Ohio | Department of Medicaid

30 Day Change Notice
Effective Date: January 1, 2023

NEW PREFERRED DRUGS	
THERAPEUTIC CLASS	**NO PA REQUIRED PREFERRED**
Analgesic Agents: Opioids	Nucynta IR
Cardiovascular Agents: Angina, Hypertension and Heart Failure	Enalapril Sol
Central Nervous System (CNS) Agents: Anti-Migraine Agents, Acute	Imitrex Nasal Spray Tosymra
Central Nervous System (CNS) Agents: Anticonvulsants*	Lamictal ODT Trileptal Susp
Central Nervous System (CNS) Agents: Attention Deficit Hyperactivity Disorder Agents	Dyanavel XR Procentra
Gastrointestinal Agents: Ulcerative Colitis	Mesalamine DR Tab
Infectious Disease Agents: Antivirals – HIV*	Lopinavir/Ritonavir Ritonavir Tab Symtuza
Ophthalmic Agents: Antihistamines & Mast Cell Stabilizers	Bepreve
Ophthalmic Agents: Glaucoma Agents	Alphagan P 0.1%
Ophthalmic Agents: Ophthalmic Steroids	Alrex Flarex Lotemax Maxidex Pred Forte
Respiratory Agents: Inhaled Agents	Proventil HFA

NEW CLINICAL PA REQUIRED PREFERRED DRUGS	
THERAPEUTIC CLASS	**CLINICAL CRITERIA REQUIRED PREFERRED**
Analgesic Agents: Gout	Colcrys Tab
Analgesic Agents: Opioids	Nucynta ER
Blood Formation, Coagulation, and Thrombosis Agents: Colony Stimulating Factors	Nivestym
Cardiovascular Agents: Angina, Hypertension and Heart Failure	Hemangeol
Endocrine Agents: Growth Hormone	Genotropin
Endocrine Agents: Uterine Fibroids	Myfembree
Immunomodulator Agents: Systemic Inflammatory Disease	Adbry Dupixent
Respiratory Agents: Monoclonal Antibodies-Anti-IL/Anti-IgE	Dupixent

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NEW STEP THERAPY PREFERRED DRUGS	
THERAPEUTIC CLASS	**STEP THERAPY REQUIRED PREFERRED**
Central Nervous System (CNS) Agents: Anticonvulsants*	Epidiolex Lacosamide
Central Nervous System (CNS) Agents: Movement Disorders	Austedo
Endocrine Agents: Endometriosis	Myfembree
Gastrointestinal Agents: Unspecified GI	Trulance

NEW NON-PREFERRED DRUGS	
THERAPEUTIC CLASS	**PA REQUIRED NON-PREFERRED**
Analgesic Agents: Gout	Probenecid/Colchicine Febuxostat Mitigare
Blood Formation, Coagulation, and Thrombosis Agents: Colony Stimulating Factors	Releuko Ziextenzo
Cardiovascular Agents: Angina, Hypertension and Heart Failure	Aspruzyo Sprinkle Camzyos Epaned Norliqva
Central Nervous System (CNS) Agents: Alzheimer's Agents*	Adlarity
Central Nervous System (CNS) Agents: Anti-Migraine Agents, Acute	Sumatriptan Nasal Spray
Central Nervous System (CNS) Agents: Anticonvulsants*	Qudexy XR Vimpat
Central Nervous System (CNS) Agents: Attention Deficit Hyperactivity Disorder Agents	Focalin XR
Central Nervous System (CNS) Agents: Atypical Antipsychotics	Risperdal
Central Nervous System (CNS) Agents: Sedative-Hypnotics, Non-Barbiturate	Quviviq
Central Nervous System (CNS) Agents: Skeletal Muscle Relaxants, Non-Benzodiazepine	Lyvispah
Dermatologic Agents: Topical Acne Products	Epsolay
Endocrine Agents: Diabetes – Non-Insulin	Mounjaro
Endocrine Agents: Growth Hormone	Omnitrope
Gastrointestinal Agents: Ulcerative Colitis	Lialda
Infectious Disease Agents: Antibiotics – Inhaled	Arikayce
Infectious Disease Agents: Antibiotics – Tetracyclines	Demeclocycline
Infectious Disease Agents: Antivirals – HIV	Kaletra Norvir Tabs

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Respiratory Agents: Inhaled Agents	Formoterol Fumarate Nebulizer Sol
Respiratory Agents: Monoclonal Antibodies-Anti-IL/Anti-IgE	Nucala
Topical Agents: Immunomodulators	Vtama

THERAPEUTIC CATEGORIES WITH CHANGES IN CRITERIA
Analgesic Agents: Gout
Analgesic Agents: Opioids
Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia Factors*
Cardiovascular Agents: Angina, Hypertension & Heart Failure
Cardiovascular Agents: Lipotropics
Cardiovascular Agents: Pulmonary Arterial Hypertension*
Central Nervous System (CNS) Agents: Anti-Migraine Agents, Acute
Central Nervous System (CNS) Agents: Anti-Migraine Agents, Cluster Headache
Central Nervous System (CNS) Agents: Anti-Migraine Agents, Prophylaxis
Central Nervous System (CNS) Agents: Anticonvulsants*
Central Nervous System (CNS) Agents: Anticonvulsants Rescue
Central Nervous System (CNS) Agents: Attention Deficit Hyperactivity Disorder Agents
Central Nervous System (CNS) Agents: Atypical Antipsychotics*
Central Nervous System (CNS) Agents: Medication Assisted Treatment of Opioid Addiction
Central Nervous System (CNS) Agents: Movement Disorders
Central Nervous System (CNS) Agents: Narcolepsy
Endocrine Agents: Androgens
Endocrine Agents: Diabetes – Insulin
Endocrine Agents: Diabetes – Non-Insulin
Endocrine Agents: Endometriosis
Endocrine Agents: Osteoporosis – Bone Ossification Enhancers
Endocrine Agents: Uterine Fibroids
Gastrointestinal Agents: Crohn's Disease
Gastrointestinal Agents: Hepatic Encephalopathy
Gastrointestinal Agents: Irritable Bowel Syndrome (IBS) with Diarrhea
Gastrointestinal Agents: Proton Pump Inhibitors
Gastrointestinal Agents: Ulcerative Colitis
Gastrointestinal Agents: Unspecified GI
Genitourinary Agents: Benign Prostatic Hyperplasia
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 – HIV*

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
Otic Agents: Antibacterial and Antibacterial/Steroid Combinations
Respiratory Agents: Antihistamines – Second Generation
Respiratory Agents: Cystic Fibrosis
Respiratory Agents: Hereditary Angioedema
Respiratory Agents: Inhaled Agents
Respiratory Agents: Nasal Preparations
Respiratory Agents: Other Agents
Topical Agents: Antifungals
Topical Agents: Antiparasitics

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
Analgesic Agents: Opioids	**BUPRENORPHINE TOPICAL (BUTRANS) CRITERIA:** • Must provide documentation of an inadequate clinical response of at least 60 consecutive days with at least one immediate release opioid formulation • Must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation **MORPHINE SULFATE ER (KADIAN, MS CONTIN) & TAPENTADOL ER (NUCYNTA) CRITERIA:** • Must provide documentation of an inadequate clinical response of at least 60 consecutive days with at least one immediate release opioid formulation **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 7 days of at least two unrelated preferred drugs **ADDITIONAL SHORT-ACTING OPIOIDS CRITERIA ~~FOR NEW STARTS~~:** • **Initial long-acting requests** can be authorized up to 90 days ○ Documentation of the following must be provided: ▪ Request is a daily dose equivalent of ≤ 80 MED ▪ Inadequate clinical response to both non-opioid pharmacologic and non-pharmacologic treatments ▪ Current use of short-acting opioids for ≥ 60 consecutive days

	▪ Treatment plan including risk assessment, substance abuse history, concurrent therapies, and requirements for random urine screenings (baseline urine drug tests must be submitted) ▪ Pain and function scores at each visit ▪ Opioid contract required to be in place and submitted with PA form • **Subsequent short-acting requests** can be authorized up to 180 days ○ Documentation of the following must be provided: ▪ Current treatment plan ▪ Demonstrated adherence to treatment plan through progress notes, including pain and function scores, random urine screenings results reviewed, concerns addressed, and no serious adverse outcomes observed • **Dose escalation requests** can be authorized up to 180 days ○ Documentation of the following must be provided: ▪ Prescriber attestation that dose escalation is likely to result in improved function and pain control ▪ Requests for a cumulative daily dose >100 MED must be prescribed by or in consultation with a pain specialist or anesthesiologist consultation **ADDITIONAL LONG-ACTING OPIOIDS CRITERIA:** • The system defines an "initial request" as having no opioid claims in the previous 90 days
Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia Factors*	**CLINICAL PA CRITERIA:** • Must provide documentation of patient's body weight **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 14 days with at least one preferred drug
Cardiovascular Agents: Angina, Hypertension & Heart Failure	**LENGTH OF AUTHORIZATIONS:** 365 days except nimodipine: 21 days **PROPRANOLOL ORAL SOLUTION (HEMANGEOL) CRITERIA:** • Must provide documentation of the patient's weight **SACUBITRIL/VALSARTAN (ENTRESTO) CRITERIA:** • Must provide documentation of chronic heart failure classified as either NYHA Class II-IV or ACC/AHA Stage B-D

	ADDITIONAL FINERENONE (KERENDIA) CRITERIA: • Must be on a maximally tolerated dose of an angiotensin-converting enzyme inhibitor or angiotensin receptor blocker • Must provide documentation of an inadequate clinical response to a SGLT2 Inhibitor **OR** provide documentation of medical necessity beyond convenience for why the patient cannot try a SGLT2 inhibitor (i.e., chronic kidney disease diagnosis) **ADDITIONAL MAVACAMTEN (CAMZYOS) CRITERIA:** • Must be prescribed by or in consultation with a cardiologist • Must provide documentation of NYHA Class II-III symptoms and left ventricular ejection fraction ≥55% **ADDITIONAL VERICIGUAT (VERQUVO) CRITERIA:** • Must provide documentation of ejection fraction
Cardiovascular Agents: Lipotropics	**LENGTH OF AUTHORIZATIONS:** See below Juxtapid (Initial) — 180 days Vascepa, Lovaza, ACL Inhibitors (Initial) — 84 days All others (Initial & Subsequent) — 365 days **ADDITIONAL LOVASTATIN ER (ALTOPREV), PITAVASTATIN (LIVALO), FLUVASTATIN (LESCOL) CRITERIA** • Must have had an inadequate clinical response of at least 30 days with two preferred drugs in the same drug class **ADDITIONAL ICOSAPENT ETHYL (VASCEPA) CRITERIA:** • Must provide documentation of baseline labs indicating triglyceride levels ≥500mg/dL after an inadequate clinical response to fibrates, niacin, and diet/exercise • Must provide documentation of discontinuation of drugs known to increase triglyceride levels (i.e., beta blockers, thiazides, and estrogens), if clinically appropriate
Cardiovascular Agents: Pulmonary Arterial Hypertension*	**CLINICAL PA CRITERIA:** • Must provide documentation of NYHA Functional Class for Pulmonary Hypertension and symptoms experienced by patient
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 two preferred drugs **ADDITIONAL UBROGEPANT (UBRELVY) CRITERIA** • Must have had an inadequate clinical response of at least 14 days with at least one preferred oral CGRP antagonist

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 **QL –** Emgality: 3 doses per 30 days (for initial loading dose only), then 1 dose per 30 days thereafter
Central Nervous System (CNS) Agents: Anti-Migraine Agents, Prophylaxis	**STEP THERAPY CRITERIA:** • Must include objective documentation of severity, frequency, type of migraine, and number of headache days per month (preferably a headache diary) **SUBSEQUENT AUTHORIZATION CRITERIA:** • Must provide documentation of patient's clinical response to treatment (preferably a headache diary or other objective documentation of severity, frequency, and number of headache days per month). **QL** – Aimovig, Ajovy: 1 dose per 30 days **QL** – Emgality: 2 doses per 30 days (for initial loading dose only), then 1 dose per 30 days thereafter
Central Nervous System (CNS) Agents: Anticonvulsants*	**GRANDFATHERING* (except ~~Epidolex and~~ Diacomit):** Patients who have a claim for a non-preferred drug in the previous 120 days will be automatically approved to continue the drug. Patients who have taken the drug previously, but do not have claims history (e.g., new to Medicaid), will need to submit a prior authorization in order to continue coverage. **CANNABIDIOL (EPIDIOLEX) CRITERIA** • Must have had an inadequate clinical response of at least 30 days with any two of the following anticonvulsants: clobazam, levetiracetam, valproic acid, lamotrigine, topiramate, rufinamide, or felbamate within the past 365 days (members who meet this criteria will not require a PA) • ~~Must have had an inadequate clinical response (inadequate seizure control or intolerance) of at least 30 days with three preferred anticonvulsant drugs (**Note**: not required for Dravet Syndrome)~~ • ~~Must provide documentation of serum transaminases (ALT and AST) and total bilirubin levels prior to starting therapy~~ • ~~Must provide documentation of patient's weight~~ ○ ~~Maximum daily dose does not exceed: 20mg/kg/day for Lennox-Gastaut syndrome or Dravet syndrome or 25mg/kg/day for Tuberous sclerosis complex (titration based on response/tolerability)~~

	• ~~Must provide baseline average number of seizure days per month (measured monthly or quarterly)~~
Central Nervous System (CNS) Agents: Anticonvulsants Rescue	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response with at least one preferred drug
Central Nervous System (CNS) Agents: Attention Deficit Hyperactivity Disorder Agents	**STEP THERAPY CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with atomoxetine **OR** at least two preferred stimulants **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least three preferred drugs **ADDITIONAL INFORMATION** • Requests for non-preferred immediate-release formulations must have all required trials with preferred immediate-release drugs, and requests for non-preferred extended-release formulations must have all required trials with preferred extended-release drugs **AR** – Dextroamphetamine Solution & Dyanavel XR: a PA is required for patients 12 years and older **AR** – Methylphenidate solution/suspension: a PA is required for patients younger than 6 years and 12 years and older
Central Nervous System (CNS) Agents: Atypical Antipsychotics*	**ADDITIONAL ARIPIPRAZOLE (ABILIFY MYCITE) CRITERIA:** • Must be prescribed by or in consultation with a psychiatrist following an aripiprazole serum blood level draw indicating need for further investigation of adherence **ADDITIONAL PIMAVANSERIN (NUPLAZID) CRITERIA:** • For Parkinson-related Hallucinations & Delusions **ALL** of the following must be met: ○ Psychotic symptoms are severe and frequent enough to warrant treatment with an antipsychotic **AND** are not related to dementia or delirium ○ The patient's other Parkinson's Disease drugs have been reduced or adjusted and psychotic symptoms persist **OR** patient is unable to tolerate adjustment of these other drugs ○ Must have been inadequate clinical response or contraindication to at least 30 days of either quetiapine or clozapine

	• An exemption to the criteria will be authorized for prescribers with a neurology specialty to a patient with a history of the related condition **ADDITIONAL FLUOXETINE/OLANZAPINE (SYMBYAX) CRITERIA** • Must provide documentation for patient's inability to use the individual drugs
Central Nervous System (CNS) Agents: Medication Assisted Treatment of Opioid Addiction	**LENGTH OF AUTHORIZATIONS**: 180 days except 14 days for Lucemyra **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs
Central Nervous System (CNS) Agents: Movement Disorders	**CLINICAL PA CRITERIA:** • Must be prescribed by or in consultation with a neurologist or psychiatrist **STEP THERAPY CRITERIA:** • Must have an inadequate clinical response of at least 90 days to a maximally tolerated dose of tetrabenazine for Huntington's Disease only **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs
Central Nervous System (CNS) Agents: Narcolepsy	**AR** – Methylphenidate: a PA is required for patients younger than 6 years
Endocrine Agents: Androgens	**SUBSEQUENT AUTHORIZATION CRITERIA:** • Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring (i.e., testosterone and hematocrit)
Endocrine Agents: Diabetes – Insulin	**STEP THERAPY CRITERIA:** • Must have had an inadequate clinical response of at least 120 days with at least one preferred drug having a similar duration of action **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 120 days with at least two preferred drugs having a similar duration of action
Endocrine Agents: Diabetes – Non-Insulin	**ADDITIONAL ORAL AND INJECTABLE COMBINATION DRUGS CRITERIA**

	• Must have had a trial of at least 120 days with the individual drugs **OR** must provide documentation of medical necessity beyond convenience for patient's inability to use the individual drugs **ADDITIONAL INFORMATION** • For non-preferred drugs that have preferred drugs in the same drug class: must provide documentation that there was at least one inadequate clinical response with a drug in same drug class
Endocrine Agents: Endometriosis	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 84 days with at least one preferred NSAID, one preferred oral contraceptive, **AND** one preferred step-therapy drug
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 class **ADDITIONAL INFORMATION** • A total lifetime duration of therapy of 730 days with any parathyroid analog will be authorized
Endocrine Agents: Uterine Fibroids	**LENGTH OF AUTHORIZATIONS**: Up to 180 Days **ADDITIONAL INFORMATION:** • A total lifetime duration of therapy of 730 days between Oriahnn and Myfembree or 180 days for Lupron Depot will be authorized
Gastrointestinal Agents: Crohn's Disease	**LENGTH OF AUTHORIZATIONS**: 365 Days; Ortikos ER – based on indication
Gastrointestinal Agents: Hepatic Encephalopathy	**STEP THERAPY CRITERIA:** • Must have had an inadequate clinical response of at least 14 days with at least one preferred drug **RIFAXAMIN (XIFAXAN) CRITERIA:** • Must have had an inadequate clinical response of at least 14 days to lactulose to be authorized for monotherapy or add on therapy **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs

Gastrointestinal Agents: Irritable Bowel Syndrome (IBS) with Diarrhea	**STEP THERAPY CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least one preferred drug **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs
Gastrointestinal Agents: Proton Pump Inhibitors	**ADDITIONAL CRITERIA FOR PPI DOSES GREATER THAN ONCE DAILY** • For any of the following diagnoses: carcinoma of GI tract, COPD, Crest Syndrome, dyspepsia, esophageal varices, gastritis, gastroparesis, scleroderma, symptomatic uncomplicated Barret's Esophagus, systemic mastocytosis, or Zollinger Ellison Syndrome: Must provide documentation of diagnosis **AND** must have failed once-daily dosing of the requested drug ○ Authorization length: 365 days **AR** - Protonix Pak/Pantoprazole Packet: a PA is required for patients 6 years and older
Gastrointestinal Agents: Ulcerative Colitis	**LENGTH OF AUTHORIZATIONS**: 365 Days; except Uceris foam – based on indication
Gastrointestinal Agents: Unspecified GI	**ADDITIONAL RIFAMYCIN DELAYED-RELEASE (AEMCOLO) CRITERIA:** • Must have the inability to take, or failure of **ALL** of the following: azithromycin, ciprofloxacin, levofloxacin, ofloxacin, or rifaximin
Genitourinary Agents: Benign Prostatic Hyperplasia	**ADDITIONAL DUTASTERIDE/TAMSULOSIN (JALYN) CRITERIA** • Must provide documentation for patient's inability to use the individual drugs
Immunomodulator Agents: Systemic Inflammatory Disease	**ADDITIONAL ALOPECIA AREATA 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 **ADDITIONAL ATOPIC DERMATITIS CRITERIA:** • Must have at least 10% body surface area (BSA) involvement with two of the following: topical corticosteroid, or topical calcineurin inhibitors [e.g., Elidel]~~, or topical PDE-4 inhibitors [e.g., Eucrisa]~~ unless atopic dermatitis is severe and involves >25% BSA

Infectious Disease Agents: Antibiotics – Cephalosporins	**LENGTH OF AUTHORIZATIONS**: Based on indication **ADDITIONAL INFORMATION** • Requests may be authorized if: ○ The patient is completing a course of therapy that was started in the hospital or other similar location or was started before Medicaid eligibility, only the remaining course will be authorized
Infectious Disease Agents: Antibiotics – Inhaled	**QL** – Tobramycin drugs: 56 doses in 56 days
Infectious Disease Agents: Antibiotics – Macrolides	**LENGTH OF AUTHORIZATIONS**: Based on indication **ADDITIONAL INFORMATION** • Requests may be authorized if: ○ The patient is completing a course of therapy that was started in the hospital or other similar location or was started before Medicaid eligibility, only the remaining course will be authorized
Infectious Disease Agents: Antibiotics – Quinolones	**LENGTH OF AUTHORIZATIONS**: Based on indication **ADDITIONAL INFORMATION** • Requests may be authorized if: ○ The patient is completing a course of therapy that was started in the hospital or other similar location or was started before Medicaid eligibility, only the remaining course will be authorized
Infectious Disease Agents: Antibiotics – Tetracyclines	**LENGTH OF AUTHORIZATIONS**: Based on indication for acute infections or 365 days for acne **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 **ADDITIONAL INFORMATION** • Requests may be authorized if: ○ The patient is completing a course of therapy that was started in the hospital or other similar location or was started before Medicaid eligibility, only the remaining course will be authorized

	AR – Doxycycline Syrup: a PA is required for patients 12 years and older
Infectious Disease Agents: Antifungals	**LENGTH OF AUTHORIZATIONS**: Based on indication **ADDITIONAL INFORMATION** • Requests may be authorized if: ○ The infection is caused by an organism resistant to **ALL** preferred antifungals (must provide diagnosis and any culture/sensitivity results) ○ The patient is completing a course of therapy that was started in the hospital or other similar location or was started before Medicaid eligibility, only the remaining course will be authorized ~~○ If the request is for a diagnosis other than fungal infection, please refer the case to a pharmacist. An off-label use may be approvable for a medication such as Nizoral for advanced prostate cancer or for Cushing's Syndrome when standard treatments have failed~~
Infectious Disease Agents: Antivirals – Hepatitis C Agents	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response defined as not achieving SVR with guideline-recommended preferred drugs
Infectious Disease Agents: Antivirals – HIV*	~~**FOSTEMSAVIR (RUKOBIA ER) CRITERIA:**~~ ~~• Must provide documentation of a multidrug-resistant HIV-1 infection~~ ~~**ADDITIONAL DARUNAVIR/COBICISTAT/EMTRICITABINE/ TENOFOVIR (SYMTUZA) CRITERIA:**~~ ~~• Must provide documentation for patient's inability to use the individual drugs~~ **AR** – Lamivudine solution: a PA is required for patients 3 years and older **AR** – Nevirapine solution: a PA is required for patients 3 years and older
Ophthalmic Agents: Antibiotic and Antibiotic-Steroid Combination Drops and Ointments	**LENGTH OF AUTHORIZATIONS**: 30 days **ADDITIONAL INFORMATION** • Requests may be authorized if: ○ The patient is completing a course of therapy that was started in the hospital or other similar location or was started before Medicaid eligibility, only the remaining course will be authorized

Ophthalmic Agents: Antihistamines & Mast Cell Stabilizers	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs
Ophthalmic Agents: Dry Eye Treatments	**STEP THERAPY CRITERIA:** • Must have had an inadequate clinical response of at least 14 days with one artificial tear or OTC dry eye drop in the previous 120 days **NON-PREFERRED CRITERIA:** Must have had an inadequate clinical response of at least 14 days with at least one preferred drug
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 class, if available **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in the same class, if available
Ophthalmic Agents: NSAIDs	**LENGTH OF AUTHORIZATIONS**: 30 days
Otic Agents: Antibacterial and Antibacterial/Steroid Combinations	**LENGTH OF AUTHORIZATIONS**: 30 days
Respiratory Agents: Antihistamines – Second Generation	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least two different preferred drugs
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 **SUBSEQUENT AUTHORIZATION CRITERIA:** • Must provide documentation of patient's clinical response to treatment (adherence to treatment demonstrated by claims history **AND** one or more of the following: FEV1, weight gain, sweat chloride, pulmonary exacerbations, etc.) and ongoing safety monitoring
Respiratory Agents: Hereditary Angioedema	**CLINICAL PA CRITERIA:** • Must provide documentation of diagnosis (i.e., C1-INH deficiency or dysfunction (Type I or II HAE)) and whether the drug will be used for prophylaxis or treatment • Must provide documentation of at-home administration

	NON-PREFERRED CRITERIA: • Must have had an inadequate clinical response of at least 60 days with at least one preferred 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 within the same class and duration of action
Respiratory Agents: Nasal Preparations	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in the same class, if available
Respiratory Agents: Other Agents	**LENGTH OF AUTHORIZATIONS:** Initial: 90 days; Subsequent: 180 days **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 90 days with at least one preferred long-acting beta agonist **AND** one preferred long-acting muscarinic antagonist-containing inhalers **SUBSEQUENT AUTHORIZATION CRITERIA:** • Must provide documentation of patient's clinical response to treatment, adherence to maintenance inhaler per pharmacy claims, and ongoing safety monitoring
Topical Agents: Antifungals	**LENGTH OF AUTHORIZATIONS**: Up to 180 days for all agents except 365 days for Jublia **ADDITIONAL EFINACONAZOLE (JUBLIA) CRITERIA:** • Must have had an inadequate clinical response of at least 365 days with at least one preferred topical drug **AND** at least 84 days with at least one preferred oral drug indicated for diagnosis **ADDITIONAL INFORMATION** • Requests may be authorized if: ○ The infection is caused by an organism resistant to preferred antibiotics drugs (note diagnosis and any culture/sensitivity results)
Topical Agents: Antiparasitics	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 14 days with at least one preferred drug

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