Department of Medicaid

30 Day Change Notice
Effective Date: July 1, 2025

NEW PREFERRED DRUGS	
THERAPEUTIC CLASS	**NO PA REQUIRED PREFERRED**
Cardiovascular Agents: Angina, Hypertension and Heart Failure	bisoprolol 5, 10mg labetalol 100, 200, 300mg spironolactone tab
Cardiovascular Agents: Antiarrhythmics	MULTAQ
Central Nervous System (CNS) Agents: Fibromyalgia Agents	SAVELLA
Central Nervous System (CNS) Agents: Neuropathic Pain	GRALISE HORIZANT
Central Nervous System (CNS) Agents: Skeletal Muscle Relaxants, Non-Benzodiazepine	methocarbamol 500, 750mg
Central Nervous System (CNS) Agents: Restless Legs Syndrome	HORIZANT
Endocrine Agents: Diabetes – Non-Insulin	glimepiride 1, 2, 4mg
Gastrointestinal Agents: Bowel Preparations	MOVIPREP
Gastrointestinal Agents: Crohn's Disease	mercaptopurine tab
Gastrointestinal Agents: Ulcerative Colitis	mesalamine ER cap 500mg PENTASA 250mg
Gastrointestinal Agents: Unspecified GI	polyethylene glycol oral powder bottle
Infectious Disease Agents: Antivirals – HIV* LEGACY CATEGORY	RUKOBIA VIREAD 150, 200mg
Respiratory Agents: Inhaled Agents	arformoterol neb
Topical Agents: Antifungals	tolnaftate cream, powder
Topical Agents: Immunomodulators	pimecrolimus [labeler 68682]

NEW CLINICAL PA REQUIRED PREFERRED DRUGS	
THERAPEUTIC CLASS	**CLINICAL CRITERIA REQUIRED PREFERRED**
Respiratory Agents: Cystic Fibrosis	ALYFTREK

NEW NON-PREFERRED DRUGS	
THERAPEUTIC CLASS	**PA REQUIRED NON-PREFERRED**

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Analgesic Agents: Opioids	tramadol IR 75mg
Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia A, von Willebrand Disease, and Factor XIII Deficiency* LEGACY CATEGORY	HYMPAVZI
Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia B* LEGACY CATEGORY	HYMPAVZI
Blood Formation, Coagulation, and Thrombosis Agents: Oral Anticoagulants	rivaroxaban tab
Blood Formation, Coagulation, and Thrombosis Agents: Oral Antiplatelet	ticagrelor
Cardiovascular Agents: Angina, Hypertension and Heart Failure	bisoprolol 2.5mg CORLANOR SOLN ivabradine tab labetalol 400mg
Cardiovascular Agents: Antiarrhythmics	quinidine IR, ER
Central Nervous System (CNS) Agents: Alzheimer's Agents* LEGACY CATEGORY	memantine/donepezil cap 14-10, 21-10, 28-10mg
Central Nervous System (CNS) Agents: Anticonvulsants* LEGACY CATEGORY	VIGAFYDE
Central Nervous System (CNS) Agents: Atypical Antipsychotics* LEGACY CATEGORY	EQUETRO ERZOFRI OPIPZA
Central Nervous System (CNS) Agents: Neuropathic Pain	gabapentin ER
Central Nervous System (CNS) Agents: Parkinson's Agents	VYALEV
Central Nervous System (CNS) Agents: Skeletal Muscle Relaxants, Non-Benzodiazepine	methocarbamol 1000mg
Endocrine Agents: Androgens	AZMIRO
Endocrine Agents: Diabetes – Hypoglycemia Treatments	glucagon emerg kit labeler 00378
Endocrine Agents: Diabetes – Non-Insulin	glimepiride 3mg metformin IR 750mg ZITUVIMET XR
Gastrointestinal Agents: Ulcerative Colitis	PENTASA 500mg
Gastrointestinal Agents: Unspecified GI	polyethylene glycol oral powder packet prucalopride
Genitourinary Agents: Electrolyte Depleter Agents	ferric citrate tab
Immunomodulator Agents: Systemic Inflammatory Disease	NEMLUVIO
Infectious Disease Agents: Antibiotics – Cephalosporins	cefaclor ER
Infectious Disease Agents: Antivirals – HIV* LEGACY CATEGORY	EMTRIVA SOLN VIREAD 250, 300mg TAB

Ophthalmic Agents: Glaucoma Agents	BETIMOL 0.25% timolol hemihydrate soln 0.5%
Respiratory Agents: Epinephrine	epinephrine (labeler 00093, 00115) NEFFY
Respiratory Agents: Inhaled Agents	BROVANA umeclidinium/vilanterol
Topical Agents: Antifungals	tolnaftate soln
Topical Agents: Immunomodulators	pimecrolimus [labeler 00591, 68462]

THERAPEUTIC CATEGORIES WITH CHANGES IN CRITERIA
Analgesic Agents: Gout
Analgesic Agents: NSAIDS
Analgesic Agents: Opioids
Blood Formation, Coagulation, and Thrombosis Agents: Colony Stimulating Factors
Blood Formation, Coagulation, and Thrombosis Agents: Hematopoietic Agents
Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia A, von Willebrand Disease, and Factor XIII Deficiency* LEGACY CATEGORY
Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia B* LEGACY CATEGORY
Blood Formation, Coagulation, and Thrombosis Agents: Heparin-Related Preparations
Blood Formation, Coagulation, and Thrombosis Agents: Oral Anticoagulants
Blood Formation, Coagulation, and Thrombosis Agents: Oral Antiplatelet
Cardiovascular Agents: Angina, Hypertension and Heart Failure
Cardiovascular Agents: Antiarrhythmics
Cardiovascular Agents: Lipotropics
Cardiovascular Agents: Pulmonary Arterial Hypertension* LEGACY CATEGORY
Central Nervous System (CNS) Agents: Alzheimer's Agents* LEGACY CATEGORY
Central Nervous System (CNS) Agents: Anticonvulsants* LEGACY CATEGORY
Central Nervous System (CNS) Agents: Anticonvulsants Rescue
Central Nervous System (CNS) Agents: Antidepressants* LEGACY CATEGORY
Central Nervous System (CNS) Agents: Attention Deficit Hyperactivity Disorder Agents
Central Nervous System (CNS) Agents: Atypical Antipsychotics* LEGACY CATEGORY
Central Nervous System (CNS) Agents: Fibromyalgia Agents
Central Nervous System (CNS) Agents: Medication Assisted Treatment of Opioid Addiction
Central Nervous System (CNS) Agents: Multiple Sclerosis* LEGACY CATEGORY
Central Nervous System (CNS) Agents: Narcolepsy
Central Nervous System (CNS) Agents: Neuropathic Pain
Central Nervous System (CNS) Agents: Parkinson's Agents
Central Nervous System (CNS) Agents: Restless Legs Syndrome
Central Nervous System (CNS) Agents: Sedative-Hypnotics, Non-Barbiturate
Central Nervous System (CNS) Agents: Skeletal Muscle Relaxants, Non-Benzodiazepine
Dermatologic Agents: Oral Acne Products
Dermatologic Agents: Topical Acne Products
Endocrine Agents: Androgens
Endocrine Agents: Diabetes – Hypoglycemia Treatments
Endocrine Agents: Diabetes – Insulin

Endocrine Agents: Diabetes – Non-Insulin
Endocrine Agents: Endometriosis
Endocrine Agents: Estrogenic Agents
Endocrine Agents: Growth Hormone
Endocrine Agents: Osteoporosis – Bone Ossification Enhancers
Gastrointestinal Agents: Anti-Emetics
Gastrointestinal Agents: Bowel Preparations
Gastrointestinal Agents: Crohn's Disease
Gastrointestinal Agents: Irritable Bowel Syndrome (IBS) with Diarrhea
Gastrointestinal Agents: Pancreatic Enzymes
Gastrointestinal Agents: Proton Pump Inhibitors
Gastrointestinal Agents: Ulcerative Colitis
Gastrointestinal Agents: Unspecified GI
Genitourinary Agents: Benign Prostatic Hyperplasia
Genitourinary Agents: Electrolyte Depleter Agents
Genitourinary Agents: Urinary Antispasmodics
Hyperkalemia Agents: Potassium Binders
Immunomodulator Agents: Systemic Inflammatory Disease
Infectious Disease Agents: Antibiotics – Cephalosporins
Infectious Disease Agents: Antibiotics – Inhaled
Infectious Disease Agents: Antibiotics – Macrolides
Infectious Disease Agents: Antibiotics – Quinolones
Infectious Disease Agents: Antibiotics – Tetracyclines
Infectious Disease Agents: Antifungals
Infectious Disease Agents: Antivirals – Hepatitis C Agents
Infectious Disease Agents: Antivirals – Herpes
Infectious Disease Agents: Antivirals – HIV* LEGACY CATEGORY
Ophthalmic Agents: Antibiotic and Antibiotic-Steroid Combination Drops and Ointments
Ophthalmic Agents: Antihistamines & Mast Cell Stabilizers
Ophthalmic Agents: Dry Eye Treatments
Ophthalmic Agents: Glaucoma Agents
Ophthalmic Agents: NSAIDs
Ophthalmic Agents: Ophthalmic Steroids
Otic Agents: Antibacterial and Antibacterial/Steroid Combinations
Respiratory Agents: Antihistamines – Second Generation
Respiratory Agents: Cystic Fibrosis
Respiratory Agents: Epinephrine
Respiratory Agents: Hereditary Angioedema
Respiratory Agents: Inhaled Agents
Respiratory Agents: Leukotriene Receptor Modifiers & Inhibitors
Respiratory Agents: Monoclonal Antibodies-Anti-IL/Anti-IgE
Respiratory Agents: Nasal Preparations
Respiratory Agents: Pulmonary Fibrosis
Topical Agents: Antifungals
Topical Agents: Antiparasitics
Topical Agents: Corticosteroids
Topical Agents: Immunomodulators

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REVISED THERAPEUTIC CATEGORY CRITERIA	
THERAPEUTIC CLASS	**SUMMARY OF CHANGE**
Analgesic Agents: Gout	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least one preferred drug in this UPDL category and indicated for diagnosis
Analgesic Agents: NSAIDS	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in this UPDL category~~, if~~ and indicated for diagnosis
Analgesic Agents: Opioids	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 7 days of at least two ~~unrelated~~ preferred drugs with different active ingredients of the same duration of action (SHORT-ACTING or LONG-ACTING) **AR** – All codeine and tramadol containing products: a PA is required for patients younger than 12 years old
Blood Formation, Coagulation, and Thrombosis Agents: Colony Stimulating Factors	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 14 days with at least one preferred drug in this UPDL category and indicated for diagnosis
Blood Formation, Coagulation, and Thrombosis Agents: Hematopoietic Agents	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 14 days with at least one preferred drug in this UPDL category and indicated for diagnosis
Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia A, von Willebrand Disease, and Factor XIII Deficiency* LEGACY CATEGORY	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 14 days with at least one preferred drug in this UPDL category and indicated for diagnosis **ADDITIONAL HYMPAVZI (MARSTACIMAB-HNCQ) CRITERIA** • Must have had an inadequate clinical response of at least 30 days with HEMLIBRA
Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia B* LEGACY CATEGORY	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 14 days with at least one preferred drug in this UPDL category and indicated for diagnosis
Blood Formation, Coagulation, and Thrombosis Agents: Heparin-Related Preparations	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 14 days with at least one preferred drug in this UPDL category and indicated for diagnosis

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Blood Formation, Coagulation, and Thrombosis Agents: Oral Anticoagulants	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs in this UPDL category and indicated for diagnosis
Blood Formation, Coagulation, and Thrombosis Agents: Oral Antiplatelet	~~All products are covered without a PA~~ **LENGTH OF AUTHORIZATION:** 365 days **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least one preferred drug in this UPDL category and indicated for diagnosis
Cardiovascular Agents: Angina, Hypertension and Heart Failure	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days of at least two preferred drugs within the same sub-section classification in this UPDL category and indicated for diagnosis ~~with the same mechanism of action, if available and indicated for the same diagnosis in this UPDL category~~
Cardiovascular Agents: Antiarrhythmics	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least one preferred drug in this UPDL category and indicated for diagnosis
Cardiovascular Agents: Lipotropics	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days (or 90 days for fibrates) with at least one preferred drug within the same sub-section classification in this UPDL category and indicated for diagnosis ~~in the same drug class~~
Cardiovascular Agents: Pulmonary Arterial Hypertension* LEGACY CATEGORY	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in this UPDL category and indicated for diagnosis, if available, one of which must be a phosphodiesterase-5 inhibitor
Central Nervous System (CNS) Agents: Alzheimer's Agents* LEGACY CATEGORY	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in this UPDL category and indicated for diagnosis
Central Nervous System (CNS) Agents: Anti-Migraine Agents, Acute	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 14 days with at least one preferred drug and one step therapy drug in this UPDL category and indicated for diagnosis, if available ~~one of which has the same mechanism of action if available~~
Central Nervous System (CNS) Agents: Anti-Migraine Agents, Cluster Headache	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 60 days to at least one preferred drug in this UPDL category and indicated for diagnosis
Central Nervous System (CNS)	**NON-PREFERRED CRITERIA:**

Agents: Anticonvulsants* LEGACY CATEGORY	• Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in this UPDL category and indicated for diagnosis • ~~For prescribers who are credentialed as a neurology specialty with Ohio Medicaid, there must have been an inadequate clinical response of at least 30 days with one preferred anticonvulsant drug in the standard tablet/capsule dosage form.~~ • Prescriptions submitted from a prescriber who is credentialed as a neurology specialty with Ohio Medicaid AND for drugs that are used only for seizures, there must have been an inadequate clinical response of at least 30 days with one preferred drug. This provision applies only to the standard tablet/capsule dosage form.
Central Nervous System (CNS) Agents: Anticonvulsants Rescue	**AR** – VALTOCO: a PA is required for patients younger than ~~6~~ 2 years old
Central Nervous System (CNS) Agents: Antidepressants* LEGACY CATEGORY	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in this UPDL category and indicated for diagnosis
Central Nervous System (CNS) Agents: Attention Deficit Hyperactivity Disorder Agents	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in this UPDL category and indicated for diagnosis.~~, if available~~
Central Nervous System (CNS) Agents: Atypical Antipsychotics* LEGACY CATEGORY	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in this UPDL category and indicated for diagnosis
Central Nervous System (CNS) Agents: Fibromyalgia Agents	All products are covered without a PA ~~**LENGTH OF AUTHORIZATIONS**: 365 Days~~ ~~**NON-PREFERRED CRITERIA:**~~ • ~~Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs in different classes (see Additional Information section below)~~ ~~**ADDITIONAL INFORMATION**~~ • ~~Drugs and drug classes include gabapentin, pregabalin, short- and/or long-acting opioids, skeletal muscle relaxants, SNRIs, SSRIs, trazodone, and tricyclic antidepressants~~
Central Nervous System (CNS)	**BUPRENORPHINE SAFETY EDITS AND DRUG UTILIZATION REVIEW CRITERIA:**

Agents: Medication Assisted Treatment of Opioid Addiction

- ~~buprenorphine injection (SUBLOCADE) dosing schedule will be limited to 300mg/30 days~~

BUPRENORPHINE INITIAL AUTHORIZATION CRITERIA

~~Safety edits are in place for dosages over 24mg of buprenorphine equivalents/day~~ Pursuant to Ohio Administrative Code 4731-33-03, dosages exceeding 32mg of buprenorphine equivalents per day will not be approved.

Has prescriber reviewed the OARRS within 7 days prior to the prior authorization request?	__ Yes __ No
Diagnosis (not approvable for pain) / ICD-10 Code	
~~Has individual been referred to counseling for addiction treatment?~~ If clinically indicated, has individual been offered a referral to counseling for addiction treatment?	__ Yes __ No __ N/A
Has the individual been offered a prescription for a naloxone kit?	__ Yes __ No
~~When is the individual's next appointment to assess induction therapy?~~	~~Date:~~

BUPRENORPHINE RENEWAL CRITERIA

~~Please provide the current duration of treatment as of the date of this request~~	
Please indicate the frequency of prescriber meetings.	
~~Has individual been actively participating in counseling AND been compliant with all sessions? Date of last counseling~~	~~__ Yes __ No~~
~~Has the dose been reduced in the past 6 months?~~	~~__ Yes __ No~~
~~Has there been an evaluation for a dose reduction since the previous PA request? If NO, please provide explanation~~	~~__ Yes __ No~~

Prescriber attests to the continued monitoring for safety and efficacy of the requested medication	__ Yes __ No
Has the prescriber reviewed Ohio Automated Rx Reporting System within 7 days prior to the PA request?	__ Yes __ No
~~If individual is receiving opioids, benzodiazepines, sedative hypnotics, carisoprodol or tramadol, has the physician coordinated with all prescribers of controlled substances and determined treatment should continue?~~	~~__ Yes __ No~~
~~If YES, has an addiction specialist recommended to continue substance abuse treatment?~~	~~__ Yes __ No~~
~~Addiction Specialist consulted _____ Phone Number _____~~	~~Date~~
Is the individual receiving opioids, benzodiazepines, sedative hypnotics, carisoprodol or tramadol?	__ Yes __ No
Skip this question if answering "No" to the previous question Has the prescriber coordinated care with the prescriber(s) of the above listed substances and evaluated the risks and benefits of the combined use of these medications?	__ Yes __ No
~~Lab testing requirements met (at least twice per quarter for first year of treatment; once per quarter thereafter)?~~	~~__ Yes __ No~~

REQUIRED FOR ALL BUPRENORPHINE REQUESTS	
~~Is the individual pregnant?~~	~~__ Yes __ No~~
~~Is the individual breastfeeding?~~	~~__ Yes __ No~~
Has the individual been explained the difference between an allergic reaction and symptoms of opioid withdrawal?	__ Yes __ No
~~Does the patient have an allergy or other contraindication to Naloxone? Please list reactions or reasons for contraindications~~	~~__ Yes __ No~~
Does the patient have an allergy to naloxone? If yes, please select appropriate box and provide additional information if needed.	__ Yes __ No __ Anaphylaxis __ Bronchospasm __ Angioneurotic edema __ Anaphylactic shock __ Hives __ Swelling of face or mouth __ Other: _____
Does the patient have a contraindication to naloxone? If yes, please select appropriate box and provide additional information if needed.	__ Yes __ No __ Pregnancy __ Breastfeeding __ Moderate to severe hepatic impairment as evidenced by Child-Pugh Class B or C __ Other: _____
Skip this question if the patient has an allergy or contraindication to naloxone Is the patient starting buprenorphine induction following use of methadone, fentanyl, or extended-release opioids? If yes, please select appropriate box and provide additional information if needed.* ***This rationale can only be used for a 30-day authorization.**	__ Yes __ N/A __ Methadone __ Fentanyl __ Extended-release opioids
Skip this question if the patient has an allergy or contraindication to naloxone Is the patient going to covert from buprenorphine mono-product to buprenorphine-naloxone combination? If yes, please provide additional information if needed.* ***This rationale can only be used for a one-time 30-day authorization.**	__ Yes __ N/A
Additional Information	

	REQUIRED FOR ALL LOFEXIDINE (LUCEMYRA) REQUESTS Provide medical justification supporting why an opioid taper (such as buprenorphine or methadone) cannot be used: Provide documentation of an inadequate clinical response (including trial dates) or contraindication to clonidine: To be exempt from the above lofexidine criteria, provide documentation that the drug was initiated in an inpatient setting: *Lucemyra length of authorization is 14 days **SIGNATURE AND DATE** ☐ I attest that I am a member of the prescriber's staff in accordance with Ohio Administrative Code rule 5160-9-03, as applicable. Only the prescribing provider or a member of the prescribing provider's staff may request prior authorization. Prescriber's Signature (or staff of prescriber) Date IF a staff member is attesting, please print your name
Central Nervous System (CNS) Agents: Multiple Sclerosis* LEGACY CATEGORY	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least one preferred drug in this UPDL category and indicated for diagnosis
Central Nervous System (CNS) Agents: Narcolepsy	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response with at least two preferred drugs - either at least 30 days of armodafinil or modafinil; **OR** at least 7 days of a preferred amphetamine or methylphenidate drug in this UPDL category and indicated for diagnosis
Central Nervous System (CNS) Agents: Neuropathic Pain	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs within the same sub-section classification ~~in different drug classes~~ in this UPDL category and indicated for diagnosis ~~**ADDITIONAL GABAPENTIN (GRALISE) AND GABAPENTIN ENCARBIL (HORIZANT) CRITERIA**~~ • ~~Must have had an inadequate clinical response to a preferred gabapentin product~~

Central Nervous System (CNS) Agents: Parkinson's Agents	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least one preferred drug within the same ~~mechanism of action~~ sub-section classification in this UPDL category~~, if~~ and indicated for diagnosis.~~, if available~~
Central Nervous System (CNS) Agents: Restless Legs Syndrome	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least one preferred drug in this UPDL category and indicated for diagnosis
Central Nervous System (CNS) Agents: Sedative-Hypnotics, Non-Barbiturate	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 7 days with at least two preferred drugs in this UPDL category and indicated for diagnosis
Central Nervous System (CNS) Agents: Skeletal Muscle Relaxants, Non-Benzodiazepine	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in this UPDL category and indicated for diagnosis
Dermatologic Agents: Oral Acne Products	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 90 days with at least two preferred drugs in this UPDL category and indicated for diagnosis
Dermatologic Agents: Topical Acne Products	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response with at least two preferred drugs within the same ~~mechanism of action~~ sub-section classification in this UPDL category. Trials must be 30 days for preferred non-retinoids and 90 days for preferred retinoids.
Endocrine Agents: Androgens	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 90 days with **ALL** preferred drugs in this UPDL category and indicated for diagnosis
Endocrine Agents: Diabetes – Hypoglycemia Treatments	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least one preferred drug in this UPDL category and indicated for diagnosis **OR** the inability of the member and/or caregiver to administer a preferred glucagon product in a timely fashion
Endocrine Agents: Diabetes – Insulin	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response (defined as the inability to reach target A1C) after at least 120 days with at least two preferred drugs having a similar duration of action in this UPDL category and indicated for diagnosis, if available
Endocrine Agents: Diabetes – Non-Insulin	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 120 days with at least three preferred drugs in this UPDL category and indicated for diagnosis, if available ~~if available.~~

Endocrine Agents: Endometriosis	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 84 days with at least one preferred step-therapy drug in this UPDL category and indicated for diagnosis
Endocrine Agents: Estrogenic Agents	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in this UPDL category within the same ~~route of administration,~~ sub-section classification and ~~if~~ indicated for diagnosis~~, if available~~.
Endocrine Agents: Growth Hormone	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 90 days with at least one preferred drug within the same sub-section classification in this UPDL category and indicated for diagnosis ~~of similar duration of action in this UPDL category~~
Endocrine Agents: Osteoporosis – Bone Ossification Enhancers	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 365 days with at least one preferred drug within the same sub-section classification in this UPDL category and indicated for diagnosis ~~with the same mechanism of action if available~~
Gastrointestinal Agents: Anti-Emetics	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 3 days with at least one preferred drug in this UPDL category within the same ~~mechanism of action, if~~ sub-section classification and indicated for diagnosis~~, if available~~.
Gastrointestinal Agents: Bowel Preparations	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response with at least one preferred drug in this UPDL category and indicated for diagnosis
Gastrointestinal Agents: Crohn's Disease	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in this UPDL category and indicated for diagnosis
Gastrointestinal Agents: Irritable Bowel Syndrome (IBS) with Diarrhea	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 14 days with at least one preferred drug and one step therapy drug in this UPDL category and indicated for diagnosis
Gastrointestinal Agents: Pancreatic Enzymes	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs in this UPDL category and indicated for diagnosis
Gastrointestinal Agents: Proton Pump Inhibitors	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in this UPDL category and indicated for diagnosis
Gastrointestinal Agents: Ulcerative Colitis	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in this UPDL category within the same ~~route of administration, if~~ sub-section classification and indicated for diagnosis, if available

Gastrointestinal Agents: Unspecified GI	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 14 days with one step therapy drug this UPDL category and indicated for diagnosis ~~, if indicated for diagnosis~~
Genitourinary Agents: Benign Prostatic Hyperplasia	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 60 days with at least two preferred drugs, with at least one preferred within the same sub-section classification ~~with the same mechanism of action, if available~~ and indicated for diagnosis, if available
Genitourinary Agents: Electrolyte Depleter Agents	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 14 days with at least ~~two~~ one preferred step therapy drug~~s~~ in this UPDL category and indicated for diagnosis, if available ~~in this UPDL category, one of which must have the same mechanism of action as the requested non-preferred drug, if available~~
Genitourinary Agents: Urinary Antispasmodics	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in this UPDL category and indicated for diagnosis, one of which must be within the same sub-section classification, ~~with different active ingredients within the same mechanism of action,~~ if available
Hyperkalemia Agents: Potassium Binders	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least one preferred drug in this UPDL category and indicated for diagnosis
Immunomodulator Agents: Systemic Inflammatory Disease	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 90 days with at least two preferred drugs in this UPDL category that are not biosimilars of the same reference product~~, if~~ and indicated for diagnosis.~~, if available~~ ○ For non-preferred ~~biosimilars~~ immunomodulators: must provide documentation of inadequate clinical response to its preferred reference product or biosimilar, in this UPDL category~~, if~~ and indicated for the diagnosis, if available **ADDITIONAL PRURIGO NODULARIS CRITERIA:** • Must be prescribed by or in consultation with a specialist (i.e., dermatologist, rheumatologist) • Must provide documentation of an inadequate clinical response of at least 90 days with a topical steroid
Infectious Disease Agents: Antibiotics – Cephalosporins	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 3 days with at least one preferred drug in this UPDL category and indicated for diagnosis
Infectious Disease Agents: Antibiotics – Inhaled	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 28 days with at least one preferred drug in this UPDL category and indicated

	for diagnosis
Infectious Disease Agents: Antibiotics – Macrolides	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 3 days with at least one preferred drug in this UPDL category and indicated for diagnosis
Infectious Disease Agents: Antibiotics – Quinolones	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 3 days with at least one preferred drug in this UPDL category and indicated for diagnosis
Infectious Disease Agents: Antibiotics – Tetracyclines	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 3 days with at least one preferred drug for acute infections **OR** at least 90 days with at least one preferred oral drug for acne in this UPDL category and indicated for diagnosis
Infectious Disease Agents: Antifungals	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 3 days with at least two preferred drugs~~, if indicated for the diagnosis in this UPDL category~~ in this UPDL category and indicated for diagnosis
Infectious Disease Agents: Antivirals – Hepatitis C Agents	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response defined as not achieving sustained virologic response (SVR) with guideline-recommended preferred drugs in this UPDL category and indicated for diagnosis
Infectious Disease Agents: Antivirals – Herpes	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 3 days with at least one preferred drug in this UPDL category and indicated for diagnosis
Infectious Disease Agents: Antivirals – HIV* LEGACY CATEGORY	~~**FOSTEMSAVIR (RUKOBIA) CRITERIA:**~~ • ~~Must provide documentation of a multidrug-resistant HIV-1 infection~~ **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least one preferred drug in this UPDL category and indicated for diagnosis. If applicable, the request must address the inability to use the individual components.
Ophthalmic Agents: Antibiotic and Antibiotic-Steroid Combination Drops and Ointments	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 3 days with at least two preferred drugs in this UPDL category and indicated for diagnosis
Ophthalmic Agents: Antihistamines & Mast Cell Stabilizers	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 7 days with at least two preferred drugs in this UPDL category and indicated for diagnosis
Ophthalmic Agents: Dry Eye Treatments	**STEP THERAPY CRITERIA:** • Must have had an inadequate clinical response of at least 14 days

	with at least one preferred drug in this UPDL category in the previous 120 days **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs in this UPDL category and indicated for diagnosis
Ophthalmic Agents: Glaucoma Agents	**STEP THERAPY CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least one preferred drug in the same sub-section classification in this UPDL category and indicated for diagnosis, if available **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs within the same sub-section classification in this UPDL category and indicated for diagnosis ~~in the same class, if available~~
Ophthalmic Agents: NSAIDs	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 3 days with at least two preferred drugs in this UPDL category and indicated for diagnosis
Ophthalmic Agents: Ophthalmic Steroids	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 7 days with at least two preferred drugs in this UPDL category and indicated for diagnosis
Otic Agents: Antibacterial and Antibacterial/Steroid Combinations	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 3 days with at least two preferred drugs in this UPDL category and indicated for diagnosis
Respiratory Agents: Antihistamines – Second Generation	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 7 days with at least two ~~different~~ preferred drugs in this UPDL category and indicated for diagnosis .
Respiratory Agents: Cystic Fibrosis	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least one preferred drug in this UPDL category and indicated for diagnosis
Respiratory Agents: Epinephrine	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response to at least one preferred drug in this UPDL category and indicated for diagnosis
Respiratory Agents: Hereditary Angioedema	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 3 days with at least one preferred acute drug in this UPDL category and indicated for diagnosis to request a non-preferred acute drug. • Must have had an inadequate clinical response of at least 14 days with at least one preferred prophylaxis drug in this UPDL category

	and indicated for diagnosis to request a non-preferred prophylaxis drug.
Respiratory Agents: Inhaled Agents	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs in this UPDL category within the same ~~mechanism of action, if~~ sub-section classification and indicated for diagnosis~~, if available~~.
Respiratory Agents: Leukotriene Receptor Modifiers & Inhibitors	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in this UPDL category and indicated for diagnosis
Respiratory Agents: Monoclonal Antibodies-Anti-IL/Anti-IgE	**CLINICAL PA CRITERIA:** • For **Chronic Obstructive Pulmonary Disease (COPD)**: o The patient must have an eosinophilic count of greater than or equal to 300 cells per mcL within 12 months prior to initiation of therapy **AND** o The patient has a history of uncontrolled disease, as indicated by greater than or equal to 2 COPD exacerbations or greater than or equal to 1 COPD exacerbation resulting in a hospitalization despite being on standard of care, defined as triple therapy (LAMA+LABA+ICS) for at least 3 months prior to request, and at a stable dose for at least 1 month prior. **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 90 days with at least one preferred drug in this UPDL category and indicated for diagnosis
Respiratory Agents: Nasal Preparations	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs in this UPDL category within the same ~~mechanism of action, if~~ sub-section classification and indicated for diagnosis.~~, if available~~
Respiratory Agents: Pulmonary Fibrosis	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least one preferred drug in this UPDL category and indicated for diagnosis
Topical Agents: Antifungals	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs in this UPDL category and indicated for diagnosis ~~, if indicated for diagnosis~~
Topical Agents: Antiparasitics	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 14 days with at least one preferred drug in this UPDL category and indicated for diagnosis

Topical Agents: Corticosteroids	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs within the same sub-section classification in this UPDL category and indicated for diagnosis, if available ~~of similar potency~~
Topical Agents: Immunomodulators	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least one preferred drug in this UPDL category and indicated for diagnosis

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