DELAWARE HEALTH AND SOCIAL SERVICES
Division of Medicaid & Medical Assistance

DELAWARE MEDICAL ASSISTANCE PROGRAM (DMAP)
PREFERRED DRUG LIST (PDL)

Effective: 1/1/2017; Updated: 4/28/2017

Contents

DELAWARE MEDICAL ASSISTANCE PROGRAM (DMAP)
PREFERRED DRUG LIST (PDL)

Effective: 1/1/2017; Updated: 4/28/2017

ACNE AGENTS, TOPICAL

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required			CRITERION***
clindamycin gel, solution erythromycin gel, solution erythromycin/benzoyl peroxide tretinoin cream tretinoin 0.01, 0.025% gel Azelex **Duac**	adapalene benzoyl peroxide clindamycin foam, lotion, swab clindamycin/benzoyl peroxide clindamycin/tretinoin erythromycin swab sulfacetamide sodium sodium sulfacetamide/sulfur tretinoin 0.05% gel tretinoin microsphere	Acanya Aczone Benzepro BP Foaming Wash Clindacin ETZ Clindacin PAC Differin▲ Epiduo ▲ Epiduo Forte▲ Fabior	Klaron Neuac Onexton Panoxyl SSS-10-5 Sulfacleanse Sumadan Sumaxin Tazorac	2 preferred medications are required before a non-preferred will be approved Class only covered up to 20 years old. Over 20 is considered cosmetic. Medical necessity prior authorization forms available on the web at: www.dmap.state.de.us/downloads/pharmacy/paforms/Medical.Necessity.pdf **Please note:** brand name drugs with a generic available are considered nonpreferred unless listed in bold. **▲–** indicates that the manufacturer does not participate in all DMMA programs.

ALZHEIMER'S AGENTS

Clinical criteria apply to class. All agents require a prior authorization.

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
donepezil 5, 10 mg memantine tablets **Exelon patch**	donepezil ODT donepezil 23mg galantamine galantamine ER memantine solution rivastigmine Namenda XR Namzaric	2 preferred medications are required before a non-preferred will be approved Prior Authorization forms available on the web at: : www.dmap.state.de.us/downloads/pharmacy/paforms/Cholinesterase.Inhibitor.pdf **Please note**: brand name drugs with a generic available are considered nonpreferred unless listed in bold.

ANALGESICS, NARCOTIC LONG ACTING

Clinical criteria apply to class. All agents require a prior authorization.

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required		CRITERION***
fentanyl transdermal 12, 25, 50, 75, 100 mcg/hr morphine ER tablets tramadol ER (gen. Ultram ER) Embeda	fentanyl transdermal 37.5, 62.5, 87.5 mcg/hr hydromorphone ER morphine ER capsules oxycodone ER	oxymorphone ER tramadol ER (gen.ConZip) Arymo^{NR} Belbuca Butrans	Hysingla ER Nucynta ER Xartemis XR Xtampza ER^{NR} Zohydro ER	2 preferred medications are required before a non-preferred will be approved NR – not yet reviewed by P&T Committee Prior Authorization forms available on the web at: www.dmap.state.de.us/information/paforms.html

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ANALGESICS, NARCOTIC SHORT ACTING

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
Preferred status implementation: 1/1/17	Prior authorization is required	
butalbital compound /codeine codeine codeine/APAP hydrocodone/APAP hydrocodone/ibuprofen hydromorphone tablets morphine tabs/solution oxycodone tablets oxycodone/APAP pentazocine/APAP tramadol	butorphanol nasal carisoprodol compound dihydrocodeine/APAP /caffeine dihydrocodeine/ASA/ caffeine fentanyl lozenge ● hydromorphone liquid, suppositories levorphanol meperidine morphine concentrate, suppositories oxycodone/ASA oxycodone concentrate oxycodone/ibuprofen oxymorphone pentazocine/naloxone tramadol/APAP Abstral Fentora Lortab solution Nucynta Primlev Reprexain Subsys Xylon	2 preferred medications are required before a non-preferred will be approved **–Quantity limits in place:** ➢ oxycodone 15mg maximum of 240 units a year ➢ oxycodone 20mg maximum of 120 units a year ➢ oxycodone 30 mg maximum of 60 units a year ➢ 120 short-acting units per 30 days with a total of 720 short-acting units a year ➢ DMMA recommends that first fill of new pain medication be limited to 15 supply ●**–Clinical criteria apply.** A clinical prior authorization is required: www.dmap.state.de.us/information/paforms.html

ANDROGENIC AGENTS, TOPICAL

Clinical criteria apply to class. All agents require a prior authorization

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
Preferred status implementation: 1/1/17	Prior authorization is required	
Androgel packet, pump ●	testosterone ● Androderm ● Axiron ● Natesto ● Vogelxo ●	●**–Clinical criteria apply.** A clinical prior authorization is required despite the medication's status as preferred or nonpreferred: www.dmap.state.de.us/downloads/pharmacy/paforms/Testosterone.Supplementation.pdf

ANGIOTENSIN MODULATORS

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
Preferred status implementation: 1/1/17	Prior authorization is required	
benazepril / HCTZ enalapril / HCTZ Epaned lisinopril / HCTZ losartan / HCTZ ramipril valsartan / HCTZ	candesartan/HCTZ captopril / HCTZ eprosartan fosinopril / HCTZ irbesartan / HCTZ moexipril / HCTZ olmesartan / HCTZ quinapril / HCTZ perindopril telmisartan / HCTZ trandolapril Edarbi / Edarbyclor Entresto Tekturna / HCT Teveten / HCT	2 preferred medications are required before a non-preferred will be approved **Dose optimization required when applicable**

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ANGIOTENSIN MODULATOR/CALCIUM CHANNEL BLOCKER COMBINATIONS

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
amlodipine/benazepril amlodipine/valsartan amlodipine/valsartan/HCTZ	olmesartan/amlodipine olmesartan/amlodipine/HCTZ telmisartan/amlodipine trandolapril/verapamil Prestalia Tekamlo / Amturnide Valturna	2 preferred medications are required before a non-preferred will be approved **Dose optimization required when applicable**

ANTIBIOTICS, GI

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
metronidazole tablets neomycin	metronidazole capsules paromomycin capsules vancomycin Alinia Dificid Xifaxan ▲ ●	**●–Clinical criteria apply.** A clinical prior authorization is required despite the medication's status as preferred or nonpreferred. Patients must try and fail lactulose before Xifaxan is approved for appropriate diagnoses. **▲–** indicates that the manufacturer does not participate in all DMMA programs.

ANTIBIOTICS, INHALED

PREFERRED AGENTS Preferred status implementation: 01/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
Bethkis Kitabis Pak	tobramycin Cayston TOBI Podhaler	

ANTIBIOTICS, TOPICAL

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
bacitracin bacitracin/polymyxin gentamicin mupirocin ointment triple antibiotic ointment	mupirocin cream neomycin/bacitracin/polymyxin/ pramoxine neomycin/polymyxin/pramoxine Altabax Centany Cortisporin Neo-Synalar	2 preferred medications are required before a non-preferred will be approved

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ANTIBIOTICS, VAGINAL

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
clindamycin metronidazole Cleocin ovules	Clindesse Metrogel-Vaginal Nuvessa Vandazole	2 preferred medications are required before a non-preferred will be approved

ANTICOAGULANTS, ORAL/SQ

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
enoxaparin warfarin Eliquis ● Fragmin▲ Pradaxa ● Xarelto ●	fondaparinux Savaysa	2 preferred medications are required before a non-preferred will be approved **–Quantity limits in place on injectable formulations:** 10 days allowed without prior authorization ▲– indicates that the manufacturer does not participate in all DMMA programs. ● Eliquis, Pradaxa and Xarelto require diagnosis code

ANTICONVULSANTS, ORAL/RECTAL

PREFERRED AGENTS Preferred status implementation: 01/1/17			NON-PREFERRED AGENTS Prior authorization is required			CRITERION***
carbamazepine tablets, chewable carbamazepine ER, XR clonazepam tablet divalproex sodium ethosuximide solution gabapentin lamotrigine IR	levetiracetam IR. solution oxcarbazepine phenobarbital phenytoin primidone topiramate tablets, sprinkle valproic acid zonisamide	Celontin **Diastat Gabitril** Peganone▲ Tegretol Suspension	carbamazepine suspension clonazepam ODT diazepam rectal ethosuximide caps felbamate lamotrigine ER, ODT levetiracetam ER tiagabine tablets topiramate ER	Aptiom Banzel ▲ Briviact Epitol Equetro Fycompa Gralise	Lyrica ● Onfi Oxtellar XR Potiga Sabril Spritam Stavzor Trokendi XR Vimpat	2 preferred medications are required before a non-preferred will be approved **Quantity limits in place**: 240 adjunctive anticonvulsants per 30 days. Greater quantities require prior authorization. **Brand name narrow therapeutic drugs automatically pay for seizure clients with seizure diagnosis in medical history** **Please note:** brand name drugs with a generic available are considered nonpreferred unless listed in bold. ▲– indicates that the manufacturer does not participate in all DMMA programs. ●–**Clinical criteria will still apply**: Prior Authorization forms available on the web at: www.dmap.state.de.us/downloads/pharmacy/paforms/Pregabalin.Lyrica.pdf

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ANTIDEPRESSANTS, OTHER

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
bupropion mirtazapine tab tranylcypromine trazodone venlafaxine venlafaxine ER caps Marplan	desvenlafaxine ER desvenlafaxine fumarate ER mirtazapine ODT nefazodone phenelzine venlafaxine ER tablets Aplenzin Emsam Fetzima Forfivo XL Oleptro Trintellix Viibryd	2 preferred medications are required before a non-preferred will be approved DMAP requires prior authorization for the following products for the pediatric patient under six (6) years of age. Prior authorization forms available on the web at: www.dmap.state.de.us/information/paforms.html

ANTIDEPRESSANTS, SSRIs

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
citalopram escitalopram tablet fluoxetine capsules fluvoxamine tablets paroxetine tablets sertraline	escitalopram solution fluoxetine tablet fluoxetine 60mg fluoxetine weekly fluvoxamine ER paroxetine CR paroxetine suspension Brisdelle Pexeva	2 preferred medications are required before a non-preferred will be approved DMAP requires prior authorization for the following products for the pediatric patient under six (6) years of age. Prior authorization forms available on the web at: www.dmap.state.de.us/information/paforms.html Liquid medications require prior authorization for clients over 10 years old.

ANTIEMETICS

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
ondansetron ODT ondansetron tablets	aprepitant dronabinol● granisetron ondansetron solution Akynzeo Anzemet Cesamet Diclegis ● Sancuso Varubi Zuplenz	● **–Clinical criteria will still apply**: indicates that a clinical prior authorization is required despite the medication's status as preferred or non-preferred available at: www.dmap.state.de.us/information/paforms.html

ANTIFUNGALS, ORAL

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
fluconazole griseofulvin suspension nystatin terbinafine	clotrimazole flucytosine griseofulvin tablets griseofulvin ultramicrosize itraconazole ketoconazole voriconazole Cresemba Lamisil Noxafil ▲ Onmel Oravig[NR] Sporanox	2 preferred medications are required before a non-preferred will be approved ▲**–** indicates that the manufacturer does not participate in all DMMA programs.

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ANTIFUNGALS, TOPICAL

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
ciclopirox solution clotrimazole ketoconazole cream, shampoo nystatin nystatin/triamcinolone	ciclopirox cream, gel, shampoo, suspension clotrimazole/ betamethasone econazole ketoconazole foam miconazole naftifine oxiconazole terbinafine Alevazol[NR] Ciclodan Ertaczo Exelderm Fungoid Jublia Kerydin Lamisil Loprox Luzu Mentax Naftin Vusion	2 preferred medications are required before a non-preferred will be approved ▲– indicates that the manufacturer does not participate in all DMMA programs.

ANTIHEMOPHILIC FACTOR VIII

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
Advate Afstyla Alphanate Humate-P Monoclate-P Recombinate	Adynovate Eloctate Helixate FS Hemofil M Koate-DVI Kogenate FS Kovaltry Novoeight Nuwiq Xyntha	2 preferred medications are required before a non-preferred will be approved

ANTIHEMOPHILIC FACTOR iX

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
Alphanine SD Benefix Mononine Rixubis	Alprolix Idelvion	2 preferred medications are required before a non-preferred will be approved

ANTIHISTAMINES, MINIMALLY SEDATING

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
cetirizine solution OTC / Rx cetirizine tablets OTC loratadine tablets OTC, solution	cetirizine chewable cetirizine-D OTC desloratadine desloratadine ODT fexofenadine OTC fexofenadine / fexofenadine-D levocetirizine syrup, tablets loratadine ODT loratadine-D OTC Clarinex-D▲ Semprex-D	2 preferred medications are required before a non-preferred will be approved ▲– indicates that the manufacturer does not participate in all DMMA programs.

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ANTIHYPERTENSIVES, SYMPATHOLYTIC

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
clonidine guanfacine methyldopa / HCTZ **Catapres-TTS**	clonidine transdermal reserpine	2 preferred medications are required before a non-preferred will be approved **Please note:** Brand name drugs with a generic available are considered nonpreferred unless listed in bold.

ANTIHYPERURICEMICS, ORAL

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
allopurinol **Mitigare●** probenecid probenecid with colchicine	colchicine● Uloric Zurampic[NR]	●Clinical criteria apply to colchicine with approval for treatment, not prophylaxis

ANTIMIGRAINE AGENTS, TRIPTANS

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
rizatriptan, rizatriptan ODT sumatriptan nasal spray, tablets	almotriptan frovatriptan naratriptan sumatriptan injection zolmitriptan Cambia Onzetra[NR] Relpax Sumavel Dosepro Treximet Zembrace	2 preferred medications are required before a non-preferred will be approved **–Quantity limits in place:** Nine (9) tablets per 45 days **Please note:** Brand name drugs with a generic available are considered nonpreferred unless listed in bold.

ANTIPARASITICS, TOPICAL

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
permethrin piperonyl butoxide/pyrethrins **Natroba**	lindane malathion spinosad Eurax ▲ Sklice	**Please note:** brand name drugs with a generic available are considered nonpreferred unless listed in bold. **▲–** indicates that the manufacturer does not participate in all DMMA programs.

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ANTIPARKINSON'S AGENTS, ORAL/TRANSDERMAL

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
Preferred status implementation: 1/1/17	Prior authorization is required	
benztropine carbidopa/levodopa IR, ER pramipexole IR ropinirole IR selegiline tablets trihexyphenidyl	bromocriptine carbidopa carbidopa/levodopa ODT carbidopa/levodopa/ entacapone entacapone pramipexole ER ropinirole XL selegiline capsules tolcapone Azilect Duopa Neupro Rytary Zelapar	2 preferred medications are required before a non-preferred will be approved

ANTIPSORIATIC AGENTS, ORAL

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
Preferred status implementation: 1/1/17	Prior authorization is required	
Soriatane	acitretin methoxsalen	**Please note:** Brand name drugs with a generic available are considered nonpreferred unless listed in bold

ANTIPSORIATIC AGENTS, TOPICAL

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
Preferred status implementation: 1/1/17	Prior authorization is required	
calcipotriene	calcipotriene/betamethasone calcitriol Enstilar Taclonex Tazorac	

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ANTIPSYCHOTICS

PREFERRED AGENTS

Preferred status implementation: 1/1/17

amitriptyline / perphenazine
aripiprazole tablets (step-edit)
chlorpromazine
clozapine
fluphenazine
fluphenazine decanoate
Geodon IM●
haloperidol decanoate
haloperidol concentrate, solution, tablets
loxapine
olanzapine injection, tablets
perphenazine
quetiapine
risperidone solution, tablets
thioridazine
thiothixene
trifluoperazine
ziprasidone
Abilify Maintena ●
Invega Sustenna●
Invega Trinza ●
Moban
Orap
Risperdal Consta●
Seroquel XR (step-edit)

NON-PREFERRED AGENTS

Prior authorization is required

aripiprazole ODT
clozapine ODT
haloperidol lactate injection
molindone
olanzapine ODT
olanzapine / fluoxetine
paliperidone ER
pimozide
risperidone ODT
Abilify injection
Adasuve
Aristada ●
Fanapt
Latuda*
Rexulti
Saphris
Versacloz
Zyprexa Relprevv●

CRITERION***

DMAP requires prior authorization for the following products for the pediatric patient under six:
www.dmap.state.de.us/information/paforms.html

All long acting injectable antipsychotics require prior authorization, forms are available at the following link:
www.dmap.state.de.us/downloads/pharmacy/paforms/Risperidone.Injection.pdf

Please note: Brand name drugs with a generic available are considered nonpreferred unless listed in bold

* (grandfathered) clients currently receiving medication at implementation date may continue without prior authorization.

Aripiprazole, Seroquel XR new starts will pay electronically if a client has tried and failed a different generic atypical antipsychotic first.

●- indicates oral therapy is required before injectable will be approved

ANTIVIRALS, ANTIRETROVIRALS

PREFERRED AGENTS

abacavir
didanosine
lamivudine
lamivudine-zidovudine
nevirapine
nevirapine ER
stavudine
zidovudine
Complera
Crixivan
Descovy
Edurant
Emtriva
Epzicom
Evotaz
Fuzeon
Genvoya
Intelence
Invirase
Isentress
Kaletra
Lexiva
Norvir
Odefsey
Prezcobix
Prezista
Rescriptor
Retrovir
Reyataz
Selzentry
Stribild
Sustiva
Tivicay
Trizivir
Truvada
Tybost
Videx
Videx EC
Viracept
Viread
Vitekta
Zerit solution
Ziagen solution

NON-PREFERRED AGENTS

Prior authorization is required

abacavir/lamivudine
lopinavir/ritonavir
Triumeq

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ANTIVIRALS, ORAL

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
acyclovir amantadine capsules famciclovir valacyclovir Relenza Tamiflu ▲	amantadine tablets oseltamivir rimantadine Sitavig	2 preferred medications are required before a non-preferred will be approved Liquid medications require prior authorization for clients over 10 years old **–Quantity limits in place for Tamiflu and Relenza** **▲–** indicates that manufacturer does not participate in all DMMA programs.

ANTIVIRALS, TOPICAL

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
Abreva Zovirax cream	acyclovir ointment Denavir Xerese	

ANXIOLYTICS

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
alprazolam tablets buspirone chlordiazepoxide clorazepate diazepam solution diazepam tablets lorazepam	alprazolam ER alprazolam Intensol alprazolam ODT diazepam intensol lorazepam Intensol meprobamate oxazepam	2 preferred medications are required before a non-preferred will be approved Quantity Limits of 120 units of benzodiazepines per 30 days. **Clinical criteria apply**: indicates that a clinical prior authorization is required despite the medication's status as preferred or non-preferred available at: www.dmap.state.de.us/information/paforms.html

BETA BLOCKERS

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
atenolol atenolol/chlorthalidone bisoprolol bisoprolol/HCTZ carvedilol labetalol metoprolol metoprolol XL propranolol propranolol/HCTZ propranolol ER sotalol	acebutolol betaxolol metoprolol/HCTZ nadolol nadolol/bendroflumethiazide pindolol timolol Bystolic Coreg CR Dutoprol Hemangeol Innopran XL Levatol Sotylize	2 preferred medications are required before a non-preferred will be approved

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BILE SALTS

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
ursodiol	Chenodal Cholbam	

BLADDER RELAXANT PREPARATIONS

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
oxybutynin oxybutynin ER Vesicare	darifenacin tolterodine tolterodine ER trospium trospium ER Gelnique Myrbetriq Oxytrol Toviaz	2 preferred medications are required before a non-preferred will be approved

BONE RESORPTION SUPPRESSION AND RELATED AGENTS

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
alendronate tablets calcitonin-salmon nasal spray	alendronate solution etidronate Ibandronate risedronate raloxifene Binosto Fosamax Plus D Miacalcin	

BPH TREATMENTS

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
alfuzosin doxazosin finasteride tamsulosin terazosin	dutasteride dutasteride/tamsulosin Cardura XL Rapaflo	2 preferred medications are required before a non-preferred will be approved

BRONCHODILATORS, BETA AGONIST

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
albuterol nebulizer, solution, syrup terbutaline ProAir HFA Proventil HFA Serevent	albuterol ER albuterol tablets levalbuterol metaproteranol Arcapta Brovana Maxair Perforomist ProAir Respiclick Striverdi Respimat Ventolin HFA	2 preferred medications are required before a non-preferred will be approved

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CALCIUM CHANNEL BLOCKERS

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
amlodipine diltiazem IR diltiazem ER capsules felodipine nicardipine nifedipine IR nifedipine ER verapamil IR verapamil ER	diltiazem ER tablets isradipine nimodipine (ICD-10 code for SAH may create system-generated approval) nisoldipine verapamil SR verapamil ER PM Cardene SR ▲ Dynacirc CR Nymalize	2 preferred medications are required before a non-preferred will be approved **–Requires dose optimization when applicable** ▲– indicates that the manufacturer does not participate in all DMMA programs

CEPHALOSPORINS AND RELATED ANTIBIOTICS

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
amoxicillin/clavulanate suspension, tablets cefaclor capsules cefadroxil tablets cefdinir cefprozil cefuroxime cephalexin capsules, suspension Suprax 500mg/5mlsuspension	amoxicillin/clavulanate XR cefaclor tablets cefadroxil suspension, tablets cefditoren cefixime cefpodoxime ceftibuten cephalexin tablets Ceftin Daxbia[NR] Suprax tablets, chewable tablets	2 preferred medications are required before a non-preferred will be approved NR – new product has not yet been reviewed by the P&T Committee

COPD AGENTS

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
albuterol/ipratropium nebulizer solution ipratropium nebulizer solution Combivent Respimat Spiriva Handihaler	Anoro Ellipta Atrovent HFA Bevespi[NR] Combivent Daliresp Incruse Ellipta Spiriva Respimat Stiolto Respimat Tudorza ●	● **–Clinical criteria will apply** NR – new product has not yet been reviewed by the P&T Committee

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COUGH and COLD

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
Preferred status implementation: 1/1/17 guaifenesin liquid OTC guaifenesin DM liquid OTC guaifenesin ER tablets guaifenesin/codeine syrup hydrocodone/chlorpheniramine susp hydrocodone/homatropine syrup promethazine DM syrup promethazine/codeine syrup phenylephrine tablets pseudoephedrine liquid, tablets Bromfed DM syrup	All other cough/cold products non-preferred	2 preferred medications are required before a non-preferred will be approved **–Quantity limits in place:** 240ml of narcotic cough suppressants per 30 days and 480ml per 90 days without a comorbid diagnosis. 120ml per 84 days and 900ml/year for Tussionex

COLONY STIMULATING FACTORS

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
Preferred status implementation: 1/1/17 Neupogen	Prior authorization is required Granix Leukine Neulasta Zarxio	

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CONTRACEPTIVES, ORAL

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
desogestrel-ethinyl estradiol desogestrel-ethinyl estradiol-ethinyl estradiol 21-5 levonorgestrel-ethinyl estradiol norethindrone norethindrone 1-ethinyl estradiol/iron (21) norethindrone 1.5-ethinyl estradiol/iron norethindrone 1-ethinyl estradiol norethindrone-ethinyl estradiol 7X3 norgestimate-ethinyl estradiol **Brevicon** **Loseasonique** **Microgestin FE** **Necon 7X3** **Seasonique** **Trinessa** **Yaz**	ethinyl estradiol/drosperinone levonorgestrel-ethinyl estradiol extended cycle norethindrone 0.4-ethinyl estradiol norethindrone acetate-ethinyl estradiol norethindrone 0.4-ethinyl estradiol/iron norethindrone 0.8-ethinyl estradiol/iron norethindrone 1-ethinyl estradiol/iron (24) norgestrel-ethinyl estradiol Beyaz Lo Loestrin Fe Minastrin Mircette* Natazia Necon 10-11 Norinyl Quartette Safyral	All emergency oral contraceptives are covered without any prior authorization. 2 preferred medications are required before a non-preferred will be approved * Class is grandfathered, meaning clients currently receiving medication at implementation date may continue without prior authorization.

CYTOKINE AND CAM ANTAGONISTS

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
Enbrel (diagnosis code required) Humira (diagnosis code required)	Actemra Amevive▲ Arcalyst Cimzia Cosentyx Entyvio Ilaris Kineret Orencia Otezla Remicade Simponi Simponi Aria Stelara Taltz[NR] Xeljanz Xeljanz XR	Approved diagnosis code required on prescription and electronic submissions. ▲– indicates that the manufacturer does not participate in all DMMA programs.

DIABETIC TESTING BLOOD GLUCOSE METERS, TEST STRIPS, LANCETS

PREFERRED AGENTS Preferred Status implementation 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
FreeStyle Freedom Lite meters/strips FreeStyle Lite meters/strips Freestyle InsuLinx meters/strips FreeStyle strips FreeStyle lancets Precision Xtra meters/strips Precision Xtra Ketone Strips	All other diabetic meters and test strips are non-preferred	

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DIURETICS

PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION***
Preferred status implementation: 1/1/17		Prior authorization is required		
amiloride-HCTZ	hydrochlorothiazide	acetazolamide	torsemide	2 preferred medications are required before a non-preferred will be approved
bumetanide	indapamide	amiloride	Diamox Sequels	
chlorothiazide	spironolactone	chlorthalidone	Diuril	
furosemide	spirololactone-HCTZ	methazolamide	Edecrin	
	triamterene-HCTZ	methyclothiazide	Microzide	
		metolozone	Neptazane	

EPINEPRINE, SELF-INJECTED

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
Preferred status implementation: 1/1/17	Prior authorization is required	
epinephrine injection		
EpiPen		

ERYTHROPOIESIS STIMULATING PROTEINS

Clinical criteria apply to class. All agents require a prior authorization.

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
Preferred status implementation: 1/1/17	Prior authorization is required	
Aranesp		Prior authorization forms available on the web at: www.dmap.state.de.us/downloads/pharmacy/paforms/Epoetin.Alpha.pdf
Epogen		
Procrit		

FLUOROQUINOLONES

PREFERRED AGENTS		NON-PREFERRED AGENTS		CRITERION***
Preferred status implementation: 1/1/17		Prior authorization is required		
ciprofloxacin tablets		ciprofloxacin ER	moxifloxacin	2 preferred medications are required before a non-preferred will be approved
levofloxacin tablets		ciprofloxacin suspension	ofloxacin	
		levofloxacin solution		

GI – CONSTIPATION – IBS - OIC

PREFERRED AGENTS	NON-PREFERRED AGENTS	
Preferred status implementation: 1/1/17	Prior authorization is required	
Amitiza	Linzess	Trial of preferred medication required before non-preferred medication will be approved
	Movantik	
	Relistor	

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GLUCOCORTICOIDS, INHALED

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
Preferred status implementation: 1/1/17	Prior authorization is required	
Advair Diskus (step-edit) ●	budesonide inhalation solution	**●–Clinical criteria apply**
Asmanex▲	fluticasone/salmeterol[NR]	age 6 and under or clients with diagnoses on file indicating developmental delays may create a system generated approval for Pulmicort respules
QVAR	Advair HFA	
Pulmicort Respules 0.25 mg & 0.5 mg (age 6 and under or clients with diagnoses on file indicating developmental delays may create a system generated approval)	Aerospan	● indicates that a prior authorization will generate if client has previously failed single agent corticosteroid or long-acting beta agonist inhaler in previous 90 days. Other information and form available on the web at: www.dmap.state.de.us/information/paforms.htmlsynjardy
Symbicort (step-edit) ●	Alvesco	▲– indicates that the manufacturer does not participate in all DMMA programs.
	Asmanex HFA	NR-not yet reviewed by P&T Committee
	Arnuity Ellpita	
	Breo Ellipta	
	Dulera	
	Flovent, Flovent HFA	
	Pulmicort Flexhaler	
	Pulmicort Respules 1 mg	

GLUCOCORTICOIDS, ORAL

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
Preferred status implementation: 1/1/17	Prior authorization is required	
budesonide EC	cortisone	2 preferred medications are required before a non-preferred will be approved
dexamethasone solution / tablet	dexamethasone elixir, intensol	
hydrocortisone	fludrocortisone	
methylprednisolone dose pack	methylprednisolone 18,16,32 mg tablet	
methylprednisolone 4mg tablets	prednisolone sodium phosphate ODT	
prednisolone sodium phosphate	**prednisone dose pack, intensol**	
prednisolone solution	Dexpak	
prednisone solution / tablets	Millipred	
Orapred ODT	Rayos	
	Uceris	
	Veripred	

GROWTH HORMONES

Clinical criteria apply to class. All agents require a prior authorization.

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
Preferred status implementation: 1/1/17	Prior authorization is required	
Norditropin ●	Genotropin ●	2 preferred medications are required before a non-preferred will be approved
Nutropin AQ ●	Humatrope▲ ●	Prior authorization available at: www.dmap.state.de.us/downloads/pharmacy/paforms/Growth.Hormone.Drug.pdf
	Omnitrope ●	▲– indicates that the manufacturer does not participate in all DMMA programs
	Saizen ●	
	Serostim ●	
	Zomacton ●	
	Zorbtive ●	

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H. PYLORI TREATMENTS

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
Pylera	lansporazole-amoxicillin-clarithromycin Omeclamox Pak	

HAE TREATMENTS

Clinical criteria apply to class. All agents require a prior authorization.

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
Berinert Danazol Firazyr Kalbitor	Cinryze Ruconest	

HEPATITIS C AGENTS

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
ribavirin tablets Epclusa Zepatier●	ribavirin capsules Daklinza● Harvoni● Pegasys▲ ● Peg-Intron▲ ● Olysio● Rebetol Ribasphere Sovaldi● Technivie● Viekira Pak● Viekira XR [NR]●	●–**Clinical criteria will still apply.** Prior authorization available at: www.dmap.state.de.us/downloads/pharmacy/paforms/Hepatitis.C.Prior.Authorization.Form.pdf ▲– indicates that the manufacturer does not participate in all DMMA programs. [NR] indicates that a product has not been reviewed by the P&T Committee, but DMMA policy states that new products will be non-preferred until reviewed by the Committee.

HISTAMINE II RECEPTOR BLOCKERS

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
famotidine tablets ranitidine syrup / tablets	cimetidine famotidine suspension nizatadine ranitidine capsules Zantac 75	

HYPOGLYCEMICS, ALPHA-GLUCOSIDASE INHIBITORS

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
acarbose	Glyset Precose	

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HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS

Clinical criteria apply to class. All agents require a prior authorization.

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
Preferred status implementation: 1/1/17	Prior authorization is required	
Bydureon(step-edit)	alogliptin ●	Step-edit : For preferred products, no PA required if client has Type II diagnosis and metformin use in last 90 days.
Byetta (step-edit)	alogliptin-metformin ●	NR – new product has not yet been reviewed by P&T Committee
Jentadueto (step-edit)	alogliptin-pioglitazone ●	**●–Clinical criteria apply for non-preferred products.** Forms available at: www.dmap.state.de.us/downloads/pharmacy/paforms/Incretin.Mimetics.pdf
Kombiglyze XR (step-edit)	Adlyxin[NR] ●	
Onglyza (step-edit)	Janumet ●	
Tanzeum (step-edit)	Janumet XR ●	
Tradjenta (step-edit)	Januvia	
	Jentadueto XR	
	Juvisync●	
	Soliqua[NR] ●	
	Symlin ●	
	Trulicity●	
	Victoza ●	
	Xultrophy[NR] ●	

HYPOGLYCEMICS, INSULINS

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
Preferred status implementation: 1/1/17	Prior authorization is required	
Humalog▲	Afrezza	▲– indicates that the manufacturer does not participate in all DMMA programs.
Humalog Mix▲	Apidra	NR – new product has not yet been reviewed by P&T Committee
Humulin▲	Basaglar[NR]	
Lantus	Humulin R 500 Kwikpen	
Levemir	Toujeo Solostar	
Novolin	Tresiba Flextouch	
Novolog	Xultrophy[NR]	
Novolog Mix		

HYPOGLYCEMICS, MEGLITINIDES

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
Preferred status implementation: 1/1/17	Prior authorization is required	
nateglinide	repaglinide/metformin	
repaglinide	Prandin	

HYPOGLYCEMICS, METFORMINS

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
Preferred status implementation: 1/1/17	Prior authorization is required	
glipizide-metformin	metformin ER (gen Fortamet)	2 preferred medications are required before a non-preferred will be approved
glyburide-metformin	Glucovance	
metformin	Glumetza	
metformin ER (gen Glucophage XR)	Riomet	

HYPOGLYCEMICS, SGLT2s

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
Preferred status implementation: 1/1/17	Prior authorization is required	
Jardiance	Farxiga	Trial of preferred medication required before non-preferred medication will be approved
Synjardy	Glyxambi	NR-not yet reviewed by P&T Committee
	Invokana	
	Invokamet	
	Synjardy X[NR]	
	Xigduo XR	

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HYPOGLYCEMICS, TZDs

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
pioglitazone	pioglitazone/glimepepiride pioglitazazone/metformin Actoplus Met XR Avandia	

IMMUNOMODULATORS, ATOPIC DERMATITIS

Clinical criteria apply to class. All agents require a prior authorization.

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
Elidel ●	tacrolimus ● Dupixent[NR] Eucrisa[NR]	●**–Clinical criteria will still apply.** Prior authorizations available at: www.dmap.state.de.us/downloads/pharmacy/paforms/Pimecrolimus.and.Tacrolimus.pdf **–Quantity limits are in place**: 400 grams per year NR – new product has not yet been reviewed by P&T Committee

IMMUNOMODULATORS, TOPICAL

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
imiquimod	Zyclara	

INTRANASAL RHINITIS AGENTS

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required		CRITERION***
azelastine (gen. Astelin) fluticasone Rx ipratropium	azelastine (gen. Astepro) budesonide flunisolide fluticasone OTC mometasone olopatadine triamcinolone	Beconase AQ Dymista Omnaris Qnasl Veramyst Zetonna	2 preferred medications are required before a non-preferred will be approved

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LEUKOTRIENE RECEPTOR ANTAGONISTS

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
montelukast tablet, chew tabs●	montelukast granules ● zafirlukast ● Accolate ● Singulair Gran Pack ● Zyflo CR ●	2 preferred medications are required before a non-preferred will be approved ●–**Clinical criteria apply.** ICD-10 code for asthma indication may create a system-generated approval for montelukast or Accolate Prior authorizations available at: www.dmap.state.de.us/downloads/pharmacy/paforms/leukotriene.pdf

LINCOSAMIDES/OXAZOLIDINONES/STREPTOGRAMINS

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
clindamycin capsules clindamycin solution (preferred for client younger than 10)	Linezolid Sivextro	

LIPOTROPICS, OTHER

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required			CRITERION***
colestipol cholestyramine//aspartame fenofibrate (except 50 and 150 mg) gemfibrozil niacin ER	cholestyramine/sucrose ezetimibe fenofibrate 50,150 mg fenofibric acid omega-3 acid ethyl esters	Antara▲ Juxtapid Kynamro Niacor	Praluent Repatha Vascepa Welchol▲	2 preferred medications are required before a non-preferred will be approved ▲– indicates that the manufacturer does not participate in all DMMA programs.

LIPOTROPICS, STATINS

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required		CRITERION***
atorvastatin lovastatin pravastatin simvastatin	amlodipine/atorvastatin fluvastatin fluvastatin ER rosuvastatin	Altoprev Liptruzet Livalo Vytorin	2 preferred medications are required before a non-preferred will be approved **–Once daily dosing required**

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MACROLIDES

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
azithromycin	clarithromycin erythromycin E.E.S. 200 suspension E.E.S. 400 tablets Eryped Ery-Tab Erythrocin PCE Zmax	

MOOD STABILIZERS

PREFERRED AGENTS Preferred status implementation: 4/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
carbamazepine tablets, chewable carbamazepine ER, XR divalproex sodium lamotrigine IR lithium[NR] valproic acid Tegretol Suspension	carbamazepine suspension lamotrigine ER, ODT	2 preferred medications are required before a non-preferred medication will be approved NR-not yet reviewed by P&T Committee

MULTIPLE SCLEROSIS

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
Aubagio Avonex ▲ Betaseron Copaxone 20mg Gilenya Rebif	glatiramer Ampyra● Copaxone 40mg Extavia Glatopa Lemtrada Ocrevus[NR] Plegridy Tecfidera	▲– indicates that the manufacturer does not participate in all DMMA programs. ● – Ampyra has a clinical prior authorization that is required despite the medication's status as preferred or non-preferred. Forms available on the web at: www.dmap.state.de.us/downloads/pharmacy/paforms/Ampyra.pdf NR-not yet reviewed by P&T Committee

NEUROPATHIC PAIN

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
duloxetine (gen. Cymbalta) gabapentin lidocaine 5% patch●	duloxetine (gen. Irenka) Gralise Horizant Lyrica Qutenza Savella	● lidocaine 5% patch (greater than 2 patches a day requires prior auth) www.dmap.state.de.us/downloads/pharmacy/paforms/Lidocaine.Topical.Patch.pdf

NITROFURAN DERIVATIVES

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
nitrofurantoin		

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NSAIDs, ORAL/TOPICAL

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
ibuprofen indomethacin IR ketorolac meloxicam tablets naproxen tablets sulindac	celecoxib● diclofenac IR, DR, ER, topical diclofenac/misoprostol diflunisal etodolac IR, SR fenoprofen ▲ flurbiprofen indomethacin ER ketoprofen IR, ER meclofenamate mefenamic acid meloxicam suspension nabumetone naproxen sodium IR, ER naproxen DR, suspension oxaprozin piroxicam tolmetin Duexis[NR] Flector Indocin Pennsaid Sprix Tivorbex Vimovo Vivlodex[NR] Zipsor Zorvolex	2 preferred medications are required before a non-preferred will be approved ● – indicates that a clinical prior authorization is required. Forms available on the web at: www.dmap.state.de.us/downloads/pharmacy/paforms/Cox-2.Celecoxib.valdecoxib.pdf ▲– indicates that the manufacturer does not participate in all DMMA programs. NR-not yet reviewed by P&T Committee

OPHTHALMICS, ALLERGIC CONJUNCTIVITIS

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
azelastine cromolyn olopatadine	epinastine Alocril Alomide Alrex Bepreve Emadine Lastacaft Pataday Pazeo	2 preferred medications are required before a non-preferred will be approved

OPHTHALMICS, ANTI-INFLAMMATORIES

PREFERRED AGENTS Preferred status implementation: 1/1/17			NON-PREFERRED AGENTS Prior authorization is required			CRITERION***
dexamethasone diclofenac fluorometholone flurbiprofen ketorolac prednisolone acetate	prednisolone sodium phosphate Durezol Flarex FML Forte	FML S.O.P. Ilevro Lotemax Maxidex Pred Mild	bromfenac ketorolac LS Acuvail Alrex Bromday	Bromsite FML Iluvien Nevanac	Ozurdex Prolensa Retisert Triesence	2 preferred medications are required before a non-preferred will be approved

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OPHTHALMICS, ANTIBIOTICS

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
bacitracin/polymyxin ciprofloxacin erythromycin gentamicin ofloxacin polymyxin/trimethopm sulfacetamide tobramycin Moxeza Tobrex ointment Vigamox	bacitracin gatifloxacin levofloxacin neomycin/bacitracin/polymyxin neomycin/polymyxin/gramicidin Azasite Besivance Ciloxan Natacyn Zymar	2 preferred medications are required before a non-preferred will be approved

OPHTHALMICS, ANTIBIOTIC-STEROID COMBINATIONS

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
neomycin/polymyxin/ dexamethasone sulfacetamide/ prednisolone Blephamide Pred-G **Tobradex suspension**	neomycin/polymyxin/HC neomycin/bacitracin/ polymyxin/HC tobramycin/dexamethasone suspension Blephamide Tobradex ointment Tobradex ST Zylet	2 preferred medications are required before a non-preferred will be approved **Please note:** Brand name drugs with a generic available are considered nonpreferred unless listed in bold.

OPHTHALMICS, GLAUCOMA AGENTS

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
brimonidine 0.1% carteolol dorzolamide dorzolamide / timolol latanoprost levobunolol pilocarpine timolol **Alphagan P 0.15%** Azopt Betimol Betoptic S Combigan Istalol Simbrinza Travatan Z	apraclonidine betaxolol bitamoprost brimonidine 0.15% metipranolol phospholine iodide Alphagan P 0.1% Cosopt PF Iopidine Lumigan Rescula Zioptan	2 preferred medications are required before a non-preferred will be approved Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. **Please note**: Brand name drugs with a generic available are considered nonpreferred unless listed in bold. For prior authorization forms, please visit: www.dmap.state.de.us/information/paforms.html

OPIATE DEPENDENCE TREATMENTS

Clinical criteria apply to class. All agents require a prior authorization.

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
buprenorphine naltrexone Suboxone Vivitrol	buprenorphine/naloxone tablets Bunavail Zubsolv	For prior authorization forms, please visit: www.dmap.state.de.us/downloads/pharmacy/paforms/Buprenorphine.pdf

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OPIATE OVERDOSE TREATMENTS

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	
naloxone Narcan nasal spray	Evzio	

OTIC ANTI-INFECTIVES, ANESTHETICS

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
acetic acid/aluminum acetic acid	acetic acid/hydrocortisone	2 preferred medications are required before a non-preferred will be approved

OTIC ANTIBIOTICS

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required		CRITERION***
ciprofloxacin neomycyin / polymyxin / hydrocortisone Ciprodex	ofloxacin Cipro HC Coly-Mycin S	Otiprio[NR] Otovel[NR]	

PAH AGENTS, ORAL & INHALED

Clinical criteria apply to class. All agents require a prior authorization.

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required		CRITERION***
sildenafil● Letairis ●▲ Tracleer ● Ventavis ●	Adcirca ● Adempas Opsumit	Orenitram ER Revatio Suspension Tyvaso ●	**●–Clinical criteria will still apply.** For prior authorization forms, please visit: www.dmap.state.de.us/downloads/pharmacy/paforms/Sildenafil.pdf **▲–** indicates that the manufacturer does not participate in all DMMA programs.

PANCREATIC ENZYMES

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
Creon Zenpep	Pancreaze Pertzye Viokace	

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PENICILLINS

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
amoxicillin ampicillin dicloxacillin penicillin G procaine penicillin Bicillin CR Bicillin LA	Moxatag	

PHOSPHATE BINDERS

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
calcium acetate Phoslyra Renagel▲ ● Renvela tablet●	Auryxia Eliphos Fosrenol ● Renvela Powder Pack Velphoro	●**–Clinical criteria will still apply:** indicates that a prior authorization is required despite the medication's status as preferred or non-preferred. Forms available: at: www.dmap.state.de.us/downloads/pharmacy/paforms/Phosphorous.Binders.pdf ▲**–** indicates that the manufacturer does not participate in all DMMA programs.

PLATELET AGGREGATION INHIBITORS

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
clopidogrel dipyridamole **Aggrenox** Brilinta	aspirin/dipyridamole ticlopidine Durlaza Effient Yosprala[NR] Zontivity	2 preferred medications are required before a non-preferred will be approved

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PRENATAL VITAMINS

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
Citranatal Assure Citranatal 90 DHA Citranatal Harmony Niva-Plus O-Cal PNV Folic Acid+Iron Prenatal Plus Prenatal Vitamin plus Low Iron Preplus Se-Natal 19 chewable Trinatal Rx1	All other prenatal products non-preferred	2 preferred medications are required before a non-preferred will be approved

PROGESTATIONAL AGENTS

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
medroxyprogesterone acetate norethindrone acetate progesterone capsule Depo-SubQ Provera Makena●	progesterone IM Crinone Prometrium	**●–Clinical criteria will still apply:** indicates that a clinical prior authorization is required despite the medication's status as preferred or non-preferred. Prior Authorization forms available on the web at: www.dmap.state.de.us/downloads/pharmacy/paforms/hydrogest.cap.Makena.pdf

PROTON PUMP INHIBITORS

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required		CRITERION***
omeprazole Rx pantoprazole Nexium suspension (preferred for age 10 and under) Protonix suspension (preferred for age 10 and under)	esomeprazole magnesium esomeprazole strontium lansoprazole ● omeprazole OTC tablets omeprazole / sodium bicarbonate● omeprazole suspension omeprazole magnesium OTC●	rabeprazole tablets Aciphex Sprinkle▲ ● Dexilant ● Nexium OTC● Prevacid Solutab Prilosec packets ●	For non-preferred products, max of 60 days approval for GERD **●–Clinical criteria will still apply:** indicates that a clinical prior authorization is required despite the medication's status as preferred or non-preferred. Prior Authorization forms available on the web at: www.dmap.state.de.us/information/paforms.html **▲–** indicates that the manufacturer does not participate in all DMMA programs.

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SEDATIVE HYPNOTICS

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
Preferred status implementation: 1/1/17	Prior authorization is required	
temazepam 15mg, 30mg zolpidem tablets	chloral hydrate eszopiclone estazolam flurazepam temazepam 7.5 ,22.5mg triazolam zaleplon zolpidem ER zolpidem sublingual Belsomra Edluar Hetlioz Rozerem Silenor Zolpimist	**–Dose optimization when applicable:** total quantity limit of one daily covered.

SKELETAL MUSCLE RELAXANTS

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
Preferred status implementation: 1/1/17	Prior authorization is required	
baclofen chlorzoxazone cyclobenzaprine methocarbamol tizanidine tablets	carisoprodol ● carisoprodol compound carisoprodol compound w/codeine ● cyclobenzaprine 7.5 mg cyclobenzaprine ER dantrolene metaxalone orphenadrine tizanidine capsules Amrix Lorzone	2 preferred medications are required before a non-preferred will be approved Total quantity limit of 120 units of muscle relaxants per 30 rolling days. **●–Clinical criteria will still apply:** indicates that a clinical prior authorization is required. Prior Authorization forms available on the web at: www.dmap.state.de.us/downloads/pharmacy/paforms/Carisoprodol.pdf

STEROIDS, TOPICAL

PREFERRED AGENTS	NON-PREFERRED AGENTS	CRITERION***
Preferred status implementation: 1/1/17	Prior authorization is required	
betamethasone dipropionate betamethasone dipropionate/propylene glycol cream fluocinolone oil fluocinonide hydrocortisone hydrocortisone acetate mometasone temovate cream/ointment triamcinolone cream, lotion, ointment Capex shampoo ▲ Hydro Skin Scalpicin	alclometasone amcinonide betamethasone valerate clobetasol clocortolonedesonide desoximetasone diflorasone fluocinolone cream, ointment, shampoo, solution flurandrenolide fluticasone halobetasol hydrocortisone butyrate hydrocortisone valerate prednicarbate triamcinolone aerosol Clodan Cordran Halog Pandel Sernivo Synalar Texacort Topicort Ultravate	2 preferred medications are required before a non-preferred will be approved **▲–** indicates that the manufacturer does not participate in all DMMA programs.

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STIMULANTS AND RELATED AGENTS

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
amphetamine salt combo ▪ dexmethylphenidate IR▪ dextroamphetamine IR tablets▪ guanfacine ER ▪ methylphenidate IR▪ methylphenidate ER 24 tablets only labelers (AHP 68084 Actavis 00591 only)▪ methylphenidate CD methylphenidate ER tablets (generic Ritalin SR) modafinil **Adderall XR** (step-edit)▪ **Focalin XR** ▪ **Methylin solution** ▪ **Procentra** ▪ Quillivant XR▪ Strattera Vyvanse ▪	armodafinil ● clonidine ER dexmethylphenidate ER dextroamphetamine ER▪ dextroamphetamine-amphetamine ER dextroamphetamine solution methamphetamine▪ methylphenidate chewable tablets methylphenidate ER 24 tablets labelers not preferred (Kremers Urban 62175, Mallinckrodt 00406, Mylan 00378) methylphenidate LA methylphenidate solution▪ Adzenys XR Aptensio XR Daytrana ● Evekeo Quillichew ER[NR] Zenzedi	2 preferred medications are required before a non-preferred will be approved Dose optimization required. **●-Indicates that clinical criteria applies for *all* ages for drugs** **▪–Clinical criteria applies for clients over age 21.** www.dmap.state.de.us/downloads/pharmacy/paforms/ADHD.Therapy.pdf Adderall XR new starts will pay electronically if the client has tried and failed Vyvanse first. NR – Product not yet reviewed by P&T Committee **Please note**: Brand name drugs with a generic available are considered nonpreferred unless listed in bold. For Prior Authorization forms, please visit: www.dmap.state.de.us/information/paforms.html

TETRACYCLINES

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
doxycycline monohydrate 50, 100 mg capsules minocycline capsules	demeclocycline doxycycline hyclate doxycycline monohydrate 75 mg capsules doxycycline monohydrate tablets minocycline ER minocycline tablets tetracycline Doryx Morgidox Oracea Solodyn	2 preferred medications are required before a non-preferred will be approved

THYROID HORMONES

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
levothyroxine sodium tablets liothyronine sodium tablets Armour thyroid Cytomel NP Thyroid	levothyroxine sodium injection liothyronine sodium injection Thyrolar Tirosint	

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ULCERATIVE COLITIS AGENTS

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
mesalamine enema sulfasalazine sulfasalazine DR Apriso ▲ Canasa	balsalazide mesalamine enema kit mesalamine DR Delzicol Dipentum Giazo Lialda Pentasa	2 preferred medications are required before a non-preferred will be approved ▲– indicates that the manufacturer does not participate in all DMMA programs.

VASODILATORS, CORONARY

PREFERRED AGENTS Preferred status implementation: 1/1/17	NON-PREFERRED AGENTS Prior authorization is required	CRITERION***
isosorbide dinitrate IR isosorbide mononitrate isosorbide mononitrate ER nitroglycerin transdermal Nitrostat sublingual	Isosorbide dinitrate ER nitroglycerin ER nitroglycerin translingual spray Dilatrate S Gonitro[NR] Isordil Nitro-Bid ointment Nitrolingual spray	NR – not yet reviewed by P&T Committee

***Be advised this criterion is for FEE-FOR-SERVICE CLIENTS ONLY. Prior authorizations for clients enrolled with a Managed Care Organization (MCO) should be processed through the MCO following MCO criteria.
HighMark Health Options criteria can be reviewed at https://www.highmarkhealthoptions.com/providers/priorauthorization
UnitedHealthcare Community Plan criteria can be reviewed at www.uhccommunityplan.com/health-professionals/de/pharmacy-program.html