

			STANDARD FORMULARY EXCEPTION CRITERIA			
					2025 NPF	Continuation of
				Approval	Excluded	Therapy
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Duration	Medicaiton	Required?
					MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
ACE-Inhibitor/CCB			Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Combination Product	Lotrel	capsules	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
					MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Acne Vulgaris Agents			Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
(Topical)	Clindagel 1% gel	clindamycin 1% gel	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
Acne Vulgaris Agents (Topical)	Winlevi	clascoterone cream	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 0.05% 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 (Amzeeg [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	
(Topical)	VVIIIIEVI	1 70	Immodycline (Artizeeq [minodycline 47/10am]). To combination products, each active chemical entity counts as one than Example. If one prescription product has 2 non-retinous, this would runin a that of 2 non-retinous topical therapies.	i yeai	163	
Acne Vulgaris Agents (Topical) – Combination Products	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	
					MSB Exclusion	
Acne Vulgaris Agents		clindamycin	NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
(Topical) –		phosphate and	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Combination Products	Veltin	tretinoin gel	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
Acne Vulgaris Agents (Topical) – Combination Products	Cabtreo	clindamycin phosphate, adapalene and benzoyl peroxide topical gel	Acne vulgaris in a patient ≥ 12 years of age.  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	
					MSB Exclusion	
Acne Vulgaris Agents (Topical) – Retinoid Products	Atralin	tretinoin gel (0.05%)	<b>NOTE:</b> A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. <b>Criteria:</b> Approve if the Brand product is being requested due to a formulation 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	*This criteria applies only to the NPF	
					MSB Exclusion	
Acne Vulgaris Agents			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
	Retin-A Micro 0.1%		Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Products	& 0.04% gel	0.04% gel	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
Acne Vulgaris Agents			Other diagnoses (e.g., acne vulgaris).  Approve if the patient meets the following (A and B):  A. Patient has tried and cannot take 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 and, according to the prescriber, has experienced inadequate efficacy or significant intolerance with one topical tretinoin-containing product.  Note: Examples of topical retinoid products include tretinoin cream (Retin-A cream, generics), tretinoin gel (Retin-A gel, generics).			
	Fabior and		Psoriasis.			
		tazarotene 0.1% foam	Approve if the patient has tried and cannot take 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	
	Carac and		The state of the s	. ,		
Actinic Keratosis	authorized generic	fluorouracil 0.5%				
	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	
3 ( )	Zyclara 2.5% and	imiguimod 2.5% and				
Agents (Topical)	3.75%	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	
Actinic Keratosis		tirbanibulin ointment	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%			
Agents (Topical)	Klisyri	1%	cream, Zyclara).	1 year	Yes	

					2025 NPF	Continuation of
				Approval	Excluded	Therapy
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Duration	Medicaiton	Required?
		peanut [Arachis				
Allorgon		hypogaea] allergen powder-dnfp for oral		See PA		
Allergen Immunotherapy	Palforzia	administration	See standard Allergen Immunotherapy – Palforzia Prior Authorization Policy criteria.	duration	Yes	
iiiiiiuiiotiieiapy	r alluizia	auministration	Gee standard Allergen Immunotnerapy – Fanorzia Finor Admonization Folicy Citienta.	duration	MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Alpha and beta-			Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
blocker	Coreg	carvedilol tablet	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
	T T	alpha1-proteinase				
Alpha1 Proteinase		inhibitor [human]	Alpha1-Antitrypsin Deficiency with Emphysema (or Chronic Obstructive Pulmonary Disease); Alpha1-Antitrypsin Deficiency-Associated Panniculitis:			
Inhibitors	Aralast NP	lyophilized powder	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				
Alpha1 Proteinase		inhibitor [human]	Alpha1-Antitrypsin Deficiency with Emphysema (or Chronic Obstructive Pulmonary Disease); Alpha1-Antitrypsin Deficiency-Associated Panniculitis:			
Inhibitors	Glassia	solution	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	
ALL 45 ::		alpha1-proteinase				
Alpha1 Proteinase	7	inhibitor [human]	Alpha1-Antitrypsin Deficiency with Emphysema (or Chronic Obstructive Pulmonary Disease); Alpha1-Antitrypsin Deficiency-Associated Panniculitis:	4	V	
Inhibitors	Zemaira	lyophilized powder	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	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		MSB Exclusion	
			Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		*This criteria applies only to	
Alpha-2 Agonists	Lucemyra	lofexidine tablets	persectiber, would result in a significant allergy or serious adverse reaction [documentation required].	1 vear	the NPF	
7 upria 2 7 igoriioto	Luccinyiu	clonidine ER tablet	presence, would result in a significant energy of schools develope reaction required.	1 your	uio itti i	
Alpha-adrenergic	Nexiclon XR and	and authorized				
Agonist		generic	Approve if the patient tried and is unable to use both clonidine immediate-release tablets AND clonidine transdermal patches.	1 year	Yes	
3	, ,			ľ		
Aluminum Chloride		aluminum chloride	Hyperhidrosis in the axillae, palms, or soles.			
Agents	Drysol	20% topical solution	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		lecanemab-irmb	No exceptions are recommended. Due to safety concerns and the lack of clinically significant efficacy data, an exception is not recommended for Lequebi. (NOTE: It is not appropriate to use standard global criteria for this medication;			
antibody	Leqembi	intravenous infusion	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		donanemab-azbt	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;		.,	
antibody	Kisunla	intravenous infusion	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	
			NOTE: A multipayers Drand washing to provide a The patient should use the professed biospikished appairs washing		MSB Exclusion	
Alzheimer's Disease		manantina autondad	NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Adents	Namenda XR	memantine extended- release capsule	Criteria: Approve if the Brand product is being requested due to a formulation 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	applies only to the NPF	
Agents	Namenua XIX	Telease capsule	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	i yeai	uic ivri	
			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, 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			
Amyloidoisis-			v. The indicated is presented by an extractance with a heatingst, generalist, of a physician who specializes in the detailed of amyloidesis, AND.  B. The patient meets one of the following criteria (i, ii, or iii):			
associated		eplontersen	i. Patient has tried Amvuttra, if formulary; OR			
Polyneuropathy		subcutaneous	ii. If Amvuttra is non-formulary; OR			
Agents	Wainua	injection	iii. Patient has already been started on Wainua.	1 year	Yes	Yes

				Approval	2025 NPF Excluded	Continuation of Therapy
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Duration	Medicaiton	Required?
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
Analgesics - Butalbital Containing Products		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/aspirin/caffeine capsule or tablet, butalbital/aspirin/caffeine capsule). If none are formulary, approve.	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 Converting Enzyme (ACE) Inhibitors	Qbrelis	lisinopril oral solution	<ol> <li>Approve if the patient has tried lisinopril tablets (Prinivl, Zestril, generics), if formulary. If lisinopril tablets (Prinivil, Zestril, generics) are non-formulary, approve.</li> <li>Approve if the patient cannot swallow or has difficulty swallowing tablets.</li> </ol>	1 year	Yes	
Angiotensin Receptor Blockers	Valsartan oral solution (previously Prexxartan)	valsartan oral solution	Direct the patient to valsartan tablets.     Approve if the patient is unable to or has difficulty swallowing oral tablets.	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/hydrochl orothiazide 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	s Avalide	irbesartan/hydrochloro thiazide 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	s 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	
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	s 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	

					2025 NPF	Continuation of
<b>-</b>				Approval	Excluded	Therapy
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Duration	Medicaiton	Required?
					MSB Exclusion	
Angiotensin Receptor			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Blockers (ARBs) and			Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Combination Products	Benicar HCT	othiazide tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
					MSB Exclusion	
Angiotensin Receptor			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Blockers (ARBs) and			Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Combination Products	Cozaar	losartan tablet	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
Ai-ti Dt			NOTE: A multipource Prend product is being requested. The potions about use the preferred bigoguius lent generic product		MSB Exclusion	
Angiotensin Receptor Blockers (ARBs) and			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.  Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		*This criteria applies only to	
Combination Products	Diovan	valsartan tablets	prescriber, Approved the binary found is being requested use to a non-intensity in the instance in types, lines, preservatives in between the binary required in the binary and the binary	1 year	the NPF	
			processor, remarkable to a regiment and green and a recommendation of the regiment and the resonance of the	. ,		
					MSB Exclusion	
Angiotensin Receptor			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Blockers (ARBs) and	D: 110T		Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Combination Products	Diovan HC1	hiazide tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
					MSB Exclusion	
Angiotensin Receptor			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Blockers (ARBs) and		valsartan/amlodipine	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Combination Products	Exforge	tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
Angietensin Desenter		vale arten/amile dinine/	NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		MSB Exclusion	
Angiotensin Receptor Blockers (ARBs) and		valsartan/amlodipine/ hydrochlorothiazide	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		*This criteria applies only to	
Combination Products	Exforge HCT	tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
					MSB Exclusion	
Angiotensin Receptor Blockers (ARBs) and		la a autam/hu dua ah la vath	NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.  Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		*This criteria applies only to	
Combination Products	Hyzaar	losartan/hydrochloroth iazide tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 vear	the NPF	
Combination 1 Todatio	riyzaar	ιαΣιασ τασιστο	presented, would result in a significant alongy of schools across reaction required.	1 your	uio ivi i	
					MSB Exclusion	
Angiotensin Receptor			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Blockers (ARBs) and	NA:i-	Ashada antan 1 1 1 1	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the	4	applies only to	
Combination Products	iviicardis	telmisartan tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
					MSB Exclusion	
Angiotensin Receptor			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Blockers (ARBs) and		telmisartan/hydrochlor	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Combination Products	Micardis HCT	othiazide tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
Angiotonoin Decenter		almooarton/amiadia	NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		MSB Exclusion	
Angiotensin Receptor Blockers (ARBs) and		olmesartan/amlodipin e/hydrochlorothiazide	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		*This criteria applies only to	
Combination Products	Tribenzor	tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
			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 formulary, 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).			
Angiotensin Receptor			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			
Blockers (ARBs) and Combination Products	Edarbyclor	azilsartan and chlorthalidone tablets	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 vear	Yes	
John Milation Floducts	Luarbycioi	ornortrandone tablets	gonoros), researan portros, como aran (morada, generos), or eprosaran. Il nore are formularly, approve.	ı yeai	103	

					2025 NPF	Continuation of
O.				Approval	Excluded	Therapy
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Duration	Medicaiton	Required?
			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			
ngiotensin Receptor	r		1. Approve in the patient has a treat tree of the following, in the are formularly of the mode are formularly. Calculated the following the formularly of the mode are formularly of th			
lockers (ARBs) and			Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement			
Combination Products		azilsartan	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	
	Norpace and			, , , , , , , , , , , , , , , , , , ,		
Anti-arrhythmic	disopyramide	disopyramide	1. Approve if the patient has tried two other anti-arrhythmic agents (e.g., amiodarone, quinidine, sotalol).			
gents	capsules	phosphate capsules	2. Approve if the patient has already been started on therapy with disopyramide (Norpace, generics) or Norpace CR.	1 year	Yes	Yes
_		disopyramide				
Anti-arrhythmic		extended-release	1. Approve if the patient has tried two other anti-arrhythmic agents (e.g., amiodarone, quinidine, sotalol).			
agents	Norpace CR	capsule	2. Approve if the patient has already been started on therapy with disopyramide (Norpace, generics) or Norpace CR.	1 year	Yes	Yes
					MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
		tobramycin solution	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Antibiotics (Inhaled)	TOBI	for inhalation	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
					MSB Exclusion	
		doxycycline hyclate	NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
	Doryx 50 mg, 200		Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Antibiotics (Oral)	mg	tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
			1. Approve if the patient has tried griseofulvin ultra 125 mg or 250 mg tablets, if formulary. If neither are formulary, approve.			
		griseofulvin	2. Approve if the prescribed dose cannot be obtained with whole tablets of the griseofulvin ultramicrosize 125 mg or 250 mg strengths.			
			3. Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use griseofulvin ultra 125 mg or 250 mg tablets.		.,	
Antibiotics (Oral)	Fulvicin P/G	tablets	A. Approve if the patient has been started on a course of therapy with Fulvicin P/G (to allow for completion of a course of therapy).	1 year	Yes	
			1. Approve if the patient has tried one of metronidazole 250 mg tablets or metronidazole 500 mg tablets. If neither are formularly, approve.			
			2. Approve if the prescribed dose cannot be obtained with whole tablets of the higher metronidazole strengths (i.e., 250 mg, 500 mg).			
Antibiotics (Oral)	metronidazole 125 mg tablets	metronidazole 125 mg tablets	3. Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use metronidazole 250mg or 500mg tablets.	4	V	
Antibiotics (Oral)	mg tablets	tablets	4. Approve if the patient has already started metronidazole therapy and the requested medication is being used to complete the course of therapy.	1 year	Yes	
			<ol> <li>Approve if the patient has tried linezolid tablets or oral suspension (Zyvox, generics), if formulary. If none are formulary, approve.</li> <li>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}].</li> </ol>			
		tedizolid phosphate	3. Approve if the patient is being treated for an organism that is resistant to linezolid (Zyvox, generics), but sensitive to Sivextro.			
Antibiotics (Oral)	Sivextro	tablets	4. Approve if the patient is being treated on a course of therapy with Sivextro (to allow for completion of a course of therapy).	1 year	Yes	
Antibiotics (Oral)	Doryx DR 80 mg	doxycycline hyclate	4. Approve if the patient has been started on a course of therapy with sivextro (to allow for completion of a course of therapy).	i yeai	162	
	and authorized	delayed-release	1. Direct patient to other doxycycline products.			
Antibiotics (Oral)	generic	tablets	1. Direct patient to the doxyyy-line products.  2. Approve if, per the prescriber, the 80 mg tablet is required to meet the prescriber dosing requirement.	1 year	Yes	
Antibiotics (Oral)	generio	doxycycline hyclate	z. Approve it, per the presentar, the 60 mg tablet is required to meet the presentated desing requirement.	i yeai	103	
		tablet, delayed-	1. Direct patient to other doxycycline products.			
Antibiotics (Oral)	Doryx MPC	release	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	
11112101100 (0141)	Boryx IIII O	metronidazole oral	1. Direct the patient to metronidazole tablets.	. you.	1.00	
Antibiotics (Oral)	Likmez	suspension	2. Approve if the patient is unable to swallow tablets or has difficulty swallowing tablets.	1 year	Yes	
(- /		<u>'</u>		ľ		
	Nitrofurantoin 50					
		nitrofurantoin 50 mg/5	1. Direct to nitrofurantoin 25 mg/5 ml oral suspension.			
Antibiotics (Oral)	(brand)	ml 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	
	Minolira and				Yes - Authorized	
Antibiotics (Oral)	authorized generic		Approve if the patient has tried minocycline extended-release tablets (Solodyn, generics), if formulary. If none are formulary, approve.	1 year	generic	
	Ximino and	minocycyline ER				
Antibiotics (Oral)	authorized generic	capsule	Approve if the patient has tried minocycline extended-release tablets (Solodyn, generics), if formulary. If none are formulary, approve	1 year	Yes	
	Firvanq and					
	authorized generic					
	vancomycin oral	vancomycin oral	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.			
Antibiotics (Oral)	solution	solution	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	
			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.			
		dabigatran etexilate	3. Patients currently receiving Pradaxa for treatment of thrombosis (e.g., deep vein thrombosis [DVT] or pulmonary embolism [PE]), approve.			
Anticoagulants (Oral)	Pradaxa	mesylate capsules	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	

					2025 NPF	Continuation of
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	Excluded Medicaiton	Therapy Required?
Therapy Class	Brand Name	Generic Name	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]).	Duration	Wedicalton	Required?
			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.			
Anticoagulants (Oral)	Pradaxa oral pellets	dabigatran oral pellets		1 year	Yes	
			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.			
			<ol> <li>Patients currently receiving Savaysa for treatment of thrombosis (e.g., deep vein thrombosis [DVT] or pulmonary embolism [PE]), approve.</li> <li>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.</li> </ol>			
Anticoagulants (Oral)	Savaysa	edoxaban tablets	4. Patients currently receiving Savaysa for prophylaxis of DVT or PE after orthopedic surgery (e.g., hip replacement surgery), approve.	1 year	Yes	
Anticoagalants (Oral)	Oavaysa	CONADAIT IADICIS	4. Patients currently receiving davaysa for propriyaxis or DVT or F.E. after ortropeute surgery (e.g., hip replacement surgery), approve.	i yeai	MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Antidepressants -			Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
	Wellbutrin SR	bupropion HCl tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
					MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Antidepressants -			Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Other	Wellbutrin XL	bupropion XL tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
		bupropion				
Antidonesconto	Farfixa VI and	hydrochloride extended-release	Patient is discated to humanian hydrophlaside VI 450 mg and/ay 200 mg tableto (Mallhuttin VI apparies)			
Antidepressants - Other	Forfivo XL and authorized generic	tablets	<ol> <li>Patient is directed to bupropion hydrochloride XL 150 mg and/or 300 mg tablets (Wellbutrin XL, generics).</li> <li>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).</li> </ol>	1 year	Yes	
Other	authorized generic	bupropion	2. Approve it, according to the prescriber, there is a significant diffical concern such that the patient is unable to use the pulproprior hydrochloride XL 130 mg and/or 300 mg tablets (Wellbuttin XL, generics).	i yeai	165	
		hydrobromide				
Antidepressants -		extended-release	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			
•	Aplenzin	tablets	non-formulary, approve.	1 year	Yes	
	'					
Antiemetic Agents -						
Substance					MSB Exclusion	
P/Neurokinin-1 (NK1)			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
receptor antagonists		fosaprepitant	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
(Injectable)	Emend IV	dimeglumine injection	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
Antiemetic Agents -			A Annual State of State of Color of Annual State of Color			
Substance			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.			
P/Neurokinin-1 (NK1) receptor antagonists		fosaprepitant	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.			
(Injectable)	Focinvez IV	intravenous infusion	4. Approve if the patient has already started Focinvez IV to complete all cycles in the current course of chemotherapy.	1 year	Yes	
(mjootablo)		maavonoao maolon	A report if the patient had an easy durited if definitely and of the state of the s	. you.		
Antiemetic Agents -						
Substance						
P/Neurokinin-1 (NK1)			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.			
receptor antagonists		aprepitant injectable	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.			
(Injectable)	Cinvanti IV	emulsion	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 -			Approve if the patient meets ONE of the following (1 or 2):			
Combination			1. Patient meets BOTH of the following (A and B):			
Substance P/NK1			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;			
receptor antagonist			AND			
and serotonin (5-HT3) receptor antagonist.		notunitont/nalanastra	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			
(Oral)	Akynzeo capsules	netupitant/palonsetron capsules	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 -	/ myrizeo capsules	oupauloa	An Approve if the pariorit has an easy statics Asyrized to complete all cycles in the outlient course of chemicine apy.	i yeai	100	
Serotonin (5-HT3)						
	ondansetron ODT	ondansetron ODT 16				
(Oral)	16 mg (brand)	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	
, ,	3 ( ====)		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 formularly	,		
			(gr only one if one is formulary). If neither are formulary, approve.			
Antiemetics -						
Antiemetics - Serotonin Receptor			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			
Antiemetics - Serotonin Receptor Antagonists (Oral and			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.			

					2025 NPF	Continuation of
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	Excluded Medicaiton	Therapy Required?
Therapy Class	Diana Name	Generic Name	Commercial L Cineta	Duration	MSB Exclusion	Requireu:
	Emend capsules		NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Antiemetics and	and Emend Trifold	aprepitant oral	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Antivertigo Agents	Pack	capsules	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].  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.	1 year	the NPF	
			<ol> <li>Approve if the patient has tried one formularly alternative from the following list: aprepliant capsules (Emend, generics) of various tablets. If notice are formularly, approve.</li> <li>Patients ≥ 12 and &lt;18 years of age: approve if the patient has tried aprepitant capsules (Emend, generics), if formularly. If aprepitant capsules (Emend, generics) are non-formularly, approve.</li> </ol>			
			3. Patients < 12 years of age: approve.			
Antiemetics and	Emend oral	aprepitant oral	4. Patients who cannot swallow or have difficulty swallowing capsules, approve.			
Antivertigo Agents	suspension	suspension	5. Approve if the patient has already started Emend oral suspension to complete all cycles in the current course of chemotherapy.	1 year	Yes	
		doxylamine succinate and pyridoxine				
		hydrochloride				
Antiemetics and		extended-release	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			
Antivertigo Agents	Bonjesta	tablets	non-formulary, approve if the patient has tried doxylamine AND pyridoxine (Vitamin B6).	1 year	Yes	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		MSB Exclusion *This criteria	
		posaconazole delaved	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Antifungals (Oral)	Noxafil tablets	release tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
,						
			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.			
Antifungals (Oral)	Tolsura	itraconazole capsules	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	
Antilungais (Orai)	Tolsula	ili acoriazoic capsules	The first including tributarion a diagnosis of onyclioning costs, the request should be defined regardless of what the patient has the or the current contained on the patient has an early been stanted on the product.	i year	MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
		oxiconazole nitrate	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Antifungals (Topical)	Oxistat Cream	cream	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
			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			
			2. In the patient rise an occurred rings infection, such as interrupt of erosio interruptions biastornycence, approve in the patient rise and, according to the prescriber has experienced inadequate emission of a significant moterance with two topical antifundals.			
		sertaconazole nitrate	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			
Antifungals (Topical)	Ertaczo	2% cream	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	
			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 antifundals.			
		oxiconazole nitrate	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			
Antifungals (Topical)	Oxistat lotion	lotion	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	
			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 antifundals.			
		econazole nitrate	with two topical antifungais.  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			
Antifungals (Topical)	Ecoza foam	topical foam	28 cream or foam (Extina, generics), Oxistat 1% lotion, oxiconazole 1% cream (Oxistat, generics), Etaczo 2% cream, Exelderm 1% cream or solution, ciclopirox 0.77% cream or get (generics), Mentax 1% cream, Xolegel 2% get.	1 year	Yes	
,						
			1. Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with four topical antifungals.			
	Exelderm and		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			
	authorized generic (sulconazole nitrate	sulconazole nitrate 1% (cream and	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,		Yes - Authorized	
Antifungals (Topical)	(Sulconazole filtrate	solution)	Note: Example of topical antitungais include: frainine 1% of 2% cream of 1% get (Naturi, generics), Naturi 2% get, Lourinin Offia (over-tine-counter [OTC]), clothinazole 1% cream (OTC formulation), econazole 1% cream, Ecoza 1% foam, ketoconazole 2% cream, ciclopirox 0.77% cream or get (generics), Luzu 1% cream, Mentax 1% cream, Xoleget 2% get.	1 year	generic only	
		,	1. Approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with four topical antifungals.	,	J	
			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.			
	Luzu and authorized		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%			
Antifungale (Tania-I)	generic (luliconazole 1% cream)		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,	1 1000	Voc	
Antifungals (Topical)	1 70 Cream)	cream	Xolegel 2% gel.	1 year	Yes	

					2025 NPF	Continuation of
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	Excluded Medicaiton	Therapy Required?
Therapy Class	Diana Name	Generic Name	Commercial L Criteria	Duration	Wedicalton	Required
			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			
Antifungals (Topical)	Xolegel	ketoconazole 2% gel	(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	
	carbinoxamine maleate 4 mg/5 ml		1. Approve if the patient has tried five oral antihistamines (e.g., clemastine, diphenhydramine, chlorpheniramine, carbinoxamine [generic], hydroxyzine, cetirizine, loratadine).			
	oral suspension		Note: OTC products would count toward meeting the requirement.			
	(brand) [authorized	carbinoxamine	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			
Antihistamines (oral) - First-generation	generic of Karbinal ER] and Karbinal ER	maleate 4 mg/5 ml	solution or syrup, clemastine syrup, cetirizine solution, or loratadine solution or syrup).  Note: OTC products would count toward meeting the requirement.	1 year	Yes	
Thot generation	Ertj and readinar Ert	orar suspension	From the product would could toward mooting the requirement.	1 your	MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Antimuscarinic Agents	Transderm-Scon	scopolamine patches	Criteria: Approve if the Brand product is being requested due to a formulation 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	applies only to the NPF	
7 than ideocarinio Agents	паначенн-осор	ocopolarillio pateries	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):	i yeai	alo IVI I	
		amantadine extended-	A. Patient derived benefit from immediate-release amantadine, but had intolerable adverse events, as determined by the prescriber [documentation required]; OR		,,	
Antiparkinson Drugs	Gocovri ER	release capsules	B. Patient could not achieve a high enough dosage to gain adequate benefit, as determined by the prescriber [documentation required].  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):	1 year	Yes	
		amantadine extended-	A. Patient derived benefit from immediate-release amantadine, but had intolerable adverse events, as determined by the prescriber [documentation required]; OR			
Antiparkinson Drugs	Osmolex ER	release tablets	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				
Carbidopa and/or		levodopa immediate-	Approve if dose prescribed cannot be obtained withcarbidopa-levodopa tablets (Sinemet, generics) or half-tablets.			
Levodopa Agents	Dhivy	release 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 –	_	foslevodopa- foscarbidopa	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.			
Carbidopa and/or		subcutaneous	2. Approve if the patient is unable to swallow oral dosage forms or has difficulty swallowing oral dosage forms.			
Levodopa Agents	Vyalev	infusion	3. Approve if the patient has already been started on therapy with Vyalev.	1 year	Yes	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
.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			an allowed of Addago, approve.	. ,		
Antiparkinson Drugs -						
Inhibitor of Monoamine Oxidase		selegiline orally	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.			
Type B Inhibitors	Zelapar		2. Approve if the patient cannot swallow or has difficulty swallowing selegiline tablets.	1 year	Yes	
Antiparkinson Drugs –						
Antiparkinson Drugs – Apomorphine				See PA		
products	Apokyn	apomorphine injection	See standard Parkinsons Disease Apomorphine Subcutaneous Prior Authorization Policy criteria	duration	Yes	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		MSB Exclusion *This criteria	
		clopidogrel bisulfaste	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Antiplatelet Agents	Plavix	tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		MSB Exclusion *This criteria	
			Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Antiprotozoals (Oral)	Alinia tablets	nitazoxanide tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
Antipsychotics (Long-			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			
Acting Injectables) –		paliperidone palmitate	significant concern for non-adherence with a 4-week or 3-month dosing interval.			
Risperidone or Paliperidone Based	Invega Hafyera	extended-release	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
i anpendone based	iiiveya i iaiyeia	injectable suspension	р. Арргоме в вве равеня наз авсаму всен Staticu On вветару мин вимена.	ı yeai	103	103

					2025 NPF	Continuation of
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	Excluded Medicaiton	Therapy Required?
Therapy Glass	Diana Hame	Generic Hame	Sommercia i E Silona	Duration	MSB Exclusion	Requireu
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
		aripiprazole tablets	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Antipsychotics (Oral)	Abilify	and oral solution	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
			NATE. A multi-course Deard product in being acquised. The potient should use the profused biographic product		MSB Exclusion	
		asenapine sublingual	NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.  Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		*This criteria applies only to	
Antipsychotics (Oral)	Saphris	tablets	personner, Approximate planta product a being required to a remaining of the product which, per the product which per the per	1 vear	the NPF	
				. ,	MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
		quetiapine fumarate	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Antipsychotics (Oral)	Seroquel	tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
					MSB Exclusion	
		quetiapine fumarate	NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Antipsychotics (Oral)	Seroquel XR	extended-release tablets	Criteria: Approve if the Brand product is being requested due to a formulation 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	applies only to the NPF	
unipsycholics (Oral)	Quetiapine 150 mg	quetiapine 150 mg	prescriber, would result in a significant airrigy or serious autories reaction (uccunentation required).  1. Direct to quetiapine 50 mg and/or quetiapine 100 mg tablets.	i yeai	ule IVF1	
Antipsychotics (Oral)	tablets	tablet	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)	Opipza	aripiprazole oral film	Approve if the patient has tried and cannot take ONE of aripiprazole ODT or aripiprazole oral solution. If neither are formulary, approve.	1 year	Yes	
					MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
			Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Antipsychotics (Oral)	Latuda	lurasidone tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
			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 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,			
			queriapine exteniou-necesse daniets [ceroquerixx, generics], aphipirazone tabiets, Mayan capsules, panipirazone tabiets, panipirazone tabiet			
		iloperidone tablets	2. Approve if the patient is currently taking Fanapt.			
Antipsychotics (Oral)	Fanapt	and titration pack	3. Approve if the patient has taken Fanapt at any time in the past.	1 year	Yes	Yes
			1. Approve if the patient has tried two other novel (atypical) antipsychotics.			
			Note: Examples of novel (atypical) antipsychotics include risperidone tablets/orally disintegrating tablets (ODT) [Risperdal, generics], Fanapt tablets, olanzapine tablets/ODT (Zyprexa/Zydis, generics), quetiapine tablets (Seroquel,			
Antipsychotics (Oral)			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, asenapine			
Muscarinic Agonist		xanomeline and	sublingual tablets (Saphris, generics), Caplyta.			
and Muscarinic	Cobenfy	trospium chloride capsules	2. Approve if the patient has already started therapy with Cobenfy. 3. Approve if the patient has taken Cobenfy at any time in the past.	1 vear	Yes	Yes
Milagoriistj	Coberny	capsules	3. Approve if the patient has taken Coberny at any time in the past.	i yeai	MSB Exclusion	162
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Antiseizure		rufinamide tablets and	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Medications	Banzel	oral suspension	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
					MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Antiseizure	.,	levetiracetam tablets	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Medications	Keppra	and solution	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
		levetiracetam	NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		MSB Exclusion *This criteria	
Antiseizure		exteended-release	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Medications	Keppra XR	tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 vear	the NPF	
			production in the degramment with gramment with the control of the	. ,	MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Antiseizure		lamotrigine tablets	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Medications	Lamictal	and chewable tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
					MSB Exclusion	
		I tolonia I	NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Antiseizure Medications	Lamictal ODT	lamotrigine oral disintegrating tablets	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the	1 vear	applies only to the NPF	
ricultations	Lamilulai OD I	disintegrating tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	i yeai	MSB Exclusion	
			INOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Antiseizure		lamotrigine extended-	NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.  Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		*This criteria applies only to	

					2025 NPF	Continuation of
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	Excluded Medicaiton	Therapy Required?
тнегару отазэ	Diana Name	Ceneric Hame	Commercial E Official	Duration	MSB Exclusion	rtequireu:
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Antiseizure		clobazam tablets and	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Medications	Onfi	suspension	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
					MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Antiseizure	0 - 111	3	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the	4	applies only to	
Medications	Sabril	powder packet	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		MSB Exclusion *This criteria	
Antiseizure			Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Medications	Topamax	topiramate tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
, out out on o	roparrax	topiramato tabloto	production, would recar in a digital country of actions advised recards the following	. you.	MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Antiseizure		oxcarbazepine tablets	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Medications	Trileptal	and suspension	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
					MSB Exclusion	
		lacosamide tablets	NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Antiseizure		and oral solution and	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Medications	Vimpat	vials	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
			NOTE: A sufficiency Board and this believe would be a first board and the confined by a sufficient and the		MSB Exclusion	
N4!!			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Antiseizure Medications	Zonegran	zonisamide capsule	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the	1 year	applies only to the NPF	
Antiseizure	topiramate 50 mg	topiramate 50 mg	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].  1. Approve if the patient has tried topiramate 25 mg sprinkle capsules. If topiramate 25 mg sprinkle capsules are non-formulary, approve.	ı year	the NPF	
Medications	sprinkle capsule	sprinkle capsule	1. Approve if according to the prescriber, there is a significant clinical concern such that the patient is unable to use topiramate 25 mg sprinke capsules are interiorinally, approve.  2. Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use topiramate 25mg sprinkle capsules.	1 vear	Yes	
viculcations	Sprinkie capsuic	эртике сарзае	2. Approve it, according to the presented, there is a significant clinical content such that the patient is unable to use optimizate 25th g sprinter capsures.	i yeai	103	
Antiseizure		lacosamide extended-				
Medications	Motpoly XR	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	Zonisade oral	zonisamide oral		1		
Medications	suspension	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		vigabatrin oral				
Medications	Vigafyde	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	Primidone 125 mg	primidone 125 mg	Approve if the patient's prescribed dose cannot be obtained with primidone 50 mg or 250 mg tablets.			
Medications	(brand)	tablet	Note: The patient is NOT required to split the 250 mg tablets in half.	1 year	Yes	
Antiseizure	F:	fenfluramine oral			V	.,
Medications	Fintepla	solution	See standard Antiepileptics – Fintepla Prior Authorization Policy criteria.	1 year	Yes	Yes
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	
viculcations	<u> гргониа</u>	Solution	1. Approve if the patient has tried diazepam rectal gel (Diastat, generics), if formulary, approve.	i yeai	163	
Antiseizure		diazepam buccal film	Note: If the patient has tried a benzodiazepine nasal spray (e.g., Valtoco or Nayzilam), this would satisfy the requirement for approval.			
Medications - Buccal	Libervant	strips	2. If the patient's caregiver is unable to administer dia type m rectal gel (Diastat, generics), approve.	1 year	Yes	
				T	MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
		valacyclovir HCl	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Antivirals (Oral)	Valtrex	caplets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
		acyclovir buccal	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			
Antivirals (Oral)	Sitavig	tablets	Zovirax 5% cream, generics), or over-the-counter (OTC) Abreva 10% cream.	1 year	Yes	
			NOTE: A sufficient Conductable below and at The state body and a sufficient below to sufficient and at		MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Antivirale (Tanias)	Zovirov ointmost	acyclovir E% cintment	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the	1 voor	applies only to the NPF	
Antivirals (Topical)	Zovirax ointment	acyclovir 5% ointment	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	ule INPF	
		acyclovir and hydrocortisone cream,	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,			
Antivirals (Tonical)	Yerese			1 year	Ves	
Antivirals (Topical)	Xerese	5%/1%	generics), Sitavig tablets, or over-the-counter (OTC) Abreva 10% cream.	1 year	Yes	

					2025 NPF	Continuation of
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	Excluded Medicaiton	Therapy Required?
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Duration	Wedicalton	Required?
			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].			
			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 (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 brand 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,			
Aromatase inhibitor	Arimidex	anastrozole tablets	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	
Alomatase illibitor	Allilidex	ariastrozole tablets	Note: When compliance with the Antordable Care Act, most Guidelines, and First Act section 27 is is NOT required, these products would be reviewed under the Standard Commercial Detault Chiefla.	i yeai	ule INFF	
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	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	

					2025 NPF	Continuation of
				Approval	Excluded	Therapy
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Duration	Medicaiton	Required?
			NOTE: A sufficiency Decident destricts in the content of The artists the cold on the configuration of the content of the conte		MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Denzadiozoninea	Xanax XR	alprazolam entended- release tablets	Criteria: Approve if the Brand product is being requised due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the	1	applies only to the NPF	
Benzodiazepines	Adriax AR	release lablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
		lorazepam extended-	1. Direct the patient to use lorazepam tablets.			
Benzodiazepines	Loreev XR	release capsules	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	
Болговіагоріпов	Doral and authorized		En Approve is, deserving to the presented, where to a digital content out that the patient to another influence to the influe	1 your	100	
Benzodiazepines	generic	guazepam tablets	Approve if the patient has tried estazolam or lorazepam, if formulary. If neither are formulary, approve.	1 vear	Yes	
'	3	· ·		<u> </u>	Yes	
		chlordiazepoxide/clidi			*This criteria	
Benzodiazepines and		nium bromide			applies only to	
Combination Products	Librax	capsules	Approve if the patient has tried clidinium-chlordiazepoxide capsules. If clidinium-chlordiazepoxide capsules are non-formulary, approve.	1 year	the NPF	
					MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Beta-Blocker			Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Products	Bystolic	nebivolol tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
Beta-Blocker	labetalol 400 mg	labetalol 400 mg	1. Direct the patient to labetalol 100 mg, 200 mg, or 300 mg tablets.			
Products	tablets	tablets	2. Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use the labetalol 100 mg, 200 mg, or 300 mg tablets.	1 year	Yes	
			h		MSB Exclusion	
Beta-Blocker and			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Beta-Blocker Combination Products	. In density	propranolol HCI	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the	4	applies only to the NPF	
Combination Products	s Inderal LA	capsules	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year		
Beta-Blocker and		metoprolol succinate	NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		MSB Exclusion *This criteria	
Beta-Blocker		extended-release	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive injection, [in], [in		applies only to	
Combination Products	Toprol XI	tablets	personiber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
Combination Froducts	TOPIOIAE	propranolol	production, would recar in a digital carried advisor reaction [section and advisor required].	1 your	110 141 1	
Beta-Blocker and		hydrochloride				
Beta-Blocker		capsule, extended	1. Direct the patient to propranolol extended-release capsules.			
Combination Products	Inderal XL	release	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	
		propranolol				
Beta-Blocker and		hydrochloride				
Beta-Blocker		capsule, extended	1. Direct the patient to propranolol extended-release capsules.			
Combination Products	Innopran XL	release	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		metoprolol succinate				
Beta-Blocker		extended-release	1. Approve if the patient has tried metoprolol succinate extended-release tablets, if formulary. If non-formulary, approve.	4	V	
Combination Products	Kapspargo Sprinkie	capsules	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	
			A necessity to the second to the recognition to the			
			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, qenerics], ibandronate tablets [Boniva, generics], alendronate oral solution, Binosto, risedronate [Actonel, Atelvia, generics], a teriparatide product (i.e., Forteo, teriparatide), Tymlos, or Prolia.			
			generics), ibandronate tablets [Boniva, generics], alendronate oral solution, Binosto, risedronate [Actione, Atelvia, generics], a temparatide product (i.e., Forteo, temparatide), Tymios, or Prolla.  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).			
		romocozumob ozza	4. Patients who have had an osteoporotic fracture or a fragility fracture: approve.			
Bone Modifiers -		romosozumab-aqqg injection for	<ul><li>Fatients 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.</li></ul>			
Other	Evenity	subcutaneous use	Note: Examples of pre-existing gastrointestinal medical conditions include esophageal lesions, esophageal ulcers, or abnormalities of the esophageal and telay esophageal which telay the control of the	1 vear	Yes	
0 11.07	only	San Satario Gao Gao	1220. Examples of the contains account medical contained cooping out to cooping out and cooping out and cooping out and cooping out and cooping out to coopi	. Jour	. 55	

					2025 NPF	Continuation of
				Approval	Excluded	Therapy
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Duration	Medicaiton	Required?
Bone Modifiers -		denosumab injection	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], isbandronate tablets [Boniva, generics], alendronate oral solution, Binosto, risedronate [Actone], 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 or depot suspension], Eligard [leuprolide acetate for injectable suspension], Trelstar (triptorelin pamoate suspension injection), Zoladex (goserelin implant), Orgovyx (relugolix tablets).  7. 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 androgen deprivation therapy include Lupron Depot [leuprolide for depot suspension], Eligard [leuprolide acetate for injectable			requirer
Other	Prolia	for subcutaneous use	9. Treatment to increase bone mineral density in patients with breast cancer: approve.	1 year	Yes	
Bone Modifiers - Other	Forteo		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-	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 vear	Yes	Yes
Fibuucis	Daxxiiy	namm for injection	<u>protes. La amples of cosmetic uses include facial mytiques, nown lines, gradetial withhining, nortzonial neuk mytiques, find and tower face and neck rejuveriation, platsyffial ballus, of rejuveriation of the periodicial region.</u>	i yeai	169	169

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
			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 a sensitivity or allergy to cow's milk protein, approve if the patient has tried one of Botox is non-formulary. 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.			
Botulinum Toxin Products	Xeomin	incobotulinumtoxinA for injection	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
			Sialornhea, Chronic, in a patient ≥ 18 years of age.  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.  Anal Fissure, Chronic, in a patient ≥ 18 years of age.  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.  Hemilfacial Spasm in a patient ≥ 18 years of age.  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 stried Dysport, if formulary. If Dysport is non-formulary, approve.  3. Approve if the patient has already been started on therapy with Botox.  Oromandibular Dystonia in a patient ≥ 18 years of age.  1. Approve if the patient has stried Dysport, if formulary. If Dysport is non-formulary, approve.  2. Approve if the patient has already been started on therapy with Botox.  Neurogenic Detrusor Overactivity in a 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.  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 in a patient ≥ 18 years of age; Hyperhidrosis, Gustatory (also referred to as Frey's Syndrome) in a patient ≥ 18 years of age; Hyperhidrosis, Gustatory (also referred to as Frey's Syndrome) in a patient ≥ 18 years of age; Hyperhidros			
Botulinum Toxin	Botox (NOT	onabotulinumtoxinA for injection	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: Approve.  Botox is not covered in the following situations: Cosmetic Uses.	1 year		
Products - Botox	cosmetic) [2 of 2]	(continued)	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.	(continued)	Yes	

				A	2025 NPF Excluded	Continuation of
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	Medicaiton	Therapy Required?
			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			
			ger).			
			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 is < 10 years of age, approve.			
			Strabismus in a patient ≥ 12 years of age: Approve.			
			Note: Common types of strabismus include esotropia, hypertropia, hypertropia.			
			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.			
Botulinum Toxin	Botox (NOT	onabotulinumtoxinA	<ul> <li>a. Patient has a sensitivity or allergy to cow's milk protein, approve.</li> <li>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.</li> </ul>			
Products - Botox	cosmetic) (1 of 2)	for injection	4. Approve if the patient has already been started on therapy with Botox.	1 year	Yes	Yes
			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):			
		PEG-3350, sodium	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			
Bowel Evacuants –		sulfate, sodium	ii. 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		MCD Evaluation	
Low Volume – Polyethylene Glycol		chloride, potassium chloride, sodium	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		MSB Exclusion *This criteria	
(PEG)-based		ascorbate, ascorbic	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,		applies only to	
Preparations	Moviprep	acid	would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	

					2025 NPF	Continuation of
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	Excluded Medicaiton	Therapy Required?
Bowel Evacuants – Low Volume – Polyethylene Glycol (PEG)-based		polyethylene glycol; electrolytes; ascorbic acid powder for	Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required.  Approve if the patient meets one of the following criteria (i or 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  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, ii, or 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 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			
Bowel Evacuants – Low Volume – Sodium Preparations	Plenvu	sodium picosulfate; magnesium oxide; anhydrous citric acid solution	Compliance with the Affordable Care Act. HRSA Guidelines, and PHS Act section 2713 is NOT required.  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.  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, if formulary: 1) PEG3350/Ascorbic Acid powder packet (Moviprep, generic) OR 2) Sod Sul-Potass Sul-Magnesium sol prep kit (Suprep, generic). If neither are formulary, approve; OR  b. Patient is 1s < 12 years of age.  2. If only PEG3350/Ascorbic Acid powder (Moviprep, generic) is formulary, approve; OR  b. Patient is 1s < 12 years of age.  2. If only PEG3350/Ascorbic Acid powder (Moviprep, generic). If neither are formulary, approve; OR  b. Patient is 1s < 12 years of age.  2. If only PEG3350/Ascorbic Acid powder (Moviprep, generic). If PEG3350/Ascorbic Acid powder packet (Moviprep, generics) are non-formulary, approve; OR  b. Patient is less than 18 years of age.  2. If only PEG3350/Ascorbic Acid powder (Moviprep, generics). If PEG3350/Ascorbic Acid powder packet (Moviprep, generics) are non-formulary, approve; OR  b. Patients with plucose-6-phosphate dehydrogenase deficiency.  3. Patient meets to be the following (a mid 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	1 month	Yes	
Bowel Evacuants – Low Volume – Sodium Sulfate- Based Preparations		magnesium sulfate; potassium sulfate; sodium sulfate solution	b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.  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 patient meets both of the following (i and ii):  ii. 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  iii. The Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent gene	1 month	MSB Exclusion *This criteria applies only to the NPF	

					2025 NPF	Continuation of
				Approval	Excluded	Therapy
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Duration	Medicaiton	Required?
Bowel Evacuants – Low Volume – Polyethylene Glycol (PEG)-based Preparations  Bowel Evacuants – Low Volume – Sodium Sulfate-based	Suflave		Combilance 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, approve if the patient meets one of the following criteria (a, b, gr c):  a. Patient has tried PEG3350/Ascorbic Acid powder packet (Moviprep, generics) are non-formulary, approve; OR  b. Patients with glucose-6-phosphate deliydrogenase deficiency.  OR  Compilance 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, gr c):  a. Patient has tried PEG3350/Ascorbic Acid powder packet (Moviprep, generics) are non-formulary, approve; OR  b. Patients with phenylectronics: OR  c. Patients with glucose-6-phosphate delhydrogenase deficiency.  3. Patient meets both of the following is grace processed (Moviprep, generics). If PEG3350/Ascorbic Acid powder packet (Moviprep, generics) are non-formulary, approve; OR  c. Patients with glucose-6-phosphate dehydrogenase deficiency.  3. Patient meets both of the following is gand b):  a. The requested non-formulary dug 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.  Compilance with the Affordable Care Act. HRSA Guidelines. and PHS Act section 2713 is NOT required.  1. Approve	1 month	Yes	Required?
Preparations	Sutab	chloride tablets	b. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.	1 month	Yes MSB Exclusion	
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	*This criteria applies only to the NPF	
			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			
Calcium Channel Blockers (CCBs)	Conjupri and levamlodipine	levamlodipine tablets	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	raimosipino	amlodipine oral	2. If the patient to amilodipine tablets.	. ,		
Blockers (CCBs)	Katerzia	suspension	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		amlodipine oral	1. Direct the patient to amlodipine tablets.			
Blockers (CCBs)	Norliqva	solution	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	
Cancer (Injectable) –						
Bortezomib Agents	Boruzu	bortezomib injection	Approve if the patient has tried bortezomib injection (Velcade, generics) if formulary. If bortezomib injection (Velcade, generics) are non-formulary, approve.	1 year	Yes	
			, , -, 3,, 3, 3, 3, 3, 3, 3, 3, 3, 3	,		
Cancer (Injectable) -		pemetrexed	1. Approve if the patient has tried one other pemetrexed injectable product.		V	
Pemetrexed Agents	Axtle	intravenous infusion	2. If generic pemetrexed injectable is not available or formulary, approve.	1 year	Yes	

					2025 NPF	Continuation of
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	Excluded Medicaiton	Therapy Required?
Thorapy Glass	Diana Hamo	Generio Hamo	FLT3-ITD Mutation-positive Acute Myeloid Leukemia.	Burution	Modification	rtoquirou:
			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.			
Cancer (Oral) – FMS-			Note: The mailtenance setting is therapy after consolidation chemotherapy.			
Like Tyrosine Kinase 3 Inhibitors for AML	Vanflyta	guizartinib tablets	<ol> <li>If, according to the prescriber, the patient has or is at risk for pulmonary toxicity, approve.</li> <li>Approve if the patient has already been started on Vanflyta therapy.</li> </ol>	1 year	Yes	Yes
O ITTIIDICOTO TOT 7 TAVIL	varmyta	quizar arrib tabloto	Acute myeloid leukemia with isocitrate dehydrogenase-1 (IDH1) mutation positive disease in a patient ≥ 18 years of age.	1 your	100	100
Cancer (Oral) -			1. Approve if the patient has tried Tibsovo. If Tibsovo is non-formulary, approve.			
Isocitrate			2. Approve if the patient has QTc prolongation OR is or will be taking medications that can prolong the QTc interval.			
Dehydrogenase-1			3. Patients with Guillain-Barre, approve.			
Inhibitors	Rezlidhia	olutasidenib capsules	4. Approve if the patient has already been started on Rezlidhia therapy.	1 year	Yes	Yes
			Multiple Myeloma.			
			Approve if the patient meets ONE of the following (A or B):  A. Patient meets ONE of the following (i, ii, or iii):			
			i. Patient mest once of the following (i, n, <u>n</u> <u>n</u> ).  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 TWO prior regimens for multiple myeloma; AND			
			b) The medication will be taken in combination with Pomalyst (pomalidomide capsules); 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 bortezomib, Darzalex (daratumumb infusion), Darzlaex Faspro (daratumumab and hyaluronidase-fihj injection), or Kyprolis (carfilzomib intravenous infusion); OR			
			b) The inequation will be taken in continuous with but each in continuous with each each each each each each each eac			
			infusion)/lenalidomide/dexamethasone, Darzalex (daratumumab intravenous infusion)/bortezomib or Kyprolis/dexamethasone, or other regimens containing a proteasome inhibitor, immunomodulatory drug, and/or anti-CD38 monoclonal			
			antibody.			
			B. Patient has already been started on therapy with Xpovio.			
			Diffuse Large B-Cell Lymphoma; High-grade B-Cell Lymphoma; HIV-related B-Cell Lymphoma; Post-transplant lymphoproliferative disorders.			
Cancer Agent –			Note: Diffuse Large B-Cell Lymphoma includes patients with histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma.			
Multiple Myeloma			Approve if the patient meets ONE of the following (A or B):			
Nuclear Export Inhibitor	Xpovio	selinexor tablets	A. Patient has tried at least TWO prior therapies; OR B. Patient has already been started on therapy with Xpovio.	1 year	Yes	Yes
ITITIDICOI	Αρονίο	Selification tablets	b. r atient has already been stanted on therapy with Apovito.	i yeai	165	163
Cancer Agent			Biliary Tract Cancer in which the tumor is human epidermal growth factor receptor 2 (HER2) positive with immunohistochemistry score of 3+ (IHC3+) as determined by an approved test in a patient ≥ 18 years of age.			
(Intravenous) -			1. Approve if the patient has tried one of the following regimens or, according to the prescriber, all the regimens are contraindicated (A, B, or C):			
Bispecific Human			A. Enhertu; OR			
Epidermal Growth			B. Trastuzumab plus Perjeta; OR			
Factor Receptor 2			C. Trastuzumab plus Tukysa.			
(HER2)-Directed Antibody	7:::	zanidatamab-hrii	Note: If none of these products are formulary approve: Enhertu, Perjeta, Tukysa.	4	V	V
Aridbody	Ziihera	intravenous infusion	2. Approve if the patient has already been started on therapy with Ziihera.	1 year	Yes MSB Exclusion	Yes
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
			Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Cancer Agent (Oral)	Targretin capsule	bexarotene capsule	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
Cancer Agents –						
(Injectable) -						
Docetaxel intravenous	3	docetaxel intravenous				
infusion	Docivyx	infusion	Approve if the patient has tried generic docetaxel. If generic decetaxel is non-formulary, approve.	1 year	Yes	
			Acute Myeloid Leukemia: Approve if the patient meets ONE of the following (1 OR 2):			
Cancer Agents -			1. Patient is ≥ 18 years of age and using the medication for post-remission maintenance; OR			
Acute myeloid leukemia (AML)			2. The patient has been started on therapy with Onureg.			
Agents	Onureg	azacitadine tablets	Peripheral T-Cell Lymphoma: Approve.	1 year	Yes	Yes
Consor Agents		bendamustine	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			
Cancer Agents – Bendamustine Agents	Vivimueta	hydrochloride intravenous infusion	Belrapzo. If none are formulary, approve.  NOTE: A trial of the requested agent would NOT count toward this requirement.	1 vear	Yes	
Dendamustine Agents	viviilluSta	III avenous III uslon	INVIE. A tial of the requested agent would not count toward this requirement.	i yeai	169	

					2025 NPF	Continuation of
				Approval	Excluded	Therapy
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Duration	Medicaiton	Required?
Cancer Agents -		bevacizumab-maly	Approve if the patient meets BOTH of the following (A and B):  A. The patient has tried three of the following: Avastin, Myasi, 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			
Bevacizumab-		injection for	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, and/or surfactant] which, according to the prescriber,			
containing Agents	Alymsys	intravenous infusion	would result in a significant allergy or serious adverse reaction.	1 year	Yes	
			Approve if the patient meets BOTH of the following (A and B):			
Cancer Agents -		l	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			
Bevacizumab- containing Agents	Vegzelma	bevacizumab-adcd intravenous infusion	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 vear	Yes	
containing Agents	vegzeima	initiavenous initiasion	Approve if the patient meets BOTH of the following (A and B):	i yeai	165	
Cancer Agents -			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			
Bevacizumab-		bevacizumab injection	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,			
containing Agents	Avastin	for intravenous use	would result in a significant allergy or serious adverse reaction.	1 year	Yes	
			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.			
			2. r dient has alleady been statled on therapy with Couliny.			
Cancer Agents -			Human Immunodeficiency Virus (HIV)-Related B-Cell Lymphomas			
Bispecific Antibodies		glofitamab	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.			
for B-Cell Lymphomas	Columvi	intravenous infusion	<u>Post-Transplant Lymphoproliferative Disorders</u> : Approve.	1 year	Yes	Yes
			<u>Diffuse Large B-Cell Lymphoma</u> .			
			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			
			2. 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.			
			3. Fallent has alleady been statled on therapy with Epithiny.			
Cancer Agents –		epcoritamab-bysp	Human Immunodeficiency Virus (HIV)-Related B-Cell Lymphomas			
Bispecific Antibodies		subcutaneous	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.			
for B-Cell Lymphomas	Epkinly	injection	<u>Post-Transplant Lymphoproliferative Disorders</u> : Approve.	1 year	Yes	Yes
			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.			
			Character Language and the Language Court Language and La			
			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			
			A retering the other or brunings of cargedies, And			
			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).			
			II. Fatient is not a canitude on intuininat or Gazyya (unintuizuniati).  2. Patient has already been started on Jaypirca therapy, approve.			
Cancer Agents -						
Bruton Tyrosine			Richter's Transformation to Diffuse Large B-Cell Lymphoma; Marginal Zone Lymphoma: Approve.			
Kinase Inhibitors	Jaypirca	pirtobrutinib tablets	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 -						
Kinase inhibitor				See D4		
(phosphatidylinositol 3 kinase [PI3K])	Itovebi	inavolisib tablets	See Oncology – Itovebi Prior Authorization Policy criteria.	See PA duration	Yes	
		avoliolo tabioto	poor onvoigy - north real real one district only district.	Garadon	. 30	

					2025 NPF	Continuation of
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	Excluded Medicaiton	Therapy Required?
Therapy Class	Brand Name	Generic Name	Non-Small Cell Lung Cancer - KRAS G12C-mutated.	Duration	Wiedicalton	Requireu:
			1. Approve if the patient has tried Lumakras. If Lumakras is non-formulary, approve.			
			2. Patient with brain metastases, approve.			
Cancer Agents -			3. Approve if the patient has already been started on therapy with Krazati.			
Kirsten rat sarcoma			Colon or Rectal Cancer - KRAS G12C-mutated; Ampullary Adenocarcinoma - KRAS G12C-mutated; Biliary Tract Cancer - KRAS G12C-mutated; Pancreatic Adenocarcinoma - KRAS G12C-mutated; Small Bowel Adenocarcinoma -			
(KRAS) inhibitor	Krazati	adagrasib tablets	KRAS G12C-mutated: Approve.	1 year	Yes	Yes
Cancer Agents - NSCLC (Oral) -MET			Non-Small Cell Lung Cancer (NSCLC) with mesenchymal-epithelial transition (MET) exon 14 skipping alterations or high-level MET amplification:			
receptor tyrosine			1. Approve if the patient has tried Tabrecta. If Tabrecta is non-formulary, approve.			
kinase inhibitor	Tepmetko	tepotinib tablets	2. Approve if the patient has already been started on Tepmetko.	1 year	Yes	Yes
			BRCA-mutated Prostate Cancer.			
Cancer Agents - PARP		niraparib and	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.			
inhibitor/Prostate		abiraterone acetate	Note: If Lynparza is non-formulary, approve.			
Cancer Agent	Akeega	tablets	2. Approve if the patient has already been started on therapy with Akeega.	1 year	Yes	Yes
			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			
			II. Patient has already been stated on the tapy with Zejula, OK  B) Patient meets both of the following (i and ii):  (ii) The 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. <u>Uterine Leiomyosarcoma</u> : Approve if the patient meets one of the following (A <u>or</u> B):			
Cancer Agents - PARP Inhibitors (oral)	Zojulo	niraparib capsules and tablets	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
PARE IIIIIDILOIS (OIAI)	Zejula	and tablets		i yeai	162 - 7/1	res
			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. <u>Uterine Leiomyosarcoma</u> : Approve if the patient meets one of the following (A <u>or</u> B):			
			A) Patient has tried one of Zejula or Lynparza. If neither is formulary, approve; OR			
Cancer Agents -			B) Patient has already started on Rubraca.			
PARP Inhibitors (oral)	Rubraca	rucaparib tablets	4. Pancreatic Adenocarcinoma: approve.	1 year	Yes- 7/1	Yes
Cancer Agents -			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		MSB Exclusion *This criteria	
Prostate Cancer		abiraterone acetate	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
(Oral)	Zytiga	tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
					MSB Exclusion	
Cancer Agents - Renal Cell Carcinoma		everolimus tablets for	NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Renai Celi Carcinoma (Oral)	Afinitor Disperz	oral suspension	Criteria: Approve if the Brand product is being requested due to a formulation 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	applies only to the NPF	
( - /				,	MSB Exclusion	
Cancer Agents -			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Renal Cell Carcinoma	1		Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
(Oral)	Afinitor tablet	everolimus tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
			Renal Cell Carcinoma. Approve if the patient meets one of the following (1, 2, or 3):			
Cancer Agents -			1. Patient has tried one of Inlyta, Lenvima, or Cabometyx. If none are formulary, approve; OR			
Renal Cell Carcinoma			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			.,
(Oral)	Fotivda	tivozanib capsules	3. Patient has already been started on therapy with Fotivda.	1 year	Yes	Yes
			Approve if the patient meets BOTH of the following (A and B):  A. Patient has tried 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): Herceptin intravenous, Kanjinti, Trazimera, Ogivri, Ontruzant, or Herzuma;			
			A. Patient has tried 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: Herceptin intravenous, Kanjinti, Trazimera, Ogivn, Ontruzant, or Herzuma; AND			
Cancer Agents -			Note: If none are formulary, approve.			
Trastuzumab-		trastuzumab-strf for	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			
containing Agents	Hercessi	intravenous injection	result in a significant allergy or serious adverse reaction.	1 year	Yes	

					2025 NPF	Continuation of
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	Excluded Medicaiton	Therapy Required?
Cancer Agents - Trastuzumab- containing Agents	Herceptin	trastuzumab for intravenous injection	Approve if the patient meets BOTH of the following (A and B):  A. Patient has tried 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): Hercessi, 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.	1 year	Yes	
Cancer Agents - Trastuzumab- containing Agents	Herceptin Hylecta	trastuzumab and hyaluronidase-oysk for subcutaneous use	<ol> <li>Approve if the patient has tried one product from the following list (if one is formulary): Herceptin intravenous, Hercessi, Kanjinti, Trazimera, Ogivri, Ontruzant, or Herzuma. If none are formulary, approve.</li> <li>Approve if the patient is unable to obtain and/or maintain intravenous access.</li> <li>If the patient has already been started on therapy with Herceptin Hylecta, approve.</li> </ol>	1 year	Yes	Yes
Cancer Agents - Trastuzumab- containing Agents	Herzuma	trastuzumab-pkrb for intravenous injection	Approve if patient meets BOTH of the following (A and B):  A. Patient has tried 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): Herceptin intravenous, Hercessi, 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.	1 year	Yes	
Cancer Agents - Trastuzumab- containing Agents	Ogivri	trastuzumab- dkst intravenous injection	Approve if the patient meets BOTH of the following (A and B):  A. Patient has tried 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): Hercessi, 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.	1 year	Yes	
Cancer Agents - Trastuzumab- containing Agents	Ontruzant	trastuzumab-dttb for intravenous injection	Approve if the patient meets BOTH of the following (A and B):  A. Patient has tried 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): Hercessi, 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.	1 year	Yes	
Cancer Agents - Tyrosine Kinase Inhibitors	Gleevec	imatinib tablets	NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.  Criteria: Approve if the Brand product is being requested due to a formulation 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 - 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) + Mektori (binimetinib tablets), Zelboraf (vemurafenib tablets) + Cotellic (cobimetinib tablets), Braftovi (encorafenib capsules) + Mektori (binimetinib tablets).  Approve if the patient has already been started on therapy with Qinlock.  Approve if the patient has tried one of dichlorphenamide tablets or Ormalvi, if formulary.	1 year	Yes	Yes
Carbonic Anhydrase Inhibitors	Keveyis and generics (including dichlorphenamide tablets, Ormalvi)	dichlorphenamide tablets	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	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	

					2025 NPF	Continuation of
				Approval	Excluded	Therapy
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Duration	Medicaiton MSB Exclusion	Required?
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Cardiovascular			Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Medications - Other	Tikosyn	dofetilide capsules	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
			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.			
Cardiovascular		ranolazine extended-	INDIE: I WO products in the same class would satisfy this chierion.  B. Patient has difficulty swallowing oral dosage forms and is unable to try a beta-blocker, calcium-channel blocker, or a nitrate: OR			
Medications - Other	Aspruzyo Sprinkle	release granules	C. Patient has already been started on a ranolazine product (e.g., Ranexa, Aspruzyo Sprinkle).	1 year	Yes	
	' ' '		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, <u>or</u> 3):			
Cardiovascular		ivabradine tablets and	<ol> <li>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</li> <li>Heart failure due to dilated cardiomyopathy, approve if the patient is &lt; 18 years of age; OR</li> </ol>			
Medications - Other	Corlanor	solution	3. Patient has already been started on Corlanor or ivabradine.	1 vear	Yes	Yes
viculcations - Other	Contanto	Solution	5. Faltient has already been started on Conation of Ivabradine.	i yeai	MSB Exclusion	103
Central Nervous			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
System Non-		guanfacine HCI	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Stimulants	Intuniv	tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
					MSB Exclusion	
Central Nervous			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
System Non- Stimulants	Strattera	atomoxetine HCI	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the	4	applies only to the NPF	
Sumulanis	Strattera	capsules clonidine	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
Central Nervous		hydrochloride				
System Non-		extended-release oral	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.			
Stimulants	Onyda XR	suspension	2. Approve if the patient is unable to swallow tablets or has difficulty swallowing tablets.	1 year	Yes	
Central Nervous					MSB Exclusion	
System Stimulants –			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Amphetamine			Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Products	Adderall	mphetamine tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
Central Nervous System Stimulants –		dextroamphetamine/a	NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		MSB Exclusion *This criteria	
Amphetamine			Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Products	Adderall XR	release capsules	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
Central Nervous		,			MSB Exclusion	
System Stimulants –			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Amphetamine		amphetamine sulfate	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Products	Evekeo	tablet	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
			A Assessed if the patient has brief and according to the procedure to the			
Central Nervous			1. 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,			
System Stimulants –		amphetamine	amplietamine mixed extended-release (E1) capsules (Adderail AR, generics), or 2) Adzenys AR ODT tablets, or 3) isdexametamine capsules (vyvarise capsule, generics) or isdexametamine capsules (vyvarise capsule).			
Amphetamine	Dyanavel XR	extended-release oral	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,			
Products	suspension	suspension	approve if the patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with Adzenys XR ODT tablets, if formulary. If Adzenys XR ODT tablets are non-formulary, approve.	1 year	Yes	
Central Nervous			1. Approve if the patient has tried Dyanavel XR oral suspension, if formulary.			
System Stimulants –		amphetamine	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			
Amphetamine	Duanaval VD total	extended-release	one is formularly from the following list: 1) amphetazinine mixed extended	1.000	Vaa	
Products	Dyanavel XR tablets	lablets	chewable tablets (Vyvanse chewable tablet, generics). If none are formulary, approve.	1 year	Yes MSB Exclusion	
					INVISE EXCILISION	
Central Nervous		methylphenidate	NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product			
		methylphenidate hydrochloride XR	NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.  Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		*This criteria applies only to	

				Approval	2025 NPF Excluded	Continuation of
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Duration	Medicaiton	Therapy Required?
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	
Central Nervous System Stimulants – Methylphenidate Products	Ritalin LA	methylphenidate long-	NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.  Criteria: Approve if the Brand product is being requested due to a formulation 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		methylphenidate hydrochloride for	1. Approve if the patient has tried QuilliChew ER tablets, if formulary, or two if two are 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 or has difficulty swallowing solid oral dosage forms or has difficulty swallowing solid oral dosage forms.	,		
Products	Quillivant XR	suspension	approve.	1 year	Yes	
Central Nervous System Stimulants – Methylphenidate Products	QuilliChew ER	methylphenidate HCI 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) Azstarvs.	1 year	Yes	
Central Nervous System Stimulants – Methylphenidate	Relexxii and	methylphenidate ER	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 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.			
Products Central Nervous System Stimulants –Amphetamine Products	authorized generic  Xelstrym	dextroamphetamine transdermal system	Note: QuilliChew ER tablets and Quillivant XR suspension count as one alternative.  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	
J		anonyuopa vapoures	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.	, year	100	
Central Nervous System/Autonomic Drugs	Sodium oxybate oral solution (AG to Xyrem) by AMNEAL	sodium oxybate oral solution	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	
			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 neither 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.			
Central Nervous System/Autonomic Drugs	Xyrem (brand)	sodium oxybate oral solution	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 none 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	

					2025 NPF	Continuation of
				Approval	Excluded	Therapy
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Duration	Medicaiton	Required?
			1. Approve if the patient has tried benznidazole, if formulary. If benznidazole is non-formulary, approve.			
Chagas Disease	1		2. Approve if the patient is less than 2 years of age.	4	V	V
Agents	Lampit	nifurtimox tablets	3. Approve if the patient has already started on therapy with Lampit.	1 year	Yes	Yes
			NATE. A multi-course Drand product in being acquised. The petions should use the professed biographic product		MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
01 1 11 11 11	<b>-</b> · ·	deferasirox tablets for	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Chelating Agents	Exjade	oral suspension	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
					MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
			Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Chelating Agents	Jadenu	deferasirox tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
					MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
		deferasirox oral	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Chelating Agents	Jadenu Sprinkles	granules	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
					MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Chelating Agents -		penicillamine	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Wilson's Disease	Cuprimine	capsules	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
			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.			
Chelating Agents -	trientine 500 ma	trientine 500 ma	5. Approve if the patient is pregnant.			
Wilson's Disease	capsules	capsules	6. Approve if the patient has been started on therapy with a trientine product.	1 year	Yes	
VVIIIOON O DIOCUCO	опролюб	oupouloo	Approve if the patient has tried trientine capsules (Syprine, generics), if formulary.	1 your	100	
			Approve if the patient has their treatment capsules (Syphine, generics), in formularly.			
			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), if one is formulary. If neither are formulary, approve.			
			1. Approve if per the prescriber, the patient is intolerant to peniciliamine or the patient to patient be prescriber, 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.			
		trientine	Approve if the patient has neurological manifestations of Wilson's Disease.			
Chelating Agets -		,	5. Approve if the patient is pregnant.		.,	
Wilson's Disease	Cuvrior	mg tablets	6. Approve if the patient has been started on therapy with a trientine product or Cuvrior.	1 year	Yes	
			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.			
		colchicine 0.5 mg	3. Patient has a creatinine clearance ≥ 50 mL/min; AND			
Colchicine Agents	Lodoco	tablets	4. Patient has tried colchicine 0.6 mg tablets or capsules [documentation required].	1 year	Yes	
			Cancer in a Patient ≥ 18 Years of Age Receiving Myelosuppressive Chemotherapy.			
		eflapegrastim-xnst	Approve if the patient has tried one pegfilgrastim product [documentation required].			
Colony Stimulating		subcutaneous	Note: Pegfligrastim products are Neulasta, Fulphila, Fylnetra, Nyvepria, Udenyca, Stimufend, and Ziextenzo.			
Factors	Rolvedon	injection	Note: If no pegfilgrastim products are formulary, approve.	1 vear	Yes	
				,		

					2025 NPF	Continuation of
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	Excluded Medicaiton	Therapy Required?
тистару ошээ	Diana ivanie	Ceneric Name	Odministrial i E Oriena	Duration	Wedication	Required:
			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): Neupogen, 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.			
		filgrastim-txid	2. Patients who require administration by intravenous infusion: approve if the patient meets the following (A and B):			
		subcutaneous or	A. Patient has tried one of Neupogen, Releuko, Zarxio, or Nivestym [documentation required], if formulary; AND			
0.10"1."		intravenous injection	Note: If none are formulary, approve.			
Colony Stimulating Factors - Filgrastim	Nypozi	(biosimilar to Neupogen)	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.	1 year	Yes	
r dotoro i iigraotiiii	1,1,502.		recent in a significant and grown to load activities to decide.	. you.		
			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			
0-1041-4		tbo-filgrastim	Note: If neither are formulary, approve.			
Colony Stimulating Factors - Filgrastim	Granix	subcutaneous injection	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.	1 year	Yes	
				. ,		
			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.			
			Positions requiring a data of 400 mag. approve if the positions made the following (A and D):			
			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.			
Colony Stimulating		filgrastim intravenous or subcutaneous	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.			
Factors - Filgrastim	Neupogen	injection	Note: If the only formulary alternative is Granix and the patient requires intravenous administration, approve.	1 year	Yes	
			1. Approve if the patient meets BOTH of the following (A <u>and</u> 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.			
		filgrastim-ayow	2. Patients who require administration by intravenous infusion: approve if the patient meets BOTH of the following (A and B):			
		subcutaneous or	A. Patient has tried one of Nypozi, Nivestym, Neupogen, or Zarxio [documentation required], if formulary; AND			
Colony Stimulating		intravenous injection (biosimilar to	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			
Factors - Filgrastim	Releuko	Neupogen)	result in a significant allergy or serious adverse reaction.	1 year	Yes	

					2025 NPF	Continuation of
				Approval	Excluded	Therapy
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Duration	Medicaiton	Required?
			1. Approve if the patient meets BOTH of the following (A and B):  A. The patient has tried four of the following products if formularly or the if three are formularly or the interest BOTH of the following products if formularly or three if three are formularly or the interest 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.			
		filgrastim-sndz	2. Patients who require administration by intravenous infusion: approve if the patient has meets the following (A and B):			
		subcutaneous or	A. Patient has tried one of Nypozi, Releuko, Neupogen, or Nivestym [documentation required], if formulary; AND			
		intravenous injection	Note: If none are formulary, approve.			
Colony Stimulating	<b>.</b> .	(biosimilar to	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		V	
Factors - Filgrastim	Zarxio	Neupogen)	result in a significant allergy or serious adverse reaction.	1 year	Yes	
			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			
			Evinetra [documentation required]: AND			
Colony Stimulating			Note: If none are formulary, approve.			
Factors -			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,		.,	
Pegfilgrastim	Stimufend	pegfilgrastim-fpgk	would result in a significant allergy or serious adverse reaction.	1 year	Yes	
			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			
Colony Stimulating		pegfilgrastim-pbbk	Note: If none are formulary, approve.			
Factors -		subcutaneous	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,		.,	
Pegfilgrastim	Fylnetra	injection	would result in a significant allergy or serious adverse reaction.	1 year	Yes	
			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			
			Eximple and focumentation required; AND			
Colony Stimulating		pegfilgrastim	Note: If none are formulary, approve.			
Factors -	l	subcutaneous	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,		.,	
Pegfilgrastim	Neulasta	injection	would result in a significant allergy or serious adverse reaction.	1 year	Yes	
			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			
Colony Stimulating		pegfilgrastim-apgf	Note: If none are formulary, approve.			
Factors -	Name	subcutaneous	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,	4	V	
Pegfilgrastim	Nyvepria	injection	would result in a significant allergy or serious adverse reaction.  Approve if the patient meets BOTH of the following (a and b):	1 year	Yes	
			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			
Colony Stimulating		pegfilgrastim-cbqv	Note: If none are formulary, approve.			
Factors - Pegfilgrastim	Udenvca	subcutaneous injection	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 vear	Yes	
regiligrasiliii	Ouerryca	Injection	would result in a significant anergy or serious adverse reaction.  Paroxysmal nocturnal hemoglobinuria in a patient ≥ 13 years of age.	i yeai	165	
			1. Approve if the patient has tried ONE of 1) an eculizumab product (Soliris, Bkemv, Epysqli) or 2) Ultomiris, if formulary. If neither are formulary, approve.			
		crovalimab-akkz	Note: All of the eculizumab products would count as one alternative (Soliris, Bkemv, Epysqli).			
		intravenous infusion	2. Patient < 18 years of age, approve if the patient has tried Ultomiris, if formulary. If Ultomiris is non-formulary, approve.			
Complement Inhibitors	PiaSky	and subcutaneous injection	3. Patient is unable to maintain intravenous access, approve.	1 voor	Yes	Voc
Inhibitors	Ріабку	Injection	4. Patient has already been started on therapy with PiaSky, approve.	1 year	res	Yes
			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):			
			Approve if the patient meets one 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 1) an eculizumab product (Soliris, Bkemv, Epysqli) or 2) Ultomiris, if formulary; OR			
			Note: All of the eculizumab products would count as one alternative (Soliris, Bkemv, Epysqli).			
			ii. Patient is unable to obtain intravenous access; AND  Note: If neither are formulary, would still need to meet criterion B.			
Complement			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			
Inhibitors -		zilucoplan	Note: If none are formulary, would still need to meet criterion A.			
Complement C5	7.11	subcutaneous	Note: If there are no formularly alternatives from criterion A or B, approve.		.,	
inhibitor	Zilbrysq	injection	2. Approve if the patient has already been started on therapy with Zilbrysq.	1 year	Yes	Yes

					2025 NPF	Continuation of
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	Excluded Medicaiton	Therapy Required?
Therapy Class	Dianu Name	methylnaltrexone	Approve if the patient has tried two products from the following list [documentation required]: Movantik, Symproic, or Amitiza (lubiprostone), if two are formulary or one if one is formulary. If none are formulary, approve if the patient has		Wedication	Requireur
Constipation Agents	Relistor	bromide tablets	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		1 year	MSB Exclusion *This criteria applies only to the NPF	
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.  Note: Examples include, but may not be limited to, Caya contoured diaphragm, condom, FC2 Female Condom, FemCap, Gynol II contraceptive gel, VCF contraceptive gel.  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  Note: Examples include, but may not be limited to, Caya contoured diaphragm, condom, FC2 Female Condom, FemCap, Gynol II contraceptive gel, VCF contraceptive gel.  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.  Compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is NOT required.	1 year	Yes	
Contraceptives	Twirla	levonorgestrel and ethinyl estradiol transdermal system	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: Examples include, but may not be limited to, Blisovi Fe, Eluryng, etonogestrel-ethinyl estradiol vaginal ring, Hailey Fe, Junel Fe, Larin Fe, Xulane.  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: Examples include, but may not be limited to, Blisovi Fe, Eluryng, etonogestrel-ethinyl estradiol vaginal ring, Hailey Fe, Junel Fe, Larin Fe, Xulane.  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	

					2025 NPF	Continuation of
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	Excluded Medicaiton	Therapy Required?
			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.  Note: Examples include, but may not be limited to, Hailey Fe, Junel Fe, Larin Fe, Mibelas 24 Fe, Microgestin Fe, norethindrone-ethinyl estradiol-iron.  OR			
		ethinyl estradiol 0.01 mg; norethindrone acetate 1 mg; ferrous	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  Note: Examples include, but may not be limited to, Hailey Fe, Junel Fe, Larin Fe, Mibelas 24 Fe, Microgestin Fe, norethindrone-ethinyl estradiol-iron.			
Contraceptives – Oral	Lo Loestrin FE	fumarate tablet	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	
			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].			
Contraceptives – Oral	Loestrin and Loestrin FE	ethinyl estradiol/norethindron e and ferrous fumarate tablets	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	
			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.			
Contraceptives – Oral	Minastrin 24 FE	norethindrone - ethinyl estradiol - iron chewable tablets	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	
			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].			
		desogestrel - ethinyl estradiol and ethinyl	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)		MSB Exclusion *This criteria applies only to	
Contraceptives - Oral	Mircette	estradiol tablets	[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	the NPF	

				Ammayal	2025 NPF Excluded	Continuation of
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	Medicaiton	Therapy Required?
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.  Note: Examples include, but may not be limited to, Blisovi Fe, drospirenone-ethinyl estradiol, Estarylla, Junel Fe, Tri-Sprintec, Sprintec.  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  Note: Examples include, but may not be limited to, Blisovi Fe, drospirenone-ethinyl estradiol, Estarylla, Junel Fe, Tri-Sprintec, Sprintec.  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		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.  Note: Examples include, but may not be limited to, Aurovela Fe, Blisovi Fe, drospirenone-ethinyl estradiol, Estarylla, Junel Fe, Tri-Sprintec, Sprintec.  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 Note: Examples include, but may not be limited to, Aurovela Fe, Blisovi Fe, drospirenone-ethinyl estradiol, Estarylla, Junel Fe, Tri-Sprintec, Sprintec.  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	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; 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 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].		MSB Exclusion *This criteria applies only to the NPF	

				Approval	2025 NPF Excluded	Continuation of Therapy
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Duration	Medicaiton	Required?
			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			
Contraceptives – Oral	Seasonique	levonorgestrel-ethinyl estradiol and ethinyl estradiol tablets	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	
			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].			
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 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	
		levonorgestrel 0.1 mg and ethinyl estradiol	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.  Note: Examples include, but may not be limited to, Altavera, Aviane, Falmina, Lessina, levonorgestrel-ethinyl estradiol, Portia, Vienva.  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  Note: Examples include, but may not be limited to, Altavera, Aviane, Falmina, Lessina, levonorgestrel-ethinyl estradiol, Portia, Vienva.			
Contraceptives - Oral	Tyblume	0.02 mg tablets	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.  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].	1 year	Yes	
Contraceptives – Oral	Yasmin	ethinyl estradiol/ drospirenone tablets	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	

					2025 NPF	Continuation of
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	Excluded Medicaiton	Therapy Required?
			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.  Note: Examples include, but may not be limited to, Charlotte 24 Fe, Finzala, Kaitlib Fe, Layolis Fe, Mibelas 24 Fe, norethindrone-ethinyl estradiol, Wymzya Fe.  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).			
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 required.  1. Approve if the patient has tried four other oral contraceptive agents.  Note: Examples include, but may not be limited to, Charlotte 24 Fe, Finzala, Kaitlib Fe, Layolis Fe, Mibelas 24 Fe, norethindrone-ethinyl estradiol, Wymzya Fe.  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	
			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			
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 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 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	
			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			
Contraceptives – Oral	Slynd	drospirenone tablet	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	
Corticosteroid (oral) - Eosinophilic Esophagitis Agent	Eohilia	budesonide oral suspension	Patient meets Gastroenterology – Echilia Prior Authorization Policy AND  Patient meets ONE of the following (1 or 2):  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 Echilia (to allow for completion of up to a 12-week course of therapy).	12 weeks	Yes	
	Llowedy	dexamethasone 20 mg tablets	Approximate the private provided approximate provided in the p	1 vear	Yes	
Corticosteroids (Oral)	Helliauy	hydrocortisone oral	Approve if the patient has tried generic dexamethasone tablets, if formulary. If dexamethasone tablets are non-formulary, approve.  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.	i yeai	162	
Corticosteroids (Oral)	Alkindi Sprinkle	granules	3. Approve if the patient's dose cannot be obtained using whole hydrocortisone tablets.	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 (Rectal Formulations)	Anusol-HC	hydrocortisone acetate suppository	Approve if the patient has tried hydrocortisone acetate suppositories. If hydrocortisone acetate suppositories are non-formulary, approve.	1 vear	Yes *This criteria applies only to the NPF	

					2025 NPF	Continuation of
				Approval	Excluded	Therapy
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Duration	Medicaiton	Required?
	Hydrocortisone-	hydrocortisone-				
Corticosteroids	pramoxine	pramoxine				
(Rectal Formulations)	suppository	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	
		pramoxine				
		hydrochloride				
Corticosteroids	D	hydrocortisone		4	V	
(Rectal Formulations)	Proctoroam-HC	acetate aerosoi, toam	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	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		MSB Exclusion *This criteria	
Corticosteroids		hydrocortisone	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
(Topical)	Anusol-HC cream	acetate cream	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
<u> </u>				, , , , , , , , , , , , , , , , , , ,	MSB Exclusion	
		hydrocortisone	NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Corticosteroids		butyrate cream, lotion,	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
(Topical)	Locoid	ointment, solution	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
					MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Corticosteroids		hydrocortisone	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the	4	applies only to	
(Topical)	Locoid Lipocream	butyrate 0.1% cream	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		MSB Exclusion *This criteria	
Corticosteroids		desoximetasone	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
(Topical)	Topicort spray	spray	persoriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 vear	the NPF	
(Торісаі)	Topicort spray	эргау	product, would result in a significant alongy of schools adverse reaction todarion adverse.	i yeai	MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Corticosteroids		fluocinonide 0.1%	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
(Topical)	Vanos	cream	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
· · · ·			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.			
Corticosteroids		clobetasol propionate	Note: Examples of topical steroid products include: desoximetasone, triamcinolone, betamethasone, clobetasol, fluocinonide, mometasone, halcinonide, diflorasone.			
(Topical)	Impoyz	cream, 0.025%	NOTE: The products must be chemically unique.	1 year	Yes	
		betamethasone	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.			
Corticosteroids		dipropionate spray	Note: Examples of topical steroid products include: desoximetasone, triamcinolone, betamethasone, clobetasol, fluocinonide, mometasone, halcinonide.		.,	
(Topical)	Sernivo spray	0.05%	NOTE: The five products must be chemically unique.	1 year	Yes	
Corticosteroids			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 conticosteroid products.			
(Topical)	Verdeso	desonide foam	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	
(Topical)	verueso	desoriide idairi		i yeai	163	
			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.			
Cushing's - Cortisol		levoketoconazole	Note: A trial of any of the products above would count toward meeting criteria regardless of the formulary status of the product.			
Synthesis Inhibitor	Recorlev	tablets	2. If the patient has already been started on Recorlev, approve if the patient has tried ketoconazole.	1 year	Yes	
			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.			
			Endower Could be Continued to the Continue of the Continued to the Continu			
			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, Metopirone (metyrapone capsules), Recorley, or mifepristone (Korlym, generics). If none are formulary, approve; OR			
			A: r attent has already been started on Isturisa.  B: Patient has already been started on Isturisa.			
Cushing's - Cortisol						

					2025 NPF	Continuation of
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	Excluded Medicaiton	Therapy Required?
Therapy Class	Brand Name	Generic Name	Continential L Criteria	Duration	MSB Exclusion	Requireu:
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Cushing's -Cortisol Receptor Blocker	Korlym	mifepristone 300 mg tablets	Criteria: Approve if the Brand product is being requested due to a formulation 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	applies only to the NPF	
receptor Breaker	i tonym	142.010	processors needs to the control of t	, your	MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Cystinuria Agents	Thiola	tiopronin tablets	Criteria: Approve if the Brand product is being requested due to a formulation 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	applies only to the NPF	
Diabetes - Oral	Glimepiride 3 mg	aleproniin tableto	processor, notice rocal and organization of control of the control	. your		
Sulfonylurea	(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	
Diabetes Agents - Dipeptidyl Peptidase- 4 (DPP-4) Inhibitor Combination Products	Oseni and sauthorized 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 Combination Products	s 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, Annumet 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, Glu	1 year	Yes	
Diabetes Agents - Dipeptidyl Peptidase- 4 (DPP-4) Inhibitor Combination Products	s 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): 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, Glu	1 year	Yes	
Diabetes Agents - Dipeptidyl Peptidase- 4 (DPP-4) Inhibitor Combination Products	Kazano and s 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, 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) and the patient has tried three metformin (Placophage) and two of the following, if two are formulary (or one if 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 ER, generics) and two of the following, if two are formulary (or one if one is formulary): approve if the patient has tried metformin (Glucophage ER, generics) and the following is two are formulary (or one if one is formulary): Jentadueto, Jentad	1 year	Yes	
Diabetes Agents - Dipeptidyl Peptidase- 4 (DPP-4) Inhibitor Combination Products	s 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), NAD two of the following, if two are formulary (or one if only one is formulary): alogliptin tablets (Nesina, authorized generics), saxagliptin tablets (Onglyza, 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	
Diabetes Agents - Dipeptidyl Peptidase- 4 (DPP-4) Inhibitor Combination Products		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,	1 year	Yes	

					2025 NPF	Continuation of
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	Excluded Medicaiton	Therapy Required?
Therapy Glass	Brana Name	Generic Name	Approve if the patient has tried Janumet XR, if formulary.	Duration	Wedicalton	Required:
Diabetes Agents - Dipeptidyl Peptidase-		sitagliptin and metformin hydrochloride	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 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, Glucophag			
4 (DPP-4) Inhibitor		extended-release	generics) AND Januvia, if formulary. If Januvia is non-formulary, approve if the patient has tried metformin (Glucophage ER, generics).			
Combination Products	Zituvimet XR	tablets	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/			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.			
Sodium Glucose Co-			Note: SGLT-2 inhibitors: Brenzavvy, Farxiga, Invokana, Jardiance, Steglatro.			
Transporter-2 (SGLT- 2) Inhibitors	Steglujan	ertugliflozin/ sitagliptin tablets	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 vear	Yes	
Diabetes Agents - Dipeptidyl Peptidase- 4 (DPP-4) Inhibitor/ Sodium Glucose Co- Transporter-2 (SGLT-		dapagliflozin/	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: Brenzavvy, Farxiga, Invokana, Jardiance, Steglatro.  DPP-4 inhibitors: Januvia, Nesina (alogliptin), Onglyza (saxagliptin), Tradjenta.			
2) Inhibitors	Qtern	saxagliptin tablets	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	
Dipeptidyl Peptidase-	Zituvio and authorized generic		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.			
4 (DPP-4) Inhibitors	sitagliptin	mg, 25 mg tablets	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-	Nesina and		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.	4	V	
4 (DPP-4) Inhibitors	authorized generic	alogliptin tablets	Note: Saxagliptin and Onglyza count as one alternative. Januvia and Zituvio would count as one alternative.  If requesting brand Onglyza: Approve if the patient has tried saxagliptin tablets (generic for Onglyza), if formulary.	1 year	Yes	
Diabetes Agents - Dipeptidyl Peptidase- 4 (DPP-4) Inhibitors	Onglyza	saxagliptin tablets	If requesting brand Onglyza. Approve if the patient has tried saxaging in tablets (generic tor Onglyza), in formularly.  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	
	3,	5 1	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			
Diabetes Agents -			sitagliptin product (Januvia or Zituvio). If none are formulary, approve.			
Dipeptidyl Peptidase- 4 (DPP-4) Inhibitors	Tradjenta	linagliptin tablets	Note: Alogliptin and Nesina count as one alternative. Saxagliptin and Onglyza 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	
	,	ŭ.	Type 2 Diabetes Mellitus.  If requesting brand Victoza:  Approve if the patient has tried and cannot take generic liraglutide due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product, if the generic is formulary.			
Diabetes Agents -			If requesting generic livedutide or generic livedutide is non formulany.			
Glucagon-Like Peptide-1 (GLP-1)		liraglutide (rDNA	If requesting generic liraglutide or generic liraglutide is non-formulary:  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.			
Agonists	Victoza and generic		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 - brand only	

					2025 NPF	Continuation of
				Approval	Excluded	Therapy
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria  Approve if the patient meets the following (1, 2, and 3):	Duration	Medicaiton	Required?
			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			
Diabetes Agents -			3. Patient was unable to adhere to a regimen using a standard basal insulin pen, according to the prescriber [documentation required].			
Insulin (Basal)	Basaglar Tempo Per		Note: Document the specific issue(s) with adherence that would be solved by the use of a Tempo Pen.	6 months	Yes	
			AFON SERVICE AND A SERVICE AND			
			Approve if the patient has tried and, according to the prescriber, experienced inadequate efficacy or significant intolerance with 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.			
			ionitulary, 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.			
i			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			
Diabetes Agents -			Insulin glargine U300, if formulary. If neither are formulary, approve.			
Insulin (Basal)	Basaglar		Note: If the patient has tried either product above, regardless of formulary status, the criterion would be satisfied.	1 year	Yes	
	Lantus and Insulin		1. Patient is directed to use Semglee (YFGN) or Insulin glargin (YFGN) [authorized generic of Semglee {YFGN}], if formulary. If neither are formulary, approve.			
	glargine (by		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,			
Diabetes Agents -			according to the prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1	Vaa	
Insulin (Basal)	Medication)	device	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	
			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,			
Diabetes Agents -			according to the prescriber, would result in a significant allergy or serious adverse reaction [documentation required].			
Insulin (Basal)	Rezvoglar		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 vear	Yes	

					2025 NPF	Continuation of
				Approval	Excluded	Therapy
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Duration	Medicaiton	Required?
			Direct to Toujeo (brand), if formulary.			
			ET with a formal to the state of the state o			
			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			
			a. ratiefina fred one of residue of insulin Degladed, in infiliating and insulin Degladed, in infiliating and insulin Degladed, in infiliating and insulin Degladed in insulin Degladed in infiliating and insulin Degladed in ins			
			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.			
			Table at the formattal produced in a strength of the strength			
			Type 1 Diabetes, Continuation of Therapy with Touleo 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			
Diabetes Agents -	Insulin glargine	insulin glargine U-300	Note: If the patient has tried any product from a. regardless of formulary status, criterion a would be satisfied.			
Insulin (Basal)	U300	SoloStar pen	b. Patient is currently receiving a Toujeo or Insulin glargine U300 dose of ≥ 100 units per injection.	1 year	Yes	
			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.			
		inculin determin I I 400	3. Pregnant patients: approve.			
Diabetes Agents -		insulin detemir U-100 vial and FlexTouch	Type 1 Diabetes, Continuation of Therapy with Levemir.			
Insulin (Basal)	Levemir	pen	4. If the patient has Type 1 diabetes and is currently taking Levemir, approve.	1 year	Yes	
moulin (Dasai)	LCVCIIII	pon	1. Patient is directed to use Semglee (YFGN) [brand] or Insulin glargine-YFGN, if formulary.	i yeai	100	
Diabetes Agents -	Semglee (non	insulin glargine LL-100	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.			
Insulin (Basal)	YFGN)	vial and pen	2. In Testiner are communally, approve in the patient has tried any product from 2. regardless of formularly status, criterion 2 would be satisfied.	1 year	Yes	
(Daoai)	511)	ria. dila pori	1 to parent nee and any product non-an regarded or formularly distinct a round be distinct.	. , oui		

					2025 NPF	Continuation of
				Approval	Excluded	Therapy
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Duration	Medicaiton	Required?
			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.			
		insulin degludec vial	IT the patient has thed any product from 5. regardless or formularly status, officerior 5 would be satisfied.			
Diabetes Agents -		and FlexTouch pen U-	Type 1 Diabetes, Continuation of therapy with Insulin Degludec or Tresiba.			
Insulin (Basal)	Insulin Degludec	100 and U-200	4. If the patient has Type 1 diabetes and is currently taking Tresiba or Insulin Degludec, approve.	1 year	Yes	
			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			
Diabetes Agents –			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): 1) an exenatide product (Bydureon BCise, Byetta), 2) Ozempic, 3) Trulicity, or 4) liraglutide (Victoza, generics). If none of the basal insulin products or none of the GLP-1 agonists are formulary, approve.			
Insulin (Basal) and			Note: Lantus, Insulin Glargine (YFGN), Semglee (YFGN), Basalgar, Toujeo, and Insulin glargine (300 would count as one alternative.			
Glucagon-Like		insulin	Note: Tresiba and Insulin Degludec would count as one alternative.			
Peptide-1 (GLP-1)		degludec/liraglutide	Note: Bydureon BCise and Byetta would count as one alternative. Victoza and its generic would count as one alternative.			
Agonist Combination	Xultophy	injection	Note: A trial of Rybelsus or Mounjaro would also count as a trial of a GLP-1 agonist.	1 year	Yes	
	Novolin 70/30					
Diabetes Agents -	Flexpen and Relion Novolin 70/30		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.			
Insulin (Human)	Flexpen	insulin, 70/30 pen	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 vear	Yes	
(		,	, and the property of the prop			
	Novolin 70/30 vials					
Diabetes Agents - Insulin (Human)	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	
moulin (Human)	Novolin N Flexpen	mount, 10/00 vidis	Proportion and passent read a treatment in 10,000 Years of Humber 10,000 (Winkperis, in John Lumber). It both Humber 10,000 Years and Humber 10,000 (Winkperis are Humber) and Humber 10,000 (Winkperis are Humber).	i yeai	103	
Diabetes Agents -	and Relion Novolin		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.			
Insulin (Human)	N Flexpen	insulin, NPH pen	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	
Diahataa Aganta	Novolin N vials and					
Diabetes Agents - Insulin (Human)	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 vear	Yes	
	1.0.5		- Production and the second se	. your		
	Novolin R Flexpen					
Diabetes Agents -	and Relion Novolin		1. Approve if the patient has tried Humulin R U-100 vials, if formulary. If Humulin R U-100 vials are non-formulary, approve.			
Insulin (Human)	R U-100 Flexpen	insulin, regular pen	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 -	Novolin R R U-100 vials and Relion					
Insulin (Human)	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 vear	Yes	
(		, garar *1010	)	, ,		

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 nonformulary, then approve if the patient meets one 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 one of Admelog or Lyumjev, if formulary status, criterion ii would be satisfied.  iii. Patient has tried any product from ii. regardless of formulary status, criterion iii would be satisfied.  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 any product from iii. regardless of formulary and C):  A. Patient has tried Apidra, if formulary: NovoLog, Insulin Aspart (authorized generic of NovoLog), or Fiasp; AND  Note: If the patient has tried one of Admelog or Lyumjev, if formulary: status, criterion B would be satisfied.  C. Patient has tried any product from B. regardless of formulary status, criterion C would be satisfied.  Note: If the patient has tried any product from C. regardless of formulary status, criterion C would be satisfied.  Note: If the patient has tried any product from C. regardless of formulary.	1 year	Yes - vial only	
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.	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.	1 year	Yes	
Diabetes Agents - Insulin (Rapid-Acting and Other)	NovoLog and	insulin aspart syringe, cartridge/Flexpen	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	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	

					2025 NPF	Continuation of
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	Excluded Medicaiton	Therapy Required?
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Duration	Medication	Requirea?
	NovoLog 70/30 and					
	authorized generic					
Diabatas Asanta		insulin aspart				
Diabetes Agents - Insulin (Rapid-Acting	protamine-insulin aspart) and Relion	protamine/insulin aspart, Flexpen				
and Other)	Novolog 70/30		Approve if the patient has tried Humalog 75/25, if formulary. If Humalog 75/25 is non-formulary, approve.	1 year	Yes	
			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			
			D. F admit risk after other of the following, in formal assistory and administed general or inflationally, finding, printing grant product from B. regardless of formularly 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			
Diabetes Agents -			Note: If the patient has tried any product from C. regardless of formulary status, criterion C would be satisfied.			
Insulin (Rapid-Acting and Other)	Fiasp	vial, pen, cartridge, PumpCart	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	
a Outor /	aop	ipour	Direct the patient to Humalog JR (brand). If Humalog JR (brand) is non-formulary, approve if the patient meets the following (A or B):	. you	. 35	
			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			
Diabetes Agents -			III. Fautent reas urea varinetay, in formulary, On  B. Patient requires ½ unit dosing.			
Insulin (Rapid-Acting			Note: If no products in A i, ii, or iii are formulary, approve.			
and Other)	Insulin Lispro JR	Insulin lispro JR	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 -		metformin extended-	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).			
Other	Glumetza	release tablets	NOTE: A trial of Glumetza would NOT count toward this requirement.	1 year	Yes	
Diabetes Agents -	metformin immediate release	metformin immediate- release tablet 625 mg				
Other	625 mg and 750 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	
			Direct to Xigduo XR (brand), if formulary.			
			If Xigduo XR (brand) is non-formulary, approve if the patient meets one of the following (1 or 2):			
Diabetes Agents -			1. Approve if the patient has tried two formulary alternatives from the following list, if formulary (or one if one is formulary): Synjardy XR, or Segluromet. If none are formulary, approve if the patient has tried metformin			
Sodium Glucose Co-			(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.			
Transporter-2 (SGLT-2) Inhibitor	dapagliflozin- metformin ER	dapagliflozin-	Note: Synjardy and Synjardy XR would count as one alternative.  2. Patients ≥ 10 years of age to < 18 years of age with type 2 diabetes mellitus: Approve if the patient has tried Synjardy, if formulary. If Synjardy is non-formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER,			
Combination Products		metformin ER tablets	2. Faterins 2 in years or age with representations and provide the provided from the patent of the patent in the p	1 year	Yes	
			1. 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			
Diabetes Agents - Sodium Glucose Co-			formulary or one if only one is formulary): Farxiga, Invokana, Jardiance, or Steglatro. Note: Synjardy and Synjardy XR would count as one alternative.			
Transporter-2 (SGLT-						
2) Inhibitor		canagliflozin and	(brand), if formulary. If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics) AND BOTH of 1) Farxiga or dapagliflozin tablet and 2) Jardiance, if formulary. If neither are formulary,			
Combination Products	Invokamet	metformin tablets	approve.	1 year	Yes	
			1. 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			
Diabetes Agents -			formulary or one if one is formulary): Farxiga, Invokana, Jardiance, or Steglatro.			
Sodium Glucose Co-			Note: Synjardy and Synjardy XR would count as one alternative.			
Transporter-2 (SGLT- 2) Inhibitor			2. Patients ≥ 10 years of age to < 18 years of age with type 2 diabetes mellitus: Approve if the patient has tried BOTH of 1) Synjardy and 2) one of dapagliflozin-metformin ER tablets (authorized generic of Xigduo XR), or Xigduo XR  (brend), if formulary, if page are formulary, approve if the patient has tried motter min (Clusephage ER generics) AND BOTH of 1) Equipment (and the patient and 3) legitlary in tablet and 3) l			
2) Inhibitor Combination Products	Invokamet XR	metformin extended- release tablets	(brand), if formulary. If none are formulary, approve if the patient has tried metformin (Glucophage, Glucophage ER, generics) AND BOTH of 1) Farxiga or dapagliflozin tablet and 2) Jardiance, if formulary. If neither are formulary, approve.	1 year	Yes	
Diabetes Agents -						
Sodium Glucose Co- Transporter-2 (SGLT-			Approve if the nation has tried two formulary alternatives from the following list (or one if only one is formulary): Symiardy Symiardy VP, or Virginiary VP. If none are formulary approve if the nation has tried matternatives			
2) Inhibitor		ertugliflozine and	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.			
_,	Segluromet	metformin tablets	Note: Synjardy and Synjardy XR would count as one alternative.	1 vear	Yes	

					2025 NPF	Continuation of
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	Excluded Medicaiton	Therapy Required?
Diabetes Agents -	Brand Name	Generic Name	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	Duration	Wedicalton	Required?
Sodium Glucose Co-			are formulary, approve.			
Transporter-2 (SGLT-			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			
2) Inhibitors	Invokana	canagliflozin tablets	significant intolerance with Jardiance, if formulary. If Jardiance is non-formulary, approve.	1 year	Yes	
Diabetes Agents -						
Sodium Glucose Co- Transporter-2 (SGLT-			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) Inhibitors	Brenzavvy	bexagliflozin tablets	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 -	<u> </u>					
Sodium Glucose Co-						
Transporter-2 (SGLT-			Patients with one of the following: 1) Heart Failure OR 2) Type 2 diabetes, Chronic Kidney Disease (CKD), and Other cardiovascular (CV) risk factors.		.,	
2) Inhibitors	Inpefa	sotagliflozin tablets	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-			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			
2) Inhibitors	Steglatro	ertugliflozin tablets	formulary, approve.	1 year	Yes	
Diabetes Agents -			Direct to Farxiga (brand), if formulary.			
Sodium Glucose Co-	dapagliflozin tablets		Effective through its own formulars.			
Transporter-2 (SGLT- 2) Inhibitors	<ul> <li>(authorized generic of Farxiga)</li> </ul>	dapagliflozin tablets	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 vear	Yes	
Diabetes Agents –	or rainiga)	uapagiiiloziii tabiets	Approve if the patient has alrea, according to the prescribed, and experienced madequate emicacy of significant intolerance with saldiance, informularly. In saldiance is non-normalarly, approve.  Approve if the patient's prescribed dose cannot be obtained with glipizide 5 mg.	i yeai	163	
Sulfonylurea	glipizide 2.5 mg	glipizide 2.5 mg	Note: The patient is NOT required to split the 5 mg tablets in half.	1 year	Yes	
	Pen needles by	Pen needles by				
	Arkray, Home Aide	Arkray, Home Aide				
	Diagnostics, HTL-	Diagnostics, HTL-				
	Strefa, Nipro	Strefa, Nipro				
	Diagnostics, Novo	Diagnostics, Novo				
	Nordisk, Owen	Nordisk, Owen				
	Mumford, Simple Diagnostics,	Mumford, Simple Diagnostics, Ultimed,				
	Ultimed, all other	all other diabetic pen	1. Approve if the patient has tried one formulary pen needle. If none are formulary, approve.			
		needles that are not	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.			
Diabetic Pen Needles	that are not BD	BD	Note: NPF prefers BD products.	1 year	Yes	
			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.			
		Blood alucose	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.			
		Blood glucose meters/test	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		Yes - certain	
Diabetic Supplies	Diabetic Supplies		Advance Voice, Fora Tri G Voic	1 year	diabetic supplies	
,,						
	Other continuous					
	glucose monitoring					
	systems					
	(receiver/reader,					
	,	Other continuous				
	[That are NOT	glucose monitoring				
	Dexcom G6,	systems	Potions made the following Diobetes. Continuous Cluscop Manifering Systems Brier Authorization Believ aritario AND			
	Dexcom G7,	(receiver/reader,	Patient meets the following Diabetes – Continuous Glucose Monitoring Systems Prior Authorization Policy criteria AND			
	Freestyle Libre 2,	transmitter, sensor)	Patient meets ONE of the following (1, 2, or 3):			
	Freestyle Libre 2	[That are NOT Dexcom G6, Dexcom	1. Approve if the patient has tried BOTH of the following systems, if formulary: 1) Freestyle Libre 2, Freestyle Libre 2 Plus, Freestyle Libre 3, or Freestyle Libre 3 Plus 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.			
	Plus], this includes	2, Freestyle Libre 2	Note: If only a Dexcom product is formulary and the patient has tried a different Dexcom product (e.g., Dexcom G4 or G5), approve.		Yes - Bigfoot	
Diabetic Supplies -	Bigfoot Unity	Plus, or Freestyle	2. If the patient is using an insulin pump system that is not compatible with one of the formulary alternatives: approve.		Unity Program	
Continuous Glucose	Program Kit,	Libre 3, Freestyle	3. If requesting the Guardian Connect and the patient is pregnant: approve if the patient has tried BOTH of the following systems, if formulary: 1) Freestyle Libre 2, Freestyle Libre 2 Plus, Freestyle Libre 3, or Freestyle Libre 3 Plus AND 2)		Kit, Eversense	
Monitoring Systems	Eversense 365	Libre 3 Plus]	Dexcom G7 system. If none are formulary, approve.	1 year	365	

					2025 NPF	Continuation of
				Approval	Excluded	Therapy
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Duration	Medicaiton	Required?
			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			
		Tempo Lancets,	2. Patient has tried standard insulin products; AND			
Diabetic Supplies -		'	3. Patient was unable to adhere to a regimen using standard insulin products, according to the prescriber [documentation required].			
Other	Tempo Refill Kit	needles	Note: Document the specific issue(s) with adherence that would be solved by the use of a Tempo product.	6 months	Yes	
			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			
Diabetic Supplies –			<ol> <li>Patient has tried standard insulin products; AND</li> <li>Patient was unable to adhere to a regimen using standard insulin products, according to the prescriber [documentation required].</li> </ol>			
Other	Tempo Smart Button	Tempo Smart Button	Note: Document the specific issue(s) with adherence that would be solved by the use of a Tempo product.	6 months	Yes	
	'	'				
		Tempo Smart Button;	Approve if the patient meets the following (1, 2, and 3):			
		Tempo Blood Glucose				
D: 1 " 0 "			2. Patient has tried standard insulin products; AND			
Diabetic Supplies – Other	Tempo Welcome Kit		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	
	'	renneedies	Note: Document the specific issue(s) with adherence that would be solved by the use of a Tempo product.	OTHORIUS	162	
	Syringes by Arkray, Home Aide	Curingan hu Arlandu				
	Diagnostics, HTL-	Syringes by Arkray, Home Aide				
	Strefa, Nipro	Diagnostics, HTL-				
		Strefa, Nipro				
		Diagnostics, Novo				
		Nordisk, Owen				
	Diagnostics, Ultimed, all other	Mumford, Simple Diagnostics, Ultimed.	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.			
		are not BD	Note: NPF prefers BD products	1 year	Yes	
					MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
			Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Direct Renin Inhibitors Duchenne Muscular	l ekturna Brand Emflaza	aliskiren tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
Duchenne Muscular Dystrophy (DMD)	(tablets and oral	deflazacort tablets		See PSM		
Agents	suspension)	and oral suspension	See standard Muscular Dystrophy - Deflazacort Preferred Specialty Management Policy criteria.	duration	Yes	
Duchenne Muscular	,	'				
Dystrophy (DMD)		vamorolone oral				
Agents	Agamree	suspension	See standard Muscular Dystrophy – Agamree Prior Authorization Policy criteria.	1 year	Yes	
Duchenne Muscular			No considered to the effective age of Amendian 45 has not been established at this time. (NOTF) It is not amended allowed allowed at this modification. Design agent age of the effective agent			
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	Amondys 45	intravenous	The Circulations of Antonings 40 has not been established at this time.	IV/A	103	
Dystrophy (DMD)		eteplirsen injection for	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			
Agents	Exondys 51	intravenous use	The effectiveness of Exondys 51 has not been established at this time.)	N/A	Yes	
Duchenne Muscular						
Dystrophy (DMD)	\		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.	N1/A	V	
Agents Duchenne Muscular	Viltepso	intravenous infusion	The effectiveness of Viltepso has not been established at this time.)	N/A	Yes	
Dystrophy (DMD)		golodirsen injection	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.			
Agents	Vyondys 53	for intravenous use	The effectiveness of Vyondys 53 has not been established at this time.)	N/A	Yes	
Duchenne Muscular		delandistrogene				
Dystrophy (DMD)	El-vido-	moxeparvovec-rokl	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.	NI/A	Vaa	
Agents	Elevidys	intravenous infusion	The effectiveness of Elevidys has not been established at this time.)	N/A	Yes	
Duchenne Muscular						
Dystrophy (DMD)						
Agents - Histone		givinostat oral		See PA		
Deacetylase Inhibitor	Duvyzat	suspension	See standard Muscular Dystrophy - Duvyzat Prior Authorization Policy criteria	duration	Yes	

					2025 NPF	Continuation of
				Approval	Excluded	Therapy
Therapy Class	Brand Name	Generic Name repository	Commercial FE Criteria	Duration	Medicaiton	Required?
		corticotropin				
Endocrine Drugs –		subcutaneous or				
Repository	Cortrophin Gel	intramuscular	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			
Corticotropin	(Purified)	injection	exceptions are recommended. There is a lack of updated clinical efficacy data and insufficient information to determine clinically meaningful benefits.)	N/A	Yes	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		MSB Exclusion *This criteria	
Endocrine Drugs -			Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Miscellaneous	Samsca	tolvaptan tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
		·			MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Endocrine Drugs -			Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Miscellaneous	Sensipar	cinacalcet tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
			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, xi. x. 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, lolmesartan, telmisartan, and valsartan.			
			ii. Non-dihydropyridine calcium channel blocker;			
			II. Not-cultydrythiane calcular calcula			
			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;			
			V. willieraucou todoi receptor antagonists.  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, 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.			
Endothelin Receptor			x. Direct renin inhibitor.			
Antagonist	Tryvio	aprocitentan tablets	Note: An example of a direct renin inhibitor is aliskiren.	1 year	Yes	
		epinephrine 0.15 mg,				
		0.3 mg auto-injector authorized generic				
Epinephrine Self-		(Amneal Pharmace,				
Administered	epinephrine auto-	Avkare, A-S				
Injectables	injector	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					MOD E	
Agents - Phosphodiesterase			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		MSB Exclusion *This criteria	
Type 5 (PDE-5)			Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive inacctive		applies only to	
Inhibitors	Cialis	tadalafil tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
Erectile Dysfunction						
Agents -					MSB Exclusion	
Phosphodiesterase			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Type 5 (PDE-5)	Vicaro	aildonafil tablata	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the	1 1000	applies only to	
Inhibitors Enuthropoiesis	Viagra	sildenafil tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	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	
(20, 10)	,	aa. zopodiii alia	p persons in the persons the product from the renorming lies. Epogon, i recite of retaining towards in equivalent to be included in equivalent to the rest of the	. your	. 55	

				Approval	2025 NPF Excluded	Continuation of Therapy
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Duration	Medicaiton	Required?
			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.			
Erythropoiesis- Stimulating Agents (ESAs)	Epogen	epoetin alfa	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	
Erythropoiesis- Stimulating Agents (ESAs)	Mircera		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)	ı 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)	n 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 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)	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)	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 Combination Products (Oral)	ı Bijuva	estradiol and progesterone 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 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	

					2025 NPF	Continuation of
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	Excluded Medicaiton	Therapy Required?
Therapy Class	Brand Name	Generic Name	Approve if the patient meets the following (A, B, and C):	Duration	Wedication	Requireur
			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 and estradiol-			
		conjugated	norethindrone); AND			
strogen Combination Products (Oral)	Premphase	estrogens/medroxypr ogesterone tablets	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 vear	Yes	
Toddoto (Ordi)	1 Temphase	ogodorono tabloto	Approve if the patient meets the following (A, B, and C):	1 your	100	
			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 and estradiol-			
		conjugated estrogens/	b. Patient has tried and, according to the prescriber, has experienced madequate enroacy OK significant intolerance with one product from the following list, in ormitary. Activelia (including generics of Activelia, military and estration-norethindrone): AND			
strogen Combination		medroxyprogesterone	C. Patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with Bijuva.			
Products (Oral) Estrogen Products	Prempro	tablets esterified estrogens	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.  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	1 year	Yes	
Oral)	Menest	tablets	Approve in the patient mas used and, according to the prescriber, has experienced inadequate enloacy or significant intolerance with two products (or one if one is formularly from the prescriber, has experienced inadequate enloacy or significant intolerance with two products (or one if one is formularly from the prescriber, has experienced inadequate enloacy or significant intolerance with two products (or one if one is formularly from the prescriber, has experienced inadequate enloacy or significant intolerance with two products (or one if one is formularly) from the prescriber, has experienced inadequate enloacy or significant intolerance with two products (or one if one is formularly) from the prescriber, has experienced inadequate enloacy or significant intolerance with two products (or one if one is formularly) from the prescriber, has experienced inadequate enloacy or significant intolerance with two products (or one if one is formularly) from the prescriber, as experienced inadequate enloacy or significant intolerance with two products (or one if one is formularly) from the prescriber, as experienced inadequate enloacy or significant intolerance with two products (or one if one is formularly) from the prescriber, as experienced inadequate enloacy or significant intolerance with two products (or one if one is formularly) from the prescriber.	1 year	Yes	
strogen Products		conjugated estrogens	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	,		
Oral)	Premarin	tablets	Menest tablets. If neither are formulary, approve.	1 year	Yes	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		MSB Exclusion *This criteria	
Estrogen Products			Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Vaginal)	Estrace Cream	estradiol cream	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		MSB Exclusion *This criteria	
Estrogen Products			Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Vaginal)	Vagifem	estradiol vaginal tablet	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
			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.			
strogen Products		estradiol 2 mg vaginal	22. 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			
Vaginal)	Estring	ring	formulary, approve.	1 year	Yes	
			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			
strogen Products		estradiol vaginal	estradiol vaginal tablet (e.g., Yuvafem, Vagifem, generics). If none are formulary, approve.			
Vaginal)	Imvexxy	insert	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	
Strogen Products		estradiol vaginal ring (0.05 mg and 0.10	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), estradiol patch (Climara, generics), estradiol patch (Vivelle Dot, generics), Menostar patch, estradiol tablets (Estrace, generics), Menest tablets, or Premarin tablets. If none are formulary,			
Vaginal)	Femring	mg)	vagina table (e.g., 1 uvalent, vaginent, generics), estitution pation (climitata, generics), estitution pation (vivelie bot, generics), menostar pation, estitution tablets (Estitution pation), menostar pation, generics), menos	1 year	Yes	
-			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			
			In the pattient 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.			
actor Deficiency		Factor VIIa	2. Congenital Factor VII Deficiency, approve. 3. Glanzmann's Thrombasthenia, approve.			
agents and Related Products	NovoSeven RT	(recombinant) powder for injection	3. Granizinamis informasurenia, approve. 4. Hemoshilia. Aduired, approve.	1 vear	Yes	Yes
		,	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.			
			<ol> <li>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.</li> <li>Approve if the patient has already been started on therapy with Rystiggo.</li> </ol>			
		rozanolixizumab-noli	9. Approve in the patient rise and early been statical on the rappy with rysingge.			
	Dti	subcutaneous	Generalized Myasthenia Gravis, anti-muscle-specific tyrosine kinase antibody-positive in a patient ≥ 18 years of age.	4	V	V
c receptor blocker	Rystiggo	infusion	Approve.	1 year	Yes MSB Exclusion	Yes
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
			Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
enofibrates	Tricor	fenofibrate tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
	Antara, Lipofen and	fenofibrate capsules	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			
enofibrates	authorized generics		two if only two are formulary, or one if only one is formulary. If none are formulary approve the requested agent.	1 vear	Yes	

					2025 NPF	Continuation of
				Approval	Excluded	Therapy
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Duration	Medicaiton	Required?
Fentanyl Transmucosal	Fentora and					
Products	authorized generic	fentanyl buccal tablet	See Opioids Transmucosal – Fentora FE	1 year	Yes	
Fertility Agents –				. ,		
Follitropin Ovulatory			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.			
Stimulants	Follistim AQ	follitropin beta	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 –			NOTE: A multipource Prond product is being requested. The nations should use the preferred bioquitiselent generic product		MSB Exclusion	
Gonadotropin- Releasing Hormone		ganirelix acetate	NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.  Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		*This criteria applies only to	
(GnRH) Antagonists	ganirelix injection	injection	personibler, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
(=	g			. ,	MSB Exclusion	
Gabapentin and			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Gabapentin-Like			Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Medications	Lyrica	pregabalin capsules	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
			NATE A sufficiency Board and state in him and the sufficient should be sufficient and the sufficient should be sufficient as a sufficient should be sufficient should be sufficient as a sufficient should be sufficient as a sufficient should be sufficient s		MSB Exclusion	
Gabapentin and Gabapentin-Like		pregabalin controlled-	NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.  Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		*This criteria applies only to	
Medications	Lyrica CR	release capsules	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 vear	the NPF	
Wedications	Lyrica Cit	Toloase capsules	prescriber, would result in a significant allergy or serious adverse reaction (documentation required).	i yeai	MSB Exclusion	
Gabapentin and			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Gabapentin-Like		gabapentin tablet,	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Medications	Neurontin	capsule and solution	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
Gabapentin and						
Gabapentin-Like	Caharana	gabapentin tablets	Appropriation and CANNOT TAVE subspection CARRILLES	1	Vaa	
Medications	Gabarone	gapapentin tablets	Approve if the patient tried and CANNOT TAKE gabapentin CAPSULES.	1 year	Yes	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		MSB Exclusion *This criteria	
Gastrointestinal Drugs		sulcralfate tablets and	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
- Miscellaneous	Carafate	oral suspension	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
					MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Gastrointestinal Drugs		glycopyrrolate oral	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
- Miscellaneous	Cuvposa	solution	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
Gastrointestinal Drugs		crofelemer delayed-	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			
- Miscellaneous	Mytesi	release tablets	experienced inadequate efficacy OR a significant intolerance with both diphenoxylate-atropine tablets AND loperamide.	1 vear	Yes	
	,			,		
Gastrointestinal Drugs	3	glycopyrrolate orally	1. Direct to glycopyrrolate tablets.			
- Miscellaneous	Dartisla ODT	disintegrating 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	
	G: //	metoclopramide nasal	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		.,	
Gastroparesis Agents	Gimoti	spray	recommended. Due to insufficient clinical efficacy data, approval is not recommended.)	N/A	Yes	
					MSB Exclusion *This criteria	
Gaucher Disease			NOTE: A multisource Brand product is being requested.		applies only to	
Medications	Zavesca	miglustat capsules	See standard Gaucher Disease – Substrate Reduction Therapy Preferred Specialty Management Policy criteria	1 year	the NPF	
			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.			
0 1 5:			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.			
Gaucher Disease Medications	Elelyso	taliglucerase alfa for injection	Note: Type 3 Gaucher disease is also known as chronic neuronopathic Gaucher disease.  3. Retire to with Caucher Disease. Type 1 or Type 3 currently extendicated on treatment with Elekson approve	1 year	Yes	Yes
Wiculcations	Liciyau	mjection	<ol> <li>Patients with Gaucher Disease Type I or Type 3 currently established on treatment with Elelyso: approve.</li> <li>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.</li> </ol>	i yeai	103	103
			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.			
Gaucher Disease		velaglucerase alfa for	Note: Type 3 Gaucher disease is also known as chronic neuronopathic Gaucher disease.			
Medications	Vpriv	injection	3. Patients with Gaucher Disease Type 1 or Type 3 currently established on treatment with Vpriv: approve.	1 year	Yes	Yes
			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.			
O. F	0 0 101	glucagon, human	2. Patient is ≥ 2 years of age but < 6 years of age, approve if the patient has tried one of Baqsimi or Gvoke, if formulary, If neither are formulary, approve.			
Glucose-Elevating	GlucaGen/GlucaGen HypoKit	recombinant for injection	<ol> <li>Astient is &lt; 2 years of age and ≥ 1 year of age, approve if the patient has tried Baqsimi, if formulary. If Baqsimi is non-formulary, approve.</li> <li>If the patient is &lt; 1 year of age, approve.</li> </ol>	1 vear	Yes	
Drugs	пуроки	injection	14. If the patient is × 1 year or age, approve.	i year	165	

				Approval	2025 NPF Excluded	Continuation of Therapy
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Duration	Medicaiton	Required?
			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 ≥ 2 years of age but < 6 years of age, approve if the patient has tried one of Baqsimi or Gvoke, if formulary. If neither are formulary, approve.			
Glucose-Elevating	Glucagon/Glucagon		3. If the patient is < 2 years of age and ≥ 1 year of age, approve if the patient has tried Baqsimi, if formulary. If Baqsimi is non-formulary, approve.			
Drugs		Emergency Kit	4. If the patient is < 1 year of age, approve.	1 year	Yes	
Ol		dasiglucagon				
Glucose-Elevating Drugs	Zegalogue	subcutaneous injection	Approve if the patient has tried BOTH of Gvoke and Bagsimi, if formulary (or one if one is formulary). If neither are formulary, approve.	1 vear	Yes	
Gonadotropin-	Zegalogue	Injection	Approve if the patient has thed BOTH or Gvoke and Baqsinni, it formularly (or one if one is formularly). If neither are formularly, approve.	i yeai	162	
Releasing Hormone			Central Precocious Puberty; Gender-Dysphoric/Gender-Incongruent Persons; Persons Undergoing Gender Reassignment (Female-To-Male or Male-To-Female).			
(GnRH) Analogs -		leuprolide acetate for	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.			
CPP	Lupron Depot-Ped	depot suspension	2. Patients < 2 years of age, approve.	1 year	Yes	
			,	,		
Gonadotropin-			Prostate Cancer:			
Releasing Hormone	Leuprolide Depot	leuprolide acetate	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):			
(GnRH) Analogs -		22.5 mg for depot	1. Approve if the patient has tried one of Camcevi, Eligard, Firmagon, Trelstar, or Orgovyx, if formulary. If none are formulary, approve.			
Prostate Cancer	Lutrate Depot)	suspension	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.	1 year	Yes	Yes
Canadatrania			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.			
Gonadotropin- Releasing Hormone		leuprolide injectable	2. Patients currently receiving therapy with Camicevi, approve it the patient has thed one of Lupron Depot of Engand. If heither are formularly, approve.			
(GnRH) Analogs -		emulsion for	Head and Neck Cancer – Salivary Gland Tumors.			
Prostate Cancer	Camcevi	subcutaneous use	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.  Head and Neck Cancer – Salivary Gland Tumors: approve.	1 year	Yes	Yes
					MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Gout Medications	0-1		Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the	4	applies only to	
Gout Medications	Colcrys	colchicine tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
			Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Gout Medications	Uloric	febuxostat tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
-			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.			
Growth Hormone Products	Humatrope	cometronic injection	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,	1 1/00	Voc	
Products	питпатгоре	somatropin injection	would result in a significant allergy or serious adverse reaction [documentation required].	1 year	Yes	
			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 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.			
Growth Hormone			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,			
Products	Norditropin Flexpro	somatropin injection	would result in a significant allergy or serious adverse reaction [documentation required].	1 year	Yes	

					2025 NPF	Continuation of
				Approval	Excluded	Therapy
Therapy Class E	Brand Name	Generic Name	Commercial FE Criteria	Duration	Medicaiton	Required?
			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.			
Growth Hormone			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,			
Products Nutre	tropin AQ Nuspin	somatropin injection	would result in a significant allergy or serious adverse reaction [documentation required].	1 year	Yes	
			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.			
Growth Hormone			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,			
Products Saize	zen/SaizenPrep	somatropin injection	ů o;	1 year	Yes	
			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			
Growth Hormone Zom	na a atam (fa uma a ulu		Note: If none are formulary, approve.  2. Better temperature to the formulary alternative (a) due to a formulation difference in the insertion in gradient(b) for a difference in tabilities are not explicitly as a formular to the proposition of the formular to t			
	macton (formerly v-Tropin)	somatropin injection	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	
Floducis lev-	v-110pii1)	Somatropin injection	would result in a significant allergy or serious adverse reaction [documentation required].	i yeai	162	
			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			
			11. Growth normone deliciency in a patient ≥ 2.5 years of age to < 3 years of age to < 3 years of age to < 3 years of age. approve if the patient mas tried Sogroya for 6 months OR experienced an intolerance with Sogroya, if formularly. If Sogroya is non-formularly, approve if the patient meets criteria #3.			
			patient meets chena #5.			
			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.			
			2. Glowal formione definitions of experienced an information of age, approve in the patient has the of objects of regular for experienced an information with the respective agent, in one is formularly.			
			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,			
Growth Hormone		lonapegsomatropin-	would result in a significant allergy or serious adverse reaction [documentation required].			
Products – Weekly		tcgd subcutaneous	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.			
Dosed Skyti	/trofa	injection	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	

					2025 NPF	Continuation of
Thorany Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	Excluded Medicaiton	Therapy
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Duration	wedication	Required?
			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 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			
Growth Hormone		somapacitan-beco	Establish a significant allergy or serious adverse reaction [documentation required].			
Products – Weekly		subcutaneous	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.			
Dosed	Sogroya	injection	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 MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Head Lice Treatments		spinosad topical	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
(Topical)	Natroba	suspension	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
			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):			
		bismuth subcitrate	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			
		potassium,	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],			
Helicobacter Pylori Agents	Pylera	metronidazole plus tetracycline capsules	Omeclamox-Pak, Voquezna Pak, or Talicia).	1 month	Yes	
, igomo	. yioid	tourdeyemie expedies	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			
Hematology Agents - Miscellaneous	District	imetelstat intravenous	C. Patient has tried or has a poor probability to respond to immosuppressive therapy.	4	V	V
Miscellaneous	Rytelo	injection motixafortide	3. Approve if the patient has already been started on therapy with Rytelo.  Peripheral blood stem cell mobilization for collection and subsequent autologous transplantation in patients with Multiple myeloma.	1 year	Yes	Yes
Hematopoietic/Throm		subcutaneous	1. Approve if the patient has tried plerixafor injection (Mozobil, generics), if formulary. If plerixafor injection (Mozobil, generics) are non-formulary, approve.			
bopoietic Agents	Aphexda	injection	2. Approve if the patient has already started therapy with Aphexda.	1 year	Yes	
Hemophilia - Factor IX Products	ì	coagulation Factor IX				
(recombinant		[recombinant],				
extended half-life products)	Rebinyn	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	(	,550.0	- Applies of the parameter successful of the recent of the recent of the parameter successful of the recent of the	, , ,		
Products		coagulation factor IX				
(recombinant standard half-life		[recombinant] solution for intravenous	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.			
products)	lxinity	injection	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		coagulation factor IX	1. Approve if the patient has tried one of BeneFIX or Ixinity, if formulary. If neither are formulary, approve.			
products)	Rixubis	[recombinant]	2. Approve if the patient is currently receiving Rixubis or has received Rixubis in the past.	1 year	Yes	Yes

					2025 NPF	Continuation of
Th	Barad Name	Oi- N	Our consist FF Oritoria	Approval	Excluded	Therapy
Therapy Class Hemophilia - Factor	Brand Name	Generic Name	Commercial FE Criteria	Duration	Medicaiton	Required?
VIII Products		antihemophilic factor	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,			
(recombinant		[recombinant] for	approve.			
	Nuwiq	intravenous injection	2. Patient is currently receiving Nuwiq or has received Nuwiq in the past: approve	1 year	Yes	Yes
Hemophilia - Factor						
VIII Products		antihemophilic factor	Delication to strict the trick true from the fallowing list (if true are farmular to a section to the fallowing list (if true are farmular to a section to the fallowing list (if the section to a section to the fallowing list (if the section to a section to the fallowing list (if the section to a section to the fallowing list (if the section to a section to the fallowing list (if the section to a section t			
(recombinant standard half-life)	Recombinate	[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
standard fian-inc)	recombinate	Injection	Patient meets Hemophilia – Alhemo Prior Authorization Policy criteria AND	i yeai	103	103
			a distributions and an amount of the Administration of the Adminis			
			For Hemophilia A.			
			1. Approve if the patient has tried Hemlibra, if formulary. If Hemlibra is non-formulary, approve.			
			2. Approve if, according to the prescriber, there is concern for a drug-drug interaction (e.g., drug interaction with Hemlibra and Feiba).			
Hamandilla Nan			3. Approve if the patient has already been started on therapy with Alhemo.			
Hemophilia – Non- Factor Routine		concizumab-mtci subcutaneous	For Hemophilia B.	See PA		
Prophylaxis Products	Alhemo	injection	Approve.	duration	Yes	
r reprijianie r readete	7 (11101110	injection.	Patient meets Hemophilia – Hympavzi Prior Authorization Policy criteria AND	uu.uuo		
			For Hemophilia A.			
			1. Approve if the patient has tried Hemlibra, if formulary. If Hemlibra is non-formulary, approve.			
			2. Approve if, according to the prescriber, there is concern for a drug-drug interaction (e.g., drug interaction with Hemlibra and Feiba).			
Hemophilia – Non-		marstacimab-hncq	3. Approve if the patient has already been started on therapy with Hympavzi.			
Factor Routine		subcutaneous	For Hemophilia B.	See PA		
Prophylaxis Products	Hympavzi	injection	Approve.	duration	Yes	
			Patient meets the following standard Hemophilia – Gene Therapy – Begvez 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.			
		fidanacogene	If the patient does not meet 1 or 2 above, direct the patient to Hemgenix.			
Hemophilia Gene		elaparvovec-dzkt		See PA		
Therapy	Beqvez	intravenous infusion	All reviews (approvals and denials) will be forwarded to the Medical Director for evaluation.	Duration	Yes	
					MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Hepatitis B Agents	Baraclude tablets	entecavir tablets	Criteria: Approve if the Brand product is being requested due to a formulation 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	applies only to the NPF	
riepatitis D Agents	Daracique tablets	entecavii tabiets	If Epclusa (brand) is formulary:	i yeai	uie ivi-i	
			In Epolusa (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 Epolusa (brand only) using the standard Hepatitis C – Epolusa PA Policy			
			1. Genotype 2 of 3 Chronic repailus C virus, Fediatic Fatient (2.3 Fedias of Age and 1.0 Fedias of Age) – New Start. Sovaduris not approved. One to review for Epolasa (unand only) using the standard repailus C – Epolasa FA Folicy criteria.			
			2. Patient Continuing Therapy with Sovaldi: Refer to the standard <i>Hepatitis C – Sovaldi PA Policy</i> 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			
			1. Genotype 2 or 3 Chronic Hepatitis C - Sovaldi PA Policy criteria.   2 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.			
	Sovaldi 200 mg		2. Patient Continuing Therapy with Sovaldi. Refer to the standard <i>Hepatitis C – Sovaldi PA Policy</i> criteria.			
	tablets and oral	sofosbuvir tablets and				

					2025 NPF	Continuation of
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	Excluded Medicaiton	Therapy Required?
Hepatitis C - Oral	Sovaldi 400 mg		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.  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.			
Agents	tablets	sofosbuvir tablets	If neither Epclusa (brand) nor sofosbuvir/velpatasvir are formulary, approve.	Varies	Yes	
Hepatitis C - Oral Agents	ledipasvir/sofosbuvir tablets 90 mg/400 mg (Authorized generic for Harvoni)	ledipasvir/sofosbuvir tablets 90 mg/400 mg glecaprevir/	Patient is directed to use Harvoni 90 mg/400 mg. If Harvoni 90 mg/400 mg is non-formulary, approve.	24 weeks	Yes	
Hepatitis C - Oral		pibrentasvir tablets		See PSM		
Agents	Mavyret	and oral pellets	See Hepatitis C Virus Direct Acting Antivirals Preferred Specialty Management (PSM) for National Preferred Formulary and Basic Formulary (Mavyret Criteria)	duration	Yes	
Hepatitis C - Oral Agents	sofosbuvir/velpatasv ir (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	
Hereditary Angioedema – Acute		icatibant injection for				
Treatment	Firazyr	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	s 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	
HMG-CoA Reductase Inhibitors and Combination Products		atorvastatin calcium	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, 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), 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.  2. Patients who cannot swallow or have difficulty swallowing tablets or capsules, approve.  2. Patients who cannot swallow or have difficulty swallowing tablets or capsules, 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	

					2025 NPF	Continuation of
				Approval	Excluded	Therapy
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Duration	Medicaiton	Required?
HMG-CoA Reductase			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 R  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 i		MSB Exclusion *This criteria applies only to	Toquito :
Combination Products	s 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.  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, exhemic stroke) are appropriate for the patient as the requested brand non-formulary drug is being prescribed for a use OTHER THAN the primary prevention of cardiovascular disease (CVD) for ging or symptoms of CVD (f	1 year	the NPF	
HMG-CoA Reductase			ischemic stroke); AND		*This criteria	
Inhibitors and	Linitan	atam restation table to	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,	1	applies only to	
Combination Products	Libitot	atorvastatin tablets	would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	

					2025 NPF	Continuation of
Th	Barrel Name	O-maria Nama	Our consist FF Oritoria	Approval	Excluded	Therapy
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Duration	Medicaiton	Required?
			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].			
HMG-CoA Reductase Inhibitors and Combination Products	Zocor	simvastatin tablets	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,	1 year	MSB Exclusion *This criteria applies only to the NPF	
Combination Products	ZOCOF	Simvastatin tadiets	would result in a significant allergy or serious adverse reaction [documentation required].	ı year	trie NPF	
HMG-CoA Reductase		lovastatin extended-	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, (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), in 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:			
Combination Products	Altoprev	release tablets	ii. Other formulary alternative(s) would not be as medically appropriate for the patient as the requested non-formulary drug.  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 year	Yes	
HMG-CoA Reductase Inhibitors and Combination Products	Ezallor Sprinkle	rosuvastatin capsules	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	

					2025 NPF	Continuation of
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	Excluded Medicaiton	Therapy Required?
merupy oluse	Diana Humo	Concret Hame	Commission 1 E Orienta	Duration	Medicalion	rtoquirou:
HMG-CoA Reductase			Approve if the patient meets the following criteria (A <u>and</u> B):  A. Patient has tried ezetimibe; AND			
Inhibitors and	Roszet and	rosuvastatin 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		Yes - Authorized	
Combination Products	authorized generic	ezetimibe	rosuvastatin (Crestor, generics) are formulary, approve.	1 year	generic only	
		chorionic gonadotropin 10,000	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.			
Human Chorionic		unit powder for	2. For a diagnosis of cryptorchidism or hypogonadism, approve if the patient has tried Pregnyl or Novarel, if formulary, approve.			
Gonadotropin, HCG Agents	chorionic gonadotropin	intramuscular injection	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	
J	Ŭ I	,				
Human						
Immunideficiency Virus (HIV-1) - Non-						
Nucleoside Reverse			4. Annual of the nation has tried one non nucleoside values transpirates inhibitor (NNDTI) are NNDTI containing product (e.g. Custing Edurant Deleting Complete Orders). Attitle Curefi Confict.			
Transcriptase Inhibitors (NNRTIs)	Pifeltro	doravirine tablets	<ol> <li>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).</li> <li>Patients already started on therapy with Pifeltro, approve.</li> </ol>	1 year	Yes	Yes
			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			
Human			B. Patient meets ONE of the following (i or ii):			
Immunideficiency Virus (HIV-1) –			i. Results of resistance testing are not available; OR ii. Patient has integrase strand-transfer inhibitor (INSTI) resistance.			
Protease Inhibitor (PI)		darunavir and	3. If the patient, according to the prescriber, needs to begin antiretroviral therapy urgently, approve.		v	v
Based Agents	Prezcobix	cobicistat tablets	4. Approve if the patient has already been started on therapy with Prezcobix.	1 year	Yes	Yes
			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, <u>or</u> 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 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			
Human Immunodeficiency			Note: Examples of integrase strand transfer inhibitors include raltegravir, dolutegravir, elvitegravir.  f) CCR5 antagonist.			
Virus (HIV) –			Note: Examples of CCR5 antagonists include Selzentry (maraviroc tablets).			
Specialized	Rukobia	release 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		elvitegravir/ cobicistat/	1. Approve if the patient has tried Biktarvy, if formulary. If Biktarvy is non-formulary, approve.			
(INSTI) Combination	Ctaile il al	emtricitabine/	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).	1	Vaa	Vaa
Products	Stribild	tenofovir tablets	3. Patients already started on therapy with Stribild: approve.	1 year	Yes	Yes

					2025 NPF	Continuation of
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	Excluded Medicaiton	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) - Non- Nucleoside Reverse Transcriptase Inhibitors (NNRTI)- Based Combination Products	Complera	emtricitabline/rilpivirin e/tenofovir disoproxil fumarate (TDF) tablets	<ol> <li>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.</li> <li>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.</li> <li>Patients already started on therapy with Complera: approve.</li> </ol>	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	<ol> <li>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.</li> <li>Patient &lt; 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.</li> <li>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.</li> <li>Patients already started on therapy with Delstrigo, approve.</li> </ol>	1 year	Yes	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].  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 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	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-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	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-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	

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
morapy class			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-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	Jul auton		rioquirou .
Hyaluronic Acid	Cufferore	sodium hyaluronate	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.	1.400	Vaa	
Derivatives	Euflexxa	injection	Note: If the patient has received all the injections in a completed series (for each targeted joint), refer to criteria above.  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	1 year	Yes	
Hyaluronic Acid Derivatives	Gel-One	hyaluronate gel injection	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-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		sodium hyaluronate	<ol> <li>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-One, Hymovis, Visco-3, Synojoynt, Triluron, or Trivisc [documentation required]. If none are formulary, approve GenVisc 850.</li> <li>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.</li> <li>Patients who have already been started on an injection series with Genvisc 850: approve to complete the series.</li> </ol>			
Derivatives	GenVisc 850	injection	Note: If the patient has received all the injections in a completed series (for each targeted joint), refer to criteria above.  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	1 year	Yes	
Hyaluronic Acid Derivatives	Hyalgan	sodium hyaluronate injection	formulary): Durolane, Euflexxa, Gel-One, Gel-Syn, GenVisc 850, Monovisc, Orthovisc, Supartz FX, 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	<ol> <li>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.</li> <li>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.</li> <li>Patients who have already been started on an injection series with Hymovis: approve to complete the series.</li> <li>Note: If the patient has received all the injections in a completed series (for each targeted joint), refer to criteria above.</li> </ol>	1 year	Yes	
Hyaluronic Acid	.,,	sodium hyaluronate	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-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.	.,,		
Derivatives	Supartz FX	injection	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	<ol> <li>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.</li> <li>Patients who have already been started on an injection series with Synvisc: approve to complete the series.</li> <li>Note: If the patient has received all the injections in a completed series (for each targeted joint), refer to criteria above.</li> </ol>	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	,		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-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.	,		
Derivatives	Triluron	sodium hyaluronate 1% injection	Note: If the patient has received all the injections in a completed series (for each targeted joint), refer to criteria above.	1 year	Yes	

Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy Required?
Hyaluronic Acid Derivatives	Trivisc	sodium hyaluronate	<ol> <li>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.</li> <li>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.</li> <li>Patients who have already been started on an injection series with Trivisc: approve to complete the series.</li> <li>Note: If the patient has received all the injections in a completed series (for each targeted joint), refer to criteria above.</li> </ol>	1 year	Yes	
Hyaluronic Acid Derivatives	Visco-3	sodium hyaluronate	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, 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	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	
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	
Hypolipoproteinemics		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 vear	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	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	
ldiopathic 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	

					2025 NPF	Continuation of
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	Excluded Medicaiton	Therapy Required?
Immune Globulins -	Drana Ivanio	Concret Name	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): Cuvitru, Hizentra, Xembify, Cutaquig, Gamunex-C or	Burution	Micarcanton	rtoquirou.
Intravenous (IVIG)		immune globulin	Gammagard Liquid. If none are formulary, approve.			
and Subcutaneous		injection (human),	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 one if two are formulary or one if only one is formulary): Alyglo, Asceniv, Bivigam, Flebogamma			
(SCIG)	Gammaked	10%	DIF, Gammagard Liquid, Gammagard S/D, Gammaplex, Gamunex-C, Octagam, Privigen or Panzyga. If none are formulary, approve.	1 year	Yes	
		Immune globulin	Primary Immunodeficiencies:			
		subcutaneous	Note: Examples of primary immunodeficiences include, but are not limited to, congenital agammaglobulinemia, X-linked agammaglobulinemia, severe combined immunodeficiency, common variable immunodeficiency.			
Immune Globulins -		[human] 16.5%	Approve if the patient has tried three products from the following list, if formulary (or two if two are formulary): Cuvitru, Hizentra, Xembify, Gamunex-C, Gammagard Liquid, or Gammaked. If none are formulary,			
Subcutaneous (SCIG)	Cutaquig	solution	approve.	1 year	Yes	
			Asthma with an eosinophilic phenotype.			
			Approve if the patient meets one of the following (A or B):			
		reslizumab for	A. <u>Initial therapy</u> 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;			
Immunological Agents	Cingair	intravenous injection	B. Patient has already been started on therapy with Cinqair.	1 year	Yes	Yes
<u> </u>		,		,		
			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.			
Immunosuppressant	F VD	tacrolimus extended-	Note: The CYP3A5*1 allele is a gene variant determined by testing that may confer faster metabolism of certain medications.	4	V	
Agents	Envarsus XR	release tablets	3. If the patient has already started on therapy with Envarsus XR, approve.	1 year	Yes	Yes
		methotrexate injection				
Immunosuppressant		for subcutaneous use;				
Agents –		10mg, 12.5 mg, 15				
Methotrexate		mg, 17.5 mg, 20 mg,				
Injections	Otrexup	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			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):			
Agents – Oral		methotrexate 2.5	1. Patient cannot swallow or has difficulty swallowing oral method reach tablets: OR			
	Xatmep	mg/mL oral solution	2. The dose prescribed cannot be obtained using whole methotrexate tablets.	1 year	Yes	
Immunosuppressant			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):			
Agents – Oral Methotrexate Agents	hilamaria	methotrexate 2 mg/mL oral solution	1. Patient cannot swallow or has difficulty swallowing oral methotrexate tablets; OR	1 vear	Yes	
Methotrexate Agents	Jylanivo	mg/mL oral solution	2. The dose prescribed cannot be obtained using whole methotrexate tablets.	i year	MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Inflammatory Bowel		mesalamine rectal	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Agents	Canasa	suppository	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
					MSB Exclusion	
Inflammata D :			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Inflammatory Bowel Agents	Delzicol	mesalamine delayed- release capsule	Criteria: Approve if the Brand product is being requested due to a formulation 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	applies only to the NPF	
луств	Deizioui	Tolcase capsule	production, would result in a symmetric analysis of solicities and the symmetric and	ı yeai	MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Inflammatory Bowel		mesalamine delayed-	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Agents	Lialda	release tablet	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
Inflammatory Powel			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 capsules (Apriso, generics) or Pentasa. If none are formulary, approve.			
Inflammatory Bowel Agents	Dipentum	olsalazine capsule	(Colazar, generics), mesalamine delayed-release capsule (Delzicol, generics), balsalazide (Colazar, generics), mesalamine extended-release capsules (Apriso, generics) or Pentasa. It none are formularly, approve.  Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.	1 vear	Yes	
, 195.110	S.portturii	o.caiazino oapodio	The parameter and the state of	. , oui	MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Inflammatory		hydroxychloroquine	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Conditions	Plaquenil	sulfate tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
Inflammate:::		hydroxychloroquine	4 Direct to generic hydroxychloroguine tablete			
Inflammatory Conditions	Sovuna	sulfate 200 mg, 300	<ol> <li>Direct to generic hydroxychloroquine tablets.</li> <li>Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use generic hydroxychloroquine tablets.</li> </ol>	1 vear	Yes	
Containons	Covulia	linia	A. Approve it, according to the presented, there is a significant children concern such that the patient is unable to use generic hydroxychioroduline tablets.	, you	100	

				Approval	2025 NPF Excluded	Continuation of Therapy
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Duration	Medicaiton	Required?
Inflammatory Conditions – Infused		vedolizumab for subcutabeous		See PSM		
Non-TNF Biologics	Entyvio SC	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.	duration	Yes	Yes
Inflammatory Conditions – Infused Non-TNF Biologics	Orencia IV	abatacept injection for	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
NOTI-TINE BIOLOGICS	Orenda IV	intravenous use	Statt-versus-riost Disease - Frevertition. Approve.	1 year	res	168
			If Actemra IV AND Tyenne IV are both formulary (or one is formulary) [For all indications]: 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			
Inflammatory Conditions – Infused Non-TNF Biologics – Tocilizumab Intravenous Agents	Tofidence IV	tocilizumab-bavi intravenous infusion	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) 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).	1 year	Yes	Yes
Inflammatory Conditions – Infused Non-TNF Biologics –		ustekinumab- aauz for	If any of the following ustekinumab intravenous (IV) products are formulary, Selarsdi IV, Stelara IV, Stelara IV, Wezlana IV, Pyzchiva IV or ustekinumab-ttwe IV, or Yesintek IV, approve if the patient meets BOTH of the following (A and B):  A. Patient has tried ALL of the following: 1) Stelara IV, 2) Steqeyma IV, 3) Wezlana IV, 4) Pyzchiva IV or ustekinumab-ttwe IV, 5) Yesintek IV, and 6) Selarsdi IV, if formulary; AND  Note: Pyzchiva IV and ustekinumab-ttwe IV count as one alternative.  B. Patient cannot continue to use all the formulary ustekinumab 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.  If none of the ustekinumab intravenous (IV) products are formulary, Selarsdi IV, Stelara IV, Steqeyma IV, Wezlana IV, Pyzchiva IV or ustekinumab-ttwe IV, Yesintek IV, approve if the patient meets ONE of the following (1 or 2):  1. Ulcerative Colitis, for an induction regimen in a patient ≥ 18 years of age.  Approve if the patient has tried two of 1) Entyvio intravenous (IV)/subcutaneous (SC), 2) Skyrizi IV/SC, or 3) Tremfya IV/SC, if two are formulary (or one if one is formulary). If none are formulary, approve.  2. Crohn's Disease, for an induction regimen in a patient ≥ 18 years of age.			
	Otulfi IV	IV infusion	Approve if the patient has tried one of 1) Entyvio IV/SC, 2) Skyrizi IV/On Body, or 3) Tremfya IV/SC, if formulary. If none are formulary, approve.	1 dose	Yes	

					2025 NPF	Continuation of
Therapy Class	Brand Name	Generic Name	Commercial FF Criteria	Approval Duration	Excluded Medicaiton	Therapy Required?
Inflammatory Conditions – Infused Non-TNF Biologics – ustekinumab Agents	Brand Name	Generic Name  ustekinumab- ttwe for IV infusion	Direct to ustekinumab-ttwe IV, if formulary.  If ustekinumab-ttwe IV is non-formulary,  If any of the following ustekinumab intravenous (IV) products are formulary, Selarsdi IV, Stelara IV, Steqeyma IV, Wezlana IV, Yesintek IV, Otulfi IV, approve if the patient meets BOTH of the following (A and B):  A. Patient has tried ALL of the following: 1) Stelara IV, 2) Steqeyma IV, 3) Wezlana IV, 4) Yesintek IV, 5) Otulfi IV, and 6) Selarsdi IV, if formulary; AND  B. Patient cannot continue to use all the formulary ustekinumab 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.  If none of the ustekinumab intravenous (IV) products are formulary, Selarsdi IV, Stelara IV, Steqeyma IV, Wezlana IV, Yesintek IV, Otulfi IV, approve if the patient meets ONE of the following (1 or 2):  1. Ulcerative Colitis, for an induction regimen in a patient ≥ 18 years of age.  Approve if the patient has tried two of 1) Entyvio intravenous (IV)/subcutaneous (SC), 2) Skyrizi IV/SC, or 3) Tremfya IV/SC, if two are formulary, approve.	Duration  1 dose	Medicaiton	Required?
Inflammatory Conditions – Infused Non-TNF Biologics – ustekinumab Agents	Steqeyma IV	ustekinumab-stba for IV infusion	If any of the following ustekinumab intravenous (IV) products are formulary, Selarsdi IV, Stelara IV, Wezlana IV, Yesintek IV, Pyzchiva IV or ustekinumab-ttwe IV, or Otulfi IV, approve if the patient meets BOTH of the following (A and B):  A. Patient has tried ALL of the following: 1) Stelara IV, 2) Wezlana IV, 3) Yesintek IV, 4) Pyzchiva IV or ustekinumab-ttwe IV, 5) Otulfi IV, and 6) Selarsdi IV, if formulary; AND  Note: Pyzchiva IV and ustekinumab-ttwe IV count as one alternative.  B. Patient cannot continue to use all the formulary ustekinumab 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.  If none of the ustekinumab intravenous (IV) products are formulary, Selarsdi IV, Stelara IV, Wezlana IV, Yesintek IV, Pyzchiva IV or ustekinumab-ttwe IV, Otulfi IV, approve if the patient meets ONE of the following (1 or 2):  1. Ulcerative Colitis, for an induction regimen in a patient ≥ 18 years of age.  Approve if the patient has tried two of 1) Entyvio intravenous (IV)/subcutaneous (SC), 2) Skyrizi IV/SC, or 3) Tremfya IV/SC, if two are formulary, approve.  2. Crohn's Disease, for an induction regimen in a patient ≥ 18 years of age.  Approve if the patient has tried one of 1) Entyvio IV/SC, 2) Skyrizi IV/On Body, or 3) Tremfya IV/SC, if formulary. If none are formulary, approve.	1 dose	Yes	
Inflammatory Conditions – Infused Non-TNF Biologics – ustekinumab Agents	Wezlana IV	ustekinumab for IV infusion	If any of the following ustekinumab intravenous (IV) products are formulary, Selarsdi IV, Stelara IV, Stelara IV, Yesintek IV, Pyzchiva IV or ustekinumab-ttwe IV, or Otulfi IV, approve if the patient meets BOTH of the following (A and B):  A. Patient has tried ALL of the following: 1) Stelara IV, 2) Steqeyma IV, 3) Yesintek IV, 4) Pyzchiva IV or ustekinumab-ttwe IV, 5) Otulfi IV, and 6) Selarsdi IV, if formulary; AND  Note: Pyzchiva IV and ustekinumab-ttwe IV count as one alternative.  B. Patient cannot continue to use all the formulary ustekinumab 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.  If none of the ustekinumab intravenous (IV) products are formulary, Selarsdi IV, Stelara IV, Steqeyma IV, Yesintek IV, Pyzchiva IV, or ustekinumab-ttwe IV, or Otulfi IV, approve if the patient meets ONE of the following (1 or 2):  1. Ulcerative Colitis, for an induction regimen in a patient ≥ 18 years of age.  Approve if the patient has tried two of 1) Entyvio intravenous (IV)/subcutaneous (SC), 2) Skyrizi IV/SC, if formulary. If none are formulary, approve.  Approve if the patient has tried one of 1) Entyvio IV/SC, 2) Skyrizi IV/On Body, or 3) Tremfya IV/SC, if formulary, If none are formulary, approve.	1 dose	Yes	
Inflammatory Conditions – Infused Non-TNF Biologics – ustekinumab Agents	Otulfi SC	ustekinumab- aauz SC	See standard Inflammatory Conditions – ustekinumab 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	
Ü	Pyzchiva SC	ustekinumab- ttwe SC	See standard Inflammatory Conditions – ustekinumab 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 – Infused Non-TNF Biologics – ustekinumab Agents	Steqeyma SC	ustekinumab-stba SC	See standard Inflammatory Conditions – ustekinumab 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	

					2025 NPF	Continuation of
				Approval	Excluded	Therapy
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Duration	Medicaiton	Required?
			Patient meets standard Inflammatory Conditions – Infliximab Intravenous Products Prior Authorization Policy criteria AND  Approve if the patient meets BOTH of the following (A and B):			·
Inflammatory			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.			
Conditions - Infused		Infliximab- axxq for	25 man and 37 a salata at 350 action.	See PA		
TNF antagonists	Avsola	intravenous use	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.	duration	Yes	
			Patient meets standard Inflammatory Conditions – Infliximab Intravenous Products Prior Authorization Policy criteria AND			
			Approve if the patient meets BOTH of the following (A <u>and</u> B):  A. Patient has tried Inflectra; AND			
Inflammatory	Remicade 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.			
Conditions - Infused	authorized generic	infliximab injection for		See PA		
TNF antagonists	infliximab	intravenous use	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.	duration	Yes	
			Patient meets standard Inflammatory Conditions – Infliximab Intravenous Products Prior Authorization Policy criteria AND			
			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			
Inflammatory Conditions - Infused		Infliximab-abda for	significant allergy or serious adverse reaction.	See PA		
	Renflexis	intravenous use	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.	duration	Yes	
Inflammatory						
Conditions - Janus				See PSM		
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.	duration	Yes	Yes
Inflammatory Conditions – SC Non-		tildrakizumab SC		See PSM		
TNF Biologics	llumya	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.	duration	Yes	Yes
Inflammatory						
Conditions – SC Non-		abatacept injection for		See PSM		
TNF Biologics	Orencia for SC 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.	duration	Yes	Yes
Inflammatory		bimekizumab-bkzx		See PSM		
Conditions – SC Non- TNF Biologics	Bimzelx	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.	duration	Yes	Yes
Inflammatory	DIIIIZGIX	brodalumab for	Secretary minimizations of containing the property of the secretary management in the property of the secretary management in the property of the secretary of	duration	103	103
Conditions – SC Non-		subcutaneous		See PSM		
TNF Biologics	Siliq	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.	duration	Yes	Yes
Inflammatory						
Conditions – SC Non-				See PSM		
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.	duration	Yes	Yes

				Approval	2025 NPF Excluded	Continuation of Therapy
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Duration	Medicaiton	Required?
Inflammatory Conditions – SC Non-		secukinumab for	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.  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 has tried Taltz, if formulary; OR  Note: If Taltz is non-formulary, approve.  2. Patient has been established on Cosentyx (IV or SC) for ≥ 90 days, approve.			
TNF Biologics	Cosentyx IV	intravenous injection	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		sarilumab subcutaneous		See PSM		
INF Biologics	Kevzara	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.	duration	Yes	Yes
Inflammatory Conditions – SC Non- TNF Biologics – ustekinumab Agents Inflammatory	Wezlana SC	ustekinumab for SC injection golimumab	See standard Inflammatory Conditions – usteknumab 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	
Conditions – SC TNF		subcutaneous		See PSM		
Antagonists	Simponi SC	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.	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	
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	

					2025 NPF	Continuation of
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	Excluded Medicaiton	Therapy Required?
Therapy Glade	Diana Namo	Generio Hamo	Outmortain 2 Outmort	Burution	Modification	rtoquirou:
nflammatory						
Conditions – SC TNF		adalimumab-bwwd		O DOM		
Antagonists - Adalimumab Agents	Hadlima	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	
Additional Agents	Hadiina	Injection	dee standard initiatination of original in order of the control of	duration	103	
Inflammatory						
Conditions – SC TNF		adalimumab-fkjp				
Antagonists - Adalimumab Agents	Hulio	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	Voc	
Adalimumab Agents	Hullo	Injection	See standard minammatory Conditions – Adammanab Products Preferred Specialty management Policy for National Preferred, right Performance, and Basic Politicians 1) Choice, 2) Attendate, 3) Legacy OK PLEX Politicians, poli	duration	Yes	
Inflammatory						
Conditions – SC TNF						
Antagonists -				See PSM	.,	
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.	duration	Yes	
Inflammatory						
Conditions – SC TNF		adalimumab-adaz				
Antagonists -		subcutaneous		See PSM		
Adalimumab Agents	Hyrimoz	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.	duration	Yes	
Inflammatan:						
Inflammatory Conditions – SC TNF		adalimumab-aacf				
Antagonists -	Idacio and	subcutaneous		See PSM		
Adalimumab Agents	adalimumab-aacf	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.	duration	Yes	
		ropeginterferon alfa- 2b-nift subcutaneous				
Interferons	Besremi	injection	See Oncology (Injectable) – Besremi Prior Authorization Policy criteria.	1 year	Yes	
		,			MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Iron Replacement (Injectable)	Feraheme	for move tol injection	Criteria: Approve if the Brand product is being requested due to a formulation 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	applies only to the NPF	
(IIIJectable)	relatiette	ferumoxytol injection	prescriber, would result in a significant aliergy or serious adverse reaction tocumentation required.	i yeai	ule INFF	
		ferric derisomaltose				
Iron Replacement		injection for	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			
(Injectable)	Monoferric	intravenous use	formulary, approve.	1 year	Yes	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		MSB Exclusion *This criteria	
Irritable Bowel			Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Syndrome Agents	Lotronex	alosetron tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].		the NPF	
		isotretinoin capsules	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,			
Isotretinoin Products	Absorica LD	low dose	approve.	1 year	Yes	
		montelukast sodium	NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		MSB Exclusion *This criteria	
Leukotriene Pathway		tablets, chewable	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Inhibitors	Singulair tablets	tablets, granules	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
			1. Approve if the patient has tried Striverdi Respimat, if formulary. If Striverdi is non-formulary, approve.			
			<ol> <li>Patient who is unable to coordinate breath and actuation with a metered-dose inhaler (MDI): approve.</li> <li>Patient with asthma: Approve if the patient is using Serevent Diskus concomitantly with an inhaled corticosteroid or an inhaled corticosteroid-containing product.</li> </ol>			
Long-Acting Beta-		salmeterol xinafoate	Patient with exercise induced bronchospasm without asthma: approve.			
Agonists (Inhalers)	Serevent Diskus	inhalation powder	Note: A patient with exercise-induced bronchospasm and asthma should be referred to criterion #3.	1 year	Yes	
<u> </u>					MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Long-Acting Beta- Agonists (nebulized)	Perforomist	formoterol fumarate inhalation solution	Criteria: Approve if the Brand product is being requested due to a formulation 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 vear	applies only to the NPF	
Agomora (Hendinzed)	CHOROTHIST	ii ii iaiauon Solution	prosonion, modita rosali, in a signinicani, ancisy or scholas adverse reaction tadament.	i year	UIC IVI I	

					2025 NPF	Continuation of
Thereny Class	Brand Name	Generic Name	Commercial FE Criteria	Approval	Excluded Medicaiton	Therapy
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Duration	Medication	Required?
Long-Acting						
Muscarinic Antagonist (LAMA)/Long-Acting	i	alveonyrrolate and				
Beta-Agonist (LABA)		glycopyrrolate and formoterol fumarate	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.			
	Bevespi Aerosphere		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		aclidinium bromide				
(LAMA)/Long-Acting		and formoterol				
Beta-Agonist (LABA)		fumarate inhalation	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.		.,	
Combination Inhalers	Duaklir Pressair	powder	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	
			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			
Lana Astina Onisida		tonontodal autondad	tablets (generics). If none are formularly, approve.			
Long-Acting Opioids (Oral)	Nucynta ER	tapentadol extended- release tablets	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	
(0.4.)	ruojina Eri	TOTOGOO KADIOKO	Approve if the patient has tried three other oral long-acting opioid products.	. you.		
			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			
Long-Acting Opioids		oxycodone extended-	formulary, approve.			
(Oral)	oxycodone ER	release tablets	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	
			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.			
Long-Acting Opioids	V4			4	V	
(Oral)	Xtampza ER	DETERx)	OxyContin. If none are formulary, approve.	1 year	Yes MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Long-Acting Opioids		buprenorphine	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
(Transdermal)	Butrans	transdermal system	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
		furosemide subcutaneous	For the treatment of edema in a patient ≥ 18 years of age with chronic heart failure or chronic kidney disease, including the nephrotic syndrome.			
		injection by on-body	Approve if the patient has tried at least one loop diuretic [documentation required] or the patient is currently taking a loop diuretic.			
Loop diuretics	Furoscix	infusor	Note: Examples of loop diuretics include furosemide, burnetanide, torsemide.	30 days	Yes	
			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, burnetanide (Burnex, generics), furosemide (Lasix, generics). If none are			
Loop diuretics	Soaanz	torsemide tablets	formulary, approve.	1 year	Yes	
Low Molecular Weight			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		MSB Exclusion *This criteria	
Heparins and Related		enoxaparin sodium	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Agents	Lovenox	injection (syringe/vial)	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
					MSB Exclusion	
		betaine trimethylglycine	<b>NOTE:</b> A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. <b>Criteria:</b> Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		*This criteria applies only to	
Metabolic Agents	Cystadane	powder for solution	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
.g			, , , , , , , , , , , , , , , , , , ,	,		

					2025 NPF	Continuation of
				Approval	Excluded	Therapy
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Duration	Medicaiton	Required?
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	
		nedosiran	Primary Hyperoxaluria Type 1 in a patient ≥ 2 years of age.			
Metabolic Disorder	Rivfloza	subcutaneous injection	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-formulary, approve.	1	Vee	Vaa
Agent	RIVIIOZA	Injection	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 (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	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 and 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	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	
Migraine Agents - Triptans	lmitrex 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	

Thereway Oleve	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	2025 NPF Excluded Medicaiton	Continuation of Therapy
Therapy Class	brand Name	Generic Name	Continercial FE Criteria	Duration	MSB Exclusion	Required?
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Migraine Agents -		rizatriptan orally	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Triptans	Maxalt MLT	disintegrating tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
Tiptano	maxan me i	alonitograming tabloto	prostately meast reason a eigenment along or extract actions reason (account reasons).	. you.	MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Migraine Agents -			Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Triptans	Relpax	eletriptan tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
'				,	MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Migraine Agents -			Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Triptans	Zomig tablets	zolmitriptan tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
		sumatriptan/				
Migraine Agents -		naproxen sodium	Approve if the patient has tried naproxen AND sumatriptan tablets (Imitrex, generics), if formulary. If sumatriptan tablets (Imitrex, generics) are non-formulary, approve.			
Triptans	Treximet	tablets	NOTE: A trial of the requested agent would NOT count toward meeting this requirement.	1 year	Yes	
			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			
Migraine Agents -		sumatriptan nasal	b. Patient has tried Zomig Nasal Spray or zolmitriptan nasal spray, if formulary.			
Triptans	Onzetra Xsail	powder	Note: If no products from a. or b. are formulary, approve.	1 year	Yes	
			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			
Miscellaneous		sofpironium topical	2. Patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with Qbrexza, if formulary.			
anticholinergic	Sofdra	gel, 12.45%	Note: If Qbrexa is non-formulary, criterion 2 is met.	1 year	Yes	
					MSB Exclusion	
		pyridostigmine tablet,	NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Miscellaneous		solution, exteneded-	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
anticholinergic	Mestinon	release tablet	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
			Hyperhidrosis, Primary Axillary in a patient ≥ 9 years of age.			
			Note: Obrexza 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].			
Miscellaneous		glycopyrronium cloth	2. Patient has tried and, according to the prescriber, has experienced inadequate efficacy OR significant intolerance with Sofdra, if formulary.			
anticholinergic	Qbrexza	2.4%, for topical use	Note: If Sofdra is non-formulary, criterion 2 is met.	1 year	Yes	
		methenamine 120				
		mg, sodium				
		phosphate monobasic				
		40.8 mg, phenyl				
		salicylate 36.2 mg,				
		methylene blue 10.8				
		mg, hyoscyamine				
Miscellaneous		sulfate 0.12 mg	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,			
Urologicals	Urimar-T	capsule	approve.	1 year	Yes	

					2025 NPF	Continuation of
				Approval	Excluded	Therapy
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Duration	Medicaiton	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 vear	Yes	
o roiogiouio	- Ciliara	capeare	GENERAL CONTROL CONTRO	. you.	MSB Exclusion	
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	*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)	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	
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].  Relapsing forms of multiple sclerosis.	1 year	MSB Exclusion *This criteria applies only to the NPF	
Multiple Sclerosis Drugs (Oral)	Aubagio	teriflunomide tablets	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. would still need to try a fumarate-based product, if one is 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			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			
Drugs (Oral)	Gilenya 0.25 mg	fingolimod capsule	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)	Tascenso ODT 0.25	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	

					2025 NPF	Continuation of
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	Excluded Medicaiton	Therapy Required?
Therapy Class	Dianu Name	Generic Name	Patient with relapsing form of multiple sclerosis.	Duration	Wedication	Requireur
			Note: Examples of relapsing forms of multiple sclerosis (MS) include clinically isolated syndrome, relapsing remitting disease, and active secondary progressive disease.			
Multiple Sclerosis	Tascenso ODT 0.5	fingolimod orally	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].			
Drugs (Oral)	mg	disintegrating tablets	2. Approve if neither fingolimod 0.5 mg capsule nor Gilenya 0.5 mg capsules are formulary.	1 year	Yes	
Multiple Sclerosis Drugs (Oral) –		dimenthy of frame areata				
Fumarate-based		dimethyl fumarate delayed-release				
Agents	Tecfidera	capsules	See standard Multiple Sclerosis (Tecfidera) Preferred Specialty Management Policy criteria.	1 year	Yes	
•		cyclobenzaprine				
		extended-release 15				
		mg and 30 mg				
Muscle Relaxants	Amrix and generic  Methocarbamol	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	
	1,000 mg tablets	methocarbamol 1.000	1. Direct the patient to methocarbamol 500 mg tablets.			
Muscle Relaxants	(brand)	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	
	/			1		
	Ozobax, Ozobax		1. Direct to oral baclofen tablets.			
Muscle Relaxants –	DS, and authorized		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			
Baclofen Agents	generics	baclofen oral solution	formulary, approve.	1 year	Yes	
		baclofen oral	1. Direct to oral baclofen tablets.			
Muscle Relaxants –		suspension, concentrated	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-			
Baclofen Agents	Fleqsuvy	formulation	formulary, approve if the patient has tried one of 1) Ozobax solution or 2) Lyvispah oral gransules, if formulary, approve.	1 year	Yes	
	<u> </u>		1. Direct the patient to oral baclofen tablets.	1		
			2. If Lvyispah will be administered via a feeding tube, approve.			
Muscle Relaxants –			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,			
Baclofen Agents	Lyvispah	baclofen oral granules	· · ·	1 year	Yes	
			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.			
Myelodysplastic		decitabine and	2. Approve if the patient is unable to obtain and/or maintain intravenous access.			
syndrome Agent	Ingovi	cedazuridine tablets	3. Approve if the patient has already started therapy with Ingovi.	1 year	Yes	Yes
			Myelofibrosis.			
			Note: Myelofibrosis includes primary myelofibrosis, post-polycythemia vera myelofibrosis, and post-essential thrombocythemia myelofibrosis.			
			1. Approve if the patient has tried Jakafi. If Jakafi is non-formulary, approve.			
			2. Approve if the patient has already been started on Inrebic.			
			Accelerated or Blast Phase Myeloproliferative Neoplasm: approve.			
Myelofibrosis Agents	Inrebic	febratinib capsules	Wyeloid/Lymphoid Neoplasms: approve.	1 year	Yes	Yes
,		,	Myelofibrosis.			
			Note: This includes primary myelofibrosis, post-polycythemia vera myelofibrosis, and post-essential thrombocythemia myelofibrosis.			
			1. Approve if the patient has tried Jakafi. If Jakafi is non-formulary, approve.			
			Note: If the patient has tried Vonjo, this would satisfy requirement for approval.			
			2. If the patient has myelofibrosis anemia, approve.			
Myelofibrosis Agents			3. Approve if the patient has already started on therapy with Ojjaara.			
JAK Inhibitors	Ojjaara	momelotinib tablets	Accelerated or Blast Phase Myeloproliferative Neoplasm: approve.	1 year	Yes	Yes
	,,					
		naloxone				
		hydrochloride				
Nalassa D. I. i. i.		intramuscular or	A Assess if the patient has tried and some primary if forms large. If pales are a partial part			
Naloxone Products for Opioid Overdose	Zimhi	subcutaneous injection 5 mg/0.5 ml	<ol> <li>Approve if the patient has tried naloxone syringes, if formulary. If naloxone syringes are non-formulary, approve.</li> <li>Approve, if according to the prescriber, a higher-strength naloxone product is needed.</li> </ol>	1 year	Yes	
Opiola Overdose	Z:::::::::::::::::::::::::::::::::::::	injection 5 mg/0.5 mi	a. αρμόνε, ii according to the presented, a higher-strength haloxone product is needed.	i yeai	MSB Exclusion	
Nasal Antihistamines		azelastine and	NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
and Combination		fluticasone propionate			applies only to	
Products	Dymista	nasal spray	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
			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			
		beclomethasone	nasal spray (Nasonex, generics), flunisolide nasal spray (generics), Omnaris, Qnasl, or Zetonna.	1.		
Nasal Steroids	Beconase AQ	nasal spray	Note: Over-the-counter (OTC) nasal steroids would count as a trial of an alternative.	1 year	Yes	

				A	Foreloaded	Continuation of
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	Excluded Medicaiton	Therapy Required?
Thorapy Class	2.4		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,	20.00.01		- rioquirou i
		ciclesonide nasal	mometasone nasal spray (Nasonex, generics), flunisolide nasal spray (generics), Qnasl, or Zetonna.			
Nasal Steroids O	Omnaris	spary	Note: Over-the-counter (OTC) nasal steroids would count as a trial of an alternative.	1 year	Yes	
		beclomethasone dipropionate nasal	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.			
lasal Steroids Q	Qnasl	aersol	Note: Over-the-counter (OTC) nasaal steroids would count as a trial of an alternative.	1 year	Yes	
			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,			
		ciclesonide nasal	mometasone nasal spray (Nasonex, generics), flunisolide nasal spray (generics), Omnaris, or Qnasl.			
Nasal Steroids Z	Zetonna	aerosol	Note: Over-the-counter (OTC) nasal steroids would count as a trial of an alternative.	1 year	Yes	
			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):			
		cysteamine bitartrate	i. Genetic testing confirmed a mutation of the CTNS gene; OR			
Nephropathic		dealyed-release	ii. White blood cell cystine concentration above the upper limit of the normal reference range for the reporting laboratory; AND			
Cystinosis	D	capsules and granule	C. The patient will not be using Cystagon and Procysbi concurrently; AND	4	V	
	Procysbi	packets	D. The patient has tried Cystagon [documentation required], if formulary. If Cystagon is non-formulary, approve.	1 year	Yes	
Neurology - Amyotrophic Lateral						
Sclerosis (ALS)		tofersen intrathecal	See standard Neurology – Qalsody Prior Authorization Policy criteria.			
Agents Q	Qalsody	injection	Note: No conditions of approval are recommended in the prior authorization policy.	N/A	Yes	
1						
leuromyelitis optica		inebilizumab-cdon injection for	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.			
	Uplizna	intravenous infusion	2. Approve if the patient has already started on therapy with Uplinza.	1 year	Yes	Yes
, ,	'		Patient meets the following Niemann-Pick Disease Type C – Miplyffa Prior Authorization Policy AND	Ĺ		
			Patient meets ONE of the following (1, 2, or 3):			
liemann-Pick lisease type C			<ol> <li>Patient has tried Aqneursa, if formulary. If Aqneursa is non-formulary, criterion A is met; OR</li> <li>Patient is &lt; 4 years of age.</li> </ol>			
	Miplyffa	arimoclomol capsules	2. Falletti is < 4 years or age.  3. Patient has already been started on therapy with Miplyffa.	1 year	Yes	Yes
3				1 , ,		
			5 Combination of Frankrich Bosinski Bos			
			<ol> <li>For the diagnosis of Treatment-Resistant Depression: approve if the patient meets the following criteria (A, B, C, D, and E):</li> <li>A. Patient is ≥ 18 years of age; AND</li> </ol>			
			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 include 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 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			
			D. The patient's history of controlled substance prescriptions has been checked using the state prescription drug monitoring program, according to the prescriber; AND			
			E. 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):			
			<ol> <li>Major Depressive Distriction with Active Suicidal Ideation of Behavior. Approve if the patient meets the following chiefla (A, B, C, D, and D).</li> <li>A Patient is ≥ 18 years of age: AND</li> </ol>			
			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			
N-methyl D-aspartate			ii. History of psychosis and the prescriber believes that the benefits of Spravato outweigh the risks; AND			
NMDA) receptor		esketamine nasal	E. The medication is prescribed by a psychiatrist.			
intagonists S	Spravato	spray	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
ISAID and Asid			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		MSB Exclusion *This criteria	
NSAID and Acid			Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Reducing Agent		ibuprofen and				

					2025 NPF	Continuation of
				Approval	Excluded	Therapy
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Duration	Medicaiton	Required?
		naproxen and			MSB Exclusion	
NSAID and Acid		esomeprazole	NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Reducing Agent		magnesium delayed-	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Combination Products	s Vimovo	release tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
					MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
NOAIDO (O. O)	0.1.1		Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
NSAIDS (Cox2)	Celebrex	celecoxib capsules	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
			Acute treatment of migraine.  1. Direct the patient to celecoxib capsules. If celecoxib capsules (Celebrex, generics) are non-formulary, approve.			
NSAIDS (Cox2)	Elyxyb	celecoxib oral solution	2. Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use celecoxib capsules.	1 vear	Yes	
110/1120 (00/12)	2.17.12	on our or an or a contract of	En reprote in decending to the protein test, there is a significant content and the patient is an account superiors.	. you.	MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
			Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
NSAIDs (Oral)	Nalfon	fenoprofen capsules	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
					MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
NCAIDa (Oral)	Zipsor	•	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the	1	applies only to the NPF	
NSAIDs (Oral)	Zipsor	capsule	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
			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.,			
	Coxanto and		Naprosyn, Naprelan, generics), dictofenac (Voltaren XR, generics), introducer (e.g., mount, generics), temporer (e.g., mount, generics), introducer (generics), naprolan, generics), introducer (generics), naprolan, generics), introducer (generics), introducer (e.g., mount, generics), introducer (generics), introducer (ge			
	oxaprozin 300 mg		Note: Over-the-counter (OTC) NSAIDs would count if prescription-strength doses were used.			
NSAIDs (Oral)		oxaprozin capsule	Note: Five unique NSAIDs should be tried.	1 year	Yes	
, ,			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).			
NOAID (O. I)		P	Note: Over-the-counter (OTC) NSAIDs would count if prescription-strength doses were used.		.,	
NSAIDs (Oral)	Dolobid	diflunisal tablets	Note: Five unique NSAIDs should be tried.	1 year	Yes	
			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.			
NSAIDs (Oral)	Vivlodex	meloxicam capsules	Note: Five unique NSAIDs should be tried.	1 year	Yes	
	Meloxicam	meloxicam	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.			
NSAIDs (Oral)	suspension	suspension	Note: Over-the-counter ibuprofen suspension would count as an alternative, regardless of formulary status.	1 year	Yes	
			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.,			
	Fenoprofen		Naprosyn, Naprelan, generics), oxaprozin (Daypro, generics), diclofenac (Voltaren XR, generics), piroxicam (Feldene, generics), indomethacin (generics).			
NSAIDs (Oral)	capsules [brand] and Fenopron	fenoprofen capsules	Note: Over-the-counter (OTC) NSAIDs would count if prescription-strength doses were used.  Note: Five unique NSAIDs should be tried.	1 year	Yes	
NOAIDS (Olai)	renopion	lenoproferr capsules	Approve if the patient has tried five prescription-strength oral NSAIDs.	i yeai	163	
			Note: : For example: nabumetone (generics), tedoloac (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).			
		nabumetone 1,000	Note: Over-the-counter (OTC) NSAIDs would count if prescription-strength doses were used.			
NSAIDs (Oral)	Relafen DS	mg tablets	Note: Five unique NSAIDs should be tried.	1 year	Yes	
			1. Approve if the patient has tried five prescription-strength, oral NSAIDs.			
			Note: Examples include: etodolac (generics), flurbiprofen (Ansaid, generics), ibuprofen (e.g., Matrin, generics), ketoprofen (generics), meloxicam (Mobic, generics), nabumetone (generics), naproxen (e.g., Naprosyn, Naprelan, generics), meloxicam (Mobic, generics), nabumetone (generics), naproxen (e.g., Naprosyn, Naprelan, generics), meloxicam (Mobic, generics), naproxen (e.g., Naprosyn, Naprelan, generics), naproxen (e.g., Naprosyn, Naprelan, generics), meloxicam (Mobic, generics), naproxen (e.g., Naprosyn, Naprelan, generics), naproxen (e.g., Naprosyn, generics), naproxen (e.g., Na			
			oxaprozin (Daypro, generics), diclofenac (Voltaren XR, generics), piroxicam (Feldene, generics), indomethacin (generics).			
	Cariy and suthering d	ketorolac	Note: Over-the-counter (OTC) NSAIDs would count if prescription-strength doses were used.  Note: Five unique NSAIDs should be tried.		Voc. Authorized	
NSAIDs (Oral)	Sprix and authorized generic	spray	2. Approve for patients with difficulty swallowing or for patients who cannot swallow.	1 year	Yes - Authorized generic only	
INOMIDS (Olai)	generic	Spray	Approve if the patient has tried five prescription-strength, oral NSAIDs.	i yeai	generic only	
			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.,			
		indomethacin.	Naprosyn, Naprelan, generics), oxaprozin (Daypro, generics), dicidena (Voltarea XR, generics), proxima (Feldene, generics), microsoft (generics), microsof			
	Tivorbex and	submicronized	Note: Over-the-counter (OTC) NSAIDs would count if prescription-strength doses were used.			
NSAIDs (Oral)			Note: Five unique NSAIDs should be tried.	1 vear	Yes - brand only	

					2025 NPF	Continuation of
Thereny Class	Brand Name	Canaria Nama	Commonsial EE Critoria	Approval	Excluded	Therapy
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria  Approve if the patient has tried five prescription-strength, oral NSAIDS.	Duration	Medicaiton	Required?
			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).			
NSAIDs (Oral)	Zorvolex and authorized generic	diclofense cancules	Note: Over-the-counter (OTC) NSAIDs would count if prescription-strength doses were used.  Note: Five unique NSAIDs should be tried.	1 year	Yes	
NOAIDS (Olai)	authorized generic	dicioleriac capsules	Note: 1 We unique NOADS should be tied.	i yeai	MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
		indomethacin oral	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
NSAIDs (Oral)	Indocin Suspension	indomethacin	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].  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	1 year	the NPF	
NSAIDs (Suppository)	Suppositories	suppositories	multiple therapeutic alternatives available.)	N/A	Yes- brand only	
` ' '					MSB Exclusion	
		diclofenac sodium	NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
NSAIDs (Topical)	Pennsaid	topical solution 2.0% pump	Criteria: Approve if the Brand product is being requested due to a formulation 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	applies only to the NPF	
(Topical)	Cilibalu	рипр	prescriber, would result in a significant diergy or serious adverse reaction [documentation required].	i yeai	UIC IVI I	
	diclofenac					
	epolamine 1.3%					
	topical patch	di ala <b>f</b> ana a an alamain a	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			
NSAIDs (Topical)	(authorized generic of Flector Patch)	1.3% topical patch	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	
rter ii 20 (1 opioui)	or rester ratery	11070 topioui putoii	Teacher the second (generally) is present according to the second repeat to generally and the second repeat to generally	. you.		
Nuclear Factor						
(erythroid-derived 2)-	Clarelence	omaveloxolone	Con standard Neurolean Clarelean Print Authorization Policy Authorization Policy arithmics	1	Vaa	
like 2 (Nrf2) Activator	Skyciarys	capsules	See standard Neurology – Skyclarys Prior Authorization Policy criteria.	1 year	Yes MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Omega-3 Fatty Acid		omega-3 acid ethyl	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Products	Lovaza	esters capsules	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
Ophthalmic –		tobramycin				
Antibiotic/Corticostero		0.3%/dexamethasone				
id Combination		0.05% ophthalmic	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.			
Products	TobraDex ST	suspension	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 –		tobramycin 0.3%/loteprednol				
Antibiotic/Corticostero		etabonate 0.5%	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.			
id Combination		ophthalmic	2. Patients < 2 years of age, approve.			
Products	Zylet	suspension	3. For the treatment of currently active eye infections: approve in patients already receiving Zylet to complete the course of therapy.	1 year	Yes	
			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,			
Ophthalmic -			olopatadine ophthalmic solution.			
Calcineurin Inhibitor		cyclosporine 0.1%	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		.,	
Immunosuppressant	Verkazia	ophthalmic emulsion	the maintenance treatment of vernal keratoconjunctivitis can be made if the patient has already tried at least one ophthalmic cyclosporine product .	1 year	Yes	
	Atropine sulfate 1%					
Ophthalmic Agent –	ophthalmic solution					
Mydriatics/	(preservative free)	atropine sulfate 1%	1. Direct the patient to generic atropine sulfate 1% ophthalmic solution.			
Cycloplegics	[brand]	ophthalmic solution	2. Patients with a known sensitivity to a preservative (e.g., benzalkonium chloride [BAK]), approve.	1 year	Yes	
Ophthalmic Agents - Complement Protein		avacincaptad pegol		See PA		
p.oont i rotolli	Izervay	intravitreal injection	See standard Ophthalmology – Izervay Prior Authorization Policy criteria.	duration	Yes	

					2025 NPF	Continuation of
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	Excluded Medicaiton	Therapy Required?
тистиру стисс			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			
Ophthalmic Agents -		•	2. Patient has experienced a significant intolerance with ONE of Eylea (not HD) or Pavblu [documentation required].	1.		
VEGF Inhibitors	Eylea HD	injection	Note: If BOTH Eylea (not HD) and Pavblu are non-formulary, approve.	1 year	Yes	
			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			
			b. Fatient continue to use the attendance to the the attendance in the inactive ingredient(s) [e.g., uniferences in stabilizing agent, bulleting agent, and/or surfactang 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			
Ophthalmic Agents -		ranibizumab	B. Patient with myopic choroidal neovascularization (mCNV); OR			
VEGF Inhibitors	Lucentis	intravitreal injection	C. Patient is currently receiving therapy with Lucentis.	1 year	Yes	Yes
			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.			
			Manually Edward following Detinal Vair Control			
Onbthalmia Aganta		faricimab-svoa	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.			
Ophthalmic Agents - VEGF Inhibitors	Vabysmo	intravitreal injection	2. Patient is currently receiving therapy with Vabysmo: approve.	1 year	Yes	Yes
VEGI IIIIIbiloio	Vabyonio	intravia car injection	2. Talicit to currently receiving therapy with valuyonio. approve.	1 your	100	100
		ranibizumab				
		intravitreal injection				
Ophthalmic Agents -			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			
VEGF Inhibitors	Susvimo	implant/insert tool	recommended. Due to safety concerns, an exception is not recommended for Susvimo.)	N/A	Yes	
		oxymetazoline				
Ophthalmic alpha		hydrochloride 0.1%	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			
adrenoceptor agonist	Upneeq	ophthalmic solution	recommended. Due to insufficient clinical efficacy data, approval is not recommended.)	N/A	Yes	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		MSB Exclusion *This criteria	
Ophthalmic Anti-		bepotastine besilate	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Allergics	Bepreve	ophthalmic solution	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
- J	'	nedocromil sodium		1		
Ophthalmic Anti-		2% ophthalmic	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),			
Allergics	Alocril	solution	bepotastine solution (Bepreve, generics), epinastine 0.05% solution (generics), Lastacaft, olopatadine solution (generics), or Zerviate. If none are formulary, approve.	1 year	Yes	
		lodoxamide	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),			
Ophthalmic Anti-	Alamaida	tromethamine 0.1%	bepotastine solution (Bepreve, generics), epinastine 0.05% solution (generics), Lastacaft, olopatadine solution (generics), or Zerviate. If none are formulary, approve.	4	V	
Allergics	Alomide	ophthalmic solution	<ol> <li>For a diagnosis of vernal keratoconjunctivitis, vernal conjunctivitis, 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.</li> <li>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</li> </ol>	1 year	Yes	
		loteprednol etabonate	1. Approve in the patient has the united products into the following list in united and only one are formularly, or one in only one is formularly, bepotastine optimization (generics), bestacaft, azelastine 0.05% solution (generics). Lastacaft, azelastine 0.05% solution (generics). Expression of the product of the produc			
Ophthalmic Anti-			2. Patients who require concurrent use of Airex with an H1 antagonist/mast cell stabilizer (e.g. azelastine (generics), bepotastine, epinastine solution [generics], Lastacaft, olopatadine ophthalmic solution [generics].			
Allergics	Alrex	suspension	Zerviate): approve.	1 year	Yes	
Ophthalmic Anti-		cetirizine 0.24%	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			
Allergics	Zerviate	ophthalmic solution	(generics), bepotastine solution (Bepreve, generics), epinastine 0.05% solution (generics), Lastacaft, or olopatadine solution (generics).	1 year	Yes	
			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)			
		besifloxacin	levofloxacin ophthalmic solution (generics). If none are formulary, approve.			
Ophthalmic Antibiotics	Bi	ophthalmic	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.	4	V	
- Quinolones	Besivance	suspension 0.6%	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	
			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			
		ciprofloxacin	Depth lamin c solution (generics), moxifloxacin ophthalmic solution (Vocation ophthalmic solution (generics), or ofloxacin ophthalmic solution (Generics). If none are formularly or one are formularly or one are formularly or one or ofloxacin ophthalmic solution (Ocuplex, generics). If none are formularly or one or ofloxacin ophthalmic solution (Ocuplex, generics). If none are formularly or ofloxacin ophthalmic solution (Ocuplex, generics).			
Ophthalmic Antibiotics		ophthalmic ointment	2. If the patient is allergic to benzalkonium chloride, approve if the patient has tried moxifloxacin (Vigamox, Moxeza, generics), if formulary, I f			
- Quinolones	Ciloxan ointment	0.3%	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	
					MSB Exclusion	
Ophthalmic Anti-			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Inflammatory Agents -		bromfenac 0.075%	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
NSAIDs	BromSite	ophthalmic solution	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	

					2025 NPF	Continuation of
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	Excluded Medicaiton	Therapy Required?
тистиру стисс				24.4	ou.ou.to	. toquilou:
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, llevro, 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), llevro, 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 llevro, 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	
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 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. 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 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; 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	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) diffuprednate (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) diffuprednate (Durezol, generics). If none are formulary, approve.	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	

				Approval	2025 NPF Excluded	Continuation of Therapy
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Duration	Medicaiton	Required?
			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			
Ophthalmic Drugs for		timolol maleate 0.25%	formulary). If none are formulary, approve.			
Glaucoma - Beta-		and 0.5% ophthalmic	Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.	1	Vaa	
Adrenergic Blocker	Timoptic in Ocudose	Solution	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		timolol hemihydrates	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)			
Glaucoma - Beta-		0.25% and 0.5%	a betaxolol ophthalmic solution (generics or Betoptic S), or 4) carteolol opthalmic solution (generics). If none are formulary, approve.			
Adrenergic Blocker	Betimol	ophthalmic solution	Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.	1 year	Yes	
					MSB Exclusion	
Ophthalmic Drugs for		brinzolamide 1%	NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Glaucoma - Carbonic Anhydrase Inhibitor		ophthalmic suspension	Criteria: Approve if the Brand product is being requested due to a formulation 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	applies only to the NPF	
Arinyurase irinibiloi	Azopi	suspension	prescriber, would result in a significant aliergy or serious adverse reaction tocumentation required.	i yeai	uie iver	
Ophthalmic Drugs for						
Glaucoma - Carbonic					MSB Exclusion	
Anhydrase		dorzolamide	NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Inhibitor/Beta-		2%/timolol 0.5%	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Adrenergic Blocker		ophthalmic solution	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
0.141.1.5		travoprost 0.004%	NOTE. A multi-course Drand and us to being a supported. The potient should use the professed bioparticular approximation		MSB Exclusion	
Ophthalmic Drugs for Glaucoma -		ophthalmic solution (benzalkonium	NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Giaucoma - Prostaglandins		(benzaikonium chloride-free)	Criteria: Approve if the Brand product is being requested due to a formulation 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	applies only to the NPF	
riostagianums	Travatari Z	chionae-nee)	prescriber, would result in a significant aliengy or serious adverse reaction required.	i yeai	MSB Exclusion	
Ophthalmic Drugs for			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Glaucoma -		latanoprost 0.005%	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Prostaglandins	Xalatan	ophthalmic solution	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
					MSB Exclusion	
Ophthalmic Drugs for			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Glaucoma -		tafluprost 0.0015%	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Prostaglandins	Zioptan	ophthalmic solution	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].  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	1 year	the NPF	
		latanoprost	1. Approve it the patient has thed, and according to the prescriber, experienced inadequate emicacy or significant intolerance with one of 1) latanoprosi ophinalmic solution (Alataan, generics) of 2) Aelpros, it formularly. If none are formularly approve.			
Ophthalmic Drugs for		ophthalmic solution.	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			
Glaucoma -			Xelpros, if formulary. If Xelpros is non-formulary, approve.			
Prostaglandins		free	3. If, according to the prescriber, the patient has a significant allergy/sensitivity to other preservatives (OTHER than benzalkonium chloride), approve.	1 year	Yes	
			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) lyuzeh, if formulary. If none are			
Ophthalmic Drugs for			formulary, approve.			
Glaucoma -		latanoprost 0.005%	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	4	V	
Prostaglandins	Xelpros	ophthalmic emulsion		1 year	Yes	
Ophthalmic Drugs for Glaucoma -		bimatoprost 0.01%	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.			
Prostaglandins	Lumigan	ophthalmic solution	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		latanoprostene bunod	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			
Glaucoma -		ophthalmic solution	ophthalmic solution (Travatan Z, generics), bimatoprost 0.03% ophthalmic solution (generics), Lumigan, or tafluprost ophthalmic solution (Zioptan, generics). If none are formulary, approve.			
Prostaglandins	Vyzulta	0.024%	Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.	1 year	Yes	
			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, lyuzeh (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			
			b. The patienthals are and, according to the prescriber, experienced inadequate emicacy Ork significant molerance with at least two other opinional two different pharmacological classes (either as monotherapy or as concomitant therapy); AND			
Ophthalmic Drugs for			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			
Glaucoma –			inhibitor (netarsudil).			
Prostaglandins –		travoprost	C. The product is NOT being used for re-treatment of an eye previously treated with iDose TR.			
Implants	iDose TR	intracameral implant	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	

					2025 NPF	Continuation of
				Approval	Excluded	Therapy
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Duration	Medicaiton	Required?
			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, lyuzeh (latanoprost 0.005% ophthalmic 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			
Ophthalmic Drugs for			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			
Glaucoma –			inhibitor (netarsudil).			
Prostaglandins –	D	h:	C. The product is NOT being used for re-treatment of an eye previously treated with Durysta.	20 4	V	
Implants	Durysta	bimatoprost implant	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	
			NOTE: A multi-curse Drand and ust be being a greated. The potions should use the professed biographic product		MSB Exclusion	
		l	NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Opiate	0.1	buprenorphine/naloxo	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Agonists/Antagonists	Suboxone	ne sublingual film	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
			NOTE: A sufficient Development of The effect house of the control		MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
		oxycodone/acetamino	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Opioids (Oral) - Other	Percocet	phen tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
0 : : 1 (0 1) 0!!	Conzip and tramadol				.,	
Opioids (Oral) - Other		tramadol ER capsule	Approve, if per the prescriber, the patient is unable to use generic tramadol ER tablets.	1 year	Yes	
	tramadol 100 mg	tramadol 100 mg			.,	
Opioids (Oral) - Other	tablets (brand)	tablets	Approve, if per the prescriber, the patient is unable to use generic tramadol 50 mg tablets.	1 year	Yes	
	oxycodone-					
	acetaminophen 10-					
	300 tablets (includes		1. Direct to oxycodone-acetaminophen 10-325 mg tablets.		Yes - Primlev	
Opioids (Oral) - Other	Primiev, Prolate)	300 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	only	
	oxycodone-					
	acetaminophen 5-	oxycodone-				
0 : : 1 (0 1) 011		•			Yes - Primlev	
Opioids (Oral) - Other	Primiev, Prolate)	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	only	
	oxycodone-					
	acetaminophen 7.5-		4 Director and decreased and a second		V D: I	
Opioids (Oral) - Other	300 tablets (includes		1. Direct to oxycodone-acetaminophen 7.5-325 mg tablets.	1	Yes - Primlev	
Opioids (Orai) - Other			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	only	
Opioids (Oral) - Other	tramadol 25 mg	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	
Opiolus (Oral) - Other	tablets (bialiu)	lancis	The patient is No Frequited to split tile of this tables in hair.	ı yeai	165	
		oxycodone				
Opioids (Oral) - Other	Ovavdo	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	
Opiolus (Oral) - Other	Chayuu	,	prepared in the patient has another take time of the ordinary products. Oxycotome hydrochionide tablets (noxicotome, generics). If oxycotome hydrochionide tablets (noxicotome, generics) are not recommendately, approve.	ı yeai	165	
	Roxybond and	oxycodone hydrochloride tablet,				
Opioids (Oral) - Other		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	
Opiolas (Orai) - Otrici	adinonized generic	coatcu	periode if the patient has their and cannot take one of the following formularly products. Oxycodonic hydrocinologic tables (foxicodonic, generics): if oxycodonic hydrocinologic tables (foxicodonic, generics) are non-formularly, approve.	i yeai	103	
			A service of the office of the self-self-self-self-self-self-self-self-			
			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/acetaminophen (Ultram, generics).			
			NOTE: A trial of the requested product does not count toward this requirement.  2. Designator 5 fears to 4 19 years of each post and a constraint 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 age of mamphine sulfate immediate release tablets or marphine sulfate immediate release and solution. If patient are formularly approved OP			
		tanantadal immadi-t-	A. Patient has tried one of morphine sulfate immediate-release tablets or morphine sulfate immediate-release oral solution. If neither are formulary, approve; OR			
Opioids (Oral) - Other	Nucynta	tapentadol immediate- release tablets	B. Patient has renal insufficiency; OR C. Patient is intolerant or allergic to morphine.	1 vear	Yes	
Opiolos (Orai) - Otner	inucynia		C. Patient is intolerant or allergic to morphine.	i year	168	
	Odele end	tramadol				
Opioids (Oral) - Other	Qdolo and	hydrochloride oral solution	Approve if the nationt is unable to quallow or has difficulty quallowing tramedal tablets	1 vear	Voc	
Opiolos (Orai) - Otner	aumonzeu generic	SOIUIION	Approve if the patient is unable to swallow or has difficulty swallowing tramadol tablets.	ı year	Yes	

				Approval	2025 NPF Excluded	Continuation of Therapy
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Duration	Medicaiton	Required?
		oxycodone and				
		acetaminophen 10-	1. Approve if the patient has tried and cannot take oxycodone-acetaminophen 10-325 mg tablets.			
Opioids (Oral) - Other	Prolate solution	300 mg/5 oral solution		1 year	Yes	
Opioids (Oral) –		celecoxib and tramadol	1. Direct the patient to tramadol tablets and celecoxib capsules as separate agents. If celecoxib capsules (Celebrex, generics) are non-formulary, approve.			
Other/NSAID	Seglentis	hydrochloride tablets	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	
		ciprofloxacin 0.2%		•		
Otic Antibiotics	Cetraxal	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	
		ciprofloxacin/	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 Antibiotics and	Cipro HC Otic	hydrocortisone otic	otic solution, if formulary, If none are formulary, approve.			
Combination Products	Suspension	suspension, 0.2%/1%	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	
			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			
	ciprofloxacin/	ciprofloxacin and	2. If otiver (unit of since of the state of			
	fluocinolone otic		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			
Otic Antibiotics and	solution (authorized	otic solution,	ciprofloxacin- dexamethasone otic suspension (Ciprodex otic suspension, generics), if formulary. If ciprofloxacin- dexamethasone otic suspension (Ciprodex otic suspension, generics) are non-formulary, approve.			
Combination Products Overactive Bladder	generic to Otovel)	0.3%/0.025%	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	
Agents (Oral and	Oxybutynin 2.5 mg	oxybutynin 2.5 mg	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			
Topical)	tablet (brand)	tablet	B. Patient's dose requires a 2.5 mg increment.	1 year	Yes	
					MSB Exclusion	
Overactive Bladder			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Agents (Oral and Topical)	Detrol	tolterodine tablets	Criteria: Approve if the Brand product is being requested due to a formulation 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	applies only to the NPF	
· opioui)	25.1.5.	tottor ourie tubioto	production, read read in a digitimatic direct advisor following the control of th	. you.	MSB Exclusion	
Overactive Bladder			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Agents (Oral and	D		Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the	_	applies only to	
Topical)	Detrol LA	release capsules	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF MSB Exclusion	
Overactive Bladder			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Agents (Oral and		solifenacin succinate	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Topical)	Vesicare	tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
		footoveding francusta	NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		MSB Exclusion *This criteria	
Overactive Bladder		extended-release	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Agents (Oral)	Toviaz	tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
			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.			
Overactive Bladder		solifenacin succinate	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.			
Agents (Oral)	Vesicare LS	oral suspension	Note: If the patient has tried Mybetriq tablets, this would meet the requirement for a trial of Myrbetriq granules.	1 year	Yes	
Pancreatic Enzymes	Portzyo	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	
r anoreauc Enzymes	r enzye	release capsules	Approve it the patient has the uniee products from the inflowing list (it thee are inflintially, or two it two are formularly, or one it one is formularly). Great, Particleaze, or Zenpep. If none are formularly, approve.	i yeai	MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
			Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Phenylketonuria	Kuvan	powder packet	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].		the NPF	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		MSB Exclusion *This criteria	
	Fosrenol chewable	lanthanum carbonate	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Phosphate Binders	Fosrenol chewable tablets	lanthanum carbonate chewablet tablets	Criteria: Approve if the Brand product is being requested due to a formulation 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	applies only to the NPF	
Phosphate Binders			prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF MSB Exclusion	
Phosphate Binders				1 year	the NPF	

					2025 NPF	Continuation of
O.				Approval	Excluded	Therapy
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Duration	Medicaiton	Required?
			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.			
	Fosrenol oral	lanthanum carbonate	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			
Phosphate Binders	powder	oral powder	(Renvela powder, generics) is non-formulary, approve.	1 year	Yes	
Potassium Sparing		spironolactone oral	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.			
Diuretics	Carospir	suspension	2. Approve if the patient cannot swallow spironolactone tablets.	1 year	Yes	
Potassium	Pokonza	potassium chloride	Annexe if the estimations allow and extraction ablatic residues ablatic residues and establish and e	1,,,,,,,,	Vaa	
Supplement	POKONZA	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	
		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	1. Direct to generic prenatal vitamins.			
Prenatals vitamins	Pregenna	tablet	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  Citranatal prenatal vitamins (examples	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	
	include Citranatal					
	RX tablets,					
	Citranatal Harmony		1. Direct to generic prenatal vitamins.			
Prenatals vitamins	capsules)	various	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	
		ascorbic acid,				
		cholecalciferol,				
		thiamine				
		hydrochloride, riboflavin,pyridoxal				
		phosphate,levomefola				
		te glucosamine, folic				
		acid,				
		methylcobalamin,				
		calcium carbonate,				
		ferrous gluconate,	4 Direct to consider consider videories			
Prenatals vitamins	Natal PNV	potassium iodide tablet, film coated	<ol> <li>Direct to generic prenatal vitamins.</li> <li>Approve if, according to the prescriber, there is a significant clinical concern such that the patient is unable to use generic prenatal vitamins.</li> </ol>	1 year	Yes	
TOTICICIO VICAITIIIIO	I valai i i v	tablet, IIIII Coaleu	14. Approve it, according to the presented, there is a significant children content such that the patient is unlable to use general preliability.	i year	100	

					2025 NPF	Continuation of
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	Excluded Medicaiton	Therapy Required?
тнегару ошээ	Brana Name	pilocarpine	Offinition 12 Official	Duration	Wedicaiton	Required:
		hydrochloride				
		ophthalmic solution,	No exception is recommended.			
Presbyopia Agents	Qlosi	0.4%	(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	
		pilocarpine 1.25%	No exception is recommended.		.,	
Presbyopia Agents	Vuity	ophthalmic solution	(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	
Drimon/						
Primary Immunoglobulin A				See PA		
Nephropathy Agents	Filspari	sparsentan tablets	See standard Nephrology – Filspari Prior Authorization Policy criteria.	duration	Yes	
Progestin – Vaginal		'	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			
Agents	Crinone 4% Gel	progesterone gel 4%	formulary, approve.	1 year	Yes	
			1. Approve if the patient has tried Crinone 8% gel [documentation required], if formulary. If Crinone 8% gel is non-formulary, approve.			
Progestin – Vaginal		progesterone vaginal	2. A patient already 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.			
Agents	Endometrin	insert	Note: Approve for 9 months or to complete the course of therapy.	1 year	Yes	
D . D		aspirin and				
Proton Pump Inhibitor Combination	Yosprala and authorized generic	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	
Combination	authorized generic	release lablets	participrazole [Frountx, generics]).	i yeai	MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Proton Pump		rabeprazole sodium	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Inhibitors (PPIs)	Aciphex	tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
· /					MSB Exclusion	
		esomeprazole	NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Proton Pump		delayed-release	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Inhibitors (PPIs)	Nexium capsules	capsules	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
	Nexium packet					
	(granules for oral	esomeprazole	NOTE: A sufficient Development of the control of th		MSB Exclusion	
Droton Dumon	suspension) 10 mg,	delayed-release	NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Proton Pump Inhibitors (PPIs)	20 mg, 40 mg packet	granules for oral suspension (packet)	Criteria: Approve if the Brand product is being requested due to a formulation 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	applies only to the NPF	
IIIIIDIOIS (FFIS)	packet	suspension (packet)	prescriber, would result in a significant alienty or serious adverse reaction tocumentation required.	i yeai	MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Proton Pump		lansoprazole delayed-	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Inhibitors (PPIs)	Prevacid	release (DR) capsules	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
		pantoprazole sodium				
		delayed-release (DR)			MSB Exclusion	
		tablets and	NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Proton Pump Inhibitors (PPIs)	Drataniy	intravenous (IV)	Criteria: Approve if the Brand product is being required due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the	1.,,,,,,,,	applies only to the NPF	
Inhibitors (PPIS)	Protonix	injection	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	MSB Exclusion	
		nantonrazole delaved-	NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Proton Pump	Protonix oral	release oral	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Inhibitors (PPIs)	suspension		prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
		,			MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Proton Pump		lansoprazole orally	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Inhibitors (PPIs)	Prevacid SoluTab	disintegrating tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
			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			
	Asinhov Chrinkla	robonrozolo godi: :	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).			
Proton Pump	Aciphex Sprinkle and authorized	rabeprazole sodium delayed-release	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).		Yes Authorized	
•				1 year		
Inhibitors (PPIs)	generic	capsules	Note: The requested agent would NOT count as a trial of an alternative.	1 year	generic only	

					2025 NPF	Continuation of
Thereny Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	Excluded Medicaiton	Therapy
Therapy Class	brand Name	Generic Name	1. Approve if the patient has tried five proton pump inhibitors (PPIs).	Duration	Wedicalton	Required?
			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 (Protonix suspension (granules), lansoprazole DR capsules, Pritosec			
	Nexium packet	esomeprazole	omeprazole/sodium bicarbonate capsules (Zegerid, generics), or omeprazole/sodium bicarbonate packet (Zegerid, generics).			
	(granules for oral	delayed-release	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).			
Proton Pump	suspension) 5 mg	granules for oral	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.			
Inhibitors (PPIs)	and 2.5 mg packets	suspension (packet)	Note: The requested agent would NOT count as a trial of an alternative.	1 year	Yes	
			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).			
		omeprazole delayed-	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).			
Proton Pump	Prilosec oral	release oral	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.		.,	
Inhibitors (PPIs)	suspension	suspension	Note: The requested agent would NOT count as a trial of an alternative.	1 year	Yes	
			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			
Destar Dessa			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			
Proton Pump Inhibitors (PPIs)	Zegerid capsules	omeprazole/ sodium bicarbonate capsules	capsules (Prilosec, generics), or Prilosec DR suspension.  Note: The requested agent would NOT count as a trial of an alternative.	1 vear	Yes	
Infilbitors (PPIS)	Zegeria capsules	bicarbonate capsules		i year	res	
		amanuazala/ aadium	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			
		omeprazole/ sodium bicarbonate powder	prote. Examples of FTs include laughtaries (expirate, graph active determined by Lapisius), resultant Dr. Capsules of administrating the Capsules of administrating the Capsules (expirate), resultant Dr. Lapisius of Capsules, assuring the Capsules (expirate), resultant Dr. Lapisius of Capsules, lansoprazole DR (assules, lansoprazole DR), participating tablets (Protonix, generics), protonix suspension (granules), lansoprazole DR (assules, lansoprazole DR), assured to the Capsules (expirate), resultant Dr. Lapisius of Capsules, lansoprazole DR), participating tablets (Protonix, generics), oneprazole DR			
Proton Pump		for oral suspension	packet (granules for data suspension), participations of the capsules for the capsules of the			
Inhibitors (PPIs)	Zegerid packets	(packets)	Note: The requested agent would NOT count as a trial of an alternative.	1 year	Yes	
( )	J	/		,		
			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).			
			(Princeet, generics), Princeet Dr. suspension, original control of the prince of the p			
			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			
		dexlansoprazole	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			
Proton Pump Inhibitors (PPIs)	Dexilant and	delayed-release	(omeprazole DR capsules [Prilosec, generics], Prilosec DR suspension). If none are formulary, approve.	4	V b	
Infilbitors (PPIS)	authorized generic	capsules		1 year	Yes - brand only	
			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			
		omeprazole and	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			
Proton Pump		sodium bicarbonate	suspension, generics]; 4) a lansoprazole product (lansoprazole DR capsules [Prevacid, generics], lansoprazole oral disintegrating tablets [Prevacid Solutab, generics]); 5) an omeprazole product (omeprazole DR capsules [Prilosec,			
Inhibitors (PPIs)	Konvomep	oral suspension	generics], Prilosec DR suspension). If none are formulary, approve.	1 year	Yes	
Pulmonary Arterial					MSB Exclusion	
Hypertension (PAH) -			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Endothelin Receptor			Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Antagonists	Letairis	ambrisentan tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
Pulmonary Arterial			NOTE: A multipayers Donad product is being required. The national should use the professed biographical product		MSB Exclusion	
Hypertension (PAH) - Phosphodiesterase 5			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.  Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		*This criteria applies only to	
Inhibitors	Adcirca	tadalafil tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 vear	the NPF	
II	/ Naciroa	tadalalli tabicto	prosonisor, modit result in a significant alicity of scribus adverse reaction [advanterization required].	ı year	UIC IVI I	

					2025 NPF	Continuation of
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	Excluded Medicaiton	Therapy Required?
Pulmonary Arterial Hypertension (PAH) - Phosphodiesterase 5		sildenafil oral	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.			
Inhibitors	Liqrev	suspension 10 mg/mL	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, 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
Respiratory - Corticosteroid		ciclesonide inhalation	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, Armuity 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, Armuity 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		V	
Inhalers	Alvesco	aerosol	Asmanex Twisthaler would count as one alternative.	1 year	Yes	
Respiratory -			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 Ovar Redil-haler. 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 Ovar Redil-haler. If none 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 Ovar Redil-haler. If none are formulary, or two if two 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 propionate diskus [authorized generic of Flovent Diskus], fluticasone propionate HFA [authorized generic of Flovent HFA]), a mometasone inhaler (Arnaity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus], fluticasone inhaler (Arnuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus], or Ovar Redil-haler. If none are formulary or two if one are formulary or two if one patient is < 6 years of age, a			
Respiratory - Corticosteroid		fluticasone propionate	Note: If the patient tried the brand version of an authorized generic equivalent product, then this trial would count towards the requirement.  Note: Armuity 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			
Inhalers	ArmonAir Digihaler		count as one alternative.	1 year	Yes	

					2025 NPF	Continuation of
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	Excluded Medicaiton	Therapy Required?
Therapy Class	Brand Name	Generic Name	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 (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, 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, or two if two are formulary, or two if two are formulary alternatives from the following list (if four 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 (ArmonAir Digihaler, Arnuity Ellipta, fluticasone propionate HFA (authorized generic of Flovent HFA]), a mometasone inhaler (ArmonAir Digihaler, Arnuity Ellipta, fluticasone propionate the flotolowing list (if three are formulary or one if only one is formulary): Asmanex Twisthaler, a fluticason	Duration	Medicaiton	Required?
Respiratory - Corticosteroid Inhalers	Flovent Diskus (brand and authorized generic)	fluticasone inhalation	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 two if two are formulary, or one if only one is formulary): Asmanex Twisthaler, a fluticasone inhaler (ArmonAir Digihaler, Armuity 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, Armuity Ellipta, and fluticasone propionate HFA (authorized generic of Flovent HFA) would count as one alternative. Asmanex Twisthaler would count as one alternative.	1 year	Yes	
			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 Dighaler, Armulty Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus]), a mometasone inhaler (ArmonAir Dighaler, Armulty Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus]), a mometasone inhaler (Armanex Twisthaler), or two if two are formulary, or one if only one is formulary): a fluticasone inhaler (ArmonAir Dighaler, Armulty Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus]), a mometasone inhaler (Armanex Twisthaler, Armanex 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, approve.  I. If the patient is < 12 years of age, approve if the patient has tried both formulary, approve.  I. If the patient is < 6 years of age, approve if the patient has tried three formulary, approve.  I. 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 no if only one is formulary): a fluticasone inhaler (Armanex Twisthaler, Armanex HFA), or one if only one is formulary): a fluticasone inhaler (Armanex Twisthaler, Armanex HFA), or Ovar Redilhaler. 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 b			
Respiratory - Corticosteroid	Florent UEA ()	fluticasone inhalation	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.	d	V	
nhalers	Flovent HFA (brand)	aerosoi HFA	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	

					2025 NPF	Continuation of
				Approval	Excluded	Therapy
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Duration	Medicaiton	Required?
Corticosteroid	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, Armuily Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus]), a mometasone inhaler (ArmonAir Digihaler, Armuily Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus]), a mometasone inhaler (ArmonAir Digihaler, Armuily Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus]), a mometasone inhaler (ArmonAir Digihaler, Armuily Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus]), a mometasone inhaler (Armanex HFA, Armuily Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus]), a mometasone inhaler (Armanex HFA, Armuily Ellipta, fluticasone) propionate diskus [authorized generic of Flovent Diskus]), a mometasone inhaler (Armanex HFA, Armuily Ellipta, fluticasone) and 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 one is only formulary). Assmars HFA, Alp Ovar Redil-faler. If neither are formulary, approve.  i. If the patient is < 12 years of age, approve if the patient has tried dhree formulary alternatives from the following list (if three are formulary, or one if only one is formulary). If Armanex HFA, if normulary, approve.  i. If the patient is < 6 years of age, approve if the patient has tried dhree formulary alternatives from the following list (if three are formulary, or one if only one is 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 three are formulary, or one if only one is formula	1 year	Yes	
Respiratory - Corticosteroid	Pulmicort Flexhaler	budesonide inhalation powder budesonide respules	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, Armuity 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 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, Armuity 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, Armuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus]), or Qvar RediHaler. If none are formulary or one if only one is formulary alternatives from the following list (if three are formulary or one if only one is formulary): Asmanex Twisthaler, a fluticasone inhaler (ArmonAir Digihaler, Armuity Ellipta, fluticasone propionate diskus [authorized generic of Flovent Diskus]), or Qvar RediHaler. If none are formulary or one if only one is formulary alternatives from the following list (if three are formulary or one if only one is formulary): Asmanex Twisthaler, a fluticasone inhaler (ArmonAir Digihaler, Armuity Ell	1 year	Yes MSB Exclusion *This criteria applies only to the NPF	
Respiratory - Corticosteroid/Long- Acting Beta-Agonist Combination Inhalers		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	

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	Orania Marife	fluticasone propionate/salmeterol	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-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): fluticasone-vilanterol powder inhalation (Breo Ellipta, authorized generic), budesonide-formoterol aerosol (Symbicort, Breyna, generics), fluticasone-salmeterol HFA (Advair HFA, authorized generic), 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 Digihaler), if one is formulary, approve.  Note: Fluticasone propionate-salmeterol inhalation powder, Wixela, and Advair Diskus count as one alternative. Fluticasone propionate/salmeterol multidose DPI (authoriz	Suraudi	medicardi	Required?
Combination Inhalers  Respiratory - Corticosteroid/Long- Acting Beta-Agonist	AirDuo RespiClick  fluticasone propionate/salmeter	inhalation powder  fluticasone propionate/salmeterol	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.  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	1 year	Yes	
Respiratory - Corticosteroid/Long- Acting Beta-Agonist Combination Inhalers	fluticasone propionate/salmeter of multidose dry powder inhaler	fluticasone propionate/salmeterol inhalation powder (authorized generic to AirDuo RespiClick)	alternative. Budesonide-formoterol aerosol, Breyna, and Symbicort count as one alternative. Each product and its authorized generic or generic count as one alternative.  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-vilanterol powder 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 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 if none are 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 neithe	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) or 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 inhalation powder (Advair Diskus, Wixela, generics). If fluticasone propionate/salmeterol inhalation powder (Advair Diskus, Wixela, generics). If 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) if formulary. If none are formulary, approve.  6. Patients with COPD who are unable to coordinate breath and actuation with a metered-	1 year	Yes	

					2025 NPF	Continuation of
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	Excluded Medicaiton	Therapy Required?
тистару спасо	Brana ramo	Conorio Italia	Chronic obstructive pulmonary disease (COPD) in a patient ≥ 18 years of age.	Duration	Modication	rtoquirou.
			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.			
Respiratory - Inhaled			LAMA/LABA Inhalers: Anoro Ellipta, Bevespi Aerosphere, Duaklir Pressair, Stiolto Respimat.  LAMA Inhalers: Incruse Ellipta, tiotropium inhaler (Spiriva HandiHaler, generics), Spiriva Respimat, Tudorza Pressair.			
Phosphodiesterase			LABA Inhalers/Nebulized: Serevent Diskus, Striverdi Respirat, induser Labra Striverdi Respirat, induser Labra Striverdi Respirat, formoterol fumarate inhalation solution (Perforomist, generics).			
(PDE)-3 and PDE-4		ensifentrine inhalation	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			
	Ohtuvayre	suspension	respiclock (AirDuo RespiClick, authorized generic), AirDuo Digihaler, or budesonide-formoterol (Symbicort, generics).	1 year	Yes	
Respiratory - Long- Acting Muscarinic						
Antagonist (LAMA)		aclidinium bromide	Approve if the patient has tried, and according to the prescriber, has experienced inadeguate efficacy OR significant intolerance with BOTH products from the following list, if formulary (or one if one is formulary): 1) Incruse Ellipta, and 2) and 2) are represented in the patient has tried, and according to the prescriber, has experienced inadeguate efficacy OR significant intolerance with BOTH products from the following list, if formulary (or one if one is formulary): 1) Incruse Ellipta, and 2) are represented in the patient has tried, and according to the prescriber, has experienced inadeguate efficacy OR significant intolerance with BOTH products from the following list, if formulary (or one if one is formulary): 1) Incruse Ellipta, and 2) are represented in the patient has tried, and according to the prescriber, has experienced inadeguate efficacy OR significant intolerance with BOTH products from the following list, if formulary (or one if one is formulary): 1) Incruse Ellipta, and 2) are represented inadeguate efficacy OR significant intolerance with BOTH products from the following list, if formulary (or one if one is formulary): 1) Incruse Ellipta, and 2) are represented inadeguate efficacy OR significant intolerance with BOTH products from the following list, if formulary (or one if one is formulary): 1) Incruse Ellipta, and 2) are represented in the presented inadeguate efficiency of the			
Inhalers	Tudorza Pressair	inhalation powder	tiotropium inhaler (tiotropium cap-inhaler [Spiriva HandiHaler, generics], or Spiriva Respimat). If neither are formulary, approve.	1 year	Yes	
					MSB Exclusion	
Dit D			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Respiratory Drugs - Other	Daliresp	roflumilast tablets	Criteria: Approve if the Brand product is being requested due to a formulation 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	applies only to the NPF	
Rett Syndrome	Башоор	trofinetide oral	presented, would result in a significant allergy of scrious adverse reaction adversariation required.	i you	uio iti i	
,	Daybue	solution	See standard Neurology - Daybue Prior Authorization Policy criteria. Note: No conditions of approval are recommended in the prior authorization policy.	1 year	Yes	
			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.			
Rituximab-containing		rituximab-arrx	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			
Agents	Riabni	intravenous injection	result in a significant allergy or serious adverse reaction.	1 year	Yes	
			Approve if the patient meets BOTH of the following (A <u>and</u> 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			
Rituximab-containing		rituximab intravenous	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			
Agents	Rituxan	injection	E. I admit committee that can format a standard and the presenting agent, buttering agent, and or surface any according to the present agent agent, and or surface any according to the present agent agent, and or surface any according to the present agent agent, and according to the present agent age	1 year	Yes	
Ü		,	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			
Rituximab-containing		rituximab-abbs	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			
Agents	Truxima	intravenous injection	b. Patient cannot continue to use each normal y alternative due to a formulation difference in the mactive ingledient(s) [e.g., differences in stabilizing agent, buffering agent, and/or sunactaing which, according to the prescriber, would result in a significant allergy or serious adverse reaction.	1 vear	Yes	
Ü		rituximab and				
		hyaluronidase human	1. Approve if the patient has tried one the following: Rituxan, Truxima, Ruxience, Riabni, but cannot continue to use the product.			
Rituximab-containing Agents	Rituxan Hycela	injection for subcutaneous use	<ol> <li>Approve if, according to the prescriber, cannot use rituximab intravenous due to an inability to obtain IV access.</li> <li>If the patient has already been started on or has previously received therapy with Rituxan Hycela, approve.</li> </ol>	1 year	Yes	
Agents	Kiluxaii Hyceia	Subcutarieous use	5. If the patient has already been started on or has previously received therapy with Kitukan riyoeta, approve.	i yeai	165	
			1. Direct the patient to a topical metronidazole product.			
Rosacea Agents		metronidazole cream	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.			
(Topical)	Noritate	1%	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	
			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:			
			popular in the patient may need any according to the presentation, may experience inacquate emocy or significant interior and one of the load groups below, in the let's a formularly product in the group.  [Group 1: An topical azelaic acid product (azelaic acid 15% gel [Finacea 15% generics], Finacea 15% generics], Finac			
			Group 2: A topical sodium sulfacetamide 10%/sulfur 5% product. (any generic sodium sulfacetamide10%/sulfur 5% product, Rosula);			
Rosacea Agents (Topical)	Zilxi	minocycline 1.5% topical foam	Group 3: A topical metroridazole product (metroridazole 0.75% or 1% [MetroCel, generics; MetroCotion, generics, Noritate]);	1.,,,,,,,,	Van	
(Topical)	ZIIXI	topical toam	Group 4: a topical ivermectin product (generic ivermectin cream or Soolantra).	1 year	Yes MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Sedative-Hypnotics			Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
and Related Agents	Ambien	zolpidem tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		MSB Exclusion *This criteria	
Sedative-Hypnotics		zolipidem extended-	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
	Ambien CR	release tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
					MSB Exclusion	
Sodativa Umastica			<b>NOTE:</b> A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product. <b>Criteria:</b> Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		*This criteria	
Sedative-Hypnotics and Related Agents	Lunesta	eszopiclone tablets		1 year	applies only to the NPF	
and Related Agents	Lunesta	eszopiclone tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	

					2025 NPF	Continuation of
				Approval	Excluded	Therapy
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Duration	Medicaiton	Required?
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		MSB Exclusion *This criteria	
Sedative-Hypnotics			Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
and Related Agents	Rozerem	ramelteon tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
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 vear	Yes	
Selective Estrogen	Suppulse (Eruna)	capealoc	(Canada garantee) or acceptor in the case formation in approve.	. you.		
Receptor Modifiers			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			
and Antiestrogens Selective Serotonin	Osphena	ospemifene tablets	(e.g., Yuvafem, Vagifem, generics), or Imvexxy If none are formulary, approve.	1 year	Yes	
Reuptake Inhibitors	citalopram 30 mg		1. Direct to citalopram 10 mg or 20 mg tablets.			
(SSRIs)	capsules	citalopram capsules	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	Zercapli and	controling 150 mm 200	1. Direct the patient to sertraline 50 mg and/or 100 mg tablets.			
Reuptake Inhibitors (SSRIs)	sertraline 150 mg, 200 mg capsules	sertraline 150 mg, 200 mg capsules	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 vear	Yes	
Selective Serotonin			· · · · · · · · · · · · · · · · · · ·			
Reuptake Inhibitors	Viibryd 10/20 mg			_	.,	
(SSRIs)	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 MSB Exclusion	
Selective Serotonin			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Reuptake Inhibitors			Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
(SSRIs)	Celexa	citalopram tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
Selective Serotonin		escitalopram oxalate	NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		MSB Exclusion *This criteria	
Reuptake Inhibitors		tablets and oral	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
(SSRIs)	Lexapro	solution	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
Selective Serotonin			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		MSB Exclusion *This criteria	
Reuptake Inhibitors		fluoxetine HCI	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
(SSRIs)	Prozac	pulvules	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
0-1	\( \text{iiib = 1.4} \( \text{iib = 1.4} \)		NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		MSB Exclusion	
Selective Serotonin Reuptake Inhibitors	Viibryd (non- starter pack) 10 mg, 20 mg,		Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		*This criteria applies only to	
(SSRIs)	40 mg	vilazodone tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
					MSB Exclusion	
Selective Serotonin Reuptake Inhibitors		sertraline 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		*This criteria applies only to	
(SSRIs)	Zoloft	and oral solution	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
Serotonin and					MSB Exclusion	
Norepinephrine Reuptake Inhibitors		duloxetine HCI	NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.  Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		*This criteria	
(SNRIs)	Cymbalta	capsules	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	applies only to the NPF	
Serotonin and					MSB Exclusion	
Norepinephrine		venlafaxine HCl	NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Reuptake Inhibitors (SNRIs)	Effexor XR	extended-release capsules	Criteria: Approve if the Brand product is being requested due to a formulation 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	applies only to the NPF	
Serotonin and		,		,	MSB Exclusion	
Norepinephrine			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Reuptake Inhibitors (SNRIs)	Pristig	dexvenlafaxine succinate tablets	Criteria: Approve if the Brand product is being requested due to a formulation 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	applies only to the NPF	
(Crartio)	Попа	odocinate 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,	, you	uno IVI I	
Serotonin and	Venlafaxine besylate		generics), duloxetine capsules (Cymbalta, generics), or venlafaxine ER tablets. If none are formulary, approve.			
Norepinephrine	ER 112.5 mg	venlafaxine extended-	NOTE: If patient has tried venlafaxine immediate-release, a trial of venlafaxine extended-release is not required.			
Reuptake Inhibitors (SNRIs)	(formerly Venbysi XR)	release 112.5 mg tablets	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 vear	Yes	Yes
Serotonin and	,	12.2.010	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	. ,	. 50	
Norepinephrine			(Effexor XR, generics), or venlafaxine extended-release tablets. If none are formulary, approve.			
Reuptake Inhibitors (SNRIs)	Drizalma Sprinkle	duloxetine delayed- release capsules	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 vear	Yes	
(OIALIS)	ылданна эрникіе	release capsules	14. Approve it the patient is unable to swallow, has unifutility swallowing, or requires authinistration via a hasogastifutible.	i yeai	162	

					2025 NPF	Continuation of
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	Excluded Medicaiton	Therapy Required?
Therapy Class	Brand Name	Generic Name	Commercial F2 Criteria	Duration	MSB Exclusion	Required?
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Short-Acting Beta-		albuterol sulfate	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Agonists (Inhaled)	ProAir HFA	inhalation aerosol	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
			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).			
Short-Acting Beta-		albuterol sulfate	Note: If there are no single-entity albuterol-containing formulary alternatives, approve.			
Agonists (Inhaled)	ProAir Digihaler	inhalation powder	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	
			1. Approve if the patient has tried one other single-entity albuterol inhaler.			
Short-Acting Beta-		albuterol sulfate	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.			
Agonists (Inhaled)	ProAir Respiclick	inhalation powder	1 mere are no single-entity and under the 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	
Agonisis (initaled)	1 TOAII TROSPIOIOR	imalation powder	Approve if the patient has tried one other single-entity albuterol inhaler.	i year	103	
Short-Acting Beta-	Ventolin HFA and	albuterol sulfate	For example, albuterol HFA (ProAir HFA or generics) or albuterol HFA (Proventil HFA or generics).			
Agonists (Inhaled)		inhalation aerosol	Note: If there are no single-entity albuterol-containing formulary alternatives, approve.	1 year	Yes	
, ,			Approve if the patient has tried one single-entity albuterol inhaler.			
Short-Acting Beta-	Xopenex HFA and	levalbuterol inhalation	For example, albuterol HFA (ProAir HFA or generics) or albuterol HFA (Proventil HFA or generics).			
Agonists (Inhaled)	levalbuterol HFA	aerosol	Note: If there are no single-entity albuterol-containing formulary alternatives, approve.	1 year	Yes	
Sickle Cell Disease			1. Approve is the patient has tried Droxia, if formulary. If Droxia is non-formulary, approve.			
Agents – Hydroxyurea	1		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.			
Agents	Siklos	hydroxyurea tablets	3. If the patient cannot swallow Droxia capsules or has difficulty swallowing Droxia capsules, approve.	1 year	Yes	
			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):			
			2. Fatient meets one of use following (A.M. p.): A. Patient has a contraindication to at least two phosphate binders; OR			
			At a detail has a contradination to a treast 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			
Sodium Hydrogen			ii. Patient has a contraindications to at least one phosphate binder.			
Exchanger 3 Inhibitor	Xphozah	tenapanor tablets	Note: Contraindication to phosphate binders include bowel obstruction, iron overload, or hypercalcemia.	1 year	Yes	
			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 <u>pheochromocytoma/paraganglioma</u> : approve if the patient meets the following (A <u>or</u> B):			
	Sandostatin LAR	octreotide injectable	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.			
Somatostatin Analogs		suspension	B. Patient in sa already been stated on the apy with satisfactable in the approve.  4. Patient with diarrhea associated with chemotherapy; enterocutaneous fistula; meningioma; Merkel cell carcinoma; pancreatic fistula; thymoma/thymic carcinoma: approve.	1 vear	Yes	
Comatostatii 7 ti lalogo	Борог	одороноюн	1. Acromegaly: neuroendocrine tumors; pheochromoctoma/paraganglioma. Approve if the patient has tried Somatuline Depot, if formulary.	1 your	100	
			If Somatuline Depot is non-formulary, approve if the patient meets (A or B):			
			A. Acromegaly; pheochromoctoma/paraganqlioma: 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.			
	lanreotide	lanreotide	i. Patient has tried Sandostatin LAR Depot, if formulary. If Sandostatin LAR Depot is non-formulary, approve; OR			
	subcutaneous	subcutaneous	ii. Patient has already been started on therapy with lanreotide subcutaneous injection.			
Somatostatin Analogs	injection [Cipla]	injection	2. Carcinoid syndrome: Approve if the patient has tried Somatuline Depot, if formulary. If Somatuline Depot is non-formulary, approve.	1 year	Yes	
			1. <u>Acromegaly:</u> 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. <u>Cushing's Disease</u> . Approve if the patient has tried Signifor (not LAR). If Signifor (not LAR) is non-formulary, approve.			
O	Cimpiford AD	pasireotide IM	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)	4	V	
Somatostatin Analogs	Signifor LAR	injection	is non-formulary, approve.	1 year	Yes	
Ctavaid Draduate		nunctoren e vegin -!	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.,			
Steroid Products (Vaginal)	Intrarosa	prasterone vaginal inserts	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	Ves	
( v agiriai)	ii ii ai osa	moorto	par repertor in according to the procession, the partoric to at an indicascut list of chaotinetical cancer, show, or deep roll throllipusts (DVT).	, year	100	

				A	2025 NPF	Continuation of
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	Excluded Medicaiton	Therapy Required?
,		testosterone				
		cypionate for	Approve if the patient has tried one of the following injectable testosterone products, if one is formulary: testosterone cypionate injection (Depo-Testosterone, generics) or testosterone enanthate injection (generics). If none are formulary,			
Testosterone Products (Injectable)	Azmiro	intramuscular injection	approve.  Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.	1 vear	Yes	
Products (injectable)	AZIIIIO	testosterone	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	i year	res	
Testosterone		undecanoate for	none are formulary, approve.			
Products (Injectable)	Aveed	intramuscular use	Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement.	1 year	Yes	
			1. Approve if the patient meets BOTH of the following, if formulary (or one if one is formulary) [a and b]:			
		taataatarana	a. Patient has tried Jatenzo, if formulary; AND			
Testosterone		testosterone undecanoate oral	b. Patient has tried one of Kyzatrex or Undecatrex, if formulary.  Note: Kyzatrex and Undecatrex count as one alternative.			
Products (Oral)	Tlando	capsules	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				
Testosterone	Kyzatrex and	undecanoate				
Products (Oral)	Undecatrex	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 1% gel	NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		MSB Exclusion *This criteria	
Testosterone		packets and pump,	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Products (Topical)	Androgel	1.62% (2021)	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
, , ,		, ,			MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Testosterone	- <i></i>		Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Products (Topical) Testosterone	Testim	testosterone gel	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
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 vear	Yes	
r roddolo (ropiodi)	140.000	teoteoterone nadar ger	Inflarmatory Rosacea.	i you	100	
			Approve if the patient meets both of the following (A and B):			
	Oracea and		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			
Tetracycline-	doxycycline 40 mg		B. Patient meets one of the following (i or ii):			
Derivatives - Oral Agents for Rosacea	capsules (authorized generic of Oracea)		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	
Agents for Nosacea	generic of Oracea)	capsules	Inflammatory Rosacea.	3 months	res - brand only	
			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			
Tetracycline-			B. Patient meets one of the following (i or ii):			
Derivatives -Oral Agents for Rosacea	Emrosi	minocycline extended- release capsules	i. Patient has tried, and according to the prescriber, has experienced inadequate efficacy with one other generic, oral minocycline 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 minocycline product.	1	Vaa	
Agents for Nosacea	EIIIIOSI	chlorthalidone 15 mg	Direct the patient to chlorthalidone tablets. Available as 25 mg, 50 mg.	1 year	Yes	
Thiazide-like Diuretics	Thalitone 15 mg	tablets	2. Approve if the patient's prescribed dose cannot be obtained with the 25 mg and/or 50 mg strength tablets.	1 year	Yes	
	Ĭ		Mulpleta is being used pre-procedure and the patient has thrombocytopenia and chronic liver disease.			
Thrombocytopenia			1. Approve if the patient has tried Doptelet, if formulary. If Doptelet is non-formulary, approve.			
agents	Mulpleta	lusutrombopag tablets	2. Approve if the patient has already started a course of therapy with Mulpleta in order to finish the course.	1 month	Yes	Yes
			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.			
			2. Approve in the particular and an article of a tribule py many available of the particular and a particula			
			Aplastic Anemia; Thrombocytopenia in a Patient with Chronic Hepatitis C; Thrombocytopenia in a Patient with Myelodysplastic Syndrome; Thrombocytopenia in a Patient Post-Allogenic Transplantation.			
Thrombocytopenia		eltrombopag choline	1. Approve if the patient has tried Promacta, if formulary. If Promacta is non-formulary, approve.			
agents	Alvaiz	tablets	2. Approve if the patient has already been started on therapy with Alvaiz.	1 year	Yes	Yes
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		MSB Exclusion *This criteria	
		liothyronine sodium	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Thyroid Supplements	Cytomel	tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
					MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Thyroid Supplements	Synthroid	levothyrovino tobleto	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the	1 year	applies only to the NPF	
Thyroid Supplements	Synthiold	levothyroxine tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	uie INFF	

					2025 NPF	Continuation of
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	Excluded Medicaiton	Therapy Required?
Therapy Class	brand Name	Generic Name	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):	Duration	Wedicalton	Requirear
			levothyroxine (Synthroid, generics), Levoxyl (generics), Unithroid (generics), Euthyrox (generics), or Tirosint capsules [documentation required]. If none are formulary, approve.			
		levothyroxine sodium	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			
Thyroid Supplements	Thyquidity	oral solution	neither are formulary, approve.	1 year	Yes	
			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 oral	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			
Thyroid Supplements	Tirosint-SOL	solution	neither are formulary, approve.	1 year	Yes	
	Tirosint and	levothyroxine	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	,		
Thyroid Supplements	authorized generic	capsules	(Synthroid, generics), Levoxyl (generics), Unithroid (generics), Euthyrox (generics), or Tirosint oral solution [documentation required]. If none are formulary, approve.	1 year	Yes	
			A consideration of the still and the still a			
Thyroid Supplements - Desiccated Thyroid			<ol> <li>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).</li> <li>Patient currently receiving Adthyza: Approve if the patient has tried one other desiccated thyroid product (e.g., Armour Thyroid, NP thyroid).</li> </ol>			
Supplements	Adthyza	thyroid tablets	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 vear	Yes	
опристента	Adilyza	triyroid tablets	Two. Come desiceated anything products are currently not available, such as relatine anything, will anything about, but a province that of these would count as a that of a desiceated triffing product.	i yeai	MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Topical Agents for			Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Atopic Dermatitis	Elidel	pimecrolimus cream	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
			NATE A MILL OF BOOK AND A STATE OF THE STATE		MSB Exclusion	
Topical agents for	Condylox 0.5%		NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria applies only to	
Condyloma acuminatum	topical gel	podofilox 0.5% gel	Criteria: Approve if the Brand product is being requested due to a formulation 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	the NPF	
acuminatum	Lexette and	podolilox 0.070 gci	prescriber, would result in a significant diergy or serious adverse reaction (documentation required).	i yeai	UIC IVI I	
Topical Corticosteroid-	- halobetasol	halobetasol	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.			
containing Agents –	propionate 0.05%	propionate topical	Note: Examples of prescription-strength topical corticosteroids products include: halobetasol propionate, betamethasone dipropinate, clobetasol propionate, diflorasone diacetate.			
Halobetasol Agents	topical foam	foam 0.05%	NOTE: The products must be chemically unique.	1 year	Yes - brand only	
Topical Corticosteroid-		halobetasol	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.			
containing Agents – Halobetasol Agents	Ultravate Lotion	propionate lotion 0.05%	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 vear	Yes	
Halobetasol Agents	Olliavate Lotion	0.0070	INCTE. The produces must be discribed and the di	i yeai	MSB Exclusion	
Topical			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Dermatological Drugs			Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Miscellaneous	Lidoderm	lidocaine 5% patch	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
			NATE. A multi-course Deard product in being acquised. The police to bould use the profused biospikinglest apparie product		MSB Exclusion	
Topical Dermatological Drugs		tazarotene 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		*This criteria applies only to	
Miscellaneous	Tazorac 0.1% cream		prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
			processors notes to the control of t	. ,		
			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.			
Topical		hydrocortisone 2%/	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,			
Dermatological Drugs Miscellaneous	Alcortin A	iodoquinol 1%/ aloe 1% gel	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 vear	Yes	
IVII 30 CII AI I I CUUS	Alcoruit A	170 gci	Examples of prescription deposit and included included. Industrial position 2.76 of earn [based open, generally, maprovin 2.76 officinity, generally for industrial, dentainly A Forting in Unitaries, And Data Officinity.	ı yeai	100	
Topical	Pliaglis and lidocaine					
Dermatological Drugs	7% and tetracaine	lidocaine 7% and	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			
Miscellaneous	7% cream (brand)	tetracaine 7% cream	Prizopak. If none are formulary, approve.	1 year	Yes	
Topical	Clonic Plus and	sodium sulfacetamide 9%- sulfur 4.25%	1 Direct the national or adjust containing sodium sulfacetamide sulfur (e.g., generic sodium sulfacetamide sulfur 0.9% 4.9% topical cleaners generic sodium sulfacetamide sulfur 9.0% 4.0% topical cleaners generic sodium sulfacetamide sulfur 9.0% topical cleaners generic sodium sulfacetamide			
Dermatological Drugs Miscellaneous	authorized generic	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 vear	Yes	
	gonone		2	. ,	. 25	
Topical						
Dermatological Drugs			1. Direct the patient to a topical product containing sodium sulfacetamide-sulfur (e.g., generic sodium sulfacetamide-sulfur 8%-4% topical suspension).			
Miscellaneous	8-4% cleanser	4% cleanser	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	
Taniani						
Topical Dermatological Drugs		sodium sulfacetamide 9% and sulfur 4.5%	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).			
Miscellaneous	Zma Clear	suspension	1. Direct the partie of a logical product containing southin suitacetamine south (e.g., generic southin suitacetamine south).  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 southin suitacetamine south.	1 vear	Yes	
			part person in accounting to the processing in the real anguinder control in our time the patient to unable to doe a governor option product containing co	. ,		

					2025 NPF	Continuation of
Therapy Class	Brand Name	Generic Name	Commercial FE Criteria	Approval Duration	Excluded Medicaiton	Therapy Required?
Thorapy Glass	Drana Hamo	Concrio Name	Gommona / 2 Gridina	Burution	modication	rtoquirou.
Topical						
Dermatological Drugs		sinecatechins	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.	4	V	
Miscellaneous	Veregen	ointment 15%	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 MSB Exclusion	
Topical			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Dermatological Drugs		tazarotene gel 0.05%	Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Tazarotene	Tazorac gel	and 0.1%	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
	Tazorac 0.05%					
Topical  Dermatological Drugs	cream and tazarotene cream	tazarotene cream	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			
Tazarotene	0.05% cream	0.05%	In requesting brain razonate 0.05% clearn. Approve in the patient razonate user the generic razonate in the patient razonate 0.05% clearn is non-ionitially or generic razonate in the patient razonate. On the patient razonate in the patient razonate in the patient razonate in the patient razonate in the patient razonate. On the patient razonate in the patient razon	1 vear	Yes	
	Vusion and		теления и при при при при при при при при при п	. ,		
Topical Diaper	miconazole-zinc		Approve if the patient has tried one topical antifungal agent.			
Dermatitis Agents	oxide-petroleum	petroleum ointment	Note: Examples include: miconazole, clotrimazole, ketoconazole, nystatin.	1 year	Yes	
		fluocinolone acetonide 0.01%/hydroquinone				
Topical Products -		4%/tretinoin 0.05%	Direct the patient to the separate entities:			
Miscellaneous	Tri-luma cream	cream	fluocinolone 0.01% cream- hydroquinone 4% cream- tretinoin 0.05% cream.	N/A	Yes	
					MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Urinary Tract Analgesic	Pyridium	phenazopyridine tablets	Criteria: Approve if the Brand product is being requested due to a formulation 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	applies only to the NPF	
Allaigesic	Fyridiani		1. Approve if the patient has tried generic ursodiol capsules or tablets.	i yeai	uie ivri	
Ursodiol Products	Reltone	mg, 400 mg	2. Approve, if according to the prescriber, the patient is unable to achieve the appropriate dosage requirement with ursodiol capsules.	1 year	Yes	
	Antivert 50 mg tablet		Patient meets both of the following (i and ii):			
	and authorized		i. Patient has tried generic 25 mg tablets; AND			
\	generic meclizine 50		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,	4	V	
Vertigo Agents	mg	medizine 50 mg tablet	would result in a significant allergy or serious adverse reaction.	1 year	Yes MSB Exclusion	
Vesicular Monoamine			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
Transporter Type 2			Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
(VMAT2) Inhibitors	Xenazine	tetrabenazine tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
			1. Approve if the patient has tried calcipotriene solution, if formulary. If calcipotriene solution is non-formulary, approve.			
Vitamin D Analogs (Topical)	Sorilux and authorized generic	coloinatriona foam	2. Approve if the patient has tried calcipotriene cream or ointment.	1 voor	Yes	
(торісаі)	authorized generic	calcipotrierie toarri	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	MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.		*This criteria	
			Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		applies only to	
Wakefulness Agents	Nuvigil	armodafinil tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
			NOTE: A sufficiency Development is being a supply of The sufficient best and the sufficient best and the supply of		MSB Exclusion	
			NOTE: A multisource Brand product is being requested. The patient should use the preferred bioequivalent generic product.  Criteria: Approve if the Brand product is being requested due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the		*This criteria applies only to	
Wakefulness Agents	Provigil	modafinil tablets	prescriber, would result in a significant allergy or serious adverse reaction [documentation required].	1 year	the NPF	
	Ĭ		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, metabolic-dysfunction associated steatotic liver disease/non-alcoholic fatty liver disease, polycystic ovarian syndrome, or coronary artery			
			disease; AND  Note: This refer to begin prior to any divergentitie postide 1 (CLD 1) generate a grant (c.g., Sevenda Wagney) or CLD 1 (diverge dependent insulination) and prior to any divergent like postide 1 (CLD 1) generate against (c.g., Zepheund).			
			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.			
			yvergin toss in a patient is 2 12 years or age and 5 to years or 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			
Weight Loss – GLP-1		liraglutide [rDNA]	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).			
receptor agonists	Saxenda	injeciton	B. Patient has tried Wegovy, if formulary. If Wegovy is non-formulary, approve.	1 year	Yes	