patient has tried two triptan products (for example, almotriptan [Axert, generics], eletriptan [Relpax, generics], frovatriptan [Frova, generics], naratriptan [Amerge, generics], rizatriptan [Maxalt, generics], sumatriptan [Imitrex, generics], zolmitriptan [Zomig, generics]); OR ii. Patient meets one of the following (1 or 2): 1. Per the prescriber, the patient has a contraindication to triptans; OR 2. Per the prescriber, the patient has had a significant intolerance to one or more triptans.	1 year	Yes	
Migraine Agents - Calcitonin Gene-Related Peptide (CGRP) Inhibitors	Vyepti	eptinezumab-jjmr injection for intravenous use	Approve if the patient has tried four of the following products, if formulary (or three if three are formulary or two if two are formulary or one if one is formulary): Aimovig, Emgality, Ajovy, and Qulipta. If none are formulary, approve.	1 year	Yes	
Migraine Agents - Triptans	Onzetra Xsail	sumatriptan nasal powder	Approve if the patient meets both of the following (a and b): a. Patient has tried one of sumatriptan nasal spray (Imitrex Nasal Spray, generics) or Tosymra, if formulary; AND b. Patient has tried Zomig Nasal Spray or zolmitriptan nasal spray, if formulary. Note: If no products from a. or b. are formulary, approve.	1 year	Yes	
Migraine Agents - Triptans	Treximet	sumatriptan/ naproxen sodium tablets	Approve if the patient has tried naproxen AND sumatriptan tablets (Imitrex, generics), if formulary. If sumatriptan tablets (Imitrex, generics) are non-formulary, approve. **NOTE:** A trial of the requested agent would NOT count toward meeting this requirement.	1 year	Yes	
Migraine Agents - Triptans	Imitrex injection	sumatriptan succinate solution for injection (injectable pen/cartridges)	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Migraine Agents - Triptans	Imitrex nasal spray	sumatriptan nasal spray	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Migraine Agents - Triptans	Imitrex tablets	sumatriptan succinate tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Migraine Agents - Triptans	Maxalt	rizatriptan tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Migraine Agents - Triptans	Maxalt MLT	rizatriptan orally disintegrating tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Migraine Agents - Triptans	Relpax	eletriptan tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Migraine Agents - Triptans	Zomig tablets	zolmitriptan tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Miscellaneous anticholinergic	Sofdra	sofpironium topical gel, 12.45%	Hyperhidrosis, Primary Axillary in a patient ≥ 9 years of age. Note: Sofdra is not intended for application to areas other than the axillae. Approve if the patient meets BOTH of the following (1 and 2): **1.** Approve if the patient meets ONE of the following (A or B): A. Patient has tried, for at least 4 weeks, and experienced inadequate efficacy with one of Drysol, Xerac AC, or Bromi-lotion **[documentation required]**; OR B. According to the prescriber, the patient has experienced a significant intolerance with one of these products **[documentation required]**; AND **2.** Patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with Qbrexza, if formulary. Note: If Qbrexa is non-formulary, criterion 2 is met.	1 year	Yes	
Miscellaneous anticholinergic	Qbrexza	glycopyrronium cloth 2.4%, for topical use	Hyperhidrosis, Primary Axillary in a patient ≥ 9 years of age. Note: Qbrexza is not intended for application to areas other than the axillae. Approve if the patient meets BOTH of the following (1 and 2): **1.** Patient meets ONE of the following (A or B): A. Patient has tried, for at least 4 weeks, and experienced inadequate efficacy with one of Drysol, Xerac AC, or Bromi-lotion **[documentation required]**; OR B. According to the prescriber, the patient has experienced a significant intolerance with one of these products **[documentation required]**. **2.** Patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with Sofdra, if formulary. Note: If Sofdra is non-formulary, criterion 2 is met.	1 year	Yes	
Miscellaneous anticholinergic	Mestinon	pyridostigmine tablet, solution, exteneded-release tablet	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Miscellaneous Urologicals	Urimar-T	methenamine 120 mg, sodium phosphate monobasic 40.8 mg, phenyl salicylate 36.2 mg, methylene blue 10.8 mg, hyoscyamine sulfate 0.12 mg capsule	Apporve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with BOTH of the following, if formulary: Uro-MP capsules AND Uro-SP capsules. If neither are formulary, approve.	1 year	Yes	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Miscellaneous Urologicals	Urneva	methenamine 120 mg, sodium phosphate monobasic 40.8 mg, phenyl salicylate 36.2 mg, methylene blue 10.8 mg, hyoscyamine sulfate 0.12 mg capsule	Apporve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with BOTH of the following, if formulary: Uro-MP capsules AND Uro-SP capsules. If neither are formulary, approve.	1 year	Yes	
Multiple Sclerosis Drugs -Injectable glatiramer	Copaxone	glatiramer acetate injection	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Multiple Sclerosis Drugs (Injectable) - CD20-directed cytolytic antibodies	Briumvi	ublituximab-xiiy intravenous infusion	Relapsing forms of multiple sclerosis. Note: Examples of relapsing forms of multiple sclerosis (MS) include clinically isolated syndrome, relapsing remitting disease, and active secondary progressive disease. **1.** Approve if the patient has tried and, according to the prescriber, has had inadequate efficacy or significant intolerance with ONE of 1) Ocrevus intravenous or Ocrevus Zunovo or 2) Kesimpta, if formulary. If none are formulary, approve. **2.** Approve if the patient has already been started on Briumvi therapy.	1 year	Yes	Yes
Multiple Sclerosis Drugs (Oral)	Tascenso ODT 0.5 mg	fingolimod orally disintegrating tablets	Patient with relapsing form of multiple sclerosis. Note: Examples of relapsing forms of multiple sclerosis (MS) include clinically isolated syndrome, relapsing remitting disease, and active secondary progressive disease. **1.** Approve if the patient is unable to swallow or has difficulty swallowing fingolimod 0.5 mg capsules or Gilenya 0.5 mg capsules **[documentation required]**. **2.** Approve if neither fingolimod 0.5 mg capsule nor Gilenya 0.5 mg capsules are formulary.	1 year	Yes	
Multiple Sclerosis Drugs (Oral)	Tascenso ODT 0.25 mg	fingolimod orally disintegrating tablets	Approve if the patient meets the following 1 AND 2: 1. Patient meets all of the following (A, B, and C): A. Patient with relapsing form of multiple sclerosis; AND Note: Examples of relapsing forms of multiple sclerosis (MS) include clinically isolated syndrome, relapsing remitting disease, and active secondary progressive disease. B. Patients ≥ 10 years of age; AND C. Patient weighs less than or equal to 40 kg **[documentation required]**; AND 2. Patients meets one of the following (A, B, OR C): A. Patient is unable to swallow or has difficulty swallowing Gilenya **[documentation required]**; OR B. Patient is unable to obtain Gilenya 0.25 mg capsules from the manufacturer; OR C. Gilenya 0.25 mg is non-formulary.	1 year	Yes	
Multiple Sclerosis Drugs (Oral)	Gilenya 0.25 mg	fingolimod capsule	Patient meets all of the following (A, B, C and D): A. Patient with relapsing form of multiple sclerosis; AND Note: Examples of relapsing forms of multiple sclerosis (MS) include clinically isolated syndrome, relapsing remitting disease, and active secondary progressive disease. B. Patients ≥ 10 years of age; AND C. Patient weighs less than or equal to 40 kg **[documentation required]**; AND D. Patient has tried Tascenso 0.25 mg orally disintegrating tablets (ODT), if formulary. If Tascenso 0.25 ODT are non-formulary, approve.	1 year	Yes	
Multiple Sclerosis Drugs (Oral)	Aubagio	teriflunomide tablets	Relapsing forms of multiple sclerosis. Note: Examples of relapsing forms of multiple sclerosis (MS) include clinically isolated syndrome, relapsing remitting disease, and active secondary progressive disease. Approve if the patient has tried teriflunomide tablets, if formulary. If teriflunomide tablets are non-formulary or generic teriflunomide is being requested, approve if the patient meets one of the following (1, 2, or 3): **1.** Patient meets the following (A and B): A. Patient has tried and, according to the prescriber, has had inadequate efficacy OR significant intolerance with one fumarate-based product, if formulary: Bafiertam, dimethyl fumarate (Tecfidera, generics), or Vumerity. If none are formulary, approve; AND B. Patient has tried and, according to the prescriber, has had inadequate efficacy OR significant intolerance with one of the following: fingolimod (Gilenya, generics), Zeposia, Mayzent, or Ponvory, if formulary. If none are formulary, would still need to try a fumarate-based product, if one is formulary. **2.** For patients with an underlying cardiovascular condition (e.g., heart failure, myocardial infarction, stroke, transient ischemic attack, unstable angina, atrioventricular [AV] block, cardiac arrhythmias, bradyarrhythmias), patient has tried and, according to the prescriber, has had inadequate efficacy OR significant intolerance with one other oral disease-modifying therapy (e.g., dimethyl fumarate, Vumerity). Note: Any oral disease modifying agent would satisfy this requirement, including dimethyl fumarate, Tecfidera, Vumerity, Bafiertam, Mavenclad, Zeposia, Mayzent, Ponvory, fingolimod, Gilenya, Tascenso ODT. **3.** Patient has been established on Aubagio for greater than or equal to 120 days.	1 year	Yes- brand only	Yes
Multiple Sclerosis Drugs (Oral)	Ampyra	dalfampridine extended-release tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Multiple Sclerosis Drugs (Oral)	Gilenya 0.5 mg	fingolimod capsule	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Multiple Sclerosis Drugs (Oral) – Fumarate-based Agents	Tecfidera	dimethyl fumarate delayed-release capsules	See standard *Multiple Sclerosis (Tecfidera) Preferred Specialty Management Policy* criteria.	1 year	Yes	
Muscle Relaxants	Methocarbamol 1,000 mg tablets (brand)	methocarbamol 1,000 mg tablets	**1.** Direct the patient to methocarbamol 500 mg tablets. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use the methocarbamol 500 mg tablets.	1 year	Yes	
Muscle Relaxants	Amrix and generic	cyclobenzaprine extended-release 15 mg and 30 mg capsule	Approve if the patient has tried and cannot take cyclobenzaprine 5 mg or 10 mg tablets (generics), if formulary. If cyclobenzaprine 5 mg or 10 mg tablets (generics) are non-formulary, approve.	1 year	Yes	
Muscle Relaxants – Baclofen Agents	Fleqsuvy	baclofen oral suspension, concentrated formulation	**1.** Direct to oral baclofen tablets. **2.** Patient is unable to or has difficulty swallowing oral tablets, approve if the patient has tried baclofen 25 mg/5ml oral suspension (generic of Fleqsuvy), if formulary. If baclofen 25 mg/5ml oral suspension (generic of Fleqsuvy) is non-formulary, approve if the patient has tried one of 1) Ozobax solution or 2) Lyvispah oral gransules, if formulary. If neither are formulary, approve.	1 year	Yes	
Muscle Relaxants – Baclofen Agents	Lyvispah	baclofen oral granules	**1.** Direct the patient to oral baclofen tablets. **2.** If Lvyispah will be administered via a feeding tube, approve. **3.** Patient is unable to or has difficulty swallowing oral tablets, approve if the patient has tried one of 1) Ozobax solution or 2) baclofen 25mg/5ml oral suspension (Fleqsuvy suspension, generics), if formulary. If neither are formulary, approve.	1 year	Yes	
Muscle Relaxants – Baclofen Agents	Ozobax, Ozobax DS, and authorized generics	baclofen oral solution	**1.** Direct to oral baclofen tablets. **2.** Patient is unable to or has difficulty swallowing oral tablets, approve if the patient has tried one of 1) baclofen 25 mg/5ml oral suspension (Fleqsuvy suspension, generics) or 2) Lyvispah oral granules, if formulary. If neither are formulary, approve.	1 year	Yes	
Myelodysplastic syndrome Agent	Inqovi	decitabine and cedazuridine tablets	Chronic Myelomonocytic Leukemia; Myelodysplastic Syndrome with Myeloproliferative Neoplasm Overlap Syndrome; Myelodysplastic Syndromes (Note: Examples of myelodysplastic syndromes include: refractory anemia, refractory anemia with ringed sideroblasts, and refractory anemia with excess blasts.). **1.** Approve if the patient has tried decitabine injection (Dacogen, generics), if formulary. If decitabine injection (Dacogen, generics) is non-formulary, approve. **2.** Approve if the patient is unable to obtain and/or maintain intravenous access. **3.** Approve if the patient has already started therapy with Inqovi.	1 year	Yes	Yes
Myelofibrosis Agents	Inrebic	febratinib capsules	Myelofibrosis; Myeloid/Lymphoid Neoplasms: **1.** Approve if the patient has tried Jakafi, if formulary. If Jakafi is non-formulary, approve. **2.** Approve if the patient has already been started on Inrebic.	1 year	Yes	Yes
Myelofibrosis Agents – JAK Inhibitors	Ojjaara	momelotinib tablets	Myelofibrosis. **1.** Approve if the patient has tried Jakafi, if formulary. If Jakafi is non-formulary, approve. Note: If the patient has tried Inrebic or Vonjo, this would satisfy requirement for approval. **2.** If the patient has a hemoglobin < 10 g/dL AND symptomatic splenomegaly and/or constitutional symptoms, approve. Note: Examples of constitutional symptoms include weight loss, night sweats, and fever. **3.** Approve if the patient has already started on therapy with Ojjaara.	1 year	Yes	Yes
Naloxone Products for Opioid Overdose	Zimhi	naloxone hydrochloride intramuscular or subcutaneous injection 5 mg/0.5 ml	**1.** Approve if the patient has tried naloxone syringes, if formulary. If naloxone syringes are non-formulary, approve. **2.** Approve, if according to the prescriber, a higher-strength naloxone product is needed.	1 year	Yes	
Nasal Antihistamines and Combination Products	Dymista	azelastine and fluticasone propionate nasal spray	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Nasal Steroids	Beconase AQ	beclomethasone nasal spray	Approve if the patient has tried five nasal steroids from the following list, if formulary (or four if four are formulary or three if three are formulary or two if two are formulary or one if one is formulary): fluticasone nasal spray, mometasone nasal spray (Nasonex, generics), flunisolide nasal spray (generics), Omnaris, Qnasl, or Zetonna. **Note**: Over-the-counter (OTC) nasal steroids would count as a trial of an alternative.	1 year	Yes	
Nasal Steroids	Omnaris	ciclesonide nasal spary	Approve if the patient has tried five nasal steroids from the following list, if formulary (or four if four are formulary or three if three are formulary or two if two are formulary or one if one is formulary): fluticasone propionate spray, mometasone nasal spray (Nasonex, generics), flunisolide nasal spray (generics), Qnasl, or Zetonna. **Note**: Over-the-counter (OTC) nasal steroids would count as a trial of an alternative.	1 year	Yes	
Nasal Steroids	Qnasl	beclomethasone dipropionate nasal aersol	Approve if the patient has tried five nasal steroids from the following list, if formulary (or four if four are formulary or three if three are formulary or two if two are formulary or one if one is formulary): fluticasone propionate spray, mometasone nasal spray (Nasonex, generics), flunisolide nasal spray (generics), Omnaris, or Zetonna. **Note**: Over-the-counter (OTC) nasal steroids would count as a trial of an alternative.	1 year	Yes	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Nasal Steroids	Zetonna	ciclesonide nasal aerosol	Approve if the patient has tried five nasal steroids from the following list, if formulary (or four if four are formulary or three if three are formulary or two if two are formulary or one if one is formulary): fluticasone propionate spray, mometasone nasal spray (Nasonex, generics), flunisolide nasal spray (generics), Omnaris, or Qnasl. **Note**: Over-the-counter (OTC) nasal steroids would count as a trial of an alternative.	1 year	Yes	
Nephropathic Cystinosis Medications	Procysbi	cysteamine bitartrate dealyed-release capsules and granule packets	Approve if the patient meets the following criteria (A, B, C, and D): A. Patients with nephropathic cystinosis; AND B. According to the prescriber, the diagnosis was confirmed by one of the following (i or ii): i. Genetic testing confirmed a mutation of the CTNS gene; OR ii. White blood cell cystine concentration above the upper limit of the normal reference range for the reporting laboratory; AND C. The patient will not be using Cystagon and Procysbi concurrently; AND D. The patient has tried Cystagon **[documentation required]**, if formulary. If Cystagon is non-formulary, approve.	1 year	Yes	
Neurology - Amyotrophic Lateral Sclerosis (ALS) Agents	Qalsody	tofersen intrathecal injection	See standard *Neurology – Qalsody Prior Authorization Policy* criteria. Note: No conditions of approval are recommended in the prior authorization policy.	N/A	Yes	
Neuromyelitis optica spectrum disorder (NMOSD) Agents	Uplizna	inebilizumab-cdon injection for intravenous infusion	Anti-aquaporin (AQ4P) antibody-positive Neuromyelitis Optica Spectrum Disorder in a patient ≥ 18 years of age. **1.** Approve if the patient has tried and, according to the prescriber, has inadequate efficacy or significant intolerance to Enspryng, if formulary. If Enspryng is non-formulary, approve. **2.** Approve if the patient has already started on therapy with Uplinza.	1 year	Yes	Yes
N-methyl D-aspartate (NMDA) receptor antagonists	Spravato	esketamine nasal spray	**1.** For the diagnosis of Treatment-Resistant Depression: approve if the patient meets the following criteria (A, B, C, D, E, and F): A. Patient is ≥ 18 years of age; AND B. Patient meets both of the following (i and ii): i. Patient has demonstrated nonresponse (≤ 25% improvement in depression symptoms or scores) to at least two different antidepressants, each from a different pharmacologic class, according to the prescriber; AND Note: Different pharmacologic classes of antidepressants inlcude selective serotonin reuptake inhibitors, serotonin-norepinephrine reuptake inhibitors, tricyclic antidepressants, bupropion, mirtazapine, etc. ii. Each antidepressant was used at therapeutic dosages for at least 6 weeks in the current episode of depression, according to the prescriber; AND C. Patient is concomitantly receiving at least one oral antidepressant; AND Note: Antidepressants may include, but are not limited to, selective serotonin reuptake inhibitors, serotonin-norepinephrine reuptake inhibitors, tricyclic antidepressants, mirtazapine, and bupropion. D. Patient has one of the following (i or ii): i. No history of psychosis; OR ii. History of psychosis and the prescriber believes that the benefits of Spravato outweigh the risks; AND E. The patient's history of controlled substance prescriptions has been checked using the state prescription drug monitoring program, according to the prescriber; AND F. The medication is prescribed by a psychiatrist. **2.** Major Depressive Disorder with Acute Suicidal Ideation or Behavior: approve if the patient meets the following criteria (A, B, C, D, and E): A. Patient is ≥ 18 years of age; AND B. Patient has major depressive disorder that is considered to be severe, according to the prescriber; AND C. Patient is concomitantly receiving at least one oral antidepressant; AND Note: Antidepressants may include, but are not limited to, selective serotonin reuptake inhibitors, serotonin-norepinephrine reuptake inhibitors, tricyclic antidepressants, mirtazapine, and bupropion. D. Patient has one of the following (i or ii): i. No history of psychosis; OR ii. History of psychosis and the prescriber believes that the benefits of Spravato outweigh the risks; AND E. The medication is prescribed by a psychiatrist. **3.** For the diagnosis of Treatment-Resistant Depression OR Major Depressive Disorder with acute suicidal ideation or behavior: approve if the patient has already started therapy with Spravato.	1 year	Yes	Yes
NSAID and Acid Reducing Agent Combination Products	Duexis	ibuprofen and famotidine tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
NSAID and Acid Reducing Agent Combination Products	Vimovo	naproxen and esomeprazole magnesium delayed-release tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
NSAIDS (Cox2)	Elyxyb	celecoxib oral solution	Acute treatment of migraine. **1.** Direct the patient to celecoxib capsules. If celecoxib capsules (Celebrex, generics) are non-formulary, approve. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use celecoxib capsules.	1 year	Yes	
NSAIDS (Cox2)	Celebrex	celecoxib capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
NSAIDs (Oral)	Coxanto and oxaprozin 300 mg (brand)	oxaprozin capsule	Approve if the patient has tried five prescription-strength, oral NSAIDs. Note: Examples include: oxaprozin (Daypro, generics), etodolac (generics), flurbiprofen (Ansaid, generics), ibuprofen (e.g., Motrin, generics), ketoprofen (generics), meloxicam (Mobic, generics), nabumetone (generics), naproxen (e.g., Naprosyn, Naprelan, generics), diclofenac (Voltaren XR, generics), piroxicam (Feldene, generics), indomethacin (generics). Note: Over-the-counter (OTC) NSAIDs would count if prescription-strength doses were used. Note: Five unique NSAIDs should be tried.	1 year	Yes	
NSAIDs (Oral)	Indocin Suspension	indomethacin oral suspension	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
NSAIDs (Oral)	Fenoprofen capsules [brand]	fenoprofen capsules	Approve if the patient has tried five prescription-strength, oral NSAIDs. **Note**: For example: fenoprofen (tablets/generic), etodolac (generics), flurbiprofen (Ansaid, generics), ibuprofen (e.g., Motrin, generics), ketoprofen (generics), meloxicam (Mobic, generics), nabumetone (generics), naproxen (e.g., Naprosyn, Naprelan, generics), oxaprozin (Daypro, generics), diclofenac (Voltaren XR, generics), piroxicam (Feldene, generics), indomethacin (generics). **Note**: Over-the-counter (OTC) NSAIDs would count if prescription-strength doses were used. **Note**: Five unique NSAIDs should be tried.	1 year	Yes	
NSAIDs (Oral)	Relafen DS	nabumetone 1,000 mg tablets	Approve if the patient has tried five prescription-strength oral NSAIDs. **Note**: : For example: nabumetone (generics), etodolac (generics), flurbiprofen (Ansaid, generics), ibuprofen (e.g., Motrin, generics), ketoprofen (generics), meloxicam (Mobic, generics), naproxen (e.g., Naprosyn, Naprelan, generics), oxaprozin (Daypro, generics), diclofenac (Voltaren XR, generics), piroxicam (Feldene, generics), indomethacin (generics). **Note**: Over-the-counter (OTC) NSAIDs would count if prescription-strength doses were used. **Note**: Five unique NSAIDs should be tried.	1 year	Yes	
NSAIDs (Oral)	Sprix and authorized generic	ketorolac tromethamine nasal spray	**1.** Approve if the patient has tried five prescription-strength, oral NSAIDs. **Note**: Examples include: etodolac (generics), flurbiprofen (Ansaid, generics), ibuprofen (e.g., Motrin, generics), ketoprofen (generics), meloxicam (Mobic, generics), nabumetone (generics), naproxen (e.g., Naprosyn, Naprelan, generics), oxaprozin (Daypro, generics), diclofenac (Voltaren XR, generics), piroxicam (Feldene, generics), indomethacin (generics). **Note**: Over-the-counter (OTC) NSAIDs would count if prescription-strength doses were used. **Note**: Five unique NSAIDs should be tried. **2.** Approve for patients with difficulty swallowing or for patients who cannot swallow.	1 year	Yes - Authorized generic only	
NSAIDs (Oral)	Tivorbex and authorized generic	indomethacin, submicronized capsules	Approve if the patient has tried five prescription-strength, oral NSAIDs. **Note**: Examples include: indomethacin (generics), etodolac (generics), flurbiprofen (Ansaid, generics), ibuprofen (e.g., Motrin, generics), ketoprofen (generics), meloxicam (Mobic, generics), nabumetone (generics), naproxen (e.g., Naprosyn, Naprelan, generics), oxaprozin (Daypro, generics), diclofenac (Voltaren XR, generics), piroxicam (Feldene, generics). **Note**: Over-the-counter (OTC) NSAIDs would count if prescription-strength doses were used. **Note**: Five unique NSAIDs should be tried.	1 year	Yes - brand only	
NSAIDs (Oral)	Zorvolex and authorized generic	diclofenac capsules	Approve if the patient has tried five prescription-strength, oral NSAIDS. **Note**: Examples include: diclofenac (Voltaren XR, generics), etodolac (generics), flurbiprofen (Ansaid, generics), ibuprofen (e.g., Motrin, generics), ketoprofen (generics), meloxicam (Mobic, generics), nabumetone (generics), naproxen (e.g., Naprosyn, Naprelan, generics), oxaprozin (Daypro, generics), piroxicam (Feldene, generics), indomethacin (generics). **Note**: Over-the-counter (OTC) NSAIDs would count if prescription-strength doses were used. **Note**: Five unique NSAIDs should be tried.	1 year	Yes	
NSAIDs (Oral)	Meloxicam suspension	meloxicam suspension	Approve if the patient has tried one of ibuprofen suspension (e.g., Motrin, generics) or naproxen suspension (e.g., Naprosyn, generics), if formulary. If neither are formulary, approve. **Note**: Over-the-counter ibuprofen suspension would count as an alternative, regardless of formulary status.	1 year	Yes	
NSAIDs (Oral)	Vivlodex	meloxicam capsules	Approve if the patient has tried five prescription-strength, oral NSAIDs. **Note**: Examples include: meloxicam (Mobic, generics), etodolac (generics), flurbiprofen (Ansaid, generics), ibuprofen (e.g., Motrin, generics), ketoprofen (generics), nabumetone (generics), naproxen (e.g., Naprosyn, Naprelan, generics), oxaprozin (Daypro, generics), diclofenac (Voltaren XR, generics), piroxicam (Feldene, generics), indomethacin (generics). **Note**: Over-the-counter (OTC) NSAIDs would count if prescription-strength doses were used. **Note**: Five unique NSAIDs should be tried.	1 year	Yes	
NSAIDs (Oral)	Dolobid	diflunisal tablets	Approve if the patient has tried five prescription-strength oral NSAIDs. Note: For example: nabumetone (generics), etodolac (generics), flurbiprofen (Ansaid, generics), ibuprofen (e.g., Motrin, generics), ketoprofen (generics), meloxicam (Mobic, generics), naproxen (e.g., Naprosyn, Naprelan, generics), oxaprozin (Daypro, generics), diclofenac (Voltaren XR, generics), piroxicam (Feldene, generics), indomethacin (generics). Note: Over-the-counter (OTC) NSAIDs would count if prescription-strength doses were used. Note: Five unique NSAIDs should be tried.	1 year	Yes	
NSAIDs (Oral)	Nalfon	fenoprofen capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
NSAIDs (Oral)	Zipsor	diclofenac potassium capsule	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
NSAIDs (Suppository)	Indocin Suppositories	indomethacin suppositories	No exceptions are recommended. There are multiple therapeutic alternatives available. (NOTE: It is not appropriate to use standard global criteria for this medication; Denial reason is: No exceptions are recommended. There are multiple therapeutic alternatives available.)	N/A	Yes- brand only	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
NSAIDs (Topical)	diclofenac epolamine 1.3% topical patch (authorized generic of Flector Patch)	diclofenac epolamine 1.3% topical patch	Direct the patient to use Flector patch (brand), if formulary. If Flector patch (brand) is non-formulary, approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with four products from the following list (if four are formulary or three if three are formulary or two if two are formulary or one if one is formulary): Licart 1.3% topical system, diclofenac 2% solution pump (Pennsaid 2.0%, generics), diclofenac sodium 1.5% topical solution (generics), or prescription diclofenac sodium topical 1% gel (Voltaren 1% gel, generics), if one is formulary. If none are formulary, approve if the patient has tried over-the-counter Voltaren 1% gel.	1 year	Yes	
NSAIDs (Topical)	Pennsaid	diclofenac sodium topical solution 2.0% pump	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Nuclear Factor (erythroid-derived 2)-like 2 (Nrf2) Activator	Skyclarys	omaveloxolone capsules	See standard *Neurology – Skyclarys Prior Authorization Policy* criteria.	1 year	Yes	
Omega-3 Fatty Acid Products	Lovaza	omega-3 acid ethyl esters capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Ophthalmic – Antibiotic/Corticosteroid Combination Products	TobraDex ST	tobramycin 0.3%/dexamethasone 0.05% ophthalmic suspension	**1.** Approve if the patient has tried tobramycin-dexamethasone ophthalmic suspension (Tobradex, generics), if formulary. If tobramycin-dexamthasone ophthalmic suspension (Tobradex, generics) are non-formulary, approve. **2.** For the treatment of currently active eye infections: approve in patients already receiving TobraDex ST to complete the course of therapy.	1 year	Yes	
Ophthalmic – Antibiotic/Corticosteroid Combination Products	Zylet	tobramycin 0.3%/loteprednol etabonate 0.5% ophthalmic suspension	**1.** Approve if the patient has tried one of tobramycin-dexamethasone ophthalmic suspension (Tobradex, generics) or TobraDex ST, if formulary. If neither are non-formulary, approve. **2.** Patients < 2 years of age, approve. **3.** For the treatment of currently active eye infections: approve in patients already receiving Zylet to complete the course of therapy.	1 year	Yes	
Ophthalmic - Calcineurin Inhibitor Immunosuppressant	Verkazia	cyclosporine 0.1% ophthalmic emulsion	Moderate to Severe Vernal Keratoconjunctivitis. **1.** Approve if the patient meets one of the following (A or B): A. Patient has tried two single-action ophthalmic medications (i.e., ophthalmic mast-cell stabilizers or ophthalmic antihistamines) for the maintenance treatment of vernal keratoconjunctivitis; OR Note: Examples of single-action ophthalmic medications for the maintenance treatment of vernal keratoconjunctivitis include ophthalmic mast-cell stabilizers (e.g., cromolyn ophthalmic solution, Alomide ophthalmic solution) and ophthalmic antihistamines (e.g., Zerviate [cetirizine solution]). B. Patient has tried one dual-action ophthalmic mast-cell stabilizer/antihistamine product for the maintenance treatment of vernal keratoconjunctivitis. Note: Examples of dual-action ophthalmic mast-cell stabilizer/antihistamine products include azelastine ophthalmic solution, beoptastine ophthalmic solution, epinastine ophthalmic solution, ketotifen ophthalmic solution, Lastacaft, olopatadine ophthalmic solution. Note: An exception to the requirement for a trial of two single-action ophthalmic medications (i.e., ophthalmic mast-cell stabilizers or ophthalmic antihistamines) or one dual-action ophthalmic mast-cell stabilizer/antihistamine product for the maintenance treatment of vernal keratoconjunctivitis can be made if the patient has already tried at least one ophthalmic cyclosporine product .	1 year	Yes	
Ophthalmic Agent – Mydriatics/ Cycloplegics	Atropine sulfate 1% ophthalmic solution (preservative free) [brand]	atropine sulfate 1% ophthalmic solution	**1.** Direct the patient to generic atropine sulfate 1% ophthalmic solution. **2.** Patients with a known sensitivity to a preservative (e.g., benzalkonium chloride [BAK]), approve.	1 year	Yes	
Ophthalmic Agents - Complement Protein C5 Inhibitor	Izervay	avacincaptad pegol intravitreal injection	See standard *Ophthalmology – Izervay Prior Authorization Policy* criteria.	1 year	Yes	
Ophthalmic Agents - VEGF Inhibitors	Susvimo	ranibizumab intravitreal injection via ocular implant and implant/insert tool	No exceptions are recommended. Due to safety concerns, an exception is not recommended for Susvimo. (NOTE: It is not appropriate to use standard global criteria for this medication; Denial reason is: No exceptions are recommended. Due to safety concerns, an exception is not recommended for Susvimo.)	N/A	Yes	
Ophthalmic Agents - VEGF Inhibitors	Eylea HD	aflibercept intravitreal injection	Diabetic macular edema; Diabetic retinopathy; Neovascular (wet) age-related macular degeneration. Approve if the patient meets BOTH of the following (1 and 2): **1.** Patient has tried ONE of Eylea (not HD) or Pavblu **[documentation required]**, if one is formulary; AND **2.** Patient has experienced a significant intolerance with ONE of Eylea (not HD) or Pavblu **[documentation required]**. Note: If BOTH Eylea (not HD) and Pavblu are non-formulary, approve.	1 year	Yes	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Ophthalmic Agents - VEGF Inhibitors	Lucentis	ranibizumab intravitreal injection	**1.** If Byooviz and Cimerli are both formulary or only one is formulary: Approve if the patient meets both of the following (A and B): A. Patient has tried both Byooviz and Cimerli (or one if one is formulary); AND B. Patient cannot continue to use the alternative(s) due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. **2.** If both Byooviz and Cimerli are non-formulary, approve if the patient meets one of the following (A, B, or C): A. Patient has tried one of Eylea or Pavblu, if formulary. If neither are formulary, approve; OR B. Patient with myopic choroidal neovascularization (mCNV); OR C. Patient is currently receiving therapy with Lucentis.	1 year	Yes	Yes
Ophthalmic Agents - VEGF Inhibitors	Vabysmo	faricimab-svoa intravitreal injection	Neovascular (Wet) Age-Related Macular Degeneration; Diabetic Macular Edema. **1.** Approve if the patient has tried one of 1) Eylea (not HD) or Pavblu OR Eylea HD, if formulary. If none are formulary, approve. **2.** Patient is currently receiving therapy with Vabysmo: approve. Macular Edema following Retinal Vein Occlusion. **1.** Approve if the patient has tried one of Eylea (not HD) or Pavblu, if formulary. If neither are formulary, approve. **2.** Patient is currently receiving therapy with Vabysmo: approve.	1 year	Yes	Yes
Ophthalmic alpha adrenoceptor agonist	Upneeq	oxymetazoline hydrochloride 0.1% ophthalmic solution	No exceptions are recommended. Due to insufficient clinical efficacy data, approval is not recommended for Upneeq. (NOTE: It is not appropriate to use standard global criteria for this medication; Denial reason is: No exceptions are recommended. Due to insufficient clinical efficacy data, approval is not recommended.)	N/A	Yes	
Ophthalmic Anti-Allergics	Alocril	nedocromil sodium 2% ophthalmic solution	Approve if the patient has tried three products from the following list (if three are formulary; or two if two are formulary; or one if one is formulary): Alomide, cromolyn sodium 4% solution (generics), azelastine 0.05% solution (generics), bepotastine solution (Bepreve, generics), epinastine 0.05% solution (generics), Lastacaft, olopatadine solution (generics), or Zerviate. If none are formulary, approve.	1 year	Yes	
Ophthalmic Anti-Allergics	Alomide	lodoxamide tromethamine 0.1% ophthalmic solution	**1.** Approve if the patient has tried three products from the following list (if three are formulary; or two if two are formulary; or one if one is formulary): Alocril, cromolyn sodium 4% solution (generics), azelastine 0.05% solution (generics), bepotastine solution (Bepreve, generics), epinastine 0.05% solution (generics), Lastacaft, olopatadine solution (generics), or Zerviate. If none are formulary, approve. **2.** For a diagnosis of vernal keratoconjunctivitis, vernal conjunctivitis, and vernal keratitis, approve if the patient has tried cromolyn sodium 4% solution (generics). If cromolyn sodium 4% solution (generic) is non-formulary, approve.	1 year	Yes	
Ophthalmic Anti-Allergics	Alrex	loteprednol etabonate 0.2% ophthalmic suspension	**1.** Approve if the patient has tried three products from the following list (if three are formulary, or two if only two are formulary, or one if only one is formulary): bepotastine ophthalmic drops (Bepreve, generics), cromolyn ophthalmic drops (generics), epinastine 0.05% solution (generics), Lastacaft, azelastine 0.05% solution (generics), olopatadine ophthalmic solution (generics), Zerviate. If none are formulary, approve. **2.** Patients who require concurrent use of Alrex with an H1 antagonist or an H1 antagonist/mast cell stabilizer (e.g. azelastine [generics], bepotastine, epinastine solution [generics], Lastacaft, olopatadine ophthalmic solution [generics], Zerviate): approve.	1 year	Yes	
Ophthalmic Anti-Allergics	Zerviate	cetirizine 0.24% ophthalmic solution	Approve if the patient has tried three products from the following list (if three are formulary; or two if two are formulary; or one if one is formulary): Alocril, Alomide, cromolyn sodium 4% solution (generics), azelastine 0.05% solution (generics), bepotastine solution (Bepreve, generics), epinastine 0.05% solution (generics), Lastacaft, or olopatadine solution (generics).	1 year	Yes	
Ophthalmic Anti-Allergics	Bepreve	bepotastine besilate ophthalmic solution	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Ophthalmic Antibiotics - Quinolones	Besivance	besifloxacin ophthalmic suspension 0.6%	**1.** Approve if the patient has tried two products from the following list, (if two are formulary, or one if one is formulary): 1) gatifloxacin ophthalmic solution (generics), 2) moxifloxacin ophthalmic solution (Vigamox, Moxeza, generics), or 3) levofloxacin ophthalmic solution (generics). If none are formulary, approve. **2.** Approve if there is laboratory data that the patient has an eye infection due to pathogens resistant to ciprofloxacin and one other ophthalmic quinolone. **3.** For the treatment of currently active eye infections: approve in patients already receiving Besivance therapy to complete the course of therapy.	1 year	Yes	
Ophthalmic Antibiotics - Quinolones	Ciloxan ointment	ciprofloxacin ophthalmic ointment 0.3%	**1.** Approve if the patient has tried four products from the following list, if formulary (or three if three are formulary, or two if two are formulary, or one if one is formulary): ciprofloxacin ophthalmic solution (Ciloxan, generics), gatifloxacin ophthalmic solution (generics), moxifloxacin ophthalmic solution (Vigamox, Moxeza, generics), levofloxacin ophthalmic solution (generics), or ofloxacin 0.3% ophthalmic solution (Ocuflox, generics). If none are formulary, approve. **2.** If the patient is allergic to benzalkonium chloride, approve if the patient has tried moxifloxacin (Vigamox, Moxeza, generics), if formulary. If moxifloxacin (Vigamox, Moxeza, generics) are non-formulary, approve. **3.** For the treatment of currently active eye infections: approve in patients already receiving Ciloxan ointment to complete the course of therapy.	1 year	Yes	
Ophthalmic Anti-Inflammatory Agents - NSAIDs	Acuvail	ketorolac tromethamine 0.45% preservative-free solution	**1.** Approve if the patient has tried two products from the following list (if two are formulary, or one of the following if one is formulary): diclofenac ophthalmic solution (generics), a bromfenac product (0.09% ophthalmic solution [generics], bromfenac ophthalmic solution 0.07% [Prolensa, generics], or bromfenac 0.075% [BromSite, generics]), Nevanac, Ilevro, or ketorolac ophthalmic solution (Acular, Acular LS, generics). If none are formulary, approve. **2.** Patients with a sulfite allergy: approve if the patient has tried two of the following, if two are formulary (or one if only one is formulary): bromfenac 0.075% (BromSite, generics), diclofenac ophthalmic solution (generics), Nevanac, Ilevro, or ketorolac ophthalmic solution (Acular, Acular LS, generics). If none are formulary, approve. **3.** Patients with a known sensitivity to a preservative (e.g., benzalkonium chloride [BAK]): approve if the patient has tried diclofenac ophthalmic solution (generics), if formulary. If diclofenac ophthalmic solution is non-formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.	1 year	Yes	
Ophthalmic Anti-Inflammatory Agents - NSAIDs	Nevanac	nepafenac ophthalmic suspension 0.1%	**1.** Approve if the patient has tried two products from the following list (if two are formulary, or one of the following if one is formulary): diclofenac ophthalmic solution (generics), ketorolac ophthalmic solution (Acular, Acular LS, generics), Acuvail, Ilevro, or a bromfenac product (0.09% ophthalmic solution [generics], bromfenac ophthalmic solution 0.07% [Prolensa, generics], or bromfenac 0.075% [BromSite, generics]). If none are formulary, approve. **2.** Patients with a sulfite allergy: approve if the patient has tried two of the following, if two are formulary (or one if only one is formulary): bromfenac 0.075% (BromSite, generics), diclofenac ophthalmic solution (generics), Ilevro, ketorolac ophthalmic solution (Acular, Acular LS, generics), or Acuvail. If none are formulary, approve. **3.** Patients < 18 years of age: approve if the patient has tried ketorolac ophthalmic solution (Acular, Acular LS, generics) or Ilevro, if one is formulary. If neither are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.	1 year	Yes	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Ophthalmic Anti-Inflammatory Agents - NSAIDs	BromSite	bromfenac 0.075% ophthalmic solution	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Ophthalmic Corticosteroids	Clobetasol propionate 0.05% ophthalmic suspension	clobetasol propionate 0.05% ophthalmic suspension	**1.** Approve if patient has tried three formulary ophthalmic corticosteroids from the following list: 1) a dexamethasone product (generics or Maxidex), 2) a fluorometholone product (FML Liquifilm, generics; FML Forte, Flarex), 3) difluprednate (Durezol, generics), 4) a loteprednol product (Lotemax, generics; Lotemax SM; Inveltys), or 5) a prednisolone product (Pred Forte, Omnipred, generics; Pred Mild), if three are formulary or two if two are formulary or one if one is formulary. If none are formulary, approve. **2.** If the patient has elevated intraocular pressure (IOP) or glaucoma after a trial of another corticosteroid (i.e., topical, inhaled, oral, ophthalmic): approve if the patient has tried one of the following, if one is formulary: 1) a fluorometholone product (FML Liquifilm, generics; FML Forte, Flarex), 2) a loteprednol product (Lotemax, generics; Lotemax SM; Inveltys), or 3) difluprednate (Durezol, generics). If none are formulary, approve.	1 year	Yes	
Ophthalmic Corticosteroids	Flarex	fluorometholone acetate ophthalmic suspension 0.1%	**1.** Approve if patient has tried three formulary ophthalmic corticosteroids from the following list: 1) a dexamethasone product (generics or Maxidex), 2) a fluorometholone product (FML Liquifilm, generics; FML Forte), 3) difluprednate (Durezol, generics), 4) a loteprednol product (Lotemax, generics; Lotemax SM; Inveltys), 5) a prednisolone product (Pred Forte, Omnipred, generics; Pred Mild), or 6) clobetasol propionate ophthalmic suspension, if three are formulary or two if two are formulary or one if one is formulary. If none are formulary, approve. **2.** If the patient has elevated intraocular pressure (IOP) or glaucoma after a trial of another corticosteroid (i.e., topical, inhaled, oral, ophthalmic): approve if the patient has tried one of the following, if one is formulary: 1) a fluorometholone product (FML Liquifilm, generics; FML Forte), 2) a loteprednol product (Lotemax, generics; Lotemax SM; Inveltys), or 3) difluprednate (Durezol, generics). If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.	1 year	Yes	
Ophthalmic Corticosteroids	FML Forte	fluorometholone 0.25% ophthalmic suspension	**1.** Approve if patient has tried three formulary ophthalmic corticosteroids from the following list: 1) a dexamethasone product (generics or Maxidex), 2) a fluorometholone product (FML Liquifilm, generics; Flarex), 3) difluprednate (Durezol, generics), 4) a loteprednol product (Lotemax, generics; Lotemax SM; Inveltys), 5) prednisolone (Pred Forte, Omnipred, generics; Pred Mild), or 6) clobetasol propionate ophthalmic suspension, if three are formulary or two if two are formulary or one if one is formulary. If none are formulary, approve. **2.** If the patient has elevated intraocular pressure (IOP) or glaucoma after a trial of another corticosteroid (i.e., topical, inhaled, oral, ophthalmic): approve if the patient has tried one of the following, if one is formulary: 1) a loteprednol product (Lotemax, generics; Lotemax SM; Inveltys), 2) a fluorometholone product (FML Liquifilm, generics; Flarex), or 3) difluprednate (Durezol, generics). If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.	1 year	Yes	
Ophthalmic Corticosteroids	Maxidex	dexamethasone 0.1% ophthalmic suspension	**1.** Approve if the patient has tried three formulary ophthalmic corticosteroids from the following list (if three are formulary or two if two are formulary or one if one is formulary): 1) dexamethasone (generics), 2) difluprednate (Durezol, generics), 3) a loteprednol product (Lotemax, generics; Lotemax SM; Inveltys), or 4) a fluorometholone product (FML Liquifilm, generics; FML Forte; Flarex), 5) a prednisolone product (Pred Forte, Omnipred, generics; Pred Mild) or 6) clobetasol propionate ophthalmic suspension. If none are formulary, approve. **2.** If the patient has elevated intraocular pressure (IOP) or glaucoma after a trial of another corticosteroid (i.e., topical, inhaled, oral, ophthalmic): approve if the patient has tried one product from the following list (if one is formulary): 1) a fluorometholone product (FML Liquifilm, generics; FML Forte; Flarex), 2) a loteprednol product (Lotemax, generics; Lotemax SM; Inveltys), or 3) difluprednate (Durezol, generics). If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.	1 year	Yes	
Ophthalmic Corticosteroids	Pred Mild	prednisolone acetate 0.12% ophthalmic suspension	**1.** Approve if the patient has tried three formulary ophthalmic corticosteroids from the following list (if three are formulary or two if two are formulary; or one if one is formulary): 1) a dexamethasone (generics or Maxidex), 2) difluprednate (Durezol, generics), 3) a loteprednol product (Lotemax, generics; Lotemax SM; Inveltys), 4) a fluorometholone product (FML Liquifilm, generics; FML Forte; Flarex), 5) a prednisolone product (Pred Forte, Omnipred, generics), or 6) clobetasol propionate ophthalmic suspension. If none are fomualry, approve. **2.** If the patient has elevated intraocular pressure (IOP) or glaucoma after a trial of another corticosteroid (i.e., topical, inhaled, oral, ophthalmic): approve if the patient has tried one product from the following list (if one is formulary): 1) a fluorometholone product (FML Liquifilm, generics; Flarex; FML Forte), 2) a loteprednol product (Lotemax, generics; Lotemax SM; Inveltys), or 3) difluprednate (Durezol, generics). If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.	1 year	Yes	
Ophthalmic Corticosteroids	Durezol	difluprednate 0.05% ophthalmic emulsion	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF 7/1/2022	
Ophthalmic Drugs for Glaucoma - Beta-Adrenergic Blocker	Betimol	timolol hemihydrates 0.25% and 0.5% ophthalmic solution	Approve if the patient has tried four of the following, if formulary (or three if three are formulary or two if two are formulary or one if one is formulary): 1) levobunolol ophthalmic solution, 2) a timolol product (Istalol, Timoptic/XE, generics), 3) a betaxolol ophthalmic solution (generics or Betoptic S), or 4) carteolol opthalmic solution (generics). If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.	1 year	Yes	
Ophthalmic Drugs for Glaucoma - Beta-Adrenergic Blocker	Timoptic in Ocudose	timolol maleate 0.25% and 0.5% ophthalmic solution	**1.** Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with four products from the following list: 1) a timolol product (Istalol, Timoptic/XE, generics), 2) levobunolol ophthalmic solution (generics), 3) betaxolol ophthalmic solution (generics or Betoptic S), or 4) carteolol opthalmic solution (generics), if four are formulary (or three if three are formulary or two if two are formulary or one if one is formulary). If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement. **2.** Approve if the patient has a known sensitivity to a preservative or when use of a preservative-free topical medication is advisable.	1 year	Yes	
Ophthalmic Drugs for Glaucoma - Beta-Adrenergic Blocker	Istalol	timolol maleate 0.5% ophthalmic solution	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Ophthalmic Drugs for Glaucoma - Carbonic Anhydrase Inhibitor	Azopt	brinzolamide 1% ophthalmic suspension	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Ophthalmic Drugs for Glaucoma - Carbonic Anhydrase Inhibitor/Beta-Adrenergic Blocker	Cosopt/Cosopt PF	dorzolamide 2%/timolol 0.5% ophthalmic solution	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Ophthalmic Drugs for Glaucoma - Prostaglandins	Lumigan	bimatoprost 0.01% ophthalmic solution	Approve if the patient has tried four formulary alternatives from the following list (or three if three are formulary or two if two are formulary or one if only one is formulary): latanoprost ophthalmic solution (Xalatan, generics), bimatoprost 0.03% ophthalmic solution (generics), travoprost ophthalmic solution (Travatan Z, generics), Vyzulta, or tafluprost ophthalmic solution (Zioptan, generics). If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.	1 year	Yes	
Ophthalmic Drugs for Glaucoma - Prostaglandins	Vyzulta	latanoprostene bunod ophthalmic solution 0.024%	Approve if the patient has tried four formulary alternatives from the following list (or three if three are formulary or two if two are formulary or one if only one is formulary): latanoprost ophthalmic solution (Xalatan, generics), travoprost ophthalmic solution (Travatan Z, generics), bimatoprost 0.03% ophthalmic solution (generics), Lumigan, or tafluprost ophthalmic solution (Zioptan, generics). If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.	1 year	Yes	
Ophthalmic Drugs for Glaucoma - Prostaglandins	Iyuzeh	latanoprost ophthalmic solution, 0.005%; preservative-free	**1.** Approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with one of 1) latanoprost ophthalmic solution (Xalatan, generics) or 2) Xelpros, if formulary. If none are formulary, approve. **2.** If according to the prescriber, the patient has a significant benzalkonium chloride allergy/sensitivity: approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with Xelpros, if formulary. If Xelpros is non-formulary, approve. **3.** If, according to the prescriber, the patient has a significant allergy/sensitivity to other preservatives (OTHER than benzalkonium chloride), approve.	1 year	Yes	
Ophthalmic Drugs for Glaucoma - Prostaglandins	Xelpros	latanoprost 0.005% ophthalmic emulsion	**1.** Approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with one of 1) latanoprost ophthalmic solution (Xalatan, generics) or 2) Iyuzeh, if formulary. If none are formulary, approve. **2.** If, according to the prescriber, the patient has a significant benzalkonium chloride allergy/sensitivity: approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with Iyuzeh, if formulary. If Iyuzeh is non-formulary, approve.	1 year	Yes	
Ophthalmic Drugs for Glaucoma - Prostaglandins	Travatan Z	travoprost 0.004% ophthalmic solution (benzalkonium chloride-free)	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Ophthalmic Drugs for Glaucoma - Prostaglandins	Xalatan	latanoprost 0.005% ophthalmic solution	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Ophthalmic Drugs for Glaucoma - Prostaglandins	Zioptan	tafluprost 0.0015% ophthalmic solution	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Ophthalmic Drugs for Glaucoma – Prostaglandins – Implants	Durysta	bimatoprost implant	Approve if the patient meets the following (A, B and C): A. The patient has tried and, according to the prescriber, experienced inadequate efficacy OR significant intolerance with at least two ophthalmic prostaglandins (either as monotherapy or as concomitant therapy); AND **Note**: Examples of ophthalmic prostaglandins include bimatoprost 0.03% ophthalmic solution, latanoprost 0.005% ophthalmic solution, travoprost 0.004% ophthalmic solution; Lumigan® (bimatoprost 0.01% ophthalmic solution), Vyzulta® (latanoprostene bunod 0.024% ophthalmic solution), Xelpros™ (latanoprost 0.005% ophthalmic emulsion), tafluprost 0.0015% ophthalmic solution, Iyuzeh (latanoprost 0.005% opthalmic solution), and Omlonti (omidenepag isopropyl 0.002% ophthalmic solution). B. The patient has tried and, according to the prescriber, experienced inadequate efficacy OR significant intolerance with at least two other ophthalmic products from two different pharmacological classes (either as monotherapy or as concomitant therapy); AND **Note**: Examples of pharmacological classes of ophthalmic products for the treatment of open-angle glaucoma or ocular hypertension include beta-blockers, alpha-agonist (brimonidine), carbonic anhydrase inhibitors, and rho kinase inhibitor (netarsudil). C. The product is NOT being used for re-treatment of an eye previously treated with Durysta. Note: Durysta is approved for a one-time use in each eye. Repeat administration in previously treated eye(s) is not approvable.	30 days	Yes	
Ophthalmic Drugs for Glaucoma – Prostaglandins – Implants	iDose TR	travoprost intracameral implant	Approve if the patient meets the following (A, B and C): A. The patient has tried and, according to the prescriber, experienced inadequate efficacy OR significant intolerance with at least two ophthalmic prostaglandins (either as monotherapy or as concomitant therapy); AND Note: Examples of ophthalmic prostaglandins include bimatoprost 0.03% ophthalmic solution, latanoprost 0.005% ophthalmic solution, travoprost 0.004% ophthalmic solution; Lumigan® (bimatoprost 0.01% ophthalmic solution), Vyzulta® (latanoprostene bunod 0.024% ophthalmic solution), Xelpros™ (latanoprost 0.005% ophthalmic emulsion), tafluprost 0.0015% ophthalmic solution, Iyuzeh (latanoprost 0.005% opthalmic solution), and Omlonti (omidenepag isopropyl 0.002% ophthalmic solution). B. The patient has tried and, according to the prescriber, experienced inadequate efficacy OR significant intolerance with at least two other ophthalmic products from two different pharmacological classes (either as monotherapy or as concomitant therapy); AND Note: Examples of pharmacological classes of ophthalmic products for the treatment of open-angle glaucoma or ocular hypertension include beta-blockers, alpha-agonist (brimonidine), carbonic anhydrase inhibitors, and rho kinase inhibitor (netarsudil). C. The product is NOT being used for re-treatment of an eye previously treated with iDose TR. Note: iDose TR is approved for a one-time use in each eye. Repeat administration in previously treated eye(s) is not approvable.	30 days	Yes	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Opiate Agonists/Antagonists	Suboxone	buprenorphine/naloxone sublingual film	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Opioids (Oral) - Other	oxycodone-acetaminophen 10-300 tablets (includes Primlev, Prolate)	oxycodone-acetaminophen 10-300 mg tablets	**1.** Direct to oxycodone-acetaminophen 10-325 mg tablets. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use oxycodone-acetaminophen 10-325 mg tablets.	1 year	Yes - Primlev only	
Opioids (Oral) - Other	oxycodone-acetaminophen 5-300 tablets (includes Primlev, Prolate)	oxycodone-acetaminophen 5-300 mg tablets	**1.** Direct to oxycodone-acetaminophen 5-325 mg tablets. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use oxycodone-acetaminophen 5-325 mg tablets.	1 year	Yes - Primlev only	
Opioids (Oral) - Other	oxycodone-acetaminophen 7.5-300 tablets (includes Primlev and Prolate)	oxycocodne-acetaminophen 7.5-300 mg tablets	**1.** Direct to oxycodone-acetaminophen 7.5-325 mg tablets. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use oxycodone-acetaminophen 7.5-325 mg tablets.	1 year	Yes - Primlev only	
Opioids (Oral) - Other	Conzip and tramadol ER capsule	tramadol ER capsule	Approve, if per the prescriber, the patient is unable to use generic tramadol ER tablets.	1 year	Yes	
Opioids (Oral) - Other	tramadol 100 mg tablets (brand)	tramadol 100 mg tablets	Approve, if per the prescriber, the patient is unable to use generic tramadol 50 mg tablets.	1 year	Yes	
Opioids (Oral) - Other	Prolate solution	oxycodone and acetaminophen 10-300 mg/5 oral solution	**1.** Approve if the patient has tried and cannot take oxycodone-acetaminophen 10-325 mg tablets. **2.** Approve if the patient is unable to swallow or has difficulty swallowing tablets.	1 year	Yes	
Opioids (Oral) - Other	Nucynta	tapentadol immediate-release tablets	**1.** Approve if the patient has tried three other oral immediate-release (NOT long-acting) centrally acting/opioid analgesics. Examples of oral immediate-release (NOT long-acting) centrally acting/opioid analgesics include, but are not limited to: hydromorphone (Dilaudid, generics), oxycodone hydrochloride tablets (Roxicodone, generics), oxymorphone (generics), morphine (generics), hydrocodone/acetaminophen (Vicodin, Vicodin ES, Norco, Lortab, Lorcet, multiple generics), oxycodone/acetaminophen (Percocet, Endocet, Roxicet, multiple generics), tramadol (Ultram, generics), tramadol/acetaminophen (Ultracet, generics). **NOTE:** A trial of the requested product does not count toward this requirement. **2.** Patients ≥ 6 years of age to < 18 years of age, approve if the patient meets ONE of the following (A, B, or C): A. Patient has tried one of morphine sulfate immediate-release tablets or morphine sulfate immediate-release oral solution. If neither are formulary, approve; OR B. Patient has renal insufficiency; OR C. Patient is intolerant or allergic to morphine.	1 year	Yes	
Opioids (Oral) - Other	Qdolo and authorized generic	tramadol hydrochloride oral solution	Approve if the patient is unable to swallow or has difficulty swallowing tramadol tablets.	1 year	Yes	
Opioids (Oral) - Other	Oxaydo	oxycodone hydrochloride tablets	Approve if the patient has tried and cannot take one of the following formulary products: oxycodone hydrochloride tablets (Roxicodone, generics). If oxycodone hydrochloride tablets (Roxicodone, generics) are non-formulary, approve.	1 year	Yes	
Opioids (Oral) - Other	Roxybond and authorized generic	oxycodone hydrochloride tablet, coated	Approve if the patient has tried and cannot take one of the following formulary products: oxycodone hydrochloride tablets (Roxicodone, generics). If oxycodone hydrochloride tablets (Roxicodone, generics) are non-formulary, approve.	1 year	Yes	
Opioids (Oral) - Other	tramadol 25 mg tablets (brand)	tramadol 25 mg tablets	Approve if the prescribed dose cannot be obtained with tramadol 50 mg. Note: The patient is NOT required to split the 50 mg tablets in half.	1 year	Yes	
Opioids (Oral) - Other	Percocet	oxycodone/acetaminophen tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Opioids (Oral) – Other/NSAID	Seglentis	celecoxib and tramadol hydrochloride tablets	**1.** Direct the patient to tramadol tablets and celecoxib capsules as separate agents. If celecoxib capsules (Celebrex, generics) are non-formulary, approve. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use tramadol and celecoxib as separate agents.	1 year	Yes	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Tetracycline-Derivatives - Oral Agents for Rosacea	Oracea and doxycycline 40 mg capsules (authorized generic of Oracea)	doxycycline 40 mg capsules	Inflammatory Rosacea. Approve if the patient meets both of the following (A and B): A. Patient has tried two of the following: 1) a topical metronidazole-containing product, 2) a topical azelaic acid-containing product or 3) topical ivermectin; AND B. Patient meets one of the following (i or ii): i. Patient has tried, and according to the prescriber, has experienced inadequate efficacy with one other generic, oral doxycycline product after a 4 week duration with the product; OR ii. Patient has tried, and according to the prescriber, has experienced a significant intolerance with one other generic, oral doxycycline product.	9 months	Yes - brand only	
Otic Antibiotics	Cetraxal	ciprofloxacin 0.2% otic solution	Approve if the patient has tried one of the following, if one is formulary: ofloxacin otic solution (generics) or ciprofloxacin 0.2% otic solution (generic). If none are formulary, approve.	1 year	Yes	
Otic Antibiotics and Combination Products	Cipro HC Otic Suspension	ciprofloxacin/ hydrocortisone otic suspension, 0.2%/1%	**1.** Approve if the patient has tried both products from the following list: 1) ciprofloxacin-dexamethasone otic suspension (Ciprodex otic suspension, generics) and 2) ciprofloxacin-fluocinolone otic (authorized generic of Otovel) or Otovel otic solution, if formulary. If none are formulary, approve. **2.** Patient has a benzalkonium chloride sensitivity: approve if the patient has tried one of ciprofloxacin-fluocinolone otic (authorized generic of Otovel) or Otovel, if formulary. If neither are formulary, approve.	1 year	Yes	
Otic Antibiotics and Combination Products	ciprofloxacin/ fluocinolone otic solution (authorized generic to Otovel)	ciprofloxacin and fluocinolone acetonide otic solution, 0.3%/0.025%	**1.** Direct the patient to Otovel (brand), if formulary. **2.** If Otovel (brand) is non-formulary, approve if the patient has tried both 1) ciprofloxacin-dexamethasone otic suspension (Ciprodex otic suspension, generics) and 2) Cipro HC otic suspension (or one if one is formulary). If neither are formulary, approve. **3.** If Otovel (brand) is non-formulary, patients treating acute otitis media through tympanostomy tubes (AOMT), patients with a perforated ear drum (tympanic membrane), or patients < 1 year of age: approve if the patient has tried ciprofloxacin- dexamethasone otic suspension (Ciprodex otic suspension, generics), if formulary. If ciprofloxacin- dexamethasone otic suspension (Ciprodex otic suspension, generics) are non-formulary, approve. **4.** If Otovel (brand) is non-formulary, patient has a known hypersensitity to a preservative (e.g., benzalkonium chloride [BAK], benzyl alcohol), approve.	1 year	Yes	
Overactive Bladder Agents (Oral and Topical)	Oxybutynin 2.5 mg tablet (brand)	oxybutynin 2.5 mg tablet	Approve if the patient has tried oxybutynin oral solution or syrup, if formulary. If neither oxybutynin oral solution nor syrup is formulary approve if the patient meets one of the following (A or B): A. Patient has tried other strengths of oxybutynin tablets; OR B. Patient's dose requires a 2.5 mg increment.	1 year	Yes	
Overactive Bladder Agents (Oral and Topical)	Detrol	tolterodine tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Overactive Bladder Agents (Oral and Topical)	Detrol LA	tolterodine, extended-release capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Overactive Bladder Agents (Oral and Topical)	Vesicare	solifenacin succinate tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Overactive Bladder Agents (Oral)	Vesicare LS	solifenacin succinate oral suspension	**1.** Approve if the patient has tried oxybutynin solution/syrup OR Myrbetriq Granules, if formulary. If neither are formulary, approve. **2.** Patient is < 5 years of age: approve if the patient has tried Myrbetriq Granules, if formulary. If Myrbetriq Granules are non-formulary, approve. **3.** Patients < 3 years of age, approve. Note: If the patient has tried any oxybutynin-containing product (e.g., immediate-release or extended-release tablets), this would meet the requirement for a trial of an oxybutynin product. Note: If the patient has tried Mybetriq tablets, this would meet the requirement for a trial of Myrbetriq granules.	1 year	Yes	
Overactive Bladder Agents (Oral)	Toviaz	fesoterodine fumarate extended-release tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Pancreatic Enzymes	Pertzye	pancrelipase delayed-release capsules	Approve if the patient has tried three products from the following list (if three are formulary, or two if two are formulary, or one if one is formulary): Creon, Pancreaze, or Zenpep. If none are formulary, approve.	1 year	Yes	
Phenylketonuria	Kuvan	sapropterin tablet and powder packet	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.		MSB Exclusion *This criteria applies only to the NPF	
Phosphate Binders	Fosrenol oral powder	lanthanum carbonate oral powder	**1.** Approve if the patient has tried two formulary alternatives from the following list (if two are formulary or one if one is formulary): sevelamer hydrochloride tablets, lanthanum carbonate chewable tablets (Fosrenol, generics), Velphoro chewable tablets, Auryxia tablets, or sevelamer carbonate tablets/powder for oral suspension (Renvela, generics). If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement. **2.** Patients who are unable to chew and swallow tablets: approve if the patient has tried sevelamer carbonate powder for oral suspension (Renvela powder, generics), if formulary. If sevelamer carbonate powder for oral suspension (Renvela powder, generics) is non-formulary, approve.	1 year	Yes	
Phosphate Binders	Fosrenol chewable tablets	lanthanum carbonate chewablet tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Phosphate Binders	Renagel	sevelamer hydrochloride tablet	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Potassium Sparing Diuretics	Carospir	spironolactone oral suspension	**1.** Approve if the patient has tried and cannot take spironolactone tablets (Aldactone, generics), if formulary. If spironolactone tablets (Aldactone, generics) are non-formulary, approve. **2.** Approve if the patient cannot swallow spironolactone tablets.	1 year	Yes	
Potassium Supplement	Pokonza	potassium chloride powder, for solution	Approve if the patient has tried one other oral potassium chloride product (e.g., potassium chloride powder for oral solution, potassium chloride oral solution).	1 year	Yes	
Prenatals vitamins	Pregenna	beta carotene, ascorbic acid, cholecalciferol, .alpha.-tocopherol acetate, pyridoxine hydrochloride, biotin, folic acid, levomefolate calcium, cyanocobalamin, calcium carbonate, magnesium oxide, ferrous bisglycinate, and potassium iodide tablet	**1.** Direct to generic prenatal vitamins. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use generic prenatal vitamins.	1 year	Yes	
Prenatals vitamins	Trinaz	ascorbic acid, cholecalciferol, thiamine hydrochloride, riboflavin, pyridoxal phosphate anhydrous, folic acid, methylcobalamin, calcium carbonate, ferrous gluconate, and potassium iodide tablet, film coated	**1.** Direct to generic prenatal vitamins. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use generic prenatal vitamins.	1 year	Yes	
Prenatals vitamins	Natal PNV	ascorbic acid, cholecalciferol, thiamine hydrochloride, riboflavin,pyridoxal phosphate,levomefolate glucosamine, folic acid, methylcobalamin, calcium carbonate, ferrous gluconate, potassium iodide tablet, film coated	**1.** Direct to generic prenatal vitamins. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use generic prenatal vitamins.	1 year	Yes	
Prenatals vitamins	Citranatal prenatal vitamins (examples include Citranatal RX tablets, Citranatal Harmony capsules)	various	**1.** Direct to generic prenatal vitamins. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use generic prenatal vitamins.	1 year	Yes	
Presbyopia Agents	Vuity	pilocarpine 1.25% ophthalmic solution	No exception is recommended. (NOTE: It is not appropriate to use standard global criteria for this medication; Denial reason is: Formulary coverage is not provided for this medication.)	N/A	Yes	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Primary Immunoglobulin A Nephropathy Agents	Filspari	sparsentan tablets	See standard *Nephrology – Filspari Prior Authorization Policy* criteria.	1 year	Yes	
Progestin – Vaginal Agents	Endometrin	progesterone vaginal insert	**1.** Approve if the patient has tried Crinone 8% gel, if formulary. If Crinone 8% gel is non-formulary, approve. **2.** Patients started on a course of therapy with Endometrin for progesterone supplementation/replacement to achieve or maintain pregnancy: approve to complete the current course of therapy.	1 year	Yes -7/1	
Progestin – Vaginal Agents	Crinone 4% Gel	progesterone gel 4%	Approve if the patient has tried one product from the following list (if one is formulary): medroxyprogesterone [Provera, generics], megestrol acetate, norethindrone tablets, or progesterone capsules (Prometrium, generics). If none are formulary, approve.	1 year	Yes	
Proton Pump Inhibitor Combination	Yosprala and authorized generic	aspirin and omeprazole delayed-release tablets	Approve if the patient has tried aspirin AND at least five proton pump inhibitors (e.g., omeprazole [Prilosec, generics], rabeprazole tablets [Aciphex, generics], lansoprazole [Prevacid, generics], esomeprazole [Nexium, generics], pantoprazole [Protonix, generics]).	1 year	Yes	
Proton Pump Inhibitors (PPIs)	Konvomep	omeprazole and sodium bicarbonate oral suspension	**1.** Approve if the patient has tried five proton pump inhibitors (PPIs). Note: Examples of PPIs include rabeprazole delayed-release (DR) tablets (Aciphex, generics), Aciphex Sprinkle DR capsules or authorized generic, dexlansoprazole DR capsules (Dexilant DR capsules, generics), esomeprazole DR capsules (Nexium, generics), Nexium DR packet (granules for oral suspension), pantoprazole DR tablets (Protonix, generics), Protonix suspension (granules), lansoprazole DR capsules (Prevacid, generics), lansoprazole orally disintegrating tablets (Prevacid SoluTab, generics), omeprazole DR capsules, omeprazole/sodium bicarbonate capsules (Zegerid, generics), or omeprazole/sodium bicarbonate packet (Zegerid, generics). **2.** Patients who have difficulty swallowing tablets/capsules: Approve if the patient has tried four proton pump inhibitors (PPIs) from the following list, if formulary (or three if three are formulary, or two if two are formulary, or one if one is formulary): 1) rabeprazole sprinkle; 2) an esomeprazole product (esomeprazole DR capsules [Nexium, generics], esomeprazole packet [Nexium granules for oral suspension, generic]); 3) pantoprazole suspension (granules) [Protonix suspension, generic]; 4) a lansoprazole product (lansoprazole DR capsules [Prevacid, generics], lansoprazole oral disintegrating tablets [Prevacid Solutab, generics]); 5) an omeprazole product (omeprazole DR capsules [Prilosec, generics], Prilosec DR suspension). If none are formulary, approve.	1 year	Yes	
Proton Pump Inhibitors (PPIs)	Dexilant and authorized generic	dexlansoprazole delayed-release capsules	**1.** Approve if the patient has tried five proton pump inhibitors (PPIs). Note: Examples of PPIs include rabeprazole delayed-release (DR) tablets (Aciphex, generics), Aciphex Sprinkle DR capsules or authorized generic, esomeprazole DR capsules (Nexium, generics), Nexium DR packet (granules for oral suspension), pantoprazole DR tablets (Protonix, generics), Protonix suspension (granules), lansoprazole DR capsules (Prevacid, generics), lansoprazole oral disintegrating tablets (Prevacid Solutab, generics), omeprazole DR capsules (Prilosec, generics), Prilosec DR suspension, omeprazole/sodium bicarbonate capsules (Zegerid, generics), or omeprazole/sodium bicarbonate packet (Zegerid, generics). Note: The requested agent would NOT count as a trial of an alternative. **2.** Patients < 18 years of age OR patients who have difficulty swallowing tablets/capsules: Approve if the patient has tried four proton pump inhibitors (PPIs) from the following list, if formulary (or three if three are formulary, or two if two are formulary, or one if one is formulary): 1) rabeprazole sprinkle; 2) an esomeprazole product (esomeprazole DR capsules [Nexium, generics], esomeprazole packet [Nexium granules for oral suspension, generic]); 3) pantoprazole suspension (granules) [Protonix suspension, generic]; 4) a lansoprazole product (lansoprazole DR capsules [Prevacid, generics], lansoprazole oral disintegrating tablets [Prevacid Solutab, generics]); 5) an omeprazole product (omeprazole DR capsules [Prilosec, generics], Prilosec DR suspension). If none are formulary, approve.	1 year	Yes - brand only	
Proton Pump Inhibitors (PPIs)	Aciphex Sprinkle and authorized generic	rabeprazole sodium delayed-release capsules	Approve if the patient has tried five proton pump inhibitors (PPIs). **Note**: Examples of PPIs include rabeprazole delayed-release (DR) tablets (Aciphex, generics), Dexilant DR capsules, esomeprazole DR capsules (Nexium, generics), Nexium DR packet (granules for oral suspension), pantoprazole DR tablets (Protonix, generics), Protonix suspension (granules), lansoprazole orally dissolving tablets (Prevacid/Solutabs, generics), omeprazole DR capsules, Prilosec DR suspension, omeprazole/sodium bicarbonate capsules (Zegerid, generics), or omeprazole/sodium bicarbonate packet (Zegerid, generics). **2.** Patients < 18 years of age OR patients who have difficulty swallowing tablets/capsules: Approve if the patient has tried two proton pump inhibitors (PPIs). **Note**: The requested agent would NOT count as a trial of an alternative.	1 year	Yes Authorized generic only	
Proton Pump Inhibitors (PPIs)	Nexium packet (granules for oral suspension) 5 mg and 2.5 mg packets	esomeprazole delayed-release granules for oral suspension (packet)	**1.** Approve if the patient has tried five proton pump inhibitors (PPIs). **Note**: Examples of PPIs include rabeprazole delayed-release (DR) tablets (Aciphex, generics), Aciphex Sprinkle DR capsules or authorized generic, Dexilant DR capsules, esomeprazole DR capsules (Nexium, generics), pantoprazole DR tablets (Protonix, generics), Protonix suspension (granules), lansoprazole DR capsules (Prevacid, generics), lansoprazole oral disintegrating tablets (Prevacid Solutab, generics), omeprazole DR capsules, Prilosec DR suspension, omeprazole/sodium bicarbonate capsules (Zegerid, generics), or omeprazole/sodium bicarbonate packet (Zegerid, generics). **2.** Patients < 18 years of age OR patients who have difficulty swallowing tablets/capsules: Approve if the patient has tried two proton pump inhibitors (PPIs). **3.** Patients < 1 year of age: approve if the patient has tried Prilosec DR suspension, if formulary. If Prilosec DR suspension is non-formulary, approve. **Note**: The requested agent would NOT count as a trial of an alternative.	1 year	Yes	
Proton Pump Inhibitors (PPIs)	Prilosec oral suspension	omeprazole delayed-release oral suspension	**1.** Approve if the patient has tried five proton pump inhibitors (PPIs). **Note**: Examples of PPIs include rabeprazole delayed-release (DR) tablets (Aciphex, generics), Aciphex Sprinkle DR capsules or authorized generic, Dexilant DR capsules, esomeprazole DR capsules (Nexium, generics), Nexium DR packet (granules for oral suspension), pantoprazole DR tablets (Protonix, generics), Protonix suspension (granules), lansoprazole DR capsules (Prevacid, generics), lansoprazole orally disintegrating tablets (Prevacid SoluTab, generics), omeprazole DR capsules, omeprazole/sodium bicarbonate capsules (Zegerid, generics), or omeprazole/sodium bicarbonate packet (Zegerid, generics). **2.** Patients < 18 years of age OR patients who have difficulty swallowing tablets/capsules: Approve if the patient has tried two proton pump inhibitors (PPIs). **3.** Patients < 1 year of age: approve if the patient has tried Nexium DR packet (granules for oral suspension), if formulary. If Nexium DR packet (granules for oral suspension), is non-formulary, approve. **Note**: The requested agent would NOT count as a trial of an alternative.	1 year	Yes	
Proton Pump Inhibitors (PPIs)	Zegerid capsules	omeprazole/ sodium bicarbonate capsules	Approve if the patient has tried five proton pump inhibitors (PPIs). **Note**: Examples of PPIs include rabeprazole delayed-release (DR) tablets (Aciphex, generics), Aciphex Sprinkle DR capsules or authorized generic, Dexilant DR capsules, esomeprazole DR capsules (Nexium, generics), Nexium DR packet (granules for oral suspension), pantoprazole DR tablets (Protonix, generics), Protonix suspension (granules), lansoprazole DR capsules, lansoprazole oral disintegrating tablets (Prevacid Solutab, generics), omeprazole DR capsules (Prilosec, generics), or Prilosec DR suspension. **Note**: The requested agent would NOT count as a trial of an alternative.	1 year	Yes	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Proton Pump Inhibitors (PPIs)	Zegerid packets	omeprazole/ sodium bicarbonate powder for oral suspension (packets)	Approve if the patient has tried five proton pump inhibitors (PPIs). **Note**: Examples of PPIs include rabeprazole delayed-release (DR) tablets (Aciphex, generics), Aciphex Sprinkle DR capsules or authorized generics, Dexilant DR capsules, esomeprazole DR capsules (Nexium, generics), Nexium DR packet (granules for oral suspension), pantoprazole DR tablets (Protonix, generics), Protonix suspension (granules), lansoprazole DR capsules, lansoprazole oral disintegrating tablets (Prevacid Solutab, generics), omeprazole DR capsules (Prilosec, generics), or Prilosec DR suspension. **Note**: The requested agent would NOT count as a trial of an alternative.	1 year	Yes	
Proton Pump Inhibitors (PPIs)	Aciphex	rabeprazole sodium tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Proton Pump Inhibitors (PPIs)	Nexium capsules	esomeprazole delayed-release capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Proton Pump Inhibitors (PPIs)	Nexium packet (granules for oral suspension) 10 mg, 20 mg, 40 mg packet	esomeprazole delayed-release granules for oral suspension (packet)	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Proton Pump Inhibitors (PPIs)	Prevacid	lansoprazole delayed-release (DR) capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Proton Pump Inhibitors (PPIs)	Prevacid SoluTab	lansoprazole orally disintegrating tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Proton Pump Inhibitors (PPIs)	Protonix	pantoprazole sodium delayed-release (DR) tablets and intravenous (IV) injection	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Proton Pump Inhibitors (PPIs)	Protonix oral suspension	pantoprazole delayed-release oral suspension (granules)	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Pulmonary Arterial Hypertension (PAH) - Endothelin Receptor Antagonists	Letairis	ambrisentan tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Pulmonary Arterial Hypertension (PAH) - Phosphodiesterase 5 Inhibitors	Liqrev	sildenafil oral suspension 10 mg/mL	Pulmonary arterial hypertension World Health Organization Group 1. **1.** Direct the patient to sildenafil powder for oral suspension 10 mg/mL (Revatio oral suspension, generics), if formulary. **2.** Approve if, according to the prescriber, there is a significant clinical concern (e.g., a significant allergy or serious adverse reaction due to inactive ingredients) such that the patient is unable to use sildenafil powder for oral suspension 10 mg/mL (Revatio oral suspension, generics). **3.** If sildenafil powder for oral suspension (10 mg/mL) is non-formulary, approve if the patient meets one of the following (A or B): A. Patient has tried Tadliq, if formulary. If Tadliq is non-formulary, approve; OR Note: This criterion would also be satisfied if the patient tried any other tadalafil product. B. Patient has already been started on a sildenafil product (e.g., sildenafil tablets or suspension, Revatio, or Liqrev).	1 year	Yes	
Pulmonary Arterial Hypertension (PAH) - Phosphodiesterase 5 Inhibitors	Tadliq	tadalafil oral suspension	Pulmonary arterial hypertension World Health Organization Group 1. **1.** Approve if the patient is unable to swallow or has difficulty swallowing tadalafil tablets (Adcirca tablets, Alyq tablets, generics), if formulary. **2.** If tadalafil tablets (Adcirca tablets, Alyq tablets, generics) are non-formulary, approve if the patient meets one of the following (A or B): A. Patent has tried sildenafil powder for oral suspension (Revatio oral suspension, generics), if formulary. If sildenafil powder for oral suspension (Revatio oral suspension, generics) is non-formulary approve; OR Note: This criterion would also be satisfied if the patient tried any other sildenafil product. B . Patient has already been started on a tadalafil product (e.g., tadalafil tablets, Adcirca tablets, Alyq, Tadliq).	1 year	Yes	Yes

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Pulmonary Arterial Hypertension (PAH) - Phosphodiesterase 5 Inhibitors	Adcirca	tadalafil tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Respiratory - Corticosteroid Inhalers	Alvesco	ciclesonide inhalation aerosol	**1.** Approve if the patient has tried four formulary alternatives from the following list (if four are formulary, or three if three are formulary, or two if two are formulary, or one if only one is formulary): a fluticasone inhaler (ArmonAir Digihaler, Arnuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus], fluticasone propionate HFA [authorized generic of Flovent HFA]), a mometasone inhaler (Asmanex HFA, Asmanex Twisthaler), Pulmicort Flexhaler, or Qvar RediHaler. If none are formulary, approve. **2.** If the patient has a low inspiratory flow rate and is unable to use a dry powder inhaler, approve if the patient has tried three formulary alternatives from the following list (if three are formulary, or two if two are formulary, or one if only one is formulary): Asmanex HFA, fluticasone propionate HFA (authorized generic of Flovent HFA), or Qvar RediHaler. If none are formulary, approve. Note: If the patient tried the brand version of an authorized generic equivalent product, then this trial would count towards the requirement. Note: ArmonAir Digihaler, Arnuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus], and fluticasone propionate HFA (authorized generic of Flovent HFA) would count as one alternative. Asmanex HFA and Asmanex Twisthaler would count as one alternative.	1 year	Yes	
Respiratory - Corticosteroid Inhalers	ArmonAir Digihaler	fluticasone propionate powder, metered	**1.** Approve if the patient has tried five formulary alternatives from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if only one is formulary): Alvesco, a fluticasone inhaler (Arnuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus], fluticasone propionate HFA [authorized generic of Flovent HFA]), a mometasone inhaler (Asmanex HFA, Asmanex Twisthaler), Pulmicort Flexhaler, or Qvar RediHaler. If none are formulary, approve. **a.** If the patient is < 12 years of age, approve if the patient has tried four formulary alternatives from the following list (if four are formulary, or three if three are formulary, or two if two are formulary, or one if only one is formulary): a fluticasone inhaler (Arnuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus], fluticasone propionate HFA [authorized generic of Flovent HFA]), a mometasone inhaler (Asmanex HFA, Asmanex Twisthaler), Pulmicort Flexhaler, or Qvar RediHaler. If none are formulary, approve. **i.** If the patient is < 12 years of age and is unable to coordinate breath and actuation with a conventional metered-dose inhaler, approve if the patient has tried four formulary alternatives from the following list (if four are formulary or three if three are formulary, or two if two are formulary, or one if only one is formulary): Asmanex Twisthaler, a fluticasone inhaler (Arnuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus]), Pulmicort Flexhaler, or Qvar RediHaler. If none are formulary, approve. **b.** If the patient is < 6 years of age, approve if the patient has tried three formulary alternatives from the following list (if three are formulary, or two if two are formulary, or one if only one is formulary): a fluticasone inhaler (Arnuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus], fluticasone propionate HFA [authorized generic of Flovent HFA]), a mometasone inhaler (Asmanex HFA, Asmanex Twisthaler), or Qvar RediHaler. If none are formulary, approve. **i.** If the patient is < 6 years of age and is unable to coordinate breath and actuation with a conventional metered-dose inhaler, approve if the patient has tried three formulary alternatives from the following list (if three are formulary or two if two are formulary, or one if only one is formulary): Asmanex Twisthaler, a fluticasone inhaler (Arnuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus]), or Qvar RediHaler. If none are formulary, approve. **c.** If the patient is ≤ 4 years of age, approve if the patient has tried three formulary alternatives from the following list (if three are formulary, or two if only two are formulary, or one if only one is formulary): Asmanex Twisthaler, a fluticasone inhaler (fluticasone propionate diskus [authorized generic of Flovent Diskus], fluticasone propionate HFA [authorized generic of Flovent HFA]), or Qvar RediHaler. If none are formulary, approve. **i.** If the patient is ≤ 4 years of age and is unable to coordinate breath and actuation with a conventional metered-dose inhaler, approve if the patient has tried three formulary alternatives from the following list (if three are formulary or two if two are formulary, or one if only one is formulary): Asmanex Twisthaler, fluticasone propionate diskus (authorized generic of Flovent Diskus), or Qvar RediHaler. If none are formulary, approve. **2.** If the patient is unable to coordinate breath and actuation with a conventional metered-dosen inhaler, approve if the patient has tried four formulary alternatives from the following list (if four are formulary or three if three are formulary, or two if two are formulary, or one if only one is formulary): Asmanex Twisthaler, a fluticasone inhaler (Arnuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus]), Pulmicort Flexhaler, or Qvar RediHaler. If none are formulary, approve. Note: If the patient tried the brand version of an authorized generic equivalent product, then this trial would count towards the requirement. Note: Arnuity Ellipta, fluticasone propionate diskus (authorized generic of Flovent Diskus), and fluticasone propionate HFA (authorized generic of Flovent HFA) would count as one alternative. Asmanex HFA and Asmanex Twisthaler would count as one alternative.	1 year	Yes	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Respiratory - Corticosteroid Inhalers	Flovent Diskus (brand and authorized generic)	fluticasone inhalation powder	**1.** Approve if the patient has tried five formulary alternatives from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if only one is formulary): Alvesco, a fluticasone inhaler (ArmonAir Digihaler, Arnuity Ellipta, fluticasone propionate HFA [authorized generic of Flovent HFA]), a mometasone inhaler (Asmanex HFA, Asmanex Twisthaler), Pulmicort Flexhaler, or Qvar RediHaler. If none are formulary, approve. **a.** If the patient is < 12 years of age, approve if the patient has tried four formulary alternatives from the following list (if four are formulary, or three if three are formulary, or two if two are formulary, or one if only one is formulary): a fluticasone inhaler (ArmonAir Digihaler, Arnuity Ellipta, fluticasone propionate HFA [authorized generic of Flovent HFA]), a mometasone inhaler (Asmanex Twisthaler, Asmanex HFA), Pulmicort Flexhaler, or Qvar RediHaler. If none are formulary, approve. **i.** If the patient is < 12 years of age and is unable to coordinate breath and actuation with a conventional metered-dose inhaler, approve if the patient has tried four formulary alternatives from the following list (if four are formulary or three if three are formulary, or two if two are formulary, or one if only one is formulary): Asmanex Twisthaler, a fluticasone inhaler (ArmonAir Digihaler, Arnuity Ellipta), Pulmicort Flexhaler, or Qvar RediHaler. If none are formulary, approve. **b.** If the patient is < 6 years of age, approve if the patient has tried three formulary alternatives from the following list (if three are formulary, or two if two are formulary, or one if only one is formulary): a fluticasone inhaler (ArmonAir Digihaler, Arnuity Ellipta, fluticasone propionate HFA [authorized generic of Flovent HFA]), a mometasone inhaler (Asmanex Twisthaler, Asmanex HFA), or Qvar RediHaler. If none are formulary, approve. **i.** If the patient is < 6 years of age and is unable to coordinate breath and actuation with a conventional metered-dose inhaler, approve if the patient has tried three formulary alternatives from the following list (if three are formulary or two if two are formulary or one if only one is formulary): Asmanex Twisthaler, a fluticasone inhaler (ArmonAir Digihaler, Arnuity Ellipa), or Qvar RediHaler, if formulary. If none are formulary, approve. **c.** If the patient is ≤ 4 years of age, approve if the patient has tried three formulary alternatives from the following list (if three are formulary or two if two are formulary or one if only one is formulary): Asmanex Twisthaler, a fluticasone inhaler (ArmonAir Digihaler, fluticasone propionate HFA [authorized generic of Flovent HFA]), or Qvar RediHaler. If none are formulary, approve. **i.** If the patient is ≤ 4 years of age and is unable to coordinate breath and actuation with a conventional metered-dose inhaler, approve if the patient has tried three formulary alternatives from the following list (if three are formulary or two if two are formulary or one if one is formulary): ArmonAir Digihaler, Asmanex Twisthaler or Qvar RediHaler. If none are formulary, approve. **2.** If the patient is unable to coordinate breath and actuation with a conventional metered-dose inhaler, approve if the patient has tried four formulary alternatives from the following list (if four are formulary or three if three are formulary, or two if two are formulary, or one if only one is formulary): Asmanex Twisthaler, a fluticasone inhaler (ArmonAir Digihaler, Arnuity Ellipta), Pulmicort Flexhaler, or Qvar RediHaler. If none are formulary, approve. Note: If the patient tried the brand version of an authorized generic equivalent product, then this trial would count towards the requirement. Note: ArmonAir Digihaler, Arnuity Ellipta, and fluticasone propionate HFA (authorized generic of Flovent HFA) would count as one alternative. Asmanex HFA and Asmanex Twisthaler would count as one alternative.	1 year	Yes	
Respiratory - Corticosteroid Inhalers	Flovent HFA (brand)	fluticasone inhalation aerosol HFA	Direct the patient to fluticasone propionate HFA, if formulary. If fluticasone propionate HFA is non-formulary: **1.** Approve if the patient has tried five formulary alternatives from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if only one is formulary): Alvesco, a fluticasone inhaler (ArmonAir Digihaler, Arnuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus]), a mometasone inhaler (Asmanex HFA, Asmanex Twisthaler), Pulmicort Flexhaler, or Qvar RediHaler. If none are formulary, approve. **a.** If the patient is < 12 years of age, approve if the patient has tried four formulary alternatives from the following list (if four are formulary, or three if three are formulary, or two if two are formulary, or one if only one is formulary): a fluticasone inhaler (ArmonAir Digihaler, Arnuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus]), a mometasone inhaler (Asmanex Twisthaler, Asmanex HFA), Pulmicort Flexhaler, or Qvar RediHaler. If none are formulary, approve. **i.** If the patient is < 12 years of age and has a low inspiratory flow rate and is unable to use a dry powder inhaler (DPI), approve if the patient has tried both formulary alternatives from the following list (if both are formulary or one if one is only formulary): Asmanex HFA AND Qvar RediHaler. If neither are formulary, approve. **ii.** If the patient is < 12 years of age and is unable to use BOTH a DPI AND a breath-actuated metered-dose inhaler (MDI) [i.e., Qvar Redihaler], approve if the patient has tried Asmanex HFA, if formulary. If Asmanex HFA is non-formulary, approve. **b.** If the patient is < 6 years of age, approve if the patient has tried three formulary alternatives from the following list (if three are formulary, or two if two are formulary, or one if only one is formulary): a fluticasone inhaler (ArmonAir Digihaler, Arnuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus]), a mometasone inhaler (Asmanex Twisthaler, Asmanex HFA), or Qvar RediHaler. If none are formulary, approve. **i.** If the patient is < 6 years of age and has a low inspiratory flow rate and is unable to use a dry powder inhaler, approve if the patient has tried both formulary alternatives from the following list (if both are formulary or one if only one is formulary): Qvar RediHaler AND Asmanex HFA. If none are formulary, approve. **ii.** If the patient is < 6 years of age and is unable to use BOTH a DPI AND a breath-actuated MDI (i.e., Qvar Redihaler), approve if the patient has tried Asmanex HFA, if formulary. If Asmanex HFA is non-formulary, approve. **c.** If the patient is 4 years of age, approve if the patient has tried three formulary alternatives from the following list (if three are formulary, or two if two are formulary, or one if only one is formulary): Asmanex Twisthaler, a fluticasone inhaler (ArmonAir Digihaler, fluticasone propionate diskus [authorized generic of Flovent Diskus]), or Qvar RediHaler. If none are formulary, approve. **i.** If the patient is 4 years of age and has a low inspiratory flow rate and is unable to use a dry powder inhaler, approve if the patient has tried Qvar RediHaler, if formulary. If Qvar RediHaler is non-formulary, approve. **ii.** If the patient is 4 year of age and is unable to use BOTH a DPI AND a breath-actuated MDI (i.e., Qvar Redihaler), approve. **d.** If the patient is < 4 years of age: approve. **2.** If the patient has a low inspiratory flow rate and is unable to use a dry powder inhaler, approve if the patient has tried three formulary alternatives from the following list (if three are formulary, or two if two are formulary, or one if only one is formulary): Alvesco, Asmanex HFA, or Qvar RediHaler. If none are formulary, approve. **3.** Patients with eosinophilic esophagitis: approve, if the patient has tried budesonide inhalation suspension (Pulmicort Respules, generic) that was made into a slurry or suspension and swallowed (not inhaled). Note: If the patient tried the brand version of an authorized generic equivalent product, then this trial would count towards the requirement. Note: ArmonAir Digihaler, Arnuity Ellipta, and fluticasone propionate diskus (authorized generic of Flovent Diskus) would count as one alternative. Asmanex HFA and Asmanex Twisthaler would count as one alternative.	1 year	Yes	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Respiratory - Corticosteroid Inhalers	Fluticasone propionate HFA (authorized generic of Flovent HFA)	fluticasone propionate HFA	**1.** Approve if the patient has tried five formulary alternatives from the following list (if five are formulary, or four if four are formulary, or three if three are formulary, or two if two are formulary, or one if only one is formulary): Alvesco, a fluticasone inhaler (ArmonAir Digihaler, Arnuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus]), a mometasone inhaler (Asmanex HFA, Asmanex Twisthaler), Pulmicort Flexhaler, or Qvar RediHaler. If none are formulary, approve. a. If the patient is < 12 years of age, approve if the patient has tried four formulary alternatives from the following list (if four are formulary, or three if three are formulary, or two if two are formulary, or one if only one is formulary): a fluticasone inhaler (ArmonAir Digihaler, Arnuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus]), a mometasone inhaler (Asmanex Twisthaler, Asmanex HFA), Pulmicort Flexhaler, or Qvar RediHaler. If none are formulary, approve. i. If the patient is < 12 years of age and has a low inspiratory flow rate and is unable to use a dry powder inhaler (DPI), approve if the patient has tried both formulary alternatives from the following list (if both are formulary or one if one is only formulary): Asmanex HFA AND Qvar RediHaler. If neither are formulary, approve. ii. If the patient is < 12 years of age and is unable to use BOTH a DPI AND a breath-actuated metered-dose inhaler (MDI) [i.e., Qvar Redihaler], approve if the patient has tried Asmanex HFA, if formulary. If Asmanex HFA is non-formulary, approve. b. If the patient is < 6 years of age, approve if the patient has tried three formulary alternatives from the following list (if three are formulary, or two if two are formulary, or one if only one is formulary): a fluticasone inhaler (ArmonAir Digihaler, Arnuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus]), a mometasone inhaler (Asmanex Twisthaler, Asmanex HFA), or Qvar RediHaler. If none are formulary, approve. i. If the patient is < 6 years of age and has a low inspiratory flow rate and is unable to use a dry powder inhaler, approve if the patient has tried both formulary alternatives from the following list (if both are formulary or one if only one is formulary): Qvar RediHaler AND Asmanex HFA. If none are formulary, approve. ii. If the patient is < 6 years of age and is unable to use BOTH a DPI AND a breath-actuated MDI (i.e., Qvar Redihaler), approve if the patient has tried Asmanex HFA, if formulary. If Asmanex HFA is non-formulary, approve. c. If the patient is 4 years of age, approve if the patient has tried three formulary alternatives from the following list (if three are formulary, or two if two are formulary, or one if only one is formulary): Asmanex Twisthaler, a fluticasone inhaler (ArmonAir Digihaler, fluticasone propionate diskus [authorized generic of Flovent Diskus]), or Qvar RediHaler. If none are formulary, approve. i. If the patient is 4 years of age and has a low inspiratory flow rate and is unable to use a dry powder inhaler, approve if the patient has tried Qvar RediHaler, if formulary. If Qvar RediHaler is non-formulary, approve. ii. If the patient is 4 year of age and is unable to use BOTH a DPI AND a breath-actuated MDI (i.e., Qvar Redihaler), approve. d. If the patient is < 4 years of age: approve. **2.** If the patient has a low inspiratory flow rate and is unable to use a dry powder inhaler, approve if the patient has tried three formulary alternatives from the following list (if three are formulary, or two if two are formulary, or one if only one is formulary): Alvesco, Asmanex HFA, or Qvar RediHaler. If none are formulary, approve. **3.** Patients with eosinophilic esophagitis: approve if the patient has tried budesonide inhalation suspension (Pulmicort Respules, generic) that was made into a slurry or suspension and swallowed (not inhaled). Note: If the patient tried the brand version of an authorized generic equivalent product, then this trial would count towards the requirement. Note: ArmonAir Digihaler, Arnuity Ellipta, and fluticasone propionate diskus (authorized generic of Flovent Diskus) would count as one alternative. Asmanex HFA and Asmanex Twisthaler would count as one alternative.	1 year	Yes	
Respiratory - Corticosteroid Inhalers	Pulmicort Flexhaler	budesonide inhalation powder	**1.** Approve if the patient has tried four formulary alternatives from the following list (if four are formulary, or three if three are formulary, or two if two are formulary, or one if only one is formulary): Alvesco, a fluticasone inhaler (ArmonAir Digihaler, Arnuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus], fluticasone propionate HFA [authorized generic of Flovent HFA]), a mometasone inhaler (Asmanex HFA, Asmanex Twisthaler), or Qvar RediHaler. If none are formulary, approve. **a.** If the patient is < 12 years of age, approve if the patient has tried three formulary alternatives from the following list (if three are formulary, or two if two are formulary, or one if only one is formulary): a fluticasone inhaler (ArmonAir Digihaler, Arnuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus], fluticasone propionate HFA [authorized generic of Flovent HFA]), a mometasone inhaler (Asmanex Twisthaler, Asmanex HFA), or Qvar RediHaler. If none are formulary, approve. **i.** If the patient is < 12 years of age and is unable to coordinate breath and actuation with a conventional metered-dose inhaler, approve if the patient has tried three formulary alternatives from the following list (if three are formulary or two if two are formulary or one if only one is formulary): Asmanex Twisthaler, a fluticasone inhaler (ArmonAir Digihaler, Arnuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus]), or Qvar RediHaler. If none are formulary, approve. **2.** If the patient is unable to coordinate breath and actuation with a conventional metered-dose inhaler, approve if the patient has tried three formulary alternatives from the following list (if three are formulary or two if two are formulary or one if only one is formulary): Asmanex Twisthaler, a fluticasone inhaler (ArmonAir Digihaler, Arnuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus]), or Qvar RediHaler. If none are formulary, approve. Note: If the patient tried the brand version of an authorized generic equivalent product, then this trial would count towards the requirement. Note: ArmonAir Digihaler, Arnuity Ellipta, fluticasone propionate diskus (authorized generic of Flovent Diskus), and fluticasone propionate HFA (authorized generic of Flovent HFA) would count as one alternative. Asmanex HFA and Asmanex Twisthaler would count as one alternative.	1 year	Yes	
Respiratory - Corticosteroid Nebulized Solutions	Pulmicort	budesonide respules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Respiratory - Corticosteroid/Long-Acting Beta-Agonist Combination Inhalers	AirDuo RespiClick	fluticasone propionate/salmeterol inhalation powder	1. Approve if the patient has tried four of the following (if four are formulary, or three if three are formulary, or two if two are formulary, or one if only one is formulary): fluticasone-salmeterol HFA (Advair HFA, authorized generic), fluticasone propionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics), fluticasone-vilanterol powder inhalation (Breo Ellipta, authorized generic), Dulera, fluticasone propionate/salmeterol multidose dry powder inhaler (authorized generic of AirDuo RespiClick, AirDuo Digihaler), or budesonide-formoterol aerosol (Symbicort, Breyna, generics). If none are formulary, approve. 2. Patients who are unable to coordinate breath and actuation with a metered-dose inhaler (MDI): approve if the patient has tried two of the following (if two are formulary or one if only one is formulary): fluticasone propionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics), fluticasone propionate/salmeterol multidose DPI (authorized generic of AirDuo RespiClick, AirDuo Digihaler), or fluticasone-vilanterol powder inhalation (Breo Ellipta, authorized generic). If none are formulary, approve. 3. Patients < 18 years of age: approve if the patient has tried three of the following (if three are formulary, or two if two are formulary, or one if only one is formulary): fluticasone-vilanterol powder inhalation (Breo Ellipta, authorized generic), budesonide-formoterol aerosol (Symbicort, Breyna, generics), fluticasone-salmeterol HFA (Advair HFA, authorized generic), fluticasone propionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics), fluticasone propionate/salmeterol multidose DPI (authorized generic of AirDuo RespiClick, AirDuo Digihaler), or Dulera. If none are formulary, approve. 4. Patients < 18 years of age who are unable to coordinate breath and actuation with a metered-dose inhaler (MDI): approve if the patient has tried one of fluticasone-vilanterol powder inhalation (Breo Ellipta, authorized generic), fluticasone propionate/salmeterol inhalation (Advair Diskus, Wixela, generics) or fluticasone propionate/salmeterol multidose DPI (authorized generic of AirDuo RespiClick, or AirDuo Digihaler), if one is formulary. If none are formulary, approve. Note: Fluticasone proprionate-salmetrol inhalation powder, Wixela, and Advair Diskus count as one alternative. Fluticasone propionate/salmeterol multidose DPI (authorized generic of AirDuo RespiClick) and AirDuo Digihaler would count as one alternative. Budesonide-formoterol aerosol, Breyna, and Symbicort count as one alternative. Each product and its authorized generic or generic count as one alternative.	1 year	Yes	
Respiratory - Corticosteroid/Long-Acting Beta-Agonist Combination Inhalers	fluticasone propionate/salmeterol HFA	fluticasone propionate/salmeterol HFA	Direct to Advair HFA (brand), if formulary. If Advair HFA (brand) is non-formulary: 1. Approve if the patient has tried four of the following, if (four are formulary, or three if three are formulary, or two if two are formulary, or one if only one is formulary): budesonide-formoterol aerosol (Symbicort, Breyna, generics), Dulera, fluticasone-vilanterol powder inhalation (Breo Ellipta, authorized generic), fluticasone propionate/salmeterol multidose dry powder inhaler (AirDuo RespiClick, authorized generics, AirDuo Digihaler), or fluticasone propionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics). If none are formulary, approve. 2. Patients < 18 years of age: approve if the patient has tried three of the following, if three are formulary (if three are formulary, or two if two are formulary, or one if only one is formulary): fluticasone-vilanterol powder inhalation (Breo Ellipta, authorized generic), budesonide-formoterol aerosol (Symbicort, Breyna, generics), Dulera, fluticasone propionate/salmeterol multidose dry powder inhaler (AirDuo RespiClick, authorized generics, AirDuo Digihaler), or fluticasone propionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics). If none are formulary, approve. 3. Patients with a low inspiratory flow rate who are unable to use a dry powder inhaler (DPI): approve if the patient has tried both 1) budesonide-formoterol (Symbicort, Breyna, generics) and 2) Dulera (if both are formulary or one if only one is formulary). If neither are formulary, approve. Note: Fluticasone proprionate-salmetrol inhalation powder, Wixela, and Advair Diskus count as one alternative. Fluticasone propionate-salmeterol multidose dry powder inhaler, AirDuo RespiClick, and AirDuo Digihaler count as one alternative. Budesonide-formoterol aerosol, Breyna, and Symbicort count as one alternative. Each product and its authorized generic or generic count as one alternative.	1 year	Yes	
Respiratory - Corticosteroid/Long-Acting Beta-Agonist Combination Inhalers	fluticasone propionate/salmeterol multidose dry powder inhaler	fluticasone propionate/salmeterol inhalation powder (authorized generic to AirDuo RespiClick)	1. Approve if the patient has tried four of the following (if four are formulary, or three if three are formulary, or two if two are formulary, or one if only one is formulary): fluticasone-salmeterol HFA (Advair HFA, authorized generic), fluticasone propionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics), AirDuo RespiClick, AirDuo Digihaler, fluticasone-vilanterol powder inhalation (Breo Ellipta, authorized generic), Dulera or budesonide-formoterol (Symbicort, Breyna, generics). If none are formulary, approve. 2. Patients who are unable to coordinate breath and actuation with a metered-dose inhaler (MDI): approve if the patient has tried two of the following (if two are formulary or one if only one is formulary): fluticasone propionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics), AirDuo RespiClick, AirDuo Digihaler, or fluticasone-vilanterol powder inhalation (Breo Ellipta, authorized generic). If none are formulary, approve. 3. Patients < 18 years of age: approve if the patient has tried three of the following (if three are formulary, or two if two are formulary, or one if only one is formulary): fluticasone-vilanterol powder inhalation (Breo Ellipta, authorized generic), budesonide-formoterol aerosol, (Symbicort, Breyna, generics), fluticasone-salmeterol HFA (Advair HFA, authorized generic), fluticasone propionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics), AirDuo RespiClick, AirDuo Digihaler, or Dulera. If none are formulary, approve. 4. Patients < 18 years of age who are unable to coordinate breath and actuation with a metered-dose inhaler (MDI): approve if the patient has tried one of fluticasone-vilanterol powder inhalation (Breo Ellipta, authorized generic), fluticasone propionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics), AirDuo RespiClick, or AirDuo Digihaler, if formulary. If neither are formulary, approve. Note: Fluticasone proprionate-salmetrol inhalation powder, Wixela, and Advair Diskus count as one alternative. AirDuo RespiClick and AirDuo Digihaler count as one alternative. Budesonide-formoterol aerosol, Breyna, and Symbicort count as one alternative. Each product and its authorized generic or generic count as one alternative.	1 year	Yes	
Respiratory - Corticosteroid/Long-Acting Beta-Agonist Combination Inhalers	Fluticasone-vilanterol	fluticasone furoate and vilanterol inhalation powder	Direct the patient to Breo Ellipta (brand), if formulary. If Breo Ellipta (brand) is non-formulary: 1. Approve if the patient has tried three of the following (if three are formulary, or two if two are formulary, or one if only one is formulary): fluticasone propionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics), fluticasone-salmeterol HFA (Advair HFA, authorized generic), fluticasone propionate/salmeterol multidose dry powder inhaler (AirDuo RespiClick, authorized generics, AirDuo Digihaler), budesonide-formoterol aerosol (Symbicort, Breyna, generics), or Dulera. If none are formulary, approve. 2. Patients < 12 years of age: Approve if the patient has tried one of the following (if formulary): fluticasone propionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics), Dulera, or budesonide-formoterol aerosol (Symbicort, Breyna, generics). If none are formulary, approve. 3. Patients ≤ 5 years of age: Approve if the patient has tried one of the following (if formulary): fluticasone propionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics) or Dulera. If neither are formulary, approve. 4. Patients who are unable to coordinate breath and actuation with a metered-dose inhaler (MDI): approve if the patient has tried one of fluticasone propionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics), fluticasone propionate/salmeterol multidose dry powder inhaler (AirDuo RespiClick, authorized generics, or AirDuo Digihaler), if one is formulary. If neither are formulary, approve. a. Patient < 12 years of age who are unable to coordinate breath and actuation with a metered-dose inhaler (MDI): Approve if the patient has tried fluticasone propionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics). If fluticasone propionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics) are non-formulary, approve. 5. Patients with COPD: Approve if the patient has tried both 1) fluticasone proprionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics) and 2) budesonide-formoterol aerosol (Symbicort, Breyna, generics) [if both are formulary or one if only one is formulary]. If none are formulary, approve. 6. Patients with COPD who are unable to coordinate breath and actuation with a metered-dose inhaler (MDI): approve if the patient has tried fluticasone proprionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics) if formulary. If fluticasone proprionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics) are non-formulary, approve. Note: Fluticasone proprionate-salmetrol inhalation powder, Wixela, and Advair Diskus count as one alternative. Fluticasone propionate-salmeterol multidose dry powder inhaler, AirDuo RespiClick, and AirDuo Digihaler count as one alternative. Budesonide-formoterol aerosol, Breyna, and Symbicort count as one alternative. Each product and its authorized generic or generic count as one alternative.	1 year	Yes	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Respiratory - Corticosteroid/Long-Acting Beta-Agonist Combination Inhalers	Advair Diskus	fluticasone propionate/salmeterol inhalation powder	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Respiratory - Inhaled Phosphodiesterase (PDE)-3 and PDE-4 Inhibitor	Ohtuvayre	ensifentrine inhalation suspension	Chronic obstructive pulmonary disease (COPD) in a patient ≥ 18 years of age. Approve if the patient has tried, and according to the prescriber, experienced inadequate efficacy OR significant intolerance with BOTH of the following products used concurrently: 1) a Long-Acting Muscarinic Antagonist (LAMA) product AND a Long-Acting Beta-Agonist (LABA) product. LAMA/LABA Inhalers: Anoro Ellipta, Bevespi Aerosphere, Duaklir Pressair, Stiolto Respimat. LAMA Inhalers: Incruse Ellipta, tiotropium inhaler (Spiriva HandiHaler, generics), Spiriva Respimat, Tudorza Pressair. LABA Inhalers/Nebulized: Serevent Diskus, Striverdi Respimat, formoterol fumarate inhalation solution (Perforomist, generics). ICS/LABA Inhalers: fluticasone-salmeterol HFA (Advair HFA, authorized generic), fluticasone-salmeterol diskus, Wixela (Advair Diskus, generics), fluticasone-vilanterol (Breo Ellipta, authorized generic), Dulera, fluticasone-salmeterol respiclock (AirDuo RespiClick, authorized generic), AirDuo Digihaler, or budesonide-formoterol (Symbicort, generics).	1 year	Yes	
Respiratory - Long-Acting Muscarinic Antagonist (LAMA) Inhalers	Tudorza Pressair	aclidinium bromide inhalation powder	Approve if the patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with BOTH products from the following list, if formulary (or one if one is formulary): 1) Incruse Ellipta, and 2) a tiotropium inhaler (tiotropium cap-inhaler [Spiriva HandiHaler, generics], or Spiriva Respimat). If neither are formulary, approve.	1 year	Yes	
Respiratory Drugs - Other	Daliresp	roflumilast tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Rett Syndrome Agents	Daybue	trofinetide oral solution	See standard *Neurology – Daybue Prior Authorization Policy* criteria. Note: No conditions of approval are recommended in the prior authorization policy.	1 year	Yes	
Rituximab-containing Agents	Riabni	rituximab-arrx intravenous injection	**1.** Approve if the patient meets BOTH of the following (a and b): **a.** The patient has tried three of the following, if three are formulary (or one or two of the following, if one or two is formulary): Truxima, Rituxan intravenous, Ruxience; AND Note: If none are formulary, approve. **b.** Patient cannot continue to use each formulary alternative due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. **2.** If the patient has already been started on or has previously received therapy with Riabni, approve.	1 year	Yes	
Rituximab-containing Agents	Rituxan	rituximab intravenous injection	**1.** Approve if the patient meets BOTH of the following (a and b): **a.** The patient has tried three of the following, if three are formulary (or one or two of the following, if one or two is formulary): Truxima, Riabni, Ruxience; AND Note: If none are formulary, approve. **b.** Patient cannot continue to use each formulary alternative due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. **2.** If the patient has already been started on or has previously received therapy with Rituxan intravenous, approve.	1 year	Yes	
Rituximab-containing Agents	Rituxan Hycela	rituximab and hyaluronidase human injection for subcutaneous use	**1.** Approve if the patient has tried one the following: Rituxan, Truxima, Ruxience, Riabni, but cannot continue to use the product. **2.** Approve if, according to the prescriber, cannot use rituximab intravenous due to an inability to obtain IV access. **3.** If the patient has already been started on or has previously received therapy with Rituxan Hycela, approve.	1 year	Yes	
Rituximab-containing Agents	Truxima	rituximab-abbs intravenous injection	**1.** Approve if the patient meets BOTH of the following (a and b): **a.** The patient has tried three of the following, if three are formulary (or one or two of the following, if one or two is formulary): Rituxan intravenous, Riabni, Ruxience; AND Note: If none are formulary, approve. **b.** Patient cannot continue to use each formulary alternative due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. **2.** If the patient has already been started on or has previously received therapy with Truxima, approve.	1 year	Yes	
Rosacea Agents (Topical)	Noritate	metronidazole cream 1%	**1.** Direct the patient to a topical metronidazole product. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use a generic topical metronidazole agent. Note: Examples of topical metronidazole products include metronidazole 0.75% cream (MetroCream, generics), metronidazole 0.75% or 1% gel (Metrogel, generics), metronidazole 0.75% lotion (MetroLotion, generics).	1 year	Yes	
Rosacea Agents (Topical)	Zilxi	minocycline 1.5% topical foam	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with one formulary product from three of the four groups below, if there is a formulary product in the group: Group 1: An topical azelaic acid product (azelaic acid 15% gel [Finacea 15% gel, generics], Finacea 15% foam, Azelex 20% cream); Group 2: A topical sodium sulfacetamide 10%/sulfur 5% product. (any generic sodium sulfacetamide10%/sulfur 5% product, Rosula); Group 3: A topical metronidazole product (metronidazole 0.75% or 1% [MetroGel, generics; MetroCream, generics; MetroLotion, generics, Noritate]); Group 4: a topical ivermectin product (generic ivermectin cream or Soolantra).	1 year	Yes	
Sedative-Hypnotics and Related Agents	zolpidem 7.5 mg capsules (brand)	zolpidem 7.5 mg capsules	Approve if the patient has tried three of the following agents, if three are formulary (or two if two are formulary, or one if only one is formulary): zolpidem tablets (other strengths) [Ambien, Ambiren CR, generics], eszopiclone tablets (Lunesta, generics), or zaleplon. If none are formulary, approve.	1 year	Yes	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Sedative-Hypnotics and Related Agents	Ambien	zolpidem tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Sedative-Hypnotics and Related Agents	Ambien CR	zolipidem extended-release tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Sedative-Hypnotics and Related Agents	Lunesta	eszopiclone tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Sedative-Hypnotics and Related Agents	Rozerem	ramelteon tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Selective Estrogen Receptor Modifiers and Antiestrogens	Osphena	ospemifene tablets	Approve if the patient has tried one vaginal estrogen product from the following list (if one is formulary): estradiol cream (Estrace cream, generics), Femring vaginal ring, Premarin vaginal cream, Estring vaginal ring, estradiol vaginal tablet (e.g., Yuvafem, Vagifem, generics), or Imvexxy If none are formulary, approve.	1 year	Yes	
Selective Serotonin Reuptake Inhibitors (SSRIs)	Viibryd 10/20 mg starter pack	vilazodone tablets	Approve if the patient is unable to use vilazodone tablets (which are not packaged in a starter pack).	1 year	Yes	
Selective Serotonin Reuptake Inhibitors (SSRIs)	citalopram 30 mg capsules	citalopram capsules	**1.** Direct to citalopram 10 mg or 20 mg tablets. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use the citalopram 10 mg and/or 20 mg tablets.	1 year	Yes	
Selective Serotonin Reuptake Inhibitors (SSRIs)	Zercapli and sertraline 150 mg, 200 mg capsules	sertraline 150 mg, 200 mg capsules	**1.** Direct the patient to sertraline 50 mg and/or 100 mg tablets. **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use the sertraline 50 mg and/or 100 mg tablet.	1 year	Yes	
Selective Serotonin Reuptake Inhibitors (SSRIs)	Celexa	citalopram tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Selective Serotonin Reuptake Inhibitors (SSRIs)	Lexapro	escitalopram oxalate tablets and oral solution	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Selective Serotonin Reuptake Inhibitors (SSRIs)	Prozac	fluoxetine HCl pulvules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Selective Serotonin Reuptake Inhibitors (SSRIs)	Viibryd (non- starter pack) 10 mg, 20 mg, 40 mg	vilazodone tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Selective Serotonin Reuptake Inhibitors (SSRIs)	Zoloft	sertraline HCl tablets and oral solution	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Serotonin and Norepinephrine Reuptake Inhibitors (SNRIs)	Drizalma Sprinkle	duloxetine delayed-release capsules	**1.** Approve if the patient has tried one product from the following list (if one is formulary): duloxetine capsules (Cymbalta, generics), Fetzima, desvenlafaxine succinate extended-release (ER) [Pristiq, generics], venlafaxine ER capsules (Effexor XR, generics), or venlafaxine extended-release tablets. If none are formulary, approve. **NOTE**: If patient has tried venlafaxine immediate-release, a trial of venlafaxine extended-release is not required. **2.** Approve if the patient is unable to swallow, has difficulty swallowing, or requires administration via a nasogastric tube.	1 year	Yes	
Serotonin and Norepinephrine Reuptake Inhibitors (SNRIs)	Venlafaxine besylate ER 112.5 mg (formerly Venbysi XR)	venlafaxine extended-release 112.5 mg tablets	**1.** Approve if the patient has tried two products from the following list (if two are formulary; or one if one is formulary): desvenlafaxine succinate ER (Pristiq, generics), Fetzima, Drizalma Sprinkle, venlafaxine ER capsules (Effexor XR, generics), duloxetine capsules (Cymbalta, generics), or venlafaxine ER tablets. If none are formulary, approve. NOTE: If patient has tried venlafaxine immediate-release, a trial of venlafaxine extended-release is not required. **2.** Approve if the patient is currently taking or has taken venlafaxine besylate ER at any time in the past. **3.** Suicidal ideation: approve.	1 year	Yes	Yes

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Serotonin and Norepinephrine Reuptake Inhibitors (SNRIs)	Cymbalta	duloxetine HCl capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Serotonin and Norepinephrine Reuptake Inhibitors (SNRIs)	Effexor XR	venlafaxine HCl extended-release capsules	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Serotonin and Norepinephrine Reuptake Inhibitors (SNRIs)	Pristiq	dexvenlafaxine succinate tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Short-Acting Beta-Agonists (Inhaled)	ProAir Digihaler	albuterol sulfate inhalation powder	**1.** Approve if the patient has tried one other single-entity albuterol inhaler. For example, albuterol HFA (ProAir HFA or generics) or albuterol HFA (Proventil HFA or generics). Note: If there are no single-entity albuterol-containing formulary alternatives, approve. **2.** Patients who are unable to coordinate breath and actuation with a metered-dose inhaler (MDI): approve if the patient has tried ProAir Respiclick, if formulary. If ProAir Respiclick is non-formulary, approve.	1 year	Yes	
Short-Acting Beta-Agonists (Inhaled)	ProAir Respiclick	albuterol sulfate inhalation powder	**1.** Approve if the patient has tried one other single-entity albuterol inhaler. For example, albuterol HFA (ProAir HFA or generics) or albuterol HFA (Proventil HFA or generics). Note: If there are no single-entity albuterol-containing formulary alternatives, approve. **2.** Patients who are unable to coordinate breath and actuation with a metered-dose inhaler (MDI): approve if the patient has tried ProAir Digihaler, if formulary. If ProAir Digihaler is non-formulary, approve.	1 year	Yes	
Short-Acting Beta-Agonists (Inhaled)	Ventolin HFA and authorized generic	albuterol sulfate inhalation aerosol	Approve if the patient has tried one other single-entity albuterol inhaler. For example, albuterol HFA (ProAir HFA or generics) or albuterol HFA (Proventil HFA or generics). Note: If there are no single-entity albuterol-containing formulary alternatives, approve.	1 year	Yes	
Short-Acting Beta-Agonists (Inhaled)	Xopenex HFA and levalbuterol HFA	levalbuterol inhalation aerosol	Approve if the patient has tried one single-entity albuterol inhaler. For example, albuterol HFA (ProAir HFA or generics) or albuterol HFA (Proventil HFA or generics). Note: If there are no single-entity albuterol-containing formulary alternatives, approve.	1 year	Yes	
Short-Acting Beta-Agonists (Inhaled)	ProAir HFA	albuterol sulfate inhalation aerosol	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Sickle Cell Disease Agents	Siklos	hydroxyurea tablets	**1.** Approve is the patient has tried Droxia, if formulary. If Droxia is non-formulary, approve. **2.** If the patient requires Siklos 100 mg or 1,000 mg tablets to achieve a dosage that cannot be achieved with the available strengths of Droxia, approve. **3.** If the patient cannot swallow or has difficulty swallowing Droxia capsules, approve.	1 year	Yes	
Sodium Hydrogen Exchanger 3 Inhibitor	Xphozah	tenapanor tablets	Approve if the patient meets one of the following (1 or 2): **1.** Patient meets BOTH of the following (A and B): A. Patient has tried at least two phosphate binders; AND Note: Examples of phosphate binders include: sevelamer, lanthanum, ferric citrate, and sucroferric oxyhydroxide, calcium carbonate, and calcium acetate. B. Patient had an inadequate response and/or intolerance to at least two phosphate binders; OR **2.** Patient meets one of the following (A or B): A. Patient has a contraindication to at least two phosphate binders; OR Note: Contraindication to phosphate binders includes bowel obstruction, iron overload, or hypercalcemia. B. Patient meets BOTH of the following (i and ii): i. Patient has inadequate response and/or intolerance to at least one phosphate binder; AND ii. Patient has a contraindications to at least one phosphate binder. Note: Contraindication to phosphate binders include bowel obstruction, iron overload, or hypercalcemia.	1 year	Yes	
Somatostatin Analogs	Signifor LAR	pasireotide IM injection	**1.** Acromegaly: Approve if the patient has tried one of Sandostatin LAR Depot, Somatuline Depot, or lanreotide subcutaneous injection, if one is formulary. If none are formulary, approve. **2.** Cushing's Disease. Approve if the patient has tried Signifor (not LAR). If Signifor (not LAR) is non-formulary, approve. **3.** Endogenous Cushing's Syndrome. Note: This includes patients awaiting surgery and patients awaiting therapeutic response after pituitary radiotherapy. Approve if patient has tried Signifor (not LAR), if formulary. If Signifor (not LAR) is non-formulary, approve.	1 year	Yes	
Somatostatin Analogs	Sandostatin LAR Depot	octreotide injectable suspension	**1.** Acromegaly: Approve if the patient has tried one of Somatuline Depot or lanreotide subcutaneous injection, if formulary. If neither are formulary, approve. **2.** Patient with neuroendocrine tumors: approve if the patient meets the following (A or B): Note: This includes (but is not limited to) carcinoid tumors, vasoactive intestinal peptide tumors (VIPomas), glucagonomas, gastrinomas, insulinomas. A. Patient has tried one of Somatuline Depot or lanreotide subcutaneous injection, if formulary. If neither are formulary, approve; OR B. Patient has already been started on therapy with Sandostatin LAR. **3.** Patient with pheochromocytoma/paraganglioma: approve if the patient meets the following (A or B): A. Patient has tried Somatuline Depot, if formulary. If Somatuline Depot is non-formulary, approve; OR B. Patient has already been started on therapy with Sandostatin LAR. **4.** Patient with enterocutaneous fistula; meningioma; pancreatic fistula; thymoma/thymic carcinoma: approve.	1 year	Yes	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Somatostatin Analogs	lanreotide subcutaneous injection [Cipla]	lanreotide subcutaneous injection	**1.** Acromegaly; neuroendocrine tumors; pheochromoctoma/paraganglioma. Approve if the patient has tried Somatuline Depot, if formulary. If Somatuline Depot is non-formulary, approve if the patient meets (A or B): **A.** Acromegaly; pheochromoctoma/paraganglioma: Approve if the patient has tried Sandostatin LAR Depot, if formulary. If Sandostatin LAR Depot is non-formulary, approve. **B.** Patients with neuroendocrine tumors: Approve if the patient meets the following (i or ii): Note: This includes (but is not limited to) carcinoid tumors, vasoactive intestinal peptide tumors (VIPomas), glucagonomas, gastrinomas, insulinomas. i. Patient has tried Sandostatin LAR Depot, if formulary. If Sandostatin LAR Depot is non-formulary, approve; OR ii. Patient has already been started on therapy with lanreotide subcutaneous injection. **2.** Carcinoid syndrome: Approve if the patient has tried Somatuline Depot, if formulary. If Somatuline Depot is non-formulary, approve.	1 year	Yes	
Steroid Products (Vaginal)	Intrarosa	prasterone vaginal inserts	**1.** Approve if the patient has tried one formulary alternative from the following list: Imvexxy, Femring vaginal ring, Premarin Cream, Estring vaginal ring, estradiol 0.01% cream (Estrace cream, generics), or estradiol vaginal tablet (e.g., Yuvafem, Vagifem, generics). If none are formulary, approve. **2.** Approve if, according to the prescriber, the patient is at an increased risk of endometrial cancer, stroke, or deep vein thrombosis (DVT).	1 year	Yes	
Testosterone Products (Injectable)	Aveed	testosterone undecanoate for intramuscular use	Approve if the patient has tried one of the following injectable testosterone products, if one is formulary: testosterone enanthate injection [generics], testosterone cypionate injection [Depo-Testosterone, generics], Azmiro, or Xyosted. If none are formulary, approve. Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.	1 year	Yes	
Testosterone Products (Oral)	Kyzatrex and Undecatrex	testosterone undecanoate capsules	Approve if the patient has tried both of Jatenzo and Tlando capsules, if formulary (or one if one is formulary). If neither are non-formulary, approve if the patient has tried two forms of topical testosterone (e.g., gel, solution, patches).	1 year	Yes	
Testosterone Products (Oral)	Tlando	testosterone undecanoate oral capsules	**1.** Approve if the patient meets BOTH of the following, if formulary (or one if one is formulary) [a and b]: a. Patient has tried Jatenzo, if formulary; AND b. Patient has tried one of Kyzatrex or Undecatrex, if formulary. Note: Kyzatrex and Undecatrex count as one alternative. **2.** If neither are formulary, approve if the patient has tried two forms of topical testosterone (e.g., gel, solution, patches).	1 year	Yes	
Testosterone Products (Topical)	Natesto	testosterone nasal gel	Approve if the patient has tried three other topical testosterone products (e.g., Androgel 1% or generics, Axiron [generics only], Androgel 1.62% or generics, Fortesta or generics, Testim or generics, Vogelxo or generics.)	1 year	Yes	
Testosterone Products (Topical)	Androgel	testosterone 1% gel packets and pump, 1.62% (2021)	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Testosterone Products (Topical)	Testim	testosterone gel	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Thiazide-like Diuretics	Thalitone 15 mg	chlorthalidone 15 mg tablets	**1.** Direct the patient to chlorthalidone tablets. Available as 25 mg, 50 mg. **2.** Approve if the patient's prescribed dose cannot be obtained with the 25 mg and/or 50 mg strength tablets.	1 year	Yes	
Thrombocytopenia agents	Alvaiz	eltrombopag choline tablets	Immune Thrombocytopenia. **1.** Approve if the patient has tried one of Promacta or Nplate, if formulary. If neither are formulary, approve. **2.** Approve if the patient has already been started on therapy with Alvaiz. Aplastic Anemia; Thrombocytopenia in a Patient with Chronic Hepatitis C; Thrombocytopenia in a Patient with Myelodysplastic Syndrome; Thrombocytopenia in a Patient Post-Allogenic Transplantation. **1.** Approve if the patient has tried Promacta, if formulary. If Promacta is non-formulary, approve. **2.** Approve if the patient has already been started on therapy with Alvaiz.	1 year	Yes	Yes
Thrombocytopenia agents	Mulpleta	lusutrombopag tablets	Mulpleta is being used pre-procedure and the patient has thrombocytopenia and chronic liver disease. **1.** Approve if the patient has tried Doptelet, if formulary. If Doptelet is non-formulary, approve. **2.** Approve if the patient has already started a course of therapy with Mulpleta in order to finish the course.	1 month	Yes	Yes
Thyroid Supplements	Thyquidity	levothyroxine sodium oral solution	**1.** Approve if the patient has tried five formulary levothyroxine products from the following list (if five are formulary or four if four are formulary or three if three are formulary or two if two are formulary or one if one is formulary): levothyroxine (Synthroid, generics), Levoxyl (generics), Unithroid (generics), Euthyrox (generics), or Tirosint capsules **[documentation required]**. If none are formulary, approve. **2.** If the patient cannot swallow or has difficulty swallowing tablets or capsules **[documentation required]**, approve if the patient has tried both Tirosint oral solution and Ermeza oral solution, if formulary (or one if one is formulary). If neither are formulary, approve.	1 year	Yes	
Thyroid Supplements	Tirosint-SOL	levothyroxine oral solution	**1.** Approve if the patient has tried five formulary levothyroxine products from the following list (if five are formulary or four if four are formulary or three if three are formulary or two if two are formulary or one if one is formulary): levothyroxine (Synthroid, generics), Levoxyl (generics), Unithroid (generics), Euthyrox (generics), or Tirosint capsules **[documentation required]**. If none are formulary, approve. **2.** If the patient cannot swallow or has difficulty swallowing tablets or capsules **[documentation required]**, approve if the patient has tried both Thyquidity oral solution and Ermeza oral solution, if formulary (or one if one is formulary). If neither are formulary, approve.	1 year	Yes	
Thyroid Supplements	Tirosint and authorized generic	levothyroxine capsules	Approve if the patient has tried five formulary levothyroxine products from the following list (if five are formulary or four are formulary or three if three are formulary or two if two are formulary or one if one is formulary): levothyroxine (Synthroid, generics), Levoxyl (generics), Unithroid (generics), Euthyrox (generics), or Tirosint oral solution **[documentation required]**. If none are formulary, approve.	1 year	Yes	
Thyroid Supplements	Cytomel	liothyronine sodium tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Thyroid Supplements	Synthroid	levothyroxine tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Thyroid Supplements - Desiccated Thyroid Supplements	Adthyza	thyroid tablets	**1.** Approve if the patient has tried one levothyroxine product (e.g., levothyroxine, Synthroid, Levoxyl) AND one other desiccated thyroid product (e.g., Armour Thyroid, NP thyroid). **2.** Patient currently receiving Adthyza: Approve if the patient has tried one other desiccated thyroid product (e.g., Armour Thyroid, NP thyroid). Note: Some desiccated thyroid products are currently not available, such as Nature thyroid, WP thyroid, Westhroid, and Thyroid tablet, but a previous trial of these would count as a trial of a desiccated thyroid product.	1 year	Yes	
Topical Agents for Atopic Dermatitis	Elidel	pimecrolimus cream	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Topical agents for Condyloma acuminatum	Condylox 0.5% topical gel	podofilox 0.5% gel	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Topical Corticosteroid-containing Agents – Halobetasol Agents	Ultravate Lotion	halobetasol propionate lotion 0.05%	Approve if the patient has tried, and according to the prescriber has experienced inadequate efficacy OR significant intolerance with four generic prescription-strength topical corticosteroid products. Note: Examples of prescription-strength topical corticosteroids products include: halobetasol propionate, betamethasone dipropinate, clobetasol propionate, diflorasone diacetate. NOTE: The products must be chemically unique.	1 year	Yes	
Topical Corticosteroid-containing Agents – Halobetasol Agents	Lexette and halobetasol propionate 0.05% topical foam	halobetasol propionate topical foam 0.05%	Approve if the patient has tried, and according to the prescriber has experienced inadequate efficacy OR significant intolerance with four generic prescription-strength topical corticosteroid products. Note: Examples of prescription-strength topical corticosteroids products include: halobetasol propionate, betamethasone dipropinate, clobetasol propionate, diflorasone diacetate. NOTE: The products must be chemically unique.	1 year	Yes - brand only	
Topical Dermatological Drugs - Miscellaneous	Alcortin A	hydrocortisone 2%/ iodoquinol 1%/ aloe 1% gel	Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with five single-entity corticosteroid topical agents AND one prescription topical anti-infective agent. Note: Examples of topical corticosteroids include: hydrocortisone cream/lotion/ointment [multiple brand and generic products], betamethasone cream/ointment/lotion [Diprolene, generics], clobetasol cream/gel/lotion [Temovate, Clobex, generics], fluocinolone ointment/cream [Synalar, generics], fluocinonide cream/ointment/gel [generics], mometasone cream/lotion/ointment [Elocon, generics], triamcinolone cream/ointment/lotion [generics]. Note: Examples of prescription topical anti-infectives include: mupirocin 2% cream [Bactroban, generics], mupirocin 2% ointment [Bactroban, generics], Centany ointment, Centany AT ointment, Altabax ointment).	1 year	Yes	
Topical Dermatological Drugs - Miscellaneous	Veregen	sinecatechins ointment 15%	**1.** Approve if the patient has tried both 1) podofilox topical solution or Condylox gel AND 2) imiquimod 5% cream (Aldara, generics), if formulary. If none are formulary, approve. **2.** For perianal warts, approve if the patient has tried both 1) Condylox gel AND 2) imiquimod 5% cream (Aldara, generics), if formulary. If neither are formulary approve.	1 year	Yes	
Topical Dermatological Drugs - Miscellaneous	Clenia Plus and authorized generic	sodium sulfacetamide 9%- sulfur 4.25% suspension	**1.** Direct the patient to a topical product containing sodium sulfacetamide-sulfur (e.g., generic sodium sulfacetamide-sulfur 9.8%-4.8% topical cleanser, generic sodium sulfacetamide-sulfur 8%-4% topical suspension). **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use a generic topical product containing sodium sulfacetamide/sulfur.	1 year	Yes	
Topical Dermatological Drugs - Miscellaneous	sulfacetamide-sulfur 8-4% cleanser	sulfacetamide-sulfur 8-4% cleanser	**1.** Direct the patient to a topical product containing sodium sulfacetamide-sulfur (e.g., generic sodium sulfacetamide-sulfur 8%-4% topical suspension). **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use a generic topical product containing sodium sulfacetamide-sulfur.	1 year	Yes	
Topical Dermatological Drugs - Miscellaneous	Zma Clear	sodium sulfacetamide 9% and sulfur 4.5% suspension	**1.** Direct the patient to a topical product containing sodium sulfacetamide-sulfur (e.g., generic sodium sulfacetamide-sulfur 9.8%-4.8% topical cleanser, generic sodium sulfacetamide-sulfur 8%-4% topical suspension). **2.** Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use a generic topical product containing sodium sulfacetamide-sulfur.	1 year	Yes	
Topical Dermatological Drugs - Miscellaneous	Pliaglis and lidocaine 7% and tetracaine 7% cream (brand)	lidocaine 7% and tetracaine 7% cream	Approve if the patient has tried and cannot use two of the following, if two are formulary (or one if only one is formulary): lidocaine and prilocaine cream (generics), lidocaine cream (generics, multiple strengths), Livixil Pak, DermacinRx Prizopak. If none are formulary, approve.	1 year	Yes	
Topical Dermatological Drugs - Miscellaneous	Lidoderm	lidocaine 5% patch	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Topical Dermatological Drugs - Miscellaneous	Tazorac 0.1% cream	tazarotene 0.1% cream	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	

Formulary Exception Criteria

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Topical Dermatological Drugs - Tazarotene	Tazorac 0.05% cream and tazarotene cream 0.05% cream	tazarotene cream 0.05%	If requesting brand Tazorac 0.05% cream: Approve if the patient has tried generic tazarotene 0.05% cream, if formulary. If generic tazarotene 0.05% cream is non-formulary or generic tazarotene is being requested, approve if the patient has tried one of 1) tazarotene 0.1% cream (Tazorac 0.1% cream, generics) or 2) tazarotene gel (Tazorac gel, generics), if one is formulary. If neither are formulary, approve.	1 year	Yes	
Topical Dermatological Drugs - Tazarotene	Tazorac gel	tazarotene gel 0.05% and 0.1%	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Topical Diaper Dermatitis Agents	Vusion and miconazole-zinc oxide-petroleum	miconazole-zinc oxide-petroleum ointment	Approve if the patient has tried one topical antifungal agent. Note: Examples include: miconazole, clotrimazole, ketoconazole, nystatin.	1 year	Yes	
Topical Products - Miscellaneous	Tri-luma cream	fluocinolone acetonide 0.01%/hydroquinone 4%/tretinoin 0.05% cream	Direct the patient to the separate entities: fluocinolone 0.01% cream- hydroquinone 4% cream- tretinoin 0.05% cream.	N/A	Yes	
Topical Roflumilast Agents	Zoryve 0.15% Cream	roflumilast 0.15% cream	Atopic dermatitis in a patient ≥ 6 years of age. Approve if the patient has tried TWO of pimecrolimus cream (Elidel cream, generics), tacrolimus ointment, or Eucrisa (if two are formulary or one if one is formulary). If none are formulary, approve.	1 year	Yes	
Urinary Tract Analgesic	Pyridium	phenazopyridine tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Ursodiol Products	Reltone	ursodiol capsules 200 mg, 400 mg	**1.** Approve if the patient has tried generic ursodiol capsules or tablets. **2.** Approve, if according to the prescriber, the patient is unable to achieve the appropriate dosage requirement with ursodiol capsules.	1 year	Yes	
Vertigo Agents	Antivert 50 mg tablet and authorized generic meclizine 50 mg	meclizine 50 mg tablet	Patient meets both of the following (i and ii): i. Patient has tried generic 25 mg tablets; AND ii. Patient cannot take generic 25 mg tablets due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction.	1 year	Yes	
Vesicular Monoamine Transporter Type 2 (VMAT2) Inhibitors	Xenazine	tetrabenazine tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Vitamin D Analogs (Topical)	Sorilux and authorized generic	calcipotriene foam	**1.** Approve if the patient has tried calcipotriene solution, if formulary. If calcipotriene solution is non-formulary, approve. **2.** Approve if the patient has tried calcipotriene cream or ointment. **3.** If the patient is using the requested medication for plaque psoriasis and is between the ages ≥ 4 and < 18 years of age, approve.	1 year	Yes	
Wakefulness Agents	Nuvigil	armodafinil tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Wakefulness Agents	Provigil	modafinil tablets	**NOTE:** A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. **Criteria:** Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Weight Loss – GLP-1 receptor agonists	Saxenda	liraglutide [rDNA] injeciton	Weight loss in a patient ≥ 18 years of age. Approve if the patient meets the following (A and B): A. At baseline, the patient has or had a body mass index (BMI) ≥ 30 kg/m2; or a BMI ≥ 27 kg/m2 and at least one of the following weight-related comorbidities: hypertension, type 2 diabetes, dyslipidemia, obstructive sleep apnea, cardiovascular disease, knee osteoarthritis, asthma, chronic obstructive pulmonary disease, non-alcoholic fatty liver disease, polycystic ovarian syndrome, or coronary artery disease; AND Note: This refers to baseline prior to any glucagon-like peptide-1 (GLP-1) agonist (e.g., Saxenda, Wegovy) or GLP-1/glucose-dependent insulinotropic polypeptide (GIP) receptor agonist (e.g., Zepbound). B. Patient has tried one of Wegovy or Zepbound, if formulary. If neither are formulary, approve. Weight loss in a patient is ≥ 12 years of age and < 18 years of age. Approve if the patient meets the following (A and B): A. At baseline, the patient has or had a BMI ≥ 95th percentile for age and sex; AND Note: This refers to baseline prior to any glucagon-like peptide-1 (GLP-1) agonist (e.g., Saxenda, Wegovy) or GLP-1/glucose-dependent insulinotropic polypeptide (GIP) receptor agonist (e.g., Zepbound). B. Patient has tried Wegovy, if formulary. If Wegovy is non-formulary, approve.	1 year	Yes	